Appendix D

LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

2015/16 QUALITY ACCOUNT/REPORT Appendix to the Annual Report

DRAFT

27th April 2016

To Auditors and Stakeholders

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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 an organisation will make those improvements and how they will be measured.

A review of our quality of services for 2015/16 is included in this account alongside our priorities and goals for quality improvement in 2016/17 and how we intend to achieve them. This report summarises how we did against the quality priorities and goals that we set in 2015/16.

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 2016/17.

The second section looks at our performance in 2015/16 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 2016/17 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 includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.

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

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

The seventh section contains comments from our external stakeholders.

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

About Our Trust

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

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

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

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

The Trust has a strong and robust clinical management culture; all clinical services are managed by Clinical Chairs, 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	Plastic Surgery ENT Cancer Services Medical Oncology

Division	Specialties	
	- Bariatric Surgery Urology	Ophthalmology Oral & Maxillofacial Surgery
	Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Anaesthetics Pain Management Orthodontics Audiology
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology Gynae-oncology	Paediatrics Fertility Neonatal Intensive Care Unit Uro-gynaecology Ambulatory Gynaecology
Diagnostics, Therapeutics & Outpatients	Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2015/16 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

In September 2015, we implemented new governance structures in the Division of Medicine and the Division of Surgery. Clinical Chairs for each division were appointed and monthly Executive Meetings established with each of the Clinical Divisions to increase clinical accountability at specialty level.

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Re-Engineering programmes that focuses on the quality improvement programmes and efficiency.

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.

During the year, we have continued to focus on quality improvement initiatives. We have maintained key work programmes such as the Mortality and Complaints Boards but have also increased leadership engagement through the introduction of a Transforming Quality Leadership 'Buddy' System.

As in previous years we consistently delivered against national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved the 18 week performance. We also maintained a low number of C Diff with 11 cases.

Our quality priorities set out for 2015/16 have been embedded into our systems and processes and we made considerable progress. We

- Achieved 90% compliance with the Acute Kidney Injury (AKI) Bundle for those patients with stage 3 AKI and 90% of all AKI patients being discharged with full information.
- Made progress with both Clinical Commissioning Groups (CCGs) towards the provision of Integrated Care moving towards Needs Based Care.
- Maintained good performance in the falls resulting in severe harm.
- Achieved a further 40% reduction in hospital acquired grade three and four pressure ulcers.
- Maintained a low rate of cardiac arrests across the Trust.
- Implemented an electronic Prescribing and Medicines Administration System to reduce the risk of prescribing and administration errors.
- Achieved an improving outpatient experience with a reduction in short notice appointments rescheduled and a reduction in patients who do not attend their appointments.

We have also continued with the plans to further strengthen the governance arrangements within the clinical divisions and for raising patient safety concerns and transforming quality. We ensured that a programme of staff engagement was initiated to be able to communicate important information to staff, but to also engage with them about quality and patient safety priorities. Over 70% of staff attended these events.

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
25th May 2016

Corporate Objectives 2016/17

In 2014 -16 the Trust's Strategic Direction was underpinned by seven corporate objectives detailed in the Operational Plan. These objectives have been reviewed and objective 5 has been changed to reflect the changes to the strategic environment in relation to the Sustainability and Transformation Plans (STP).

1. **Deliver Excellent Clinical Outcomes**
    - Year on year reduction in HSMR in all diagnostic categories

2. **Improve Patient Safety**
    - Year on year reduction in clinical error resulting in harm
    - Year on year reduction in HAI

3. **Improve Patient Experience**
    - Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance

4. **Deliver National Quality & Performance Targets**
    - Deliver sustained performance with all CQC outcome measures
    - Deliver nationally mandated waiting times & other indicators

5. **Implement our New Strategic Plan**
    - Deliver new service models in line with the emerging STP.
        - Emergency Hospital
        - Women & Children's Hospital
        - Elective Centre
        - Academic Unit
    - Implementation of preferred option for the re-development of the site in line with the emerging STP.

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

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

Part 2

2. Report on Priorities for Improvement in 2015/16

Last year we identified three quality priorities. This section 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 current year.

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

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

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

Why was this a priority?

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

What did we do?

The two key priorities for this year's AKI improvement project were to support early recognition and effective management for patients with AKI and also to provide a plan of care at discharge.

Objective 1. To support early recognition and effective management of patients presenting as emergencies admissions with AKI,

In order to support early recognition and effective management, the Trust has continued to use the AKI alerting system established last year in the electronic investigation results reporting system. The alerting system highlights when a patient has an abnormal creatinine, the indicator used to identify AKI. The reports also provide an indicator of the severity of the acute kidney injury, and provides clear guidance on the steps to take to support effective management for a patient with AKI.

The Trust has reinforced the importance of providing training and education in AKI, by making it mandatory for all junior doctors to complete the programme in induction. The

programme provides education in recognition and effective management of AKI. Training has also been provided to nurses in EAU, in acute management of patients with AKI. In addition training has been provided to the multi-disciplinary team at specific training sessions and at clinical governance meetings.

Objective 2. Provide a plan of care to monitor kidney function after discharge.

A process has been set up to provide patients who were diagnosed with stage 2 or stage 3 AKI during their in-patient stay, with a discharge summary that includes the following key items of information:

- Information regarding medication changes during the inpatient stay, especially nephrotoxic medication that might be harmful to patients with deteriorating renal function. This information helps inform the patient's GP to plan medication carefully as the patients kidney function is restored.
- Stage of AKI (a key aspect of AKI diagnosis with stage 3 being the most severe
- Recommendations regarding the type of blood tests required on discharge for monitoring renal function post discharge.
- Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).

How did we perform?
More than 90% of our junior doctors have completed the AKI eLearning training module, increasing the likelihood that patients with AKI will get the treatment necessary to maximise their recovery.

An AKI discharge template has been developed and the discharge letter is started when a patient develops stage 2 or 3 AKI. The template prompts the doctor writing the discharge letter to complete the necessary information regarding medication changes and recommended blood tests for monitoring renal function. In Quarter 4, compliance at the time of reporting has been excellent with more than 90% of AKI patient discharged with full information.

Key Clinical Outcome Priority 2

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

Why was this a priority?

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

During 2014/15, the Trust worked with stakeholders within the Luton and Central Bedfordshire health economy to progress a new integrated model of care for the local elderly population. Progress has been made in the past year in designing a new model of care that will ensure patients receive care that is coordinated and delivered in the most appropriate setting. The work has focused on identifying the population group, gaining consent from patients, finding technical solutions to the sharing of information, reorganising Primary Care into "Clusters" of GP practices and aligning elderly care consultants to the Clusters. We are now ready to introduce new pathways of care to test the model and implement it across Luton and South Bedfordshire.

What did we do?

During 2015/2016 the Integrated Care for Older People work focused on delivering two components; one was delivered externally, in collaboration with the Better Together Board. It focused on the alignment of health and social care services around the GP Clusters and the setting up of multi-disciplinary teams (MDT) to support the management of complex patients in order to avoid unnecessary admissions to hospital. The second component was delivered internally and explored the possibility of care being organised in a way that supported the Cluster population model and provided continuity of care for patients from one admission to the next.

The pilot was led by a Geriatrician working across Primary Care with the Cluster 1 GPs in Luton. The proposal was for the Geriatrician to directly manage the care of patients from Cluster 1 requiring specialist elderly medicine. It also involved the Geriatrician attending Cluster 1 practice MDT meetings, the setting up of “hot” clinics to see patients on the same day or within 24hrs of referral and seeing patients in their own home when this was appropriate.

How did we perform?

The Cluster alignment has been completed in Luton and the MDTs are in the process of being standardised. The Cluster 1 Pilot was able to demonstrate that a new model of care that will provide continuity of care for patients and allow more collaborative work with Primary Care is possible. There were a number of qualitative benefits for patients and GPs identified through the pilot. This was especially the case with patients living in Care Homes and immobile patients in their own home. GPs benefited from the easy access to a specialist opinion and the pilot was also able to identify changes that need to be put in place within the current medical model to enable the full roll out of integrated care. A programme has been launched to introduce a Needs Based Care approach which will be the vehicle used to introduce integrated care to all medical specialties.

Key Clinical Outcome Priority 3

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

Why is this a priority?

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

What did we do?

The sepsis quality priority for 2015-16 has been to focus on patients of all ages presenting with sepsis in our Emergency Department. There have been two main objectives:

- Timely recognition of severe sepsis and septic shock
- The provision of antibiotics within an hour to those patients presenting as severely septic, or in septic shock

To support these two key objectives sepsis screening tools for both adults and paediatric patients have been revised. The revised tools have been implemented alongside training and education for all staff in all the clinical areas accepting patients as emergencies.

Pathways for septic patients arriving at the hospital have been revised to ensure delays are minimised and patients are managed effectively so that those patients with either severe sepsis or septic shock get their antibiotics within the hour.

How did we perform?

Audit has shown that compliance with sepsis screening is now above 90% and 71% of patients presenting with severe sepsis or septic shock now receive antibiotics within one hour.

Priority 2: Patient Safety

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

Why was this a priority?

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

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

A whole system steering group has been established to ensure that efforts to increase service availability seven days a week work in partnership. The National Self-Assessment tool kit has been completed and five areas for focus selected for this financial year. The priorities align with the ten Keogh clinical standards and will need to be delivered across all organisations.

What did we do?

Four clinical standards out of the ten have been prioritised. The four standards are; Time to first consultant review; Availability of diagnostics; Consultant-led interventions; and Ongoing consultant review. These are considered the most likely to have the greatest impact on reducing variation in mortality risk. In August 2015 the Trust took part in a baseline audit to understand the extent to which the Trust was delivering these four priority clinical standards.

The Trust has processes in place to monitor time to first consultant review and work is on-going with junior medical staff to ensure accurate documentation.

Imaging has expanded service provision across a number of modalities, with MRI operating hours increased further during the course of 15/16 to meet demand and ensure patients are appointed within 6 weeks. Weekend services are already established in all main imaging modalities, but additional lists have been initiated.

Ultrasound has plans to expand direct access and create capacity to meet the 2 week wait demand and support cancer pathways. Breast Screening has also facilitated growth in evening clinics to meet Breast Symptomatic demand and achieve cancer performance targets.

Pathology introduced a substantive shift system to improve out of hours services and 7 day service provision, with increased investment in staff and training competencies to meet new regulatory standards, and Outpatients have also introduced a substantively staffed service on Wednesday and Thursday evenings and on Saturdays, improving access, expanding patient choice and enabling specialty service growth with the commencement of new consultant posts within the Trust.

How did we perform?

7 day working is embedded in a number of services within the Trust and working patterns and rotas are already designed with this in mind. Significant progress has been made in imaging and work is planned for delivering the on-going consultant review standard.
The Trust has participated in the national 7 Day Services progress survey in April 2016 with results expected to be made available by the end of May 2016.

Key Patient Safety Priority 2

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

Why was this a priority?

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

We will continue in our use of the monthly Safety Thermometer audits during 2016/17 which will provide on-going measurement of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE.

What did we do?

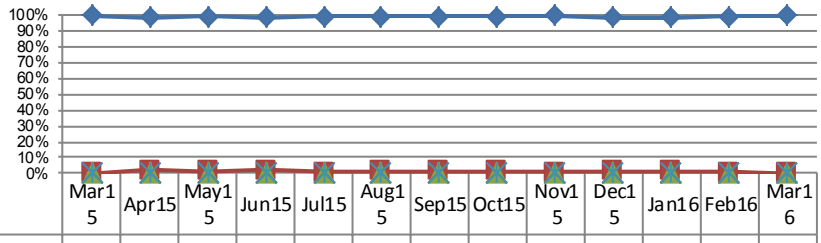
During 15/16 we continued to participate in the point of care survey measuring any new harms patients incurred during their inpatient stay. Ward staff were encouraged to review their results each month and discuss their findings. Any new harms which patients incurred was subject to a root cause analysis.

In support of the monthly prevalence we also monitored the incidence figures ensuring that appropriate interventions are made, led by the respective Clinical Nurse Specialists.

How did we perform?

During 2015/16 we consistently achieved new harm free care score of over 98%.

New Harm Free: patients with New-Harm Free Care
LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
New Harm Free	99.67	98.03	98.62	97.94	99	98.68	98.72	98.54	99.09	98.19	98.36	98.96	99.54
One New Harm	0.33	1.97	1.23	2.06	1	1.32	1.28	1.46	0.91	1.81	1.64	1.04	0.46
Two New Harms	0	0	0.15	0	0	0	0	0	0	0	0	0	0
Three New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Four New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	612	609	650	582	600	607	623	616	657	663	611	670	649

- ***Pressure Ulcers -*** The Trust continue to reduce the overall incidence of category two and three hospital acquired avoidable pressure ulcers (reduced by a further 40% on last year's rate). This was achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability Nurse has actively engaged in the countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers, this has also included the development of a system wide Wound Care Formulary.

- ***Falls -*** During 2015/16 the 1000 bed days data has remained similar: 4.24 in 2014/15 and 4.32 in 2015/16. There were 29 falls with harm in 2014/15 and 20 in 2015/16. Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. We have maintained our current prevalence level focusing our attention on our management of the frail elderly and working with the dementia nurse specialist on at risk dementia patients, looking at how we manage the patients in the clinical setting using individual risk assessment and cohort nursing/specialling "at risk" patients as appropriate.

- ***Catheter Related Urinary Tract Infections -*** The use of urinary catheters has remained relatively static during the year at 18%, peaks and troughs in usage determined by the acuity and number of in patients at the time of the prevalence study (0.4%) The Continence Nurse Specialist works with wards with high usage and ensures that a robust process is in place to evaluating the need for catheters on a daily basis. There has been no catheter related urinary tract infection during the last two months of the year.

- ***VTE -*** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. During the year the VTE compliance has been above 95%.

Key Patient Safety Priority 3

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

Why was this a priority?

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

What did we do?

The main objective in the last year has been to achieve a further 20% reduction in 'Avoidable' cardiac arrests. To support this key outcome it has been essential to make improvements all along the deteriorating patient pathway.

To assist with identifying areas for improvement and to support clinical engagement in the improvement process, reviews of all the cardiac arrests are carried out by the resuscitation team and reviewed in conjunction with the clinical teams. Action plans are devised by the clinical teams and put in place to minimise re-occurrence of issues identified. Lessons learned are shared at clinical governance meetings, to support the wider learning from incidents. Clinical areas with the highest numbers of cardiac arrests, have reviewed the arrests occurring on their wards over the year to identify what are the lessons to be learned, in order to devise strategies to reduce the incidence of arrests occurring in those areas, .

Key objectives to achieve the reduction in cardiac arrests were:

1. 20% improvement on 2014-15 baseline for timely and appropriate observations
2. 20% improvement on 2014-15 baseline for timely escalation of concerns to medical staff
3. 20% improvement on 2014-15 baseline for medical response times
4. 20% improvement on 2014-15 for failure to take appropriate action to prevent further deterioration.
5. Improvement in appropriate timely clinical decision making regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) / Treatment Escalation Plans / Personal Resuscitation planning.

Objective 1 Wardware our electronic observations system has been used to support timely and appropriate patient observations. The aim is that each patient has a monitoring plan set around their individual and changing requirements, and that this plan is adhered to.

A Standard Operating Procedure (SOP) has been implemented which sets out the roles and responsibilities for all the nursing healthcare team regarding management of the deteriorating patient. It also sets out an acceptable timeframe for overdue observations, and

compliance is measured for each patient against their monitoring plan. Feeding back compliance rates to wards where there have been concerns has promoted a more reliable observation process.

Objective 2 To support a timely escalation process an escalation protocol has been devised and implemented. Staff are encouraged to use the communication tool SBAR (Situation, Background, Action, Recommendation), when escalating concerns regarding deteriorating patients.

Objective 3 and 4 To support a timely and appropriate response and action by medical staff when managing the deteriorating patients. Case scenarios regarding cardiac arrests are shared with junior doctors to explore issues related to the management of the deteriorating patient. This provides the junior doctors an opportunity to review cardiac arrest case studies in a safe and learning environment.

Objective 5 Themes from the cardiac arrest Root Cause Analysis (RCA) have highlighted that at times there are concerns regarding the timeliness of the decision making of the medical teams. Specifically the use of Do Not Attempt Resuscitation (DNAR) and Personal Resuscitation Plans could be improved upon as they are not always completed with appropriate ceilings of care for patients. The Resuscitation committee are leading a stream of work, and clinicians from all Divisions are attending training at University College London Hospital. The training provides guidance in having difficult conversations, it includes the legal and ethical position regarding DNAR decisions. A Grand Round session is to be held. University College London are attending to facilitate the training to the attending medical staff. It is anticipated that this will help resolve many of the concerns of senior clinicians about ethical and legal issues regarding DNAR decisions, enabling them to make more timely decisions for appropriate patients.

How did we perform?

The delivery of the improvement programme to safely and effectively manage the deteriorating patient has made notable improvements right across the deteriorating patient pathway. There has been a reduction of 42% in the inpatient cardiac arrest rate. Further work needs to be undertaken over the next year to ensure that the Trust devises strategies to sustain this improvement.

Key Patient Safety Priority 4

- **Reduce avoidable harm by ensuring a patient's current medicines are correctly identified, communicated and prescribed at admission**

Why was this a priority?

Considerable evidence exists to demonstrate that mistakes can be made in correctly identifying and recording patient's current medicine history when they transfer from one care setting to another – for example from a residential care home into an acute hospital. This can lead to patients missing critical medicines which can result in extra interventions during their inpatient stay and lead to a longer hospital stay.

What did we do?

- Used the implementation of Electronic Prescribing and Medicine Administration (ePMA) system to develop a 'Pharmacist Friend' dashboard to support identification and

prioritisation of patients for medicines reconciliation based on their risk of adverse medication events

- A business case was written and presented to the Medical Division to expand provision of pharmacy- led medicines reconciliation for all emergency patients within 24 hours of admission, 7 days a week as part of the Medical Division's project to move to a Keogh compliant 7 day working medical model. This business case was incorporated into the larger Needs Based Care business case. A decision on funding is still awaited.

How did we perform?

- More than 85% of patients identified, using the risk prioritisation tool as at high risk of medication related adverse events, received a pharmacy- led medicines reconciliation at some point within their inpatient stay.

Priority 3: Patient Experience

Key Patient Experience Priority 1

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

Why was this a priority?

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

What did we do?

The outpatient administration department has worked closely with the Divisions of Medicine and Surgery to implement a pilot across several clinical specialties to introduce partial booking. This change to the appointment booking process facilitates improved transparency and management of waiting lists, allows for better service planning and more effective response to fluctuations in demand, and benefits patients with improved choice of access. On the basis of a successful pilot and subsequent business case, Outpatients will be implementing partial booking across the Trust over the course of 2016/17.

The Division successfully tendered for the procurement of an automated self check-in system across Outpatients in 2015. In view of the corporate need to progress the business case for and replacement of the Trust's current Patient Administration System (PAS) the decision was taken to pause implementation of a self check-in system and combine it with the introduction of the new PAS, so that the systems are compatible and we maximise our use of resources.

How did we perform?

Roll out of partial booking was achieved across several clinical specialities in 2015/16, including Rheumatology, ENT, Respiratory, Trauma and Orthopaedics and Urology. This accounts for about one third of Trust activity. Recruitment to achieve the resource required for a full roll out plan across the Trust is underway.

We have also seen substantial reductions in DNA rates have been achieved, with follow up DNA rates from April 2015 to the present across those specialties that have gone live with partial booking showing an overall reduction of 1.6%. The target is to achieve an overall Trust follow up DNA rate reduction of 2% in 2016/17 with full implementation of partial booking.

The incidence of hospital initiated rescheduling appointments by the Trust (as opposed to when a patient chooses to move their appointment) has also been reduced in the specialties where partial booking has been introduced, improving patient experience and contributing to additional clinic capacity and attendances.
A comparison of data from Quarter 4 2014/15 to Quarter 4 2015/16 in Rheumatology, ENT, Respiratory, Trauma and Orthopaedics and Urology shows that:

1. First appointment moves have reduced from 3.1% down to 1.4%
2. Follow up appointment moves have reduced from 13.5% to 1.6%

Key Patient Experience Priority 2

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

Why was this a priority?

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

What did we do and how did we perform?

- **Strengthened resource and communication**

Investment in the Palliative Care Team has been strengthened to include a team leader who will focus on clinical leadership supported by two band 7 Clinical Nurse Specialists. In addition to this, an End of Life Nurse has been employed following a successful Macmillan bid. This role is crucial and focuses on promoting appropriate (EOL) care on all the adult wards. This nurse sees every EOL patient in the Trust to ensure that best care is being delivered. The full team was in place by November 2015.

Both the Palliative Care Team leader and the Palliative Care consultant have presented at the Grand Round to update consultants regarding the national agenda for the improvement of palliative care. In addition, the Palliative Care team leader has presented to various medical groups promoting this agenda. The Matron for Cancer services, and Palliative Care, has also provided training and updated groups of senior nurses. Members of the Palliative Care team presented improvements to EOLC at a public meeting of our Foundation Trust members in December, which was very well received.

The End of Life Strategy group membership has been broadened to include more decision makers who can implement change throughout the Trust, and also includes CCG

representation. Collaborative working with community colleagues has been strengthened by introducing a daily conference call with the Keech Hospice to ensure access to hospice beds for appropriate patients.

- **Improved the recognition of End of Life**

The Palliative Care team and the Resuscitation team have worked with Consultants to improve the way we use our 'Personal Resuscitation Plans' (PRPs) more effectively. This enables the identification of triggers for recognising those patients who may be dying thus allowing for more timely discussions with patients and families regarding DNACPR (Do not attempt Cardio-pulmonary Resuscitation). To ensure that PRPs are used effectively, a prompt for the dying patient has been added to the DNACPR form.

- **Improved care planning**

Collaborative working with the Emergency Department (ED) has enabled the introduction of the End of Life Care pathway for the department. ED are also monitoring palliative patients who have been inappropriately referred to ED and following investigation have shared the lessons that can be learned to prevent patients from dying in the ED. These cases are reported and shared with other providers and commissioners at the End of Life Strategy Meeting. It is intended that the themes will be taken to our regional meetings to understand and improve services.

The 'Individualised Care plan for the Dying Patient' was introduced at the beginning of the year and used throughout the Trust as a replacement for the Liverpool Care Pathway. It complies with national guidelines and has been shown through audit to be helping improve the use of appropriate anticipatory prescribing to reduce palliative symptoms. This was reviewed and updated in December and its use continues to improve EOLC delivery.
A 'Must Do' card for palliative care patients has been produced to remind clinical teams of the essential steps in complying with national guidelines around the EOL care plan. These have been distributed throughout the Trust to every clinician and nurse.

A guidance to anticipatory medications was devised by our palliative care consultant and palliative team leader and is available on the intranet as well as on the wards in a palliative care folder. In addition to this, an information folder has been produced and is now available on all wards containing a wide range of literature to support staff, patients and relatives. The palliative care team are also ensuring all patients and carers are offered an information pack. The palliative team have made efforts to engage more fully with the chaplaincy team within the trust. As they have also gained additional staff a chaplain has now joined the palliative MDT as a core member. In addition to this chaplaincy representation will be joining the LIG spirituality task and finish group, and also now attends the Trust EOLC Strategy group.

Key Patient Experience Priority 3

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

Why was this a priority?

Patients with dementia and delirium can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, which leads to difficulties with activities of daily living, and complex care needs. In the later stages of the disease, there are high levels of dependency and morbidity. These care needs often challenge the

skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge.

What did we do?
We continued to asses patients aged over 75 who were admitted to hospital as part of a National Dementia screening programme.

- Any person with a positive screening was offered a management plan and further screening either as an inpatient or as a recommended plan for primary care services on discharge.
- A working group was established to share, develop and review organisational care pathways across Bedfordshire and review.
- The content of the hospital Electronic Discharge Letter (EDL) was reviewed to provide sufficient information for the GPs with information that would help develop the plan of care for any patients newly diagnosed with Dementia while in hospital.
- The Clinical Nurse Specialist (CNS) for Dementia developed an education strategy aligned with the National framework. All staff with a substantive post were offered Dementia awareness education booklet. All mandatory training now includes Dementia awareness. Collaborative work with care providers in the community includes inviting community staff to relevant training. Information of where and how to access free training is available.
- The CNS for Dementia is involved in provider forums and quality assessment of care homes in Central Bedfordshire, which monitors the staff training and level of awareness.
- A carer's survey has been carried out over the past year to collect feedback across the local pathway. Action plans and action logs are provided to CCG's as part of our local CQUIN.

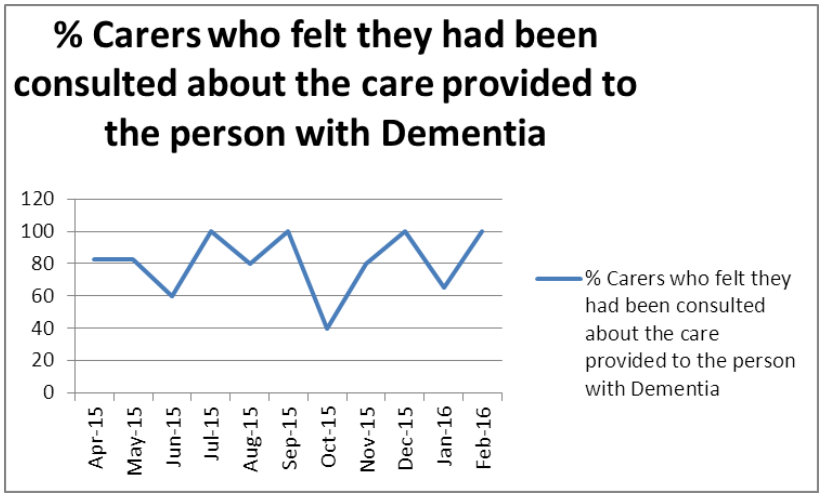
How did we perform?

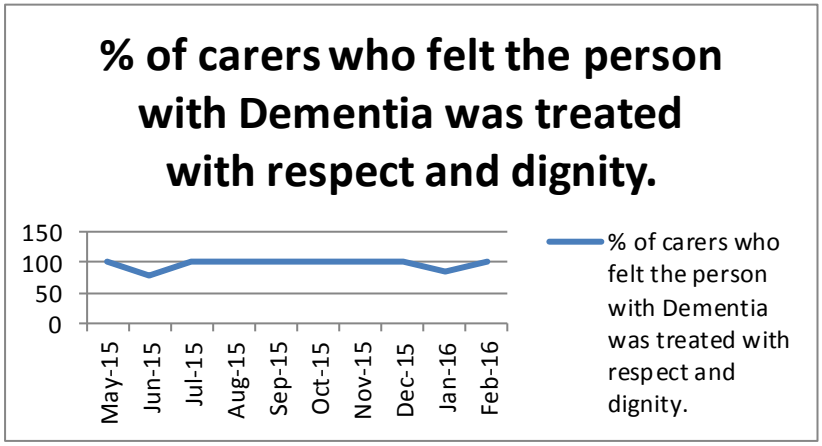
- The Trust was compliant with over 95% of screening taking place each quarter; 90% compliance with onwards referrals and recommendations for patients with cognitive dysfunction in line with local pathways.

- A robust training plan has been implemented and all 4000 staff were given a dementia awareness booklet in February 2016. Feedback is being collected and is generally positive.

- Feedback is on-going and evidence of the impact of training will be evaluated using patient and carer feedback, complaints, compliments and incidents. Staff comments and feedback on the impact training is being gathered.

- Feedback has been received from the carers survey which refers to aspects of care in hospital and the wider health economy. This information is being used to inform local commissioners of any areas of improvement recommended by the carers of people with dementia. Each organisation has evaluated its findings and discussed themes to report.





The main themes for the Trust have included being 'updated and involved in care'.
In response the CNS for Dementia has proposed that the Trust supports the national 'Johns Campaign' which focuses on the rights of carers to stay with a person with dementia while they are in hospital and to relax standard visiting hours. Our Board has agreed to this. Adopting 'John's Campaign' will have a positive impact on the wellbeing and recovery patients with dementia, with the potential to reduce harms, reduce the number of patients who need 'specialling' – where a member of staff is allocated to monitor the patient so they are not able to harm themselves or wander - improved patient satisfaction, patient experience and reduced length of stay.

Our hospital carers packs have been reviewed and information added to improve access to community support.

3. Priorities for Improvement in 2016/17

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 recognises 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

- **Improve the management of patients with acute kidney injury (AKI)**

Why is this a priority?
AKI is a sudden reduction in kidney function. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. This was a key priority for the Trust last year where we focused on implementing a Trust wide electronic system to improve detection, developed an AKI management care bundle and improved AKI diagnosis and treatment.

What will we do?
Building on this work, there are three key priorities for this year. These will focus on:

- Working collaboratively with UCL Partners, (as part of our sign up to safety work), to devise optimum 'standards for recognition and treatment' of AKI.
- Improving the use of fluid balance charts to ensure an accurate record of fluid intake and output and an early escalation score.
- Providing a plan of care for the GP to monitor kidney function after discharge.

These objectives will be delivered by:

- Supporting the continued use of the AKI clinical management bundle (evidenced based clinical interventions) which provides clear guidance on the steps to take in managing patients presenting with AKI
- In conjunction with UCLP collaborative implement 'Standards for recognition and treatment' of AKI', and devise and implement appropriate improvement strategies.
- Provide Multidisciplinary team (MDT) education and training to support early recognition and effective management of patients presenting with AKI
- Identify standards for fluid charting to improve the use of fluid charts to ensure an accurate record is made of patient's fluid intake and output
- Devise and implement an improvement programme to improve the accuracy of fluid charting.
- Providing a plan of care for the GP to monitor kidney function after discharge

How will improvement be measured and reported?

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

Success Criteria

- Continued and improved use of AKI Alerting system
- Implementation of the standards for recognition and treatment of AKI.
- Monitor compliance with AKI standards
- Provision of a plan of care to monitor patients identified with AKI whilst in hospital after discharge
- Establish a baseline for accuracy of fluid charts.

Key Clinical Outcome Priority 2

- **Improve the management of patients with severe sepsis**

Why is this a priority?
Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality.

What will we do?
The Trust will build on the work commenced in emergency care in 2015 with a particular focus on:

- Embedding the timely delivery of the sepsis bundle to all patient groups presenting as an emergency
- Implementing the use of the sepsis screening tools for patients who develop sepsis as an inpatient
- Commencing rollout of the sepsis care bundle to patients developing sepsis as an inpatient

How will improvement be measured and reported?

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

Success Criteria

- Compliance with appropriate sepsis screening (audit) for emergencies and ward – based patients.
- Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward –based patients.

Key Clinical Outcome Priority 3

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why is this a priority?
The Trust's 12 month rolling HSMR remains statistically high, but the monthly trend has seen 5 consecutive months of improvement within expected ranges. It is likely that the 12 month HSMR will remain elevated until the particularly high values seen in January, April and May 2015 fall out of the indicator. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

What will we do?

The Trust Mortality Board will oversee the delivery of:

- The refinement and embedding of our ongoing review of all mortality to identify avoidable deaths. This aligns with the national initiative by Sir Bruce Keogh, to which we will continue to report our findings.
- The Trust will complete on-going reviews for trends and correlations within our clinical information. Using external benchmarks, particularly the newly available SHMI by diagnosis type, we will review all areas of concern.
- The Trust will respond to the findings of the external quality assurance of our mortality surveillance processes commissioned at the end of 2015/16. In this manner the Trust intends to improve our benchmarked mortality to the upper quartile of performance.

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

- Improving HSMR
- On-going review by the Mortality Board

Key Clinical Outcome Priority 4

- **Reduce our antibiotic consumption**

Why is this a priority?

Antimicrobial resistance (AMR) has risen over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming into the market as reduced in recent years and between 2010 and 2013, the total antibiotic prescribing has increased by 6%. This leaves the prospect of reduced treatment option when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance.

What will we do?

For 2016/17, the Trust has an AMR CQUIN that:

- Aims to reduce total antibiotic consumption and also the reduction in the use of certain board-spectrum antibiotics.
- Focuses on antimicrobial stewardship and ensuring antibiotic review within 72 hours

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

- A baseline of antibiotic consumption (audit)
- Implementation of a process for antibiotic reviews within 72hrs.

Priority 2: Patient Safety

Key Patient Safety Priority 1

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

Why is this a priority?

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care identify where things go wrong and take prompt action. It is used by nurses to measure and track the proportion of patients in our care with pressure ulcers, urinary tract infections, VTE and who have incurred a fall and sustained harm. In addition to collection of this prevalence data, the Trust will also continue to monitor and improve the incidence of these key harms.

What will we do?

- ***Pressure Ulcers.*** The Trust will continue to reduce the numbers of category 2&3 hospital acquired avoidable pressure ulcers. Having achieved a 65% reduction in incidence from hospital acquired grade 3 pressure ulcers over the last two years, the focus for 2016 will be further reducing grade 2 pressure ulcers. This will be achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability team will also continue to participate in the countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers.
- ***Falls.*** Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. To date the Trust has been successful in reducing the overall number of falls and the challenge for 2016 is to reduce the number of falls that result in severe harm. This will involve improved risk assessment and management of the frail elderly and working closely with the Falls and Dementia nurse specialist on this more vulnerable group of patients.
- ***Catheter Related Urinary Tract Infections.*** We will aim to reduce the number of patients who develop a urinary tract infection through use of a urinary catheter. The focus during the year will be targeting areas where high use is noted.

- ***VTE.*** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. In addition to ensuring that all relevant patients will be risk assessed, prescribed and administered the appropriate preventative treatment, the sharing of lessons learnt from any hospital acquired thrombosis will be the key focus.

How will improvement be measured and reported?

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

Success Criteria

- The data set from the Safety Thermometer tool will be collected, collated and reported on providing the Trust with a snapshot (prevalence) of the four key 'harms', occurring on a particular day each month in the Trust. These data in conjunction with additional incidence data will then be used to drive improvements in practice and will be reviewed bi monthly as part of the nursing quality assurance framework. Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and reported to the Board.
- Further reduce incidence of grade 2 pressure ulcers.
- Maintain the current position in providing 98% or above in new harm free care (95% in 2013/14, 97% in 2014/15 98% in 2015/16))
- Maintain the current prevalence of patients who experience a fall and incur harm
- Aim that no more that 16% of all inpatients will have a urinary catheter
- Maintain 95% (minimum) patients to have had a VTE risk assessment and those that are identified as at risk of developing a thrombosis are provided with appropriate prophylaxis

Key Patient Safety Priority 2

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

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2015 -16 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration.

What will we do?

This has been a key Trust quality priority for two years and this year the focus will be on:

- Improving the identification of the deteriorating patient that is dying. This will be enabled by increasing and improving the setting of appropriate ceilings of care, the use of Personal Resuscitation Plans and where appropriate and timely DNAPR. To achieve this objective it has been identified that it is necessary to provide training and education to senior medical staff. The training provided will need to cover guidance in having difficult conversations, and the legal and ethical position regarding DNARCP. The Trust are working closely with UCLP to deliver this training.

How will improvement be measured and reported?

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

Success Criteria:

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
  1. Timely and appropriate observations
  2. Timely escalation of concerns to medical staff
  3. Timely medical response times,
  4. Improvement in timely and appropriate decision making by medical staff.

Key Patient Safety Priority 3

- **Further development of stroke services**

Why is this a priority?

Central to the Trust strategy to become a 'Hyper-Acute Emergency' hospital, is to deliver optimum stroke care through further investment in our 'Hyper-Acute' stroke Unit. Following an increase in therapies staffing and an additional two Stroke Physicians, 2016 will focus on the recruitment of additional speech and language staff and a senior Clinical Nurse Specialist to improve nurse leadership and ensure all performance targets are met. Data capture for SSNAP will be improved to ensure that all activity and key clinical interventions are accurately recorded. More ambitiously, the senior nursing team in conjunction with the new specialist nurse will design a revised educational programme to train nurses in key competencies. Multi-agency working will focus on further developing our repatriation policy to improve direct access to the unit.

What will we do?

An important factor in the successful implementation of evidence-based stroke care will be the emphasis on staff taking ownership of how to translate the goals of various policies into practice. For example, the physiotherapists will be encouraged to perform their own team goal-setting and to devise their strategies for meeting targets such as the 72-hour assessment. The speech and language therapy staff will be involved in adapting guidelines to their own specific practice. A commitment to multidisciplinary team working underpins all these initiatives.

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 compliance with the Sentinel Stroke Audit (SSNAP)

Priority 3: Patient Experience

Key Patient Experience Priority 1

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

Why is this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

What will we do?

- Continue to build and develop the Palliative Team raising the profile of specialist palliative care expertise and the new EOLC Nurse role.
- Continue to present to clinical meetings across the multidisciplinary teams in order to promote the EOL Individualised Care plan and embed the national guidelines of palliative care. In particular helping to identify the dying patient and foster appropriate, timely conversations around EOL.
- Continue to promote "small things make a difference"- i.e. introduction of new linen patient property bags.
- Continue to strengthen the EOL Strategy Group making it a robust steering group for the delivery of palliative care standards we can be proud of.
- Supporting our staff on the wards and promoting our ethos that palliative care is everyone's business from the cleaner to the consultant.
- Improve communication through additional and improved leaflets available to our patients.
- Gather palliative champions have been identified on each ward and equipping them to be advocates and role models of palliative care.
- Work with our chaplaincy team to improve the delivery of good spiritual and religious care to this cohort of patients, family and friends.
- Continue to audit of the EOL Individualised Care Plan and enhancing its correct use.
- Gather feedback on patient and carers experience.

How will improvement be measured and reported?

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

Success Criteria

- Improved performance in the national 'Care of the Dying' audit
- Improved performance in the further local audits of the EOL Individualised Care Plan
- A reduction in incidents and complaints through the End of Life Steering Group
- Continued improved feedback from patients and carers

Key Patient Experience Priority 2

- **Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium**

Why is this a priority?

Patients with Dementia and Delirium can have complex care needs. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge.

What will we do?

This has been a key quality priority for the Trust for some years with improvements in timely assessment, referral, treatment and support for carers. 2016 will focus on delivering the Trust dementia strategy through the following priorities:

- Working with the primary care services (our GPs) to improve the information they receive from our Consultants. This will enable the GPs to prioritise those patients who are more complex and require immediate support in the community
- Ensuring that appropriate dementia training is available to all staff and work with the commissioners to deliver a collaborative training programme across the local health and care economy
- The impact of the environment on the person with dementia will be recognised as a fundamental influence on the wellbeing and recovery of the patient. The redevelopment of the hospital site will embrace dementia friendly design where appropriate by promoting an enabling and safe environment.

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

- Reduction in the number of falls for a patient with Dementia
- Maintain and increase the number of staff with appropriate knowledge and skills training
- Reduced number of emergency re-admissions within 30 days
- Maintain good feedback on overall quality and experience from carer/ patient survey

Key Patient Experience Priority 3

- **Completing the Roll Out of Partial Booking across the Trust**

Why is this a priority?

Outpatients have successfully completed the pilot of partial booking in several specialties in Medicine and Surgery over the course of 2015/16. The initiative that has worked well for clinicians, business managers and most importantly, our patients. Partial booking has brought substantial benefits in terms of improved waiting list management and service capacity planning, reducing the multiple rescheduling of patient appointments and reducing DNA rates in these specific specialty areas.

What will we do?

This next year will focus on the roll out of the programme across the whole of the Trust, providing increased momentum to enabling the Trust to further improve efficiency in appointment scheduling and reduce the volume of missed appointments.

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

- Reduce the volume of missed appointments to 8%.

4. Statements related to the Quality of Services Provided

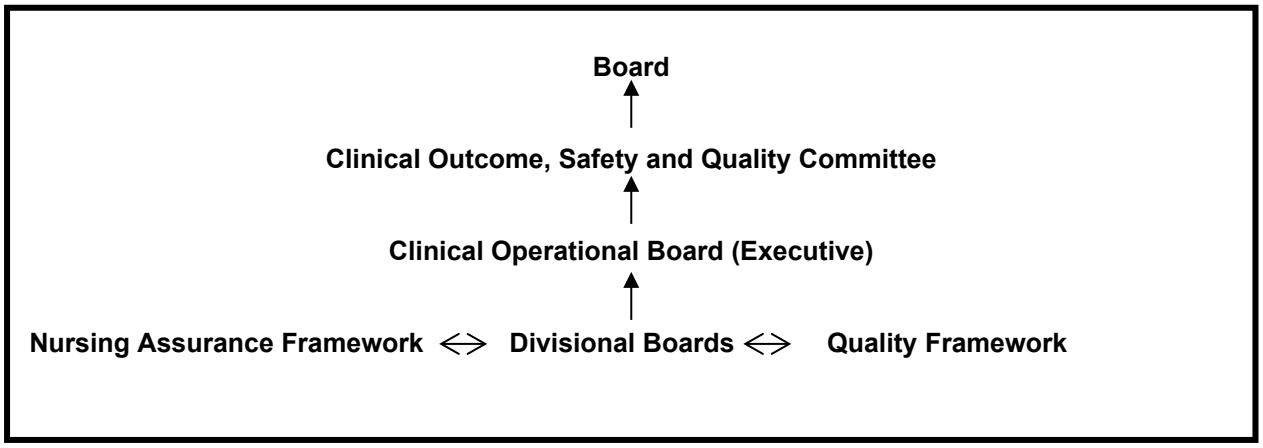
4.1 Review of Services

During 2015/16 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports every two months including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee. These reports include domains of patient safety, patient experience and clinical outcome. During 2014/15 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- An external review of the Trust's approach to mortality reviews
- The Transforming Quality Leadership programme
- An external CQC style peer review as part of our Nursing Quality Framework

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

Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2015/16.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 29 of the 56 National Clinical Audits that met the Quality Accounts inclusion criteria.

The Trust participated in 25.5 (88%) of the eligible national audits

The following 3.5 audits which we were eligible but *did not participate* are:

- National Audit of Intermediate Care - due to Divisional restructure

- National Diabetes Audit - due to software issues. Anticipated participation in 2015/16 dependant on installation of Diamond database
- National Ophthalmology Audit - due to software issues. Business Case for the Electronic Patient Records system called Medisoft submitted
- UK Parkinson's Audit - DME/Neurology participated - Therapies were not aware of their elements of the audit

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

Details are provided within the table 1 below.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All patients with diagnosis of MI	Will be completed ahead of deadline (July 2016)
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible No			
Bowel Cancer (NBOCAP)	Royal College of Surgeons	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	All (100%)
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	100%	Jan - Dec 2015 - 162 cases submitted
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All ITU Admissions	396 Cases (100%)
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR) Adult and Children	Eligible No			
Coronary Angioplasty/National Audit of Percutaneous	National Institute for Cardiovascular Outcomes	Eligible Yes Participated	Apr 2015 - Mar 2016	All PCI	270 Cases

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Coronary Interventions (PCI)	Research (NICOR)	Yes			
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health		Apr 2015 - Mar 2016	All eligible cases	Data collection in progress. 100% (153 cases will be submitted by June 2016)
Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	Total cases submitted 43 (Primary Hip Replacement: 7, Primary Knee Replacement: 14, Groin Hernia: 20, Varicose Veins: 2
Emergency Use of Oxygen	British Thoracic Society	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30+30+1	15
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians of London	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30	100%
Inflammatory Bowel Disease (IBD) programme	IBD Audit managed by Royal College of Physicians ***Transitioning to*** IBD Registry managed by the British Society of Gastroenterology	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	20	20
Major Trauma Audit	The Trauma Audit and Research Network (TARN)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	158 Cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Eligible Yes			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
		Participated No*			
National Audit of Pulmonary Hypertension	Health & Social Care Information Centre (HSCIC)	Eligible No			
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Cardiac Arrests	122 (additional x20 to be entered)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Royal College of Physicians	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Eligible No			
National Complicated Diverticulitis Audit (CAD)	The National CADS project	Eligible No			
National Diabetes Audit - Adults	Health and Social Care Information Centre (HSCIC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	100%
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	98%
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Heart Failure Diagnosis	257 Cases Ongoing data entry
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	Eligible Yes Participated No*			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Prostate Cancer Audit	Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Vascular Registry	Royal College of Surgeons of England	Eligible No			
Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Oesophago-gastric Cancer (NAOGC)	The Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All newly diagnosed UGI cancer patients receiving treatment will be submitted.	Not yet concluded.
Paediatric Asthma	British Thoracic Society	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases during November 2015	74 cases (100%)
Paediatric Intensive Care (PICANet)	University of Leeds	Eligible No			
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists' Centre for Quality Improvement (CCQI)	Eligible No			
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
Renal Replacement Therapy (Renal Registry)	UK Renal Registry	Eligible No			
Rheumatoid and Early Inflammatory Arthritis	Northgate Public Services	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All cases of early arthritis	22
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All Stroke cases	100%

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	Eligible No			
UK Parkinson's Audit	Parkinson's UK	Eligible Yes Participated Partly Yes*	1st April 2015 and 31st March 2016	DME and Neurology	100%
Vital signs in children (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases submitted - data to Jan 2016
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	Reported in section 4.3
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) - University of Manchester	Eligible No			
Adult Asthma	British Thoracic Society	Eligible No			
Chronic Kidney Disease in primary care	Informatica Systems Ltd	Eligible No			
Non-Invasive Ventilation - Adults	British Thoracic Society	Eligible No			
Paediatric Pneumonia	British Thoracic Society	Eligible No			

*

Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Sepsis	NCEPOD	2/5 – 40%	Yes
2	Gastrointestinal Haemorrhage	NCEPOD	2/3 – 75%	Yes
3	Mental Health	NCEPOD	1/5 - 20% **	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

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

** This study is still open and returns being made

4.4 Participation in Clinical Research

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

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

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

A proportion of Luton and Dunstable University Hospital income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable University Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. Through discussions with our commissioners we agreed a number of improvement goals for 2015/16.

Goals and Indicators

Indicator Number	Indicator Name	% of the Value
1	Acute Kidney Injury	10%
2a	Sepsis Screening	5%
2b	Sepsis antibiotic administration	5%
3a	Dementia – Find, assess, investigate and refer	6%
3b	Dementia – staff training	1%
3c	Dementia – supporting carers	3%

4a	Avoidable Admissions - Luton	5.6%
4a	Avoidable Admissions - Beds	2.4%
4b	Mental Health Attendances	8%
5	Clinical Navigation	10%
6	High Resource Patients – Luton	28%
6	High Resource Patients – Bedfordshire	12%
8a	Mental Health Data Coding	4%

The Trust monetary total for the associated CQUIN payment in 2015/16 was £4,800,000 and the Trust achieved 88% of the value.

4.6 Care Quality Commission Registration

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

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

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

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

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

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

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

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

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

The Care Quality Commission's team of inspectors visited the hospital over three days in January 2016 and carried out two further unannounced inspections to formally inspect and assess the quality of the care the trust provides. We are expecting the report in May 2016.

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

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.

Transforming Quality Leadership 'Buddy' System
During 2015, we implemented a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided board to ward reviews and also supported staff to raise concerns and issues to the management team. This programme has developed into a revised quality monitoring framework.

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.

The Trust has been making progress with data quality during the year 2015/16. There are many processes carried out by the Information Team, which identify data quality issues.

Listed below are a few of the processes that are either carried out on a routine or adhoc basis by the Department:

- CCG challenges
- Monthly and weekly data quality reports sent out to users e.g. attendance not specified
- Theatre reports
- Benchmarking analysis – SUS dashboards
- Data Accuracy checks
- Completeness and Validity checks
- A&E not known GP checks
- A&E 0 wait arrival – departure times

During 2015/16 we have taken the following actions to improve data quality:

- Employed a full time Senior Data Quality Analyst
- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Added additional Data Quality Procedures to improve on areas e.g. ZZ postcodes, Choose from Dropdown Menu Referrals, No Health Authorities attached to patients
- Used automated reporting to increase the visibility of any data quality problems and expanded our contacts within the departments
- Continued to work with Commissioners to monitor and improve data quality pro actively in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2015/16 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 outpatient care and 96.2% 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 outpatient care and 100% for A&E care

Action Plan for Data Quality Improvement for 2016/17

CCGs Challenges

1. Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (e.g. Elective Admissions and their decision to admit dates)
2. Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
3. Continue to improve the NHS Number coverage
4. Continue to monitor Multiple Firsts

Attendance not specified

1. Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT and Divisions to reiterate the importance and financial impact
2. Continue Outpatient Data Quality meetings.

Theatres

1. Increase the frequency of DQ Theatres reports from monthly to weekly to give staff more manageable numbers.

SUS dashboards

1. Work with Divisions to improve the completeness of the fields where the National Average is not being met (e.g. Paediatric HDU to improve PCCP data entry – slowly improving)

2. Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients)

Data Quality Accuracy Checks

1. Maintain the number of audits on patient notes.

Completeness and validity checks

1. Remind staff about the importance of entering all relevant information as accurately as possible via Email and Liaising with IT Applications Training Team for individual ad hoc refresher training.

Other Data Quality meetings

The Information Team are working towards holding data quality meetings with A&E, Theatres, Inpatients and Maternity.

Clinical coding error rate

The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit carried out by an established coding agency.

An error rate of 10% was reported for primary diagnosis coding (clinical coding) and 8.3% for primary procedure coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

Information Governance toolkit attainment levels

The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2015/16 was **71%** 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 2014/15

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. 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	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	2	3	3 ***	1	N/A	The Trust has a zero tolerance for MRSA. During 15/16 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	97.2*	96*	106*	112*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	17	19	10	11	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	51**	30	19	11	N/A	Demonstrating an improving position.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	4	4	3	2	N/A	Demonstrating an improving position.
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.8	1.6	1.6	1.04	N/A	Maintaining good performance.
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.7 days	3.6 days	3.4 days	3.2 days	N/A	Demonstrating an improving position in line with the Trust plans.

Performance Indicator	Type of Indicator and Source of data	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	5.5	4.87	4.25	4.32	5.5	Maintaining performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	78.3%	84.7%	79.5%	69.4%	Target of 80%	This has continued to be a challenge and the Trust has a robust action plan in place to improve performance.
% of fractured neck of femur to theatre in 36hrs (n)	Clinical Effectiveness Dr Foster	80%	82%	75%	78%	N/A	There has been an improvement in the performance
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	52.5*	76*	79*	69.7*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	87.7*	91*	109*	112.8*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	11.4%	4.7%	6.7%	7.2%	N/A	There has been a slight increase. A review of Trust data has been undertaken and no concerns were identified.
% Caesarean Section rates	Patient Experience Obstetric dashboard	25.5%	25.7%	27.8%	Awaiting data from Maternity	25%	
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	8.7	9.0	8.9	From inpatient survey (to be received May 2016)	Range 8.2 – 9.8	

Performance Indicator	Type of Indicator and Source of data	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
Complaints rate per 1000 discharges (in patients)	Patient Experience Complaints database and Dr Foster number of spells for the year	3.62	7.01	7.12	6.29	N/A	The Trust continues to encourage patients to complain to enable learning.
% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	8.0	7.9	7.8	From inpatient survey (to be received May 2016)	Range 7.1 – 9.2	
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95% all year	Achieved >95% all year	Achieved >95% all year	Achieved >95% all year	N/A	Maintaining a good performance.

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

* Denotes calendar year

** 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.

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

5.2 Major quality improvement achievements within 2015/16

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Improving Quality

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Mortality and Complaints Boards

The Mortality Board and Complaints Board continued throughout 2015/16. Both meetings are chaired by the Chief Executive Officer (CEO) and have wide representation from divisions and also include Non-Executive Directors.

The Trust Mortality Board managed an action plan and:

- Completed detailed case reviews of areas of concern
- Initiated on-going reviews of all patient deaths
- Arranged for an external review of our response to the elevated HSMR.

To date no major clinical issue has been identified, although a series of service changes are planned, some of which are already implemented to further improve the overall quality of care patients receive.

The Complaints Board continues to see improvements in the management of complaints by the Divisions. The divisions have continued to implement changes to the governance of complaints to manage the process and implement any learning.

Raising Concerns and Freedom to Speak Up Guardian

We have continued our focus on encouraging our staff to raise any concerns. During July 2015, the CEO followed up an initial letter she had sent in January 2015, and wrote to all staff asking them to tell her (confidentially) if they believe a patient has suffered harm or if there has been a near miss and they do not feel confident that the incident is being properly addressed.

National guidance has also been received that requires us to have a 'Freedom to Speak Up Guardian Role' that we need to have in place by the end of March 2017 and work began to develop proposals for implementation.

Engagement Events – 'Good Better Best'

At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important was the large scale, trust wide 'Good, Better, Best' events where all staff came together to identify quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. The events also provided the opportunity to feedback learning from serious incidents and any action taken as a result of issues raised. It is planned to continue these events throughout 2016/17.

Compliance Manager

During 2015, we developed a key organisational role of 'Compliance Manager'. This role was pivotal to our on-going assessment of quality across the Trust in line with the CQC Core Standards and Key Lines of Enquiry. The role will continue to monitor compliance and ensure that we further develop systems and processes in order to maintain, further develop and enhance quality.

Transforming Quality Leadership 'Buddy' System

Building on the Compliance Manager role, we implemented a programme of quality reviews with the leadership team was implemented to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. It also supported a key part of the Trust preparation for the CQC inspection. This programme has developed into a revised quality monitoring framework.

Revised On-going Compliance and Quality Monitoring framework

In March 2016, the Clinical Outcome Safety and Quality Committee agreed a revised On-going Compliance and Quality Monitoring framework.

We will implement an improved co-ordinated monitoring framework which is linked to the fundamental standards of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The components of the framework are already in place within the Trust, but the framework outlines how the following will be co-ordinated:

- Senior Manager Buddy link to clinical areas /checklist
- Peer Review Programme (both internal and external)
- Nursing and Midwifery quality and safety indicators (Harm Free Care / Nurse Sensitive Indicators / Safety Thermometer)
- Patient-Led Assessments of the Care Environment (PLACE)
- Friends & Family Test
- Non-Executive Directors walk round
- Patient Surveys (internal and external)
- Staff satisfaction surveys (externally led)
- Staff Appraisals
- Staff 1:1s
- Incident reports / Number of Serious Incidents
- Annual Full Inspection

The introduction of an annual CQC style **'Full Inspection'** of all wards and registered locations of the Trust will be conducted over the period of a week, using subject experts from all departments of the Trust (including cleaning and catering contractors). This inspection will result in each clinical area being awarded an annual rating to ensure that they are Safe, Effective, Caring, Responsive and Well Led. These ratings will be aligned to the CQC rating scale. (Outstanding, Good, Requires Improvement and Inadequate).

This will also be linked to a Nursing and Midwifery Ward Accreditation Award Scheme, which is currently being finalised. The programme will be on-going and will commence in April 2016, with our first 'Full Inspection' planned for October 2016.

We will use forums already accessible and committed to measuring the CQC standards which includes the annual PLACE inspection, Back to the Floor Friday (BTFF) as well as the information from audits undertaken on both a regular and ad hoc basis.

We will relaunch the internal Peer Review Programme implementing a new framework linked to the CQC's Key Lines of Enquiry (KLOEs) which will enable the reviewers to award a percentage aligned to a RAG rating. There will be a consistent approach throughout the Peer Reviewing Programme, all answers/evidence /observations on the framework measurable, we are currently developing a scoring system which will enable a final percentage score to be calculated and subsequently aligned to a rating category to each domain. Simple guidance, for the monitoring tool and the scoring system will be produced for all 'reviewers'.

We continually look to share best practice with others and we engage with other NHS organisations inviting them to visit the Trust once every six months.

5.3 Friends and Family Test

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

FFT was first introduced at the L&D during 2012/13, seeking feedback from adults who had been inpatients. This was extended to both the Accident and Emergency Department and Maternity Services, followed by inclusion of patients who had received Day Case procedures and those who had been seen in Outpatients. Since April 2015 FFT has been implemented across the entire Trust and reported nationally each month with the aim of ensuring that all our patients are given the opportunity to identify whether or not they would recommend our service to their friends or family.

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

The FFT question posed to patients is:
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

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

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

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2015/16 has seen a decline in the response rates for FFT. In March 2016 the Trust achieved a response rate of 18.4% for inpatients, 1.5% for A&E and 28.7% for Maternity. In response to the lower response rates in A&E, the Trust implemented a number of actions to improve:

- Introduction of a link on Ipads for access to the FFT on wards.
- Monthly updates for wards and areas providing the number of cards/responses to collect to achieve a 40% response rate for wards and 20% for Emergency Department.
- Updates in staff brief
- Accident and Emergency Department have plans to implement text messaging patients to gain feedback on the services which should improve the response rate.

Table 1 Inpatients Percentage Recommend Scores 2015/16

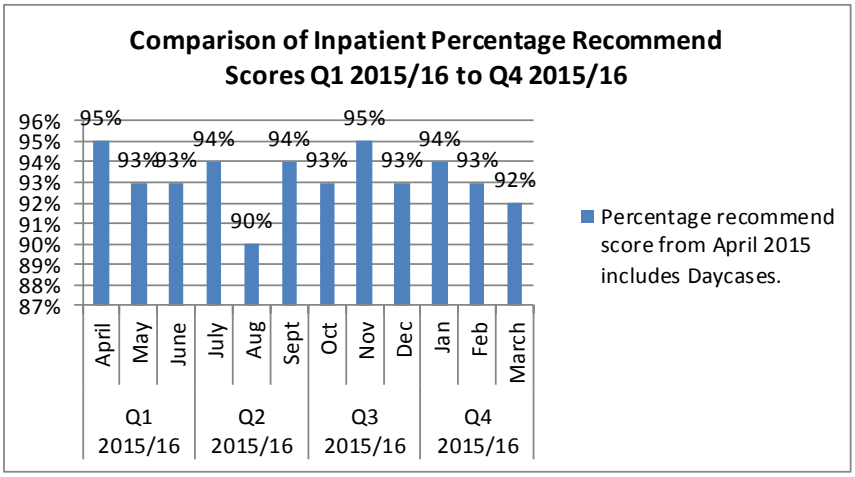


Table 2 Accident and Emergency Percentage Recommend Scores 2015/16

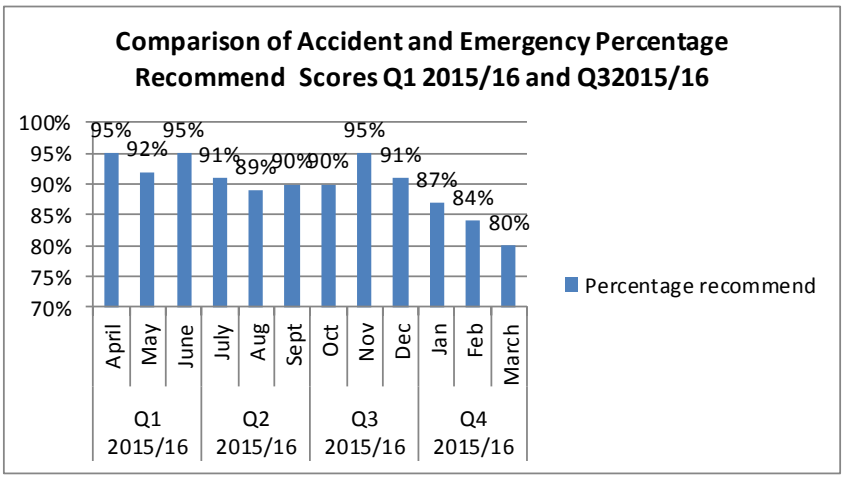


Table 3 Maternity Percentage Recommend Scores 2015/16

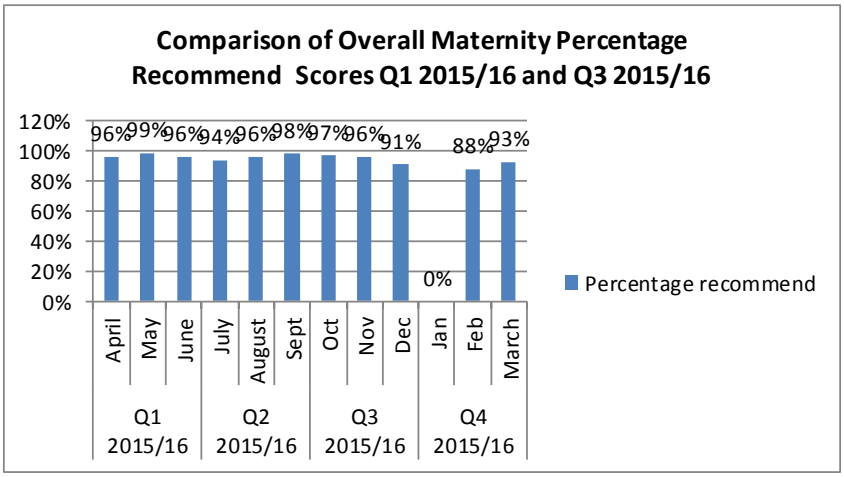
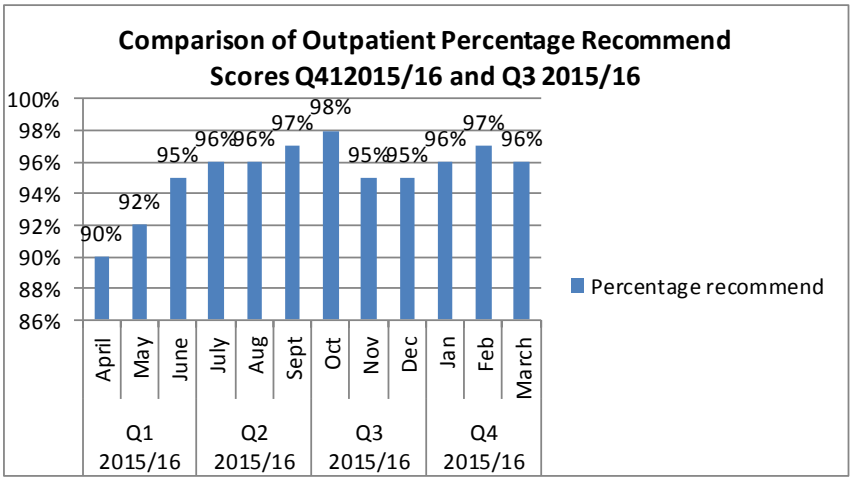
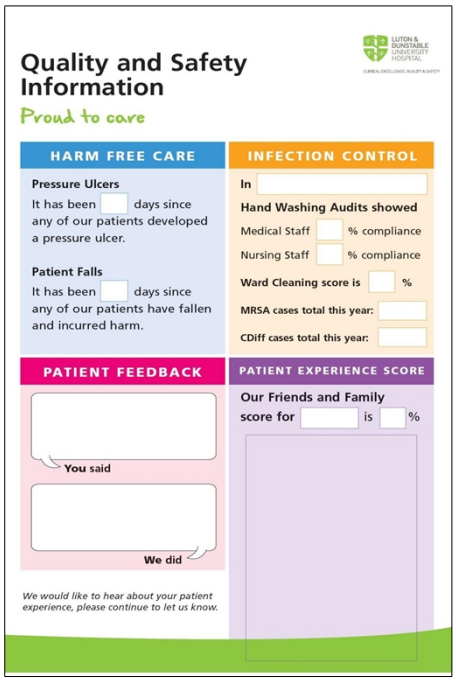


Table 4 Outpatients Percentage Recommend Scores 2015/16



The following are examples of action taken in response to feedback about individual wards:

- Improved structure of ward rounds due to feedback that communication could be improved.
- One ward has reduced noise at night by closing the doors to the bays and aiming to complete transfers to other wards by 11pm.
- Paediatrics have developed a communication sheet for each child's file. This gives a clear outline of the care plans for the child which can be communicated by any member of staff. This will help us to ensure that all communication is consistent.


Quality and Safety Information

Proud to care

HARM FREE CARE

Pressure Ulcers
It has been ____ days since any of our patients developed a pressure ulcer.

Patient Falls
It has been ____ days since any of our patients have fallen and incurred harm.

INFECTION CONTROL

In ____
Hand Washing Audits showed
Medical Staff ____ % compliance
Nursing Staff ____ % compliance
Ward Cleaning score is ____ %
MRSA cases total this year: ____
CDiff cases total this year: ____

PATIENT FEEDBACK

You said

We did

We would like to hear about your patient experience, please continue to let us know.

PATIENT EXPERIENCE SCORE

Our Friends and Family score for ____ is ____ %

Wards use the Quality and Safety Information Boards to report on the FFT recommend score and to display 'You Said/We Did' information for their patients to see. This information is updated monthly.

To be completed once the 2015 survey is received in May 2016

National Inpatient Survey 2015

The report of the L&D inpatient survey was received on the 13th April 2015 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and action plans developed by divisions and reviewed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who

were treated in July 2014 were surveyed. 850 patients were invited to participate and 330 responded, representing a response rate of 41%.

Results of the national in-patient survey 2015

Category	2011	2012	2013	2014	2015	Trust year on year comparison	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	7.1	8.4	8.4	8.2		Decreased	The same
Waiting lists and planned admission, answered by those referred to hospital	6.3	9.0	9.1	8.9		Decreased	The same
Waiting to get to a bed on a ward	6.6	7.0	6.5	7.1		Increased	The same
The hospital and ward	7.8	8.1	8.1	8.0		No change	The same
Doctors	7.9	8.2	8.4	8.4		No change	The same
Nurses	7.9	8.1	8.2	8.1		No change	The same
Care and treatment	7.1	7.5	7.6	7.6		No change	The same
Operations and procedures, answered by patients who had an operation or procedure	8.3	8.3	8.2	8.4		Increased	The same
Leaving hospital	6.8	7.0	7.1	6.8		Decreased	The same
Overall views and experiences	6.0	5.5	5.5	5.5		No change	The same

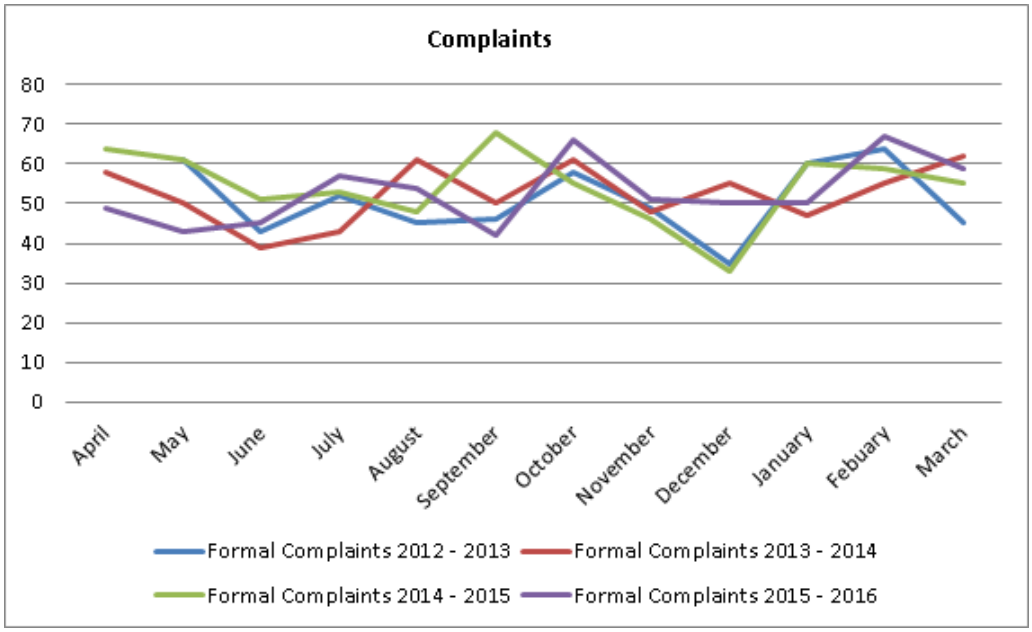
Note all scores out of 10

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

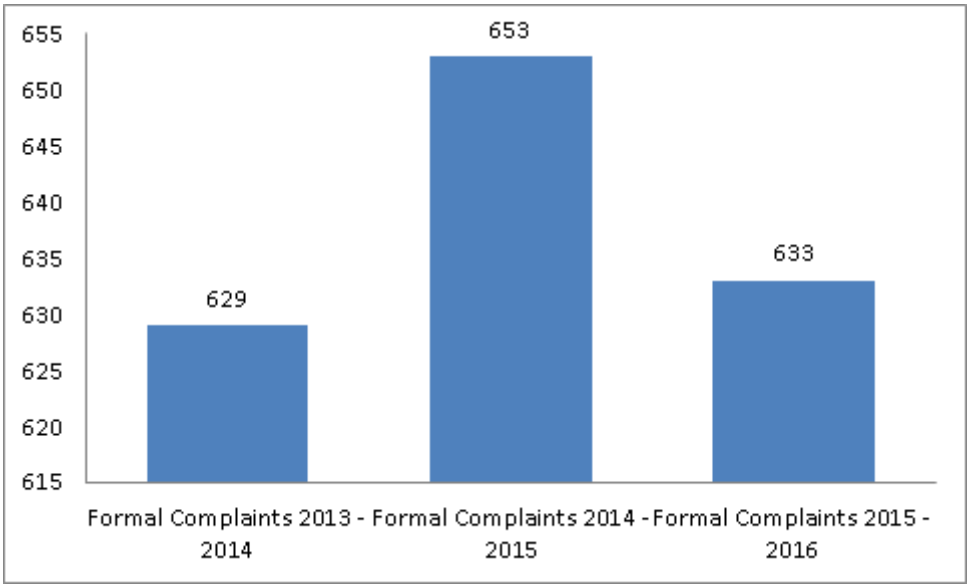
5.5 Complaints

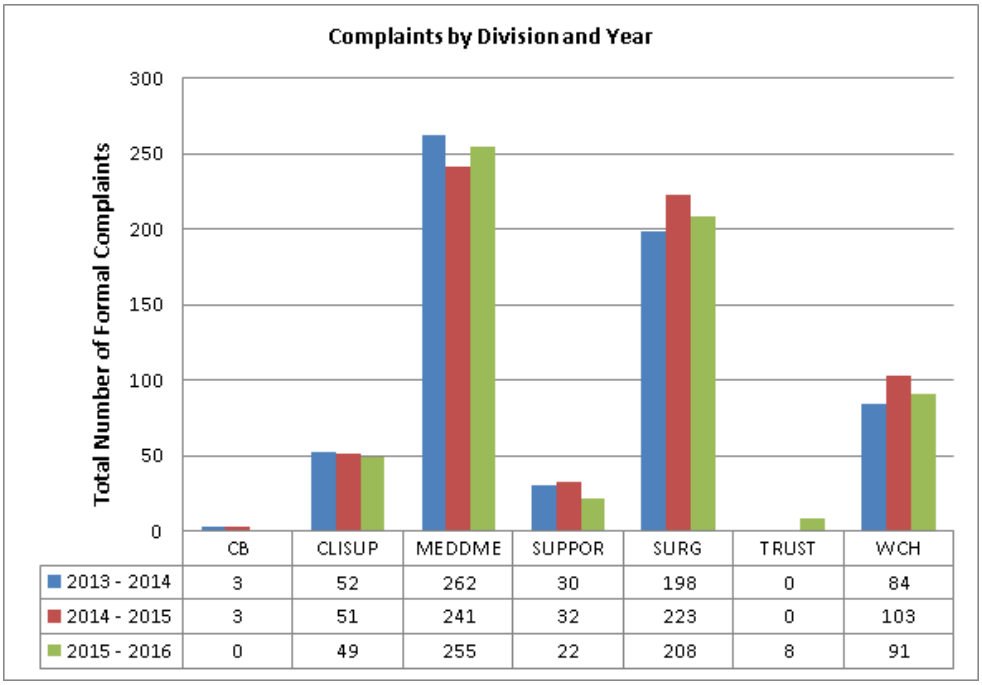
In 2015/16 the Trust has continued to welcome patient feedback. Following review of the Complaints and Concerns Policy, there has been a continuing focus to ensure that we efficiently answer complaints and concerns in a timely manner and continually use this information to improve our services.

During 2015/16 we received 633 formal complaints compared to 653 in 2014/15. The breakdown shows a decrease in the number of formal complaints received at the Trust since the last financial year. Whilst complaints have remained static with no significant increase or decrease it is recognised that there is a heightened public awareness of the option to complain. The Trust has made significant effort to resolve people's concerns quickly, reducing the need for them to follow the formal complaints process.



	TOTAL
Formal Complaints 2013 - 2014	629
Formal Complaints 2014 - 2015	653
Formal Complaints 2015 - 2016	633





	CB	CLISUP	MEDDME	SUPPOR	SURG	TRUST	WCH
2013 - 2014	3	52	262	30	198	0	84
2014 - 2015	3	51	241	32	223	0	103
2015 - 2016	0	49	255	22	208	8	91

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received 595 formal complaints. A breakdown of complaints (by month, by category is contained within the Quality Account.

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

The majority of complainants were resolved at local resolution level. Some of the meetings were headed by the General Managers and some meetings were with the Medical Director or the CEO. However, 12 complainants asked the Parliamentary and Health Service Ombudsman (PHSO) to review their complaints. Following this process, five complaints have been investigated and a final report has been done, two are waiting for a decision' and five are being investigated by the Ombudsman.

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

- If people are not happy with their response they are invited to come for a Local Resolution Meeting to discuss their concerns.
- We are sending our questionnaires with all our responses for patient feed -back.
- Patient Affairs completes a weekly update and this includes the overdue complaints for every division and therefore this is escalated to senior managers.

Compliments
During the reporting period over approximately 6,500 compliments were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager. This is an increase of 1,500 from the previous year. Below are some of the compliments we received recently:

“I came to A&E on Sunday morning 21st February 2016 with chest pains.
From the moment we arrived we were treated fantastic by superb staff who all acted calm and professional which straight away calmed me down and put me at ease I was seen very quickly and given a full check- up. The doctor and nurse who cared for me were first class can you pass on my thanks to them unfortunately I cannot remember their names I think the staff do a fantastic job.”

“I would like to thank you for the kind and caring treatment I received at the breast screening unit.”

“My son has recently been in for an operation and I wanted to say a massive thank you to the staff in the hedgehog ward on the 8/02/2016 and all the staff who looked after him in the ground floor theatre. I can't put into words how amazing everyone was on that day with me being a nervous wreck. Thank you all so much.”

“I visited the A&E dept today after having a coughing episode and passing out and damaging rib tissue. I would like to commend the Triage nurse and two doctors who examined and treated me. They were friendly, extremely efficient and a credit to your hospital and the NHS. I hope my thanks can be passed on to the dept.”

“I would just like to say that I went into hospital on the 22/12/15 for a hysterectomy. He [the consultant] did a fantastic job and the nurses on ward 34 were great! I had barely any pain afterwards and am so happy I went through the procedure. Many thanks for all that your staff did for me.”

“I have just had to stay on ward 21 for two nights and the care was first class a hard working team that were kind compassionate and professional. Restored my faith in the NHS.”

“[The patient] was admitted to your hospital in November 2015 and died on ward 14 on the 15th November. I wanted to thank all the staff on this ward for the incredible care and compassion they showed to him in his last weeks. It was a great help for those of us who loved him to know he was in such good hands. We knew he wouldn't be allowed to suffer or feel uncomfortable. All the staff were first class - genuinely caring and highly competent. The cleaning staff worked so hard and were also so friendly and interested in how we were doing. We were all so impressed with everyone connected with this ward; I do hope you will pass on this email to them. We won't forget what they did.”

5.6 Performance against Key National Priorities 2015/16

		2012/13	2013/14	2014/15	2015/16	Target 15/16
Target 1: Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	17	19	10	11	6
Target 2: MRSA	To achieve contracted level of 0 cases per annum	2	3	3*	1	0
Target 3: Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	99.6%	99.8%	100%	100% **	96%
Target 4: Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	90.3%	91.5%	91%	99.8% **	85%
Target 5: Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.6%	95.7%	95.5%	95.8% **	93%

		2012/13	2013/14	2014/15	2015/16	Target 15/16
Target 6: Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	98.9%	100%	98.9%	98.7% **	94%
	Anti-cancer Drugs	99.8%	100%	100%	99.8% **	98%
Target 7: Patient Waiting Times	Referral to treatment - percentage treatment within 18 weeks - admitted	Target achieved in all 12 months of the year	93.6%	94.1%	92.9%	90%
Target 8: Patient Waiting Times	Referral to treatment - percentage treatment within 18 weeks - non admitted	Target achieved in all 12 months of the year	97.1%	96.8%	97%	95%
Target 9: Patient Waiting Times	Referral to treatment - percentage patients waiting so far within 18 weeks - incomplete pathways	Target achieved in all 12 months of the year	96.5%	96.9%	96.3%	92%
Target 10: Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.5%	98.4	98.6%	98.6%	95%
Target 11: Learning Disability	Compliance with requirements regarding access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved	Achieved

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

** currently to February 2016 – March data to be added in May 2016

5.7 Performance against Core Indicators 2015/16

Indicator: Summary hospital-level mortality indicator ("SHMI")						
SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality; however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. The L&D is a provider of level 3 Neo-natal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital. Other benchmarking data is used to provide assurance on performance and data is also subject to on-going review. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings						
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 –Sep 12)	As expected	As expected			2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 –Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 – Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 –Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 – Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 –Sep 15)	As expected	As expected			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level *(The palliative care indicator is a contextual indicator*	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 –Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 – Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 –Sep 15)	13.8%	26.7%	0%	53.5%	N/A
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: • Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2015/16 and the Mortality Board maintains ongoing oversight of any indicators that flag as an outlier.						

Indicator: Readmission rates					
The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 – 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%

	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

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

- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates

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

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

**The most recent available data on The Information Centre for Health and Social Care is 2011/12 uploaded in December 2013. The next information upload is in August 2016.*

Indicator: Patient Reported Outcome Measures (PROMs) scores

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

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14*	0.079	0.085	0.139	0.008
	2014/15	0.088	0.081	0.125	0.009
	2015/16	**	0.088	0.13	0.08
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14*	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054
	2015/16	**	0.1	0.13	0.037
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14*	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14*	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207

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

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

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

- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- Patient level data is scrutinised and surgical team performance reviewed. The Trust completed a review in April 2015 that identified no concerns at the patient level.
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

** Relates to April to September 2015 (most recent data published in February 2016 by HSCIC)*
*** Score not available due to low returns*

Waiting for Inpatient Survey (due May 2016)

Indicator: Responsiveness to the personal needs of patients during the reporting period					
This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions: • Were you involved as much as you wanted to be in decisions about your care and treatment? • Did you find someone on the hospital staff to talk to about your worries and fears? • Were you given enough privacy when discussing your condition or treatment? • Did a member of staff tell you about medication side effects to watch for when you went home? • Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Responsiveness to the personal needs of patients.	2010/11	74.1	75.7	87.3	68.2
	2011/12	71.7	75.6	87.8	67.4
	2012/13	73.5	76.5	88.2	68
	2013/14	74.2	75.9	87	67.1
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16				
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.					

Indicator: Staff recommendation					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%
	2015/16	72%	70%		
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons • The source of the data is the National Staff Survey.					
The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by: • The hospital runs with a clinically led, operating structure. • The Chairman and Non-Executive Directors have a programme of clinical visits and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee. • Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process.					

Waiting for Inpatient Survey (due May 2016)

Indicator: Patients recommendation (New Measure)					
The percentage of patients during the reporting period who would recommend the Trust as a provider of care to the or friends from the inpatient survey					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11				38%
	2011/12				33%
	2012/13				35%
	2013/14				38%
	2014/15				38%
	2015/16				
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 Patient Survey.					

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

-

Indicator: Risk assessment for venous thromboembolism (VTE)					
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.	2010/11 – Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 – Q4	95.3%	94.2%	100%	87.9%
	2013/14 – Q4	95.1%	96.1%	100%	74.6%
	2014/15 – Q4	95%	96%	100%	74%
	2015/16 – Q3	95.7%	95.5%	100%	94.1%

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 throughout 2015/16.
- We are planning to implement an electronic solution to the risk assessment process.
- We undertake root cause analysis on all patients who develop a VTE.

Indicator: *Clostridium difficile* infection rate					
The rate for 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of *C. difficile* infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.1	Not Avail*	Not Avail*	Not Avail*

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

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

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

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

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

Indicator: Patient safety incident rate					
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.					
	Reporting period	L&D Score	National Average	Lowest score (worst)	Highest score (best)

Total number and rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2010/11	**	**	**	**
	2011/12	**	**	**	**
	2012/13	**	**	**	**
	2013/14	**	**	**	**
	2014/15	37.52	35.1	17	72
	2015/16	34.9	38.2	18	74
Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	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
- 32 Serious Incidents were reported in 2015/16 compared to 46 in 2014/15 and 36 in 2013/14 (excluding pressure ulcers).
- The Trust reported 3 Never Events in 2015/16 under the following Department of Health criteria - a wrong route injectable medicine, a wrong patient procedure and a retained foreign object post-procedure. The Trust was also made aware by HM Coroner of a retained foreign object following a surgical procedure carried out in 2001. The inquest concluded that the patient's disease processes and the presence of swab contributed to his death and for which the Trust has apologised. The systems and processes that were in place in 2001 have since been revised and following the introduction of the World Health Organisation Safer Surgical Checklist (2009), the introduction of the Never Event list by the Department of Health (2009) and changes in clinical practice to the procedure that was performed, the Trust is confident that this type of event cannot recur.
- The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2015/16 this target was met in 21 out of 32 cases (66%).
- The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2015/16 this target was met in 20 out of 26 cases (77%). Six incidents were still under investigation at the time of data collection but it is anticipated that these would all meet their deadlines for submission.
- The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.

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

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

**Data not available on Health and Social Care Information Centre*
*** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available*

5.9 Embedding Quality – Workforce factors

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to achieve this through many different routes, including delivery of learning and development; good leadership and good communication. This journey starts from the point that an individual applies for a post with us and continues through their employment with the Trust.

Recruitment

In recent years we have been particularly busy in terms of the recruitment of staff both clinical and non-clinical. This has continued throughout 2015/16 where we advertised1018 posts advertised that resulted in 946 new starters (excluding bank starters, staff transferring from bank to permanent posts and existing staff being promoted).

The Trust put a particular emphasis on the recruitment of Registered Nurses and Health Care Assistants and below we set out some of the work that we have been doing.

- **Registered Nurse Recruitment**

In addition to recruiting locally through newly qualified student nurses and holding bi-monthly recruitment open days. We have also looked nationally and have been proactive in participating in Recruitment Fairs in Scotland, Belfast and Dublin.

The Trust has also looked further afield in Europe (Portugal, Italy and Spain) as well as campaigns in India and the Philippines.

- **Health Care Assistants (HCAs)**

Throughout the year bi-monthly HCA recruitment campaigns have been held and these have resulted in 115 HCAs commencing in post. We have also held additional open days for some speciality campaigns, for instance Theatres HCAs.

The development and progress of HCAs is monitored through completion of the induction Care Certificate competencies within 12 weeks of commencing at the Trust. This baseline competency programme is a national requirement for all care workers. For care assistants without a level two qualification as part of their employment, 54 HCAs have commenced a Clinical Apprenticeship in General Healthcare following on from their induction. This contributes greatly to the employer's apprenticeship targets set by Health Education East of England HEEoE).

The Foundation Degree, (FD) is the qualification required of our Assistant Practitioners (AP) currently being employed in specialist areas of the trust and more recently on general elderly care wards. From the September 2015 intake, we have three completing the foundation degree. APs are skilled up to the first year of a Student nurse academically with four or more years of practical experience having completed level two and three general healthcare qualifications. The medical division have now employed eight new APs across the wards.

The FD, plus Maths and English at level two is also the entry requirements for those who wish to undertake the new Flexible Nursing Pathway being developed in partnership with the University of Bedfordshire, HEEoE and local service providers including the L&D. For the flexible nursing pathway students can work towards a nursing degree and study alongside the traditional three year students. Students are required to work for three days per week in their normal role and undertake the requirements of the nursing programme on the other two days per week. The students are jointly funded by the employer and the HEEoE. In March 2016, five of our staff have commenced this exciting new programme.

Sickness Absence Project

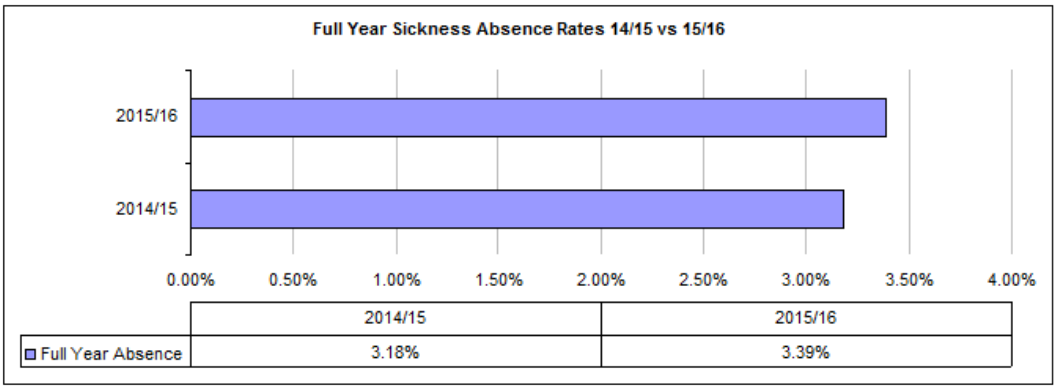
The sickness absence project has been running for just over two years during which time we have seen a significant reduction in sickness absence levels across the Trust.

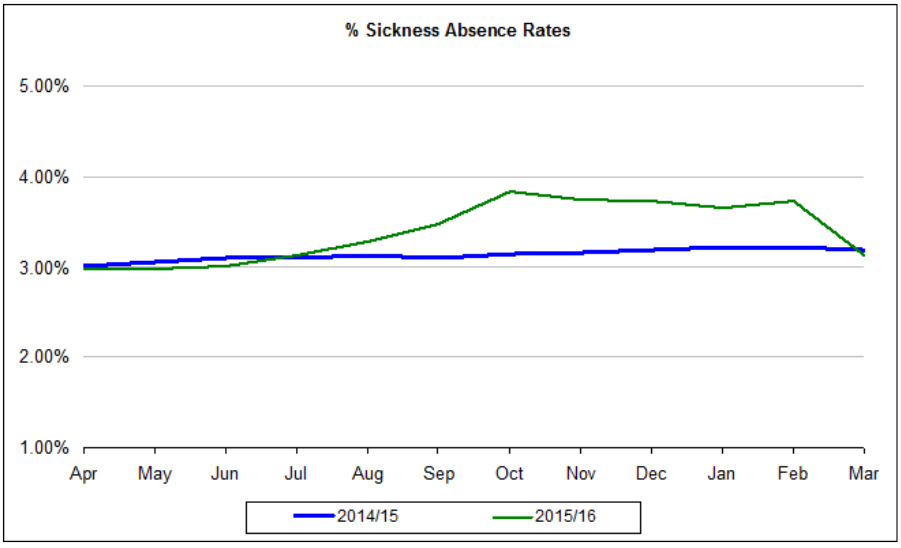
The project has delivered a cultural shift towards managing sickness absence with a more proactive action orientated approach being adopted by line managers to address sickness absence caseloads. This has included coaching and training of line managers and also delivering the message that sickness absence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

recruited with the right skill set for the right positions with the appropriate controls and processes.

As a result of this focus, the Trust has one of the lowest sickness absence rates of any acute Trust in the East of England and one of the leading Acute Trusts across NHS England when it comes to sickness absence rates.

We are now moving into a phase of sustainability and continuing to embed the principles of absence management whilst ensuring that absence is continually managed through meaningful dialogue and in line with the Trust policy.





- **Staff Engagement and Consultation**

The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year was again higher than the national average. In addition, the Trust scored in the top 20% of Trusts across the country with 73% of staff reporting that they were able to contribute towards improvements at work , good, communication between senior management and staff was also found to be above (better than) average.:

- **Staff Recognition**

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

- In recognition of their long service, staff were invited to an awards event at Luton Hoo Hotel in February 2016. This was the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25 years. The event was enjoyed by all who attended and many happy memories were shared in respect of service over the years.

  During National Volunteers week which is held in June 2015, we arranged a day trip to the seaside for our volunteers, which was a very enjoyable day. A further event was held in in January 2016 where 80 volunteers enjoyed an afternoon at the Pantomime at a local theatre.

Communicating and engaging with our staff

The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2015 Staff Survey showed that the Trust scored above average for its overall staff engagement score. Similarly, we scored above average for the percentage of staff reporting good communication between senior management and staff.

Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Messages are delivered in a variety of ways both within individual teams and department and across the Trust as a whole.

Examples of staff communications and engagement include:

- Weekly face-to-face staff briefings are led by our Executive Team, where we share information on key operational issues
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A fortnightly newsletter is sent to all nursing staff, which includes information on patient safety issues. During the coming year, we are working to broaden the scope of this newsletter to include other groups of clinical staff
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets monthly with our Council of Governors, which includes eight elected staff governors

Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust

- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

- Staff Involvement Group

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

Engagement events 2015

During the summer of 2015, over 68% of all Trust staff attended a series of engagement events hosted by the Chief Executive, during which staff from all departments identified the aspects of their working lives that they are most proud of, along with the key issues they wanted the Trust to take action on in their areas. These events were a direct response to feedback from staff in 2014, when our Chief Executive asked all staff via a survey and face to face meetings for feedback on how they would like to be communicated with.

As a result of the positive feedback received from staff a further engagement event was repeated during a week in December 2015, where a similar number of staff attended. The December events included detailed feedback from the summer events, with a comprehensive booklet given out to every attendee, as well as information to support staff in the lead up to our Care Quality Commission inspection in January 2016.

During the December events, we asked staff to list the top two strengths of their team and the Trust, as well as two areas where we needed to make improvements and how we were doing this. This information was shared with all teams for their individual areas in advance of the CQC inspection. Overall feedback was positive and constructive, as shown in the following summary.

Things our staff are proud of:

- The patient is at the heart and centre of all we do every day
- Patient feedback is excellent and most patients have a good experience
- Staff work well together in teams and across teams to support each other and to ensure the patient always has a good experience
- The Trust is collaborative and innovative
- Teams are good at communicating with one another
- Managers and senior leaders are visible and available
- The Trust is a good place to work and our culture and clinical reputation help attract new staff

Things our staff feel we need to improve on:

- Availability of specific equipment
- Availability of space to provide services
- Having sufficient time to complete training and on-going development
- Having the right staffing in all services

Staff Involvement Group Newsletter

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

5.10 Improving the quality of our environment

Whilst the Trust continues to develop and consolidate ideas for the redevelopment of the hospital site, parts of the existing hospital estate will be retained over the longer term. During 2015/16, we have therefore carried out an extensive programme of works to refurbish corridors, lift lobbies, outpatient areas and wards. The works have been designed to improve the general environment of these areas, and include:-

- New flooring
- New suspended ceilings (in corridors)
- Upgraded lighting with energy efficient LED based systems
- New wall protection fittings to prevent damage to walls from equipment such as patient beds
- General redecoration

In addition to redecoration, improvement works were completed on inpatient wards 10, 11 and 12 to improve privacy and dignity for patients.

We introduced a commercial partner – Engie - during 2015/16 to run our cleaning and catering services. Engie have now completed the refurbishment of the Chiltern Restaurant with new food counters and a new range of meal options.

In addition to the planned refurbishment works the 'Urology One Stop Centre' development was completed and opened to patients in September 2015. This new facility provides a suite of new consulting and treatment rooms enabling patients to be treated in an outpatient setting. In November 2015, our new orthopaedic centre opened in a vacant part of the Travelodge on Dunstable Road, approximately half a mile from the main hospital site with dedicated parking. The new centre provides care in a modern environment, whilst also freeing up space within the Emergency Department in the main hospital.

We have continued to actively engage with patients via PLACE (Patient Led Assessment of the Care Environment) Committee. The Committee is formed of a mix of staff and patients who undertake to carry out monthly inspections of the care environment providing valuable feedback on where improvements can be made for the benefit of patients. This work feeds into an annual inspection which is reported into the Department of Health.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focussed on delivering care more efficiently and effectively. This is a formal programme to resolve the fact that overall systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity to improve both quality and efficiency.

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

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

This year has been focussed on what we have described as a "Partial Booking" implementation. This means that for patients requiring an appointment more than 6 weeks in advance a waiting list is maintained. Partial Booking is now live for over half of our bookings. This has required considerable design of optimised central support processes for

specialities. There has been a very positive impact on reducing appointment rescheduling in areas that are live and established with a decrease from 13.5% to 1.6% of patients having multiple moves of their follow-up appointments. This has also seen *did not attend* (DNA) rates decrease by 1.6% to almost 8%. Given this impact there is an urgent focus to get this service improvement across all follow-up appointments by the summer of 2016.

Also within Outpatients we have completed detailed work to examine the flow of activity within clinics using improvement science techniques to refine our approach speciality by speciality. This has focussed on 3 representative specialities: Orthopaedics, Respiratory, ENT and Neurology. Using external expertise we combined an understanding of the pathway, the balance of capacity and demand for a pathway, and also optimised support and flow.

Last year we completed the tender for a Patient Self-Check-In and Flow solution for Outpatients to transform our patients' journey from arrival at the site, to arrival in the clinical room for the appointment. This included screens to guide the patient, and manage expectations around timing in a similar manner to the flow through an airport. However, the implementation of the solution was put on hold due to the potential impact of changing the Trust's patient administration system (PAS).

eRostering: The roll-out of eRostering to nursing and other non-medical staff completed this year, including the most complex area such as Theatres and Delivery Suite. The effectiveness of established staff utilisation has seen consistent improvement across the year. The Trust has also scoped and designed an extension of this system to cover the entire workforce, including trainee medical staff. The push for Carter efficiencies; the drive to control agency rates and usage, and the need to ensure we are using our established contracted hours to deliver maximum safety for the funds spent, have all shown the critical who are actively looking to extend this functionality to trainee doctors. There is, however, much more work to be completed using the system to deliver the best use of staff resources.

A Unified PAS/ePR for the Trust: Considerable work was completed preparing an investment case for the Lorenzo Regional Care system. The Trust successfully passed through two of the three gateways to access central funding, but the launch of the Sustainability and Transformation Plan (STP) process, where the Trust is working across a wider footprint has led to a hiatus while all options are considered.

Business Development: The Trust has continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. These will continue, but will take place on the margin of our traditional catchment areas. We have worked hard to ensure we are the easiest place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. This will involve enhanced investment in marketing materials, but will require careful alignment with capacity released by re-engineering our processes. We have launched a strategically important maternity hub in Leighton Buzzard including the delivery of antenatal imaging conveniently located for local appointments. We have also been successful in securing a contract to deliver an innovative modern Sexual Health service for the area of Luton.

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

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

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

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

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement 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 2015/16 and supporting guidance;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2015 to March 2016
    - papers relating to Quality reported to the board over the period April 2015 to May 2016
    - feedback from commissioners dated XXXXX
    - feedback from governors dated 10/02/2016
    - feedback from local Healthwatch organisations received XXXXX
    - feedback from Overview and Scrutiny Committee received XXXXX
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XXXXX
    - the 2014 national patient survey XXXXX
    - the 2014 national staff survey 24/02/2016
    - the Head of Internal Audit's annual opinion over the trust's control environment dated XXXX
    - CQC Intelligent Monitoring Report dated July 2014 and December 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; We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

- 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

25th May 2016
.....Date.....Chairman

25th May 2016
.....Date.....Chief Executive

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

7. Comments from stakeholders:

Comments received from the Trust Stakeholders

Comment	Response

8. Independent Auditor’s Assurance Report

9. Glossary of Terms

Term	Description
Anticoagulation	A substance that prevents/stops blood from clotting
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile conditions
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.

Term	Description
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
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
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion

Term	Description
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SEPT	South Essex Partnership University NHS Foundation Trust
SHMI	Summary Hospital-level Mortality Indicator (**SHMI**) is an indicator which reports on mortality at trust level across the NHS in England using a standard
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

Research – Glossary of terms

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

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

Local Clinical Audits

Local Clinical Audits April 2015 – March 2016 (Projects managed by the Clinical Quality Department)

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
GYNAECOLOGY RECORD KEEPING AUDIT 2014	**O&G**	**Audit**	**April 2015**	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** Total number of standards measured = 70 50 standards (71%) Fully compliant 11 standards (16%) Moderate compliance 9 standards (13%) Low compliance. The percentage of standards fully compliant has increased (compared to previous audit) from 62% to 71%. The percentage of standards with either moderate or low compliance has decreased. **Key Recommendations:** • Increase awareness to improve documentation of review of test result • Nursing & Medical staff to be made aware of responsibilities in ensuring documentation complete/correct in relation to continuation sheets, NHS no, Hospital No and Consultant • Improve printing of names / use of stamps • Improve education to Medical staff to ensure completion of discharge letters, drugs on admission, tests and investigations
ANNUAL HEALTH RECORDS AUDIT GENERAL MEDICINE	**GENERAL MEDICINE**	**Audit**	**April 2015**	**Main Aims:** To measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings. **Findings:** Only 9/66 (14%) standards were proved red while 9/66 (14%) were recorded as amber and 48 (72%) were evidenced as green. The results suggest a good evidence of compliance with the standards however significant improvement is required in following areas:

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Height and Weight measurements in physical examination • Signing, naming, dating and timing of corrections • Drugs on admission in discharge letter • Accurate record of the changes made to the patients regular medications **(on admission)** in the discharge letter **Key Recommendations:** • To monitor and ensure that poor compliance areas are periodically checked and recorded • To monitor and review initial clerking notes • To monitor and review a sample EDL periodically with the team
AUDIT ON THE MANAGEMENT OF POST EXPOSURE PROPHYLAXIS AGAINST HIV INFECTION	**GUM**	**Audit**	**April 2015**	**Main Aims:** The practice of prescribing PEPSE in our department is compared with the recommended BHIVA national guidelines. **Findings:** • Proportion of PEPSE patients having a baseline HIV test was 94% • Proportion of PEPSE prescriptions administered within 72 hours of risk exposure was 90% • Proportion of PEPSE prescriptions that fit within recommended indications was 78% • Proportion of individuals completing 4-week course of PEPSE was 50% • Proportion of individuals seeking PEPSE undergoing testing for STIs was 43% • Proportion of individuals completing 12-week post-PEP HIV antibody/antigen test was 36% • 22% of the patients did not require PEPSE as per guideline and it was prescribed as the patients have requsted. Initial consultation with patients requesting for PEPSE and giving evidenced based information to the patients to arrive at an informed decision should be encouraged • Only half of all people who were given PEPSE have completed the course. A few took PEPSE until the results of the source patient was known. A few did not continue due to the sideffects.Therefore it is recommended to prescribe for 5 days or 2 weeks at the initial visit to minimise the wastage • By introducing a standerdised proforma for the mamnagement of PEP would improve the standards of PEP provision

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Key Recommendations: • A standardised proforma for the management of people seeking for PEP provision to be introduced. • All the patients need to be screened for STIs. • All the patients to be seen and followed up by the HA. • All the patients are put in the HA diary and followed up according to the guidelines. • Initial prescription for a maximam of 2 weeks is advised and patients are encouraged to return in 2 weeks to monitor adherence and side effects. During the followup visit, further 2 weeks of PEP need to be given in the department
AUDIT ON LSVT	**SPEECH & LANGUAGE THERAPY**	**Audit**	**May 2015**	**Main Aims:** The main aim of this audit is to measure the change in loudness of the patient in producing "ah", functional phrases and in conversation, but also to discover the patient's perception of their change in speech. It hopes to identify if modified LSVT is a valuable therapy option or not. **Findings:** • Audit reveals a significant change in loudness post LSVT. The audit proves an increase in loudness in production of "ah", functional words and conversation in nearly all patients. The rationale of LSVT is to focus on loudness which will also prime the other modalities important in spoken communication eg articulation, intelligibilty, resonance, intonation. • The scores from the VHI show a pleasing improvement in pateints' self rating. Only one person had shown no reduction in their disability rating, 3 people had a statistically non-significant reduction in their scores and 3 people had made stastically significant improvements in their perception of their speech on their lives. • The perceptual rating scale again showed a move in a positive direction. Patients generally felt more positive about their voices. • The general trend is that people feeling more positive after therapy. This is most noticeable when looking at "loudness" and "shakiness" which clearly correlate with the therapy. The therapy focuses on increasing volume which results in a stronger more fluent air flow and a subsequent reduction in "shakiness". • When looking at "hoarseness and scratchiness of voice", "monotone voice" & "slurring", there is some improvement, but perhaps the change is not as substantial as might be hoped for. These are changes that one might expect to folow in if loudness has improved. • Self rating of strain again has not shown a strong trend of reduced "strain". It is likely

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				that the LSVT has led to an increased awareness of the amount of effort required to increase volume and clarity. With time it is expected that the amount of effort required would become more habitual. • Self ratings of "mumbling" and "others understanding" reveal a reduction in mumbling, and an increased perception of being understood by others. This has to be a particularly important positive result of therapy intervention. • Self rating of participation in conversations and starting conversations reveal a trend to increased participation in conversations and an increase in initiating conversations. When one considers disability, it is customary to measure participation in society and a reduction in dependence and passivity. This has to be positive if the (small number of) patients feel that they can initiate nad join in with conversations more. • Overall the results are a good validation of using modified LSVT in order to increase loudness and therefore increase quality of voice and hence interaction and hence quality of life. The therapy programme relies on a therapist being able to offer one hour's therapy 3 times a week for 4 weeks for each patient to benefit. Unfortunately the adult Speech & Language Therapy service is not staffed adequately to be able to offer this therapy to adults with Parkinsons Disease. **Key Recommendations:** 1. SLT to seek support from relevant commissioners to offer funded modified LSVT therapy programmes to up to 10 patients with PD at Luton & Dunstable Hospital every year 2. SLT to present study to local PD voluntary groups to seek funding of modified LSVT therapy programmes to up to 10 patients with PD at Luton & Dunstable Hospital every year
SURVEY OF URINARY INCONTINENCE IN DME WARDS **N = 114**	**DME**	**Audit**	**June 2015**	**Main aims:** • Identify incidence and prevalence of urinary Incontinence across DME wards • Develop service in order to improve practice **Findings:** • Survey shows that urinary incontinence is an important common health problem as evidenced by the incidence and prevalence in this group. • Both incidence and prevalence increases with age. • The study included 114 patients, 50% male, 50 % female. The report does show higher incidence/prevalence in female. • The incidence and prevalence of the incontinence problem varies from 17% to 63%.

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				One has to remember that there are various terminologies used when you mention incontinence such as urge incontinence, stress incontinence, mixed incontinence, overflow incontinence (dry or wet), nocturia or it can be transient incontinence. Our study showed a variety of presentations in these different groups of incontinence. • In 88 out of 114 cases of incontinence the symptoms were present for months in 90% of the cases. • 68% of these group of patients did not ask for help from any healthcare professionals in our study • For those who fulfilled exclusion criteria for this study due to critical illness or in altered mental status, the information of incontinence was gathered from the nurse and care giver and it showed that 14 out the 20 cases there was clear cut evidence of incontinence in those critically ill patients. • All these findings suggest that this is a major health problem in this group of patients. Incontinence is one of the geriatric giants and it affects the quality of life leading to increased medical morbidity, psychological morbidity (poor self esteem, social withdrawal, depression, sexual dysfunction). It also increases carer's burden and contributes to decisions to place individuals in a nursing home. • Urinary incontinence is also associated with mortality. The healthcare costs as per 2001 UK figure for incontinence is around £473 million. • Our current resource within our Trust is currently a one whole time equivalent continence advisor looking into bowel and bladder incontinence as well as looking into catheter care. There is also help with a few urology specialist nurses who deal with more complex issues along with some Urologists /urogynaecology clinician. • Currently there is no dedicated geriatrician with a special interest in incontinence. • Though it is counted as a routine screening by the nurses as well as the doctors, this does not happen on a regular basis due to resource constraints. • Incontinence obviously leads to mortality, morbidity, increased direct and indirect healthcare costs leading to a burden on our health and social care costs. • Also to remember in our territory, there is a community team employed by Primary Care Trust looking into incontinence. At this point I am certainly not aware that both the hospital and the community teams work in collaboration on this particular issue. **Key Recommendations:** • Training: Induction Jnr. Doctors to routinely ask all patients over 65 about incontinence • The newly devised continence assessment form to be completed by nurses/doctors and a copy sent to continence advisor.Any concerns to be:

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				a) Highlighted immediately to the clinician involved. b) Highlight to the continence advisor. c) Advise patients/carers to fill bladder diary. • Promote awareness of this problem to patients by providing leaflets/posters which are currently available from Age UK. • Improve awareness of this problem to the healthcare professionals, junior doctors and clinicians as well as nurses by regular teaching and training. The DME department already has got regular training arranged by the continence advisor • Develop continence care pathway • Identify clinical lead within existing DME resources. Set up a business case for multidisciplinary clinic involving urologists, continence advisor, and Geriatric consultant with special interest in incontinence.
END OF LIFE CARE CQUIN 2014/15 **THIRD PHASE** **N= 40**	**Corporate**	**Audit**	**July 2015**	**Main aims:** • Review current end of life care • Review evidence of symptom assessment and control • Assess the use of processes relevant to end of life care, i.e. DNACPR and PRP • Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities **Findings:** ***1. To assess the care by looking at evidence of symptom assessment and control*** • 88% of patients were identified as being in the last days/hours of life. • In 95% of cases there was evidence in the notes that a health care professional believed the patient to be dying in the last 3 days of life. • 28% of cases reviewed had documented evidence that patients complained of pain and of those, all (100%) had actions undertaken to resolve the symptoms. 91% noted the actions were effective. • 5% of patients had nausea and vomiting and action was taken in all cases with effectiveness of the intervention noted in all cases. • 33% of patients had breathlessness as a symptom. 85% had action taken to resolve the symptom and in 91% of cases effectiveness of action was noted. • 25% of patients were described as having terminal agitation, of which 90% had action taken to resolve it and 89% noted its effectiveness. • 15% of patients had noisy respiratory secretions, action was taken in all cases and 83% noted the effectiveness of the action. • In 83% of cases there was evidence that usual medications were reviewed when the patient was identified as dying.

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				2. Assess the use of processes relevant to end of life care such as the DNACPR and PRP • 93% of cases reviewed had a DNACPR and 75% of those had been discussed with the family. • 85% of patients had a Personal Resuscitation Plan and of those 44% were reviewed since it was initiated. • 7% of patients had an Advance Statement. ***3. Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities*** • In 15% of cases there was evidence the patients preferred place of death was documented. In 28% of cases the patients' preferences and concerns were noted. No patients had an advanced decision to refuse treatment in place. • Advice was sought from the palliative care team in 23% of cases. Spiritial and/or religious wishes were discussed in 33% of cases. • In 83% of cases, there was documented evidence the patient/family's views were discussed. In 78% of cases, there was evidence the family had the plan of care explained and timesacles were estimated in 68% of cases. The fact the patient was dying was discussed with family in 68% of cases. • Hospital facilities were only explained in 13% of cases. In 75% of cases the staff discussed the patients care with family on each of the last 3 days. • Following the patients death, 13% of cases indicated the death was certified by a Nurse and 43% of records indicated information leaflets were offered to the bereaved. In 60% of cases, bereavement support was offered to the family/next of kin. **Key recommendations:** • Continued education about the recognition of dying. This will be achieved in the education attached to rolling out the Individualised Care Plan for the Dying Patient. Also ward based coaching for medical staff. • To continue educating both nursing and medical staff on the importance of prescribing for the 5 common symptoms for the dying patient when introducing the Individualised Care Plan for the Dying Patient. To also capture during ward based coaching sessions. • To raise awareness when rolling out the Individualised Care Plan for the Dying Patient. At the same time introducing a spot check audit, to be lead by senior nursing staff. Discharge liaison and the Palliative Care team – including the site specific nurses. To

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				nurture ongoing learning and improvement. • To provide education on the importance of supporting famililies when an end of life event is evident. Learning will be indicated in the documentation of the Individualised Care Plan for the Dying Patient. Further inforced with spot check audits. • To increase the evidence of DNACPR being discussed with the family or the next of kin. To be achieved through spot check audits and further education at the point of need
AUDIT OF FLUID BALANCE MONITORING **N= 47**	**General Medicine**	**Audit**	**July 2015**	**Main aims:** The aim of this audit is to evaluate if fluid balance is well assessed in the Emergency Assessment Unit (EAU) at Luton and Dunstable Hospital and if NICE guidelines are respected. Main objectives are: • To identify current practice • To measure current practice against best practice • To improve current practice **Findings:** • The audit identified a lack of fluid balance monitoring and completion of fluid balance charts when patients are admitted to EAU • A good result has been found with regards to recording vital parameters such as BP and HR, both reported in 100% of cases • The audit highlighted that staff often undermined the importance of recording hydration and fluid volume indicators, such as capillary refill, lying and standing blood pressure, JVP and oedema. According to NICE guidelines, it is important to report at least one of the following: Capillary Refill Time, skin turgor and lying and standing BP. Despite such requirement, in only 2% of patients this information was collected • Skin turgor was not recorded at all, even if 50% of patients were under 70 years of age • The presence or absence of oedema is also a requirement to evaluate, as it indicates a fluid retention in the body and a higher risk of fluid overload if intravenous therapy is not given appropriately. NICE guidelines recommend to record signs of oedema from lungs, ankle and sacral area. The latter was never specificately mentioned, but assumed to be included when in clinical notes is written “no signs of oedema”. Ankle oedema was included or excluded in 45% of cases whereas the presence or absence of basal crackles was recorded in 81% of cases • Another sign of fluid overload is the JVP which together with oedema and age parameters, should play an important role in the fluid management, was recorded in less than 50% of cases

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Despite the missing information regarding multiple aspects of fluid balance, over 2/3 of patients received fluids on admission, almost 1/6 received electrolites and 15% of patients received furosemide • Half of the patients had fluid charts completed • The audit identified what appears to be a lack of standardisation and monitoring of fluid balance. It seemed that staff concentrated more on respiratory and cardiac systems (HR, BP, basal crackles), paying less attention to the important role of fluid balance assessment **Key recommendations:** Discuss findings with nurses and junior doctors in order to increase awareness
	OMFS	**Patient Su**	**August 2015**	**Main Aims:** • Identify levels of patient satisfaction (surgical patients) within OMFS • Identify specific areas for improving patient experience **Findings:** • All patients, at the initial consultation, were given a clear and thorough explanation of what the procedure involved • 60% of patients were seen on time when they arrived for their surgical appointment. The remaining 40% felt they were not seen on time, of which 44% experienced a 10-20 minute delay and 56% experienced a 20-40 minute delay • All patients stated the procedure was explained to them when they were called into surgery • 98% of patients stated they signed a consent form • 89% of patients were asked about their medical history before the procedure began • The majority of patients (94%) scored 5 (excellent) when asked how confident they felt with their Surgeon and dental team. The remaining 6% scored 1 or 2 (poor/fairly poor) • The majority of patients (94%) scored 5 (excellent) when asked whether the dental team were sensitive to their needs throughout the procedure • 92% of patients scored 5 (excellent) when asked whether they felt they were treated with dignity and whether their privacy was respected • The majority of patients (94%) scored 5 (excellent) when asked whether they were given clear verbal and written post-operative instructions • 88% of patients scored 5 (excellent) when asked whether they were given appropriate contact details in case of any concerns or further queries regarding their surgery. 10%

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				scored 1 (poor) • 92% of patients scored 5 (excellent) when asked how they would rate the care and treatment received on the day of surgery • All patients stated they would recommend the department to friends and family **Key recommendations:** • Provide clear instructions (verbal & written) • Reduce background noise • Highlight emergency contact numbers • Start on time: both nurses & surgeons • Set up and ensure the room is ready for surgical cases as a priority • Inform patients of any delay • A new consent form must be signed for each procedure • Surgeon to update medical history at every surgery visit
PAEDIATRIC HAEMATOLOGY PATIENT SATISFACTION SURVEY **N = 11**	**Paediatrics**	**Patient Su**	**August 2015**	**Main Aims:** • To identify levels of patient satisfaction amongst paediatric haematology patients • To ensure the service provided at the L&D meets the needs of families and to ensure problems are kept to a minimum • To identify further specific areas for improving patient experience and services to meet current demand **Findings:** • 46% of parents were happy with their child's appointment arrangements 'all the time'. 18% were happy with arrangements 'most of the time' and 36% were happy 'sometimes' • 46% of parents stated they get their appointment on time 'all the time'. Eighteen present stated they get their appointment on time 'most of the time' and the remaining 36% stated 'sometimes' • 18% of parents stated they are seen on the appointment time 'all of the time'. 27% stated 'most of the time', 27% stated 'sometimes' and the remaining 27% stated they are 'never' seen on their appointment time • The majority of parents (91%) stated staff were friendly and helpful either 'all the time' (36%) or 'most of the time' (55%) • The majority of parents (78%) stated their child's pre-transfusion bloods were done in Outpatients.

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• 18% of parents stated they were happy with the way the staff took their child's blood 'all the time'. 30% stated they were happy 'most of the time. The remaining 46% stated they were happy 'sometimes' • 37% of parents stated play distraction is used whilst their child is having bloods taken 'all the time'. 27% said this was the case 'most of the time'. 9% stated this was the case 'sometimes, and 18% stated this is 'never' the case • 37% of parents stated they understood what bloods were taken for which tests 'all the time'. 27% of parents stated this was the case 'most of the time'. 18% felt this was the case 'sometimes' and the remaining 18% felt they can 'never' understand which bloods are taken for which tests • 55% of parents felt the Doctors are friendly 'all the time'. 36% felt this is the case 'most of the time'. The remaining 9% of patients felt Doctors are friendly only 'sometimes'. • The majority of parents (82%) felt they could ask questions 'all the time' (46%) or 'most of the time' (36%). The remaining 18% felt they could ask questions 'sometimes' • The majority of parents (91%) felt the Doctors explained the treatment plan in a way they could understand 'all the time' (73%) or 'most of the time' (18%) • Thirty three percent of parents felt there is good communication regarding their child's latest treatment plan between the Doctors and their London Hospital 'all the time' in 33% of cases, 'most of the time' in 33% of cases, 'sometimes' in 22% of cases, and 'never' in 11% of cases • All parents (100%) would prefer to bring their child in on a Saturday instead of a week day • All parents felt staff are friendly either 'all the time' (64%) or 'most of the time' (36%) • Most parents felt their child's cannula is sited soon after their arrival either 'all the time' (18%) or 'most of the time' (73%) • 18% of parents felt their child's cannula is inserted skilfully 'all the time' in 18% of cases, 'most of the time' in 36% of cases and 'sometimes' in 46% of cases • 46% of parents felt the play therapist is always available for their child's cannula procedure 'all the time'. 18% of parents felt this was the case 'most of the time, and 27% felt this was the case 'sometimes' • 10% of parents felt their child finds the cannulation procedure frightening 'all the time'. 10% felt this was the case 'most of the time', and 70% of parents felt their child found the cannulation procedure frightening 'sometimes' • When asked whether parents were happy with the time it takes for the blood transfusion bag to arrive via the porter, 18% felt they were happy 'all the time'; 36% felt

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				happy most of the time; and 46% felt happy 'sometimes' • When asked whether parents were happy with the time it takes to put up the blood transfusion, 9% felt they were happy 'all the time'; 46% felt happy 'most of the time'; 36% felt happy 'sometimes'; and 9% were 'never' happy with the time it takes • When asked whether parents were satisfied with the transfusion procedure, 27% felt satisfied 'all of the time'; 55% felt satisfied 'most of the time'; 18% felt satisfied sometimes • When asked whether parents felt there is enough play and distraction for their child, 37% felt this was the case 'all of the time'; 27% felt this was the case 'most of the time'; 18% felt this was the case 'sometimes'; and 9% felt this is 'never' the case • When asked whether parents felt the staff talk to them and their child regarding problems they are having with their condition, 18% felt this was the case 'all the time'; 18% felt this was the case 'most of the time'; 46% felt this was the case 'sometimes'; and 18% felt this is 'never' the case • 60% of parents felt they would like more psychological help for them and their child in dealing with their condition • 27% of parents felt the service is flexible to allow for holidays away 'all the time'; 46% felt this was the case 'most of the time', and 27% felt the service is flexible 'sometimes' • For parents with teenagers, 33% felt their teenager has enough information regarding their condition 'most of the time', 33% felt they had enough information 'sometimes' and 33% felt they 'never' have enough information • All parents (100%) felt their child's opinion regarding their care is taken into consideration 'most of the time' • 33% of parents felt they would like more teenage appropriate activities for their child 'all the time', 33% felt this the case 'sometimes', and 33% felt they would 'never' like more teenage appropriate activities for their child • 67% of parents felt their teenager would like to know more information regarding their condition • When asked whether parents felt they had adequate support in the community, 12% answered 'most of the time'; 38% answered 'sometimes'; and 50% answered 'never' • Only 11% of children have a school care plan • 71% of parents felt their child's school does not understand about their child's condition • When asked whether parents felt they are given enough verbal and written information regarding their child's condition, 12% felt this is the case 'most of the time'; 63% felt this was the case 'sometimes'; and 25% felt they are 'never' given enough information

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				regarding their child's condition • The majority of parents (80%) are not aware of all the charities offering support • None of the parents are aware of patient information days run by these charities **Key recommendations:** • Discuss blood bag collection delay with transfusion and Zoe Garside Transfusion specialist nurse • Either Annabel Roxas or Karen Reep to be on duty for cannulation • Discuss Community support and Community care plans for schools with service managers and Maureen Scarlet and Haematology team
URINARY CATHETER MANAGEMENT AUDIT **N =**	**DME**	**Clinical Au**	**August 2015**	**Main aims:** • Assess the practice of urinary catheter management in DME patients in Luton & Dunstable Hospital • To ensure correct and accurate documentation of catheterisation • To highlight areas requiring improvement **Areas of good practice** • 79% of patients with new catheter inserted had reasons for the insertion explained in casenotes. However, although positive, still room for improvement, aiming for 100% • More than 80% had a catheter identification sticker placed in the case notes • Almost 100% had catheter care plan at the bedside and the drainage bag was in the correct position • Safeguarding issues identified in 2 cases (pressure sores), accounting for 9% **Areas to improve** • Understand why increased number of catheters used in some wards compared to others in DME, for reaudit • Recording the place where catheter was inserted • Reason for insertion: 31% in DME patients had a LTC in situ done in the community; leaves 69% of patients new catheter done in LDH, reasons to be reviewed • 71% aseptic technique was documented. Aiming for 100% • 71% only had the residual urine volume recorded, should be 100% • Poor use of bladder scanning (only 8%) prior to catheter insertion –knowledge and costs barriers • Poor bowel assessment (33%) prior to insertion

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• No prostate assessment done in more than 90% of male patients prior to catheter insertion • Only 63% had a next change date on the bag • Different drainage bags are used across the Trust • About a fifth of cases did not have the catheter to remain in situ reviewed on a daily basis –high risk of infections • More than 90% of patients had no documentations that they consented to have the catheter inserted, nor of explanations of the procedure, or plans to remove the catheter and trial of TWOC • No documentation of continence issues being reviewed by the Therapists • No referrals to the Continence service in 96% of cases **Recommendations:** • Training, Induction Programmes & Teaching, Part of DME teaching program + Feed-back from attendees • Re-audit, including QIP • To involve trust wide Clinical Directors, as High Risk Practice (CQC) • To involve trust wide Clinical Directors, as High Risk Practice (CQC) • Business case for new scanners across the Trust • Trust awareness via Grand Round
AUDIT ON URINARY INCONTINENCE CARE AT LUTON AND DUNSTABLE HOSPITAL **N = 64**	**DME**	**Clinical Au**	**August 2015**	**Main aims:** • Assess the prevalence of urinary incontinence in elderly patients in the Department of Medicine for the Elderly (now Directorate, DME), in Luton & Dunstable Hospital • To ensure correct and accurate documentation of urinary incontinence • To evaluate if patients were appropriately assessed and managed • To highlight areas for improvement **Areas of Good Practice:** • Majority of patients with urinary incontinence (UI) in this audit were identified in ED (73%) and in the wards (11%), collaborative working with community staff is required to identify such patients within community • Identified 10% of terminally ill patients with UI and consequences of the UI • 79% of patients had their symptoms recorded in the notes • 82.5% of patients had their medication reviewed • Functional ability assessed in 93%

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Cognition assessed in 86%, although aim is 100% • 100% had renal function checked **Areas to Improve:** • Although majority of patients with urinary incontinence (UI) in this audit were identified in ED (73%) and in the wards (11%), good as a Trust: needs to be identified in the community • Cognition assessed in 86%, aim is 100% • Most cases of UI were chronic or unknown length of time • Identified 34% of patients with acute UI who were not referred to continence services • Detailed history about symptoms of UI varies between 5% to 49%: aim 100% • Bladder diary not completed in any of patients • Only 65% of patients had their medical condition accessed and optimised • 7% of patients had an assessment of the impact of incontinence on quality of life. However this was not standardised assessment. None of patient's quality of life has been recorded by standard assessment (eg Kings Health Questionnaire) • Poor examination to look for the cause of urinary incontinence • Only 21% of patients had post void residual volume checked • 40% causes of urinary incontinence related to constipation. However only 17% of patients had digital rectal examination performed • 40% had recorded a treatment plan in the notes. However in 81% it only included a containment pads • 45% of patients had a catheter inserted with no reason for catheterisation and/or plan for removal of catheter documented in the notes • 76% had as consequences of urinary incontinence either UTI, Urosepsis or Pressure ulcers • No care plan or information on causes and treatment provided to patients • 88% of patients had no follow up • 95% not given any information how to cope with UI. Those 5% who had where given information on continence products only **Recommendations** • Training & Induction of staff • Develop teaching program in collaboration with Bedfordshire Continence Service and MDT

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Re-audit and extend to entire Medicine, QIPs • Involve new CDs • Standardised documentation across the Trust (Bladder diaries, care plan etc) • New clerking proforma for Quality of Life (QOL) • Development of Trustwide Continence Service
ACUTE ENT CLINIC PATIENT SATISFACTION SURVEY **N = 88**	**ENT**	**Patient Su**	**September 2015**	**Main Aims:** • To identify levels of patient satisfaction within the Acute ENT Clinic • To identify specific areas for improving patient experience **Findings:** • 60% of patients stated they were given a choice of appointment times • 48% of patients stated there was a delay in clinic. Of those, 40% were told how long they would have to wait. The remaining 60% were not told how long they would have to wait. • On a scale of 1 – 5 where 1 is poor and 5 is excellent, 54% of patients rated the cleanliness of the ENT department as 5, 38% rated it as 4, and 7% rated the cleanliness as 3 • 50% of patients scored 5(excellent) when asked if they were welcomed at reception. 24% scored 4, 10% of patients scored 3 (average) and the remaining scored either 2 or 1 (poor) • 85% of patients scored 5 (excellent) when asked if they were treated with dignity and respect. 8% scored 4, 2% scored 3 (average) and 5% scored 1 (poor) • The majority of patients (90%) scored 5 (excellent) or 4 (good) when asked if they were treated with sufficient privacy • Most patients (85%) felt staff were friendly and sensitive to their needs by scoring 5 (excellent). 10% of patients scored 4 and the remaining 6% scored either 2 or 1 (poor) • For those patients who contacted the department for any reason prior to the appointment, 74% scored 5 (excellent) with the service they received, 18% scored 4 • 94% of patients stated the staff treating/examining them introduced themselves • Most patients (86%) scored 5 (excellent) when asked if the Doctor explained the reason for any treatment or action in a way that they understood. 6% scored 4, 3% scored 3 (average) and the remaining 5% scored 1 (poor) • Most patients (86%) scored 5 (excellent) when asked if they received a sufficient answer to any questions. 7% scored 4, 1% scored 3 (average) and the remaining 6% scored 1 (poor)

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• The majority of patients (98%) felt they had enough time to discuss their health or medical problem with the Doctor • Almost all patients (99%) felt the Doctor listened to what they had to say • 98% of patients felt they had confidence and trust in the Doctor examining and treating them • Most patients (81%) scored 5 (excellent) when asked if they were involved as much as they wanted in decisions about their care/treatment. 10% scored 4 (good), 3% scored 3 (average) and the remaining 6% scored 1 (poor) • 72% of staff stated staff told them who to contact if they were worried about their condition/treatment after leaving the hospital • 80% of patients scored 5 (excellent) when asked how they would rate their overall care and treatment. 14% scored 4, 1% scored 3 (average). The remaining 5% scored either 1 or 2 (poor) • Most patients (70%) scored 5 (excellent) when asked how they felt their treatment was progressing. 19% scored 4 and the remaining 11% scored between 1-3. **Recommendations:** • Prompt start to clinic. Reduce delays where possible • Inform all patients of any delays of more than 20 minutes • Repeat survey in 9 months
GENERAL PAEDIATRICS INTERNAL HEALTH RECORD KEEPING AUDIT 2015 **N = 30**	**Paediatrics**	**Audit**	**September 2015**	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** Total number of standards measured = 68 45 standards (66%) Fully compliant 5 standards (7%) High compliance 10 standards (15%) Moderate compliance 8 standards (12%) Low compliance. The percentage of standards fully compliant has increased from 51% to 66%. The percentage of standards with either moderate or low compliance has decreased, which indicate a general improvement since the previous audit in 2014

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Key Recommendations: • Raise awareness of issues identified amongst Medical & Nursing staff and by presenting at CG meeting and discussing at Departmental meetings and Junior Doctor Inductions.
PRE-OPERATIVE AIRWAY ASSESSMENT AUDIT **N = 74**	**Anaesthetics**	**Audit**	**September 2015**	**Main Aims:** • Establish current practice in assessment of pre-operative airway • Identify areas of good compliance • Identify areas of poor practice with a view to making improvements **Findings:** • 65% of cases were assessed by a Consultant, 28% by a Middle Grade Doctor and the remaining 7% by an SHO • 86% of cases were patients undergoing a maxillofacial procedure. The remaining 14% were patients undergoing an ENT procedure • Documentation of OSA was documented in 5% of cases. OSA documentation was not evident in 95% of cases • 21% of patients had a BMI of >35, the remaining 79% of patients had a BMI of <35 • The ASA grade was not evident in 3 cases. Of the remaining 71 cases, 48% of patients had an ASA grade of I, 32% had an ASA grade of II, 17% had an ASA grade of III and 3% of patients had an ASA grade of IV • There was no airway assessment undertaken in 16 cases (22%). Of the remaining 58 cases, 86% of patients had Mal scoring, 40% Jaw, 86% Dentures and 33% Neck • In 84% of cases the Assessor/Anaesthetist was the same. The remaining 16% of cases had a different Assessor/Anaesthetist • There was a predicted difficult airway assessed in 32% of cases • There was an actual incidence of difficult airway in 31% of cases • The airway assessment was documented to be complete in 22% of cases and incomplete in 78% of cases • Airway documentation was evident in 92% of cases **Key Recommendations:** • All patients to be assessed by the same Anaesthetist who performs the Anaesthesia • All patients to have a pre-operative airway assessment • All patients require full airway assessment documentation

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
DIAGNOSIS AND INITIAL MANAGEMENT OF TRANSIENT ISCHAEMIC ATTACK (TIA) **N = 20**	**DME**	**Audit**	**September 2015**	**Main Aims:** • Identify whether the Luton & Dunstable Hospital Trust are adhering to the NICE recommendations & Quality Standards for the diagnosis and initial management of TIA • Identify areas where compliance needs to be improved • Identify areas of good practice **Findings:** • There has been an improvement in risk satisfaction using ABCD2 score. • For patients attending A&E dept. various validated stroke scales have been used (NIHSS & mRS) • Written information to patients is provided very well (100%) • Initial Aspirin treatment is given in only 50% of cases and in this area to be improved. **Key recommendations:** • Present audit at A&E Departmental Meeting to raise this issue and educate A&E staff.
FEEDING AT RISK **N = 10**	**Therapies**	**Audit**	**September 2015**	**Main Aims:** • Investigate timeliness in clinical decision making for patients who present with dysphagia (swallowing problems) • Establishing who was involved in the decision making process • Establishing clarity of documented decisions • Establishing and documenting mental capacity in the medical notes • Establishing the need for a change in practice based on audit outcomes **Findings:** • 80% of the patients had a confirmed diagnosis of dementia and lacked capacity to make their own decisions on nutrition planning. Whilst the sample included mostly dementia patients, the FAR decision making process would be applicable for all patients who are unsafe for oral intake where alternative feeding is not appropriate. • There was evidence of rapid decision making for 60% of patients following consideration for FAR. (70% if include community patient) • There were 2 examples of MDT approach and best interest meeting - but inconsistent approach to decision making (opinions provided but lack of MDT discussion / meeting) • Inconsistent documentation of the FAR decision (40%) or discussion including outcome of mental capacity assessments in the medical notes

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Delayed nutrition planning after FAR decision in 3 patients. (Reason for this may include SLT awaiting decision before providing recommendations / SLT unaware decision had been made / deterioration in patients condition .) • There were delays in identifying a swallowing problem following admission to hospital with a mean of 4 days recorded. Reasons for this could include patients who were admitted to hospital who remained *unresponsive* or were *not expected to survive due to the severity of their condition* but subsequently improved, those who developed swallowing problems *during* admission and *insufficient numbers of nurses trained to screen for swallowing problems on admission to hospital.* • The Speech and Language Therapy (SLT) team completed the initial specialist swallowing assessment within 2 days of receipt of referral for all patients, 60% of patients were assessed on the same day. **Key recommendations:** • To involve all stakeholders in a process to develop a clear Feeding at Risk Protocol and Pathway for the Luton and Dunstable Hospital • To improve communication across multi-disciplinary teams and family / carers with increased clarity and documentation in the FAR decision making process including documentation of capacity assessments when indicated. • To formalize and introduce Risk Feeding Guidelines in the acute and community settings and ensure ongoing care is handed over to the G.P , care home , palliative care teams , community matrons. • To improve the management of nutrition and hydration in advanced dementia and palliative care patients and help prevent unnecessary delays in decision making and re-admissions to hospital following discharge.
GENERAL SURGERY INTERNAL HEALTH RECORD KEEPING AUDIT 2015 **N = 20**	**General Surgery**	**Audit**	**October 2015**	**Main Aims:** • To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings from 2014. **Findings:** • Standards Fully Compliant: 43% of Standards • High Compliance: 7% of Standards • Moderate Compliance: 20% of Standards • Low Compliance: 30% of Standards • The percentage of standards fully compliant has slightly decreased from 45% to 43%. The percentage of standards with either moderate or low compliance has remained

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				the same/increased, which indicate a general decline since the previous audit in 2014. **Key Recommendations:** • Decline in including all patient details (HN, NHS no, Name) on all records. This was often found on reverse of continuation sheets where label not fixed. Raise awareness of need to label both sides of continuation sheets as all pages are legal documents and scanned in as individual sides of A4. Provide a session on record keeping at FY1 induction. • Documentation of key aspects of history has declined (95 – 55%). Are Clinicians being rushed and unable to record these? Are they being recorded elsewhere if surgical proforma is hard to navigate? Does this need to be addressed in teaching or does proforma need to change? Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction. • Legibility, date, time, signature and name printing has declined. Are staff unaware that these must all be included in all entries? If clinicians are rushed, could staff be provided with a stamp which includes their names and details? Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction. • Poor completion of Yellow Boards. Encourage clinicians to write review on Yellow Board so that it is easily identified in notes. Audit to be presented and discussed in CGM. • Decline in evidence of involvement of patient / carers in decision making process. Is it just poorly recorded or are we not involving patients in this process? Perhaps patient / carer satisfaction questionnaires could be designed and reviewed to look specifically at this and teaching provided for clinicians highlighting the importance of documenting patient / carer involvement. Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction.
Faecal Incontinence Care **N = 50**	**DME**	**Audit**	**October 2015**	**Main Aims:** • Assess the prevalence of faecal incontinence in elderly patients in the Directorate of Medicine for the Elderly, in Luton & Dunstable Hospital • To ensure correct and accurate documentation of faecal incontinence • To evaluate if patients were appropriately assessed and managed • To highlight areas for improvement **Findings:** • Areas of Good Practice: • Cognition assessed in 80% of cases, there is room for improvement

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Functional assessment done in 82% of cases • Patients with faecal loading • All patients identified with faecal loading had Bristol Stool Chart and were prescribed laxatives/enemas/suppositories • Bowel Management Care Plan is used and updated daily in 83% of cases • Areas to Improve: • Improve documentation on FI/constipation • Assessment of FI/constipation: needs to be comprehensive • Improve assessment of impact of FI on quality of life (QOL) • Use the Dementia CQUIN to improve cognitive assessment • Rectal examination only done in 52% of cases • Faecal loading only assessed in 52% of cases • Neurological examination only done in 20% of cases • Cause of FI was only identified in 30% of cases • Poor documentation on condition-specific interventions done • Improve diagnosis and treatment of comorbidities • Improve toileting advice and schedules • Improve medications and pharmacological interventions • Bowel training regimes • Dietician input • Advice on lifestyle • Treatment plan appear to include mostly containment devices • To provide a copy of their Bowel Management Care Plan to patients, as not done in 92% of cases • Only 50% of cases had documented evidence of a full discussion with the patient and carers/relatives of the causes and treatment of their bowel problem **Key recommendations:** • Training & Induction of staff • Develop teaching program in collaboration with Bedfordshire Continence Service and MDT • Re-audit and extend to entire Medicine, QIPs • Involve new CDs • Standardised documentation across the Trust • Adapted Kings Healthcare Questionnaire (QOL)

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Development of Trustwide Continence Service.
Complex Regional Pain Syndrome Audit **N=10**	**Therapeutics**	**Audit**	**November 2015**	**Main Aims:** The main aim of the audit was to measure how compliant hand therapies were in following the new therapy guidelines, implementing therapeutic modalities and issuing patient hand-outs between the 1st August 2014 and the 1st August 2015 **Findings:** Total of 13 standards: • 1 standard = fully compliant • 5 standards = moderate compliance • 7 standards = low compliance **Key Recommendations:** • Present audit findings at quarterly staff meeting in January 2016 • Further training on CRPS and review of guidelines with hand therapy team.
Trustwide Pain Survey 2015 **N = 118**	**Corporate**	**Patient Su**	**November 2015**	**Main Aims:** • Measure the efficacy of the action plans formulated within previous years • Inform the ongoing development of pain management care for all in-patients **Findings:** • Pain scores were recorded with every observation in 92% of cases. However, in 8% of cases, pain scores were not recorded at all, in the women's and children's directorate. In surgery and medicine 100% of patients had a pain score documented. The previous survey identified 71% of patients had their pain score assessed and documented on the observation chart with every observation. This was recorded intermittently in 26% of cases and not at all in 3% of cases. It is clear that the introduction of WardWare into the hospital has had a big impact on pain assessment documentation. However, the women's and children's directorate do not have ward ware due to specific needs for documentation in these areas. • 75% of patients surveyed reported they experienced pain during their admission. 83% experiencing pain described it as unbearable. The previous survey identified 86% of patients experienced pain during their admission. We know acute pain is usually associated with an underlying physiological (labour pain) or pathological (postoperative pain) process. Therefore it is understandable that many of our patients are admitted with a painful problem. It may be recurrent, with or without a background of ongoing chronic pain, (e.g. sickle cell disease, rheumatoid arthritis). Particularly

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				after surgery, patients will be subjected to degrees of pain and we need to be able to assess this pain, commence pain strategies preoperatively if possible and implement strategies to minimise the pain so that the patient is able to deep breath, cough and mobilise comfortably postoperatively. • 91% of patients reported that staff asked if they were in pain compared to 92% in the previous survey. However, it is interesting as this differs as 100% of patients had a pain score documented on Ward Ware. This shows a small difference in patients self report and what is documented. • 75% of patients felt that staff were understanding and sympathetic about their pain. 12% of patients felt 'some staff' were understanding, whilst 13% of patients felt staff were not understanding about their pain. The previous survey identified 90% of patients felt hospital staff were understanding/sympathetic about their pain. Nine percent of patients felt hospital staff were not understanding / sympathetic about their pain. The audit shows a lesser amount of sympathy and understanding was offered within the medical directorate. • Suggestions were made by staff to reduce pain in 89% of cases, of which, painkillers was suggested in the majority (72%). The previous survey identified suggestions were made by staff to reduce pain in 95% of cases. Pain killers were suggested in 82% of cases, pain killers + changing position/walking/other was suggested in 16% of cases and changing position/walking/other was suggested in 2% of cases. 11% of patients felt nothing was suggested. This is an increase from the last audit which showed 5% of patients felt nothing was offered. We noticed that this again was within the medical directorate. This may be due to the nature of pain that is within the different directorate. In the medical directorate it may be that patients are suffering with long term conditions and chronic pain associated with this. The management of acute and chronic pain differs significantly. There is a more proactive approach to acute pain to reduce complications of surgery and to improve outcome. In chronic pain medication can have limitations and it is often not appropriate to manage with medication alone. The patient may perceive this as the nurses or doctors not giving any suggestions for reducing their pain. • 62% of patients reported that they received pain medication immediately after it was requested. 19% of patients reported they waited for an acceptable amount of time, and 19% felt they had to wait a long time to receive pain medication. The previous survey identified 82% of patients received pain medication straight away, 8% of patients waited an acceptable amount of time, 8% of patients had to wait a long time, and 2% of patients did not receive their pain medication. Patients are waiting longer

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				for their analgesia than in 2012 audit. Over this time period tramadol (a opioid analgesia) has been changed schedule, and is now classed as a controlled drug in this trust. The implication being that it now needs to be checked by two nurses. We have also introduced EPMA which could affect the time it takes to administer the analgesia. • There has been a slight decrease (from 71% to 66%) in the percentage of patients reporting that a nurse/doctor returned to check on their pain following pain relief. The worst performing area was the medical directorate. Only 43% of patients reported that the nurse or doctor re-evaluated the pain after an intervention was made. 50% said the nurse did not evaluate. • 89% of patients felt nursing staff helped manage their pain. This has decreased from 2013 were 95% felt the staff did everything they could to control the pain. 11% did not compared to 6% in 2012. We need to develop a better understanding of the patients who reported that staff did not do everything they could to control the pain. A further audit is necessary enable a better understanding of why patients feel that nurses are not controlling their pain. • 61% of patients experienced pain during the night, of which 70% felt it was managed appropriately. The previous survey identified 59% of patients experienced pain during the night, of which, 76% felt it was managed appropriately and 22% felt it was not managed appropriately. Patients do tend to experience more pain at night time. This is a common problem for anyone suffering with pain, this may be due to environment factors for example: sleeping in a different bed, noise levels, no distraction. • 57% of patients felt overall their pain was managed very well, 17% felt it was managed reasonably well, 20% felt it could have been managed better and 6% felt it was not managed well at all. The previous survey identified 51% of patients felt their pain was managed very well overall, 30% felt it was managed reasonably well, 8% felt it could have been managed better, and 7% of patients felt their pain was managed not at all well. These are similar outcomes from the previous audit in 2012. **Key Recommendations:** • Continue training in importance of pain assessment and management. In the surgical division: • Continue improving patient expectation and self-management of pain. Use mobilisation as an aid to improve pain control. • Continue to work with enhanced recovery and MDT. To have guideline in place for orthopaedics.

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				In the medical division: • Present finding of this audit to medical directorate MDT. • Complete further audit to focus on highlight issues – management of chronic pain in inpatients on medical wards. • Have small group to action some change to enable ownership to the ward areas to improve assessment and management of patients in pain. • Group to develop action plan. • Pain service to continue and develop further workshops in medical areas. • Work with pharmacy colleagues to explore changes to policy relating to tramadol and schedule 3 controlled drugs (inc oral morphine) with exemption of safe custody requirement. • Highlight this to patients to ensure patients ask nursing staff for painkillers in a timely fashion. Include this in training.
ENT Internal Health Record Keeping Audit 2015 **N = 30**	**ENT**	**Audit**	**November 2015**	**Main Aims:** • To measure compliance with standards set out by NHSLA, CHKS and local guidelines. **Findings:** • Standard fully compliant (100%): 64% of standards • High compliance (91-99%) : 17% of standards • Moderate compliance (75-90%): 10% of standards • Low compliance (<75%): 9% of standards **Key Recommendations:** Raise staff awareness at departmental meeting on following: 1. to ensure copy of A&E clerking with patient ID on form when accepting patients 2. to use sticky labels for notes – but three point identification should be sufficient name, DoB, hospital or nhs number 3. to check height and weight recorded in nursing documents on admission 4. to complete investigations & results section with nil if none carried out. Raise staff awareness at departmental meeting on following: 1. to request letter from referrer for every accepted referral 2. to use sticky labels for notes – but three point identification should be sufficient name, DoB, hospital or nhs number 3. to ensure all relevant sections of consent form are filled out at time of completion Re-Audit in 1 years time

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions

RE-AUDIT OF PERMEATAL TRANSTYMPANIC MYRINGOPLASTY
 	
N = 13
	ENT	**Audit**	**November 2015**	**Main Aims:**
				• To re-assess the outcome of Permeatal Transcanal Myringoplasty with tragal cartilage and perichondrium in terms of:
				  o Graft success rate
				  o Hearing improvement
				• To analyse post operative complications and follow up trends
				• To assess improvement in day case rates
				• To assess improvement in the use of endoscopes
				
				Findings:
				Permeatal Transtympanic Myringoplasty using tragal cartilage and perichondrium is a less invasive technique with equally good outcome in terms of graft take, improvement of hearing and low complication rate.
				• Ten (77%) patients were aged between 31 – 60 years
				• No patients had associated medical conditions i.e. DM and IHD
				• 46% of patients were male as compared with 54% females
				• No patients were indicated as smokers
				• All patients had central membrane perforation
				• Size of tympanic membrane perforation was 20 – 39% for 7 (54%) patients. The size for the remaining of patients was 40 – 59% (23% of patients) and 60- 79% (for 23% of patients)
				• 38% of patients had left sided tympanic membrane perforation. The remaining 62% of patients had right sided tympanic membrane perforation
				• Otitis media was the underlying cause for most (92%) of patients
				• Type of hearing loss was conductive in 69% patients
				• Average air conduction threshold was 31 – 45 for 7 (54%) patients pre-op and 5 (38%) patients post-op
				• Recurrent ear infection was the most frequent indication for surgery in all cases (100%)
				• Type 1 Tympanoplasty was carried out in 12 (92%) patients
				• No patients underwent revision operation
				• 54% of patients had overnight stay at hospital
				• Current operation technique was Microscopic, Permeatal Transtympanic in 39% of patients and Endoscopic Permeatal Transtympanic in 61%
				• Graft material was Tragal Cartillage and Perichondrium in all cases

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Middle ear mucosa was normal in 92% cases • Condition of ossicles was intact in 92% of cases • First follow up was 2 weeks post op in 61% of cases • Second follow up was 5 -8 weeks in 38% of cases, 9-12 weeks in 31% of cases and 13-16 weeks in 23% of cases. One patient had their second follow up between 31-52 weeks • Third follow up ranged from 6 weeks to 44 weeks • Condition of graft was recorded as taken in 46% of cases and partial failure in 38% of cases • Post-operative audiology was carried out between 1-40 weeks with 50% of cases carried out between 11-20 weeks post-surgery **Key Recommendations:** • The audit identified inadequate/ inappropriate surgical instruments. Action to put forth a business case for acquiring Endoscopic Ear Surgery instruments • Audit also identified unnecessary overnight stays. Action: All endoscopic myrigoplasty patients should be discharged home same day • Erratic Post op follow up schedule also identified. Action: Follow ups should be as follows: First follow up = 2 weeks 2nd follow up = 6 weeks 3rd follow up = 6 months • Erratic post op audiology schedule identified. Action: 1st audiogram = at 2nd follow up 2nd audiogram = at 6 month f/up
SAFER MEASUREMENT & ADMINISTRATION OF ORAL LIQUID MEDICINES **N = 34**	**Corporate**	**Audit**	**January 2016**	**Mains Aims:** Assess practice in all clinical areas against the standards for oral liquid medicine administration to enable improvements in practice where necessary. The aim is to ensure that we provide safe care to our patients. **Objectives:** • Ensure availability of purple oral syringes in all areas where oral liquid medicines are administered • Ensure oral liquid medicines are prepared and administered using the appropriate device, e.g. graduated measuring cup, measuring spoon or by using a purple oral syringe if syringe administration is required

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Findings: • 32 of the 33 wards/clinical areas that are required to stock purple, oral liquid medicine syringes (97%) were compliant. One ward was out of stock. Action has been taken to immediately rectify by borrowing from another area until their supply arrives • The observational audit identified that staff in all clinical areas were compliant with best practice in administering oral liquid medicine using appropriate devices • The most frequently used devices to administer oral liquid medicines were graduated measuring cups (45%) and oral liquid syringes (44%). On 11% of occasions a combination of the two devices was, or would have been, used • No nurse used (or would have used) a measuring spoon **Key Recommendations:** -One clinical area did not have a stock or purple oral syringes at the time of the audit Action: Immediately stock that area by borrowing from another clinical area. Ensure that the ward has a system in place to ensure that the syringes are consistently stocked up. Matron for that area to do a spot check in one week. Add medicine pots and purple syringes to the checklists for the opening of contingency wards -Less than 100% of wards had a stock of purple oral syringes on the date of the audit and a Never Event related to a failure to keep a stock Action: Dedicate a Back to the Floor Friday Matron review to checking that practice and purple oral syringe stocks remain at 100%
ENDOSCOPY PATIENT SATISFACTION SURVEY **N = 98**	**Medicine**	**Patient Su**	**January 2016**	**Main Aims:** • To collect information about patients' experiences during their hospital visit to the Endoscopy Unit • To identify patients' level of satisfaction within the Endoscopy Unit • To identify improvements in current practice and levels of patient satisfaction following the 2014 survey **Findings:** • The majority of patients (97%) rated the booking procedure as either excellent or good • 97% of patients felt the amount of information given by the Booking office was about right • 96% of patients felt the test was done quickly enough after being referred • 66% of patients were offered a choice of dates/times to have the test • Seven patients (7%) were asked to move their appointment, of which 2 patients were

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				given an earlier date • 97% of patients felt they received enough information about what the test involved and 98% felt the information was easy to understand • The majority of patients (98%) found the instructions about the preparation clear to understand • The majority of patients (99%) rated the courtesy of staff in the Booking Office either very good or good • 15% of patients felt the Endoscopy unit was not clearly signposted • The majority of patients (98%) felt they were dealt with promptly and efficiently at the Endoscopy unit reception • Patients rated the courtesy of receptionists in the Endoscopy reception area as either very good (74%), good (23%) or satisfactory (3%) • 33% of patients stated there was a delay before they had their test and in a large number of these cases, no reason was given for the delay • 85% of staff rated the courtesy of the nurse preparing them for the test as either very good or good • The majority of patients (99%) felt the amount of information given to them by the Nurse preparing them for the test was either very good or good. The majority (98%) also felt the amount of information given was about right • Most patients (97%) felt they were given enough privacy when changing or being prepared for their procedure • 98% of patients felt their privacy/dignity was respected whilst on the Unit • 99% of patients stated the Endoscopist introduced themselves to them • The majority of patients (99%) rated the courtesy of the Endoscopist as with very good or good • 66% of patients felt the comfort level during the test was acceptable. 30% felt the comfort level was uncomfortable but acceptable. 2% felt the comfort level was unacceptably uncomfortable and 2% of patients could not remember • 29% of patients felt the test was more uncomfortable than they thought it would be • 44% of patients stated they were placed in a single sex area, 21% stated they were not placed in a single sex are and the remaining 35% did not know whether or not they were in a single sex area • 77% of patients stated the results of the test were explained to them afterwards and 72% stated they were given written information about the results of their test • For those patients who had a biopsy, 70% stated it was made clear to them how they

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				could get the results • 72% of patients stated they or their relative were given written information about the sedative • 62% of patients were given a telephone number to ring if they needed advice after the test • 61% of patients were advised about any necessary follow up appointments before leaving the department • 73% of patients felt they would be extremely likely to recommend the Endoscopy Unit to friends and family. 25% felt they would be likely to recommend the unit **Key Recommendations:** • Admission nurses to keep patients and their relatives advised of any delays, and update white-board in reception area when appropriate • Endoscopy staff to ensure patients are placed in single sex area. A question to be added to the questionnaire for the 2016 survey to ask if patients went straight from procedure room to seated recovery (which is unisex)
AUDIT OF YELLOW BOARD REFERRALS TRAUMA & ORTHOPAEDICS **N = 181**	**T&O**	**Audit**	**January 2016**	**Main Aims:** • Evaluate the current use of Yellow Board referrals for Trauma & Orthopaedics • Identify areas for improvement, recommend suggestions and implement changes where necessary **Findings:** • One hundred and eighty eight patients were identified from ICE service provider • Out of 188 patients only 181 patients were included in the review; 7 were excluded due to inadequate request details (2), not on service provider (2), incorrect date on service provider (3) • Average age of patients was 47.5 years • 52% of patients were female, the remaining 48% were male • A large number of patients (35%) were referred from Geriatrics followed by Gastroenterology • 31% of referrer's were a CMT Grade, 26% were FY1's, 20% were FY2's, 10% were SpR's, 7% were Consultants and 6% were Staff Grade • The duration of symptoms was noted in 34% of cases. In 66% of cases the duration of symptoms was not documented • Previous treatment was only mentioned in 63 of the 181 cases

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				• The referral was felt appropriate in 56% of cases and inappropriate in 44% of cases • 78% of referrals were urgent; the remaining 22% were routine referrals • 29% of patients were suitable for elective orthopaedic /fracture clinic. 71% of patients were felt not suitable • 42% of patients consumed 10 minutes of time; 58% consumed 30 minutes of time • Registrars feedback was evident in 51% of cases • The Orthopaedic Consultants name was noted in only 12% of cases • The Registrars full name was mentioned in 19% of cases **Key Recommendations:** • Improve documentation with clear precise information on the yellow board e.g. duration of symptoms and relevant past treatment given in order to prioritise the request. • Clear documentation for the reason of admission to the hospital. • Orthopaedic team reviewing patient to document in the medical notes of the Ortho consultant on call. • To save time, Orthopaedics Registrars to reply back to the queries on Yellow Board following trauma meetings. • Registrars completing the Yellow Board to document their surnames • Prepare a list of appropriate/inappropriate for the Yellow Board referral form Orthopaedic point of view
TRAUMA AND ORTHOPAEDICS INTERNAL HEALTH RECORD KEEPING AUDIT 2015 **N = 20**	**T&O**	**Audit**	**March 2016**	**Main Aims:** • To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings from 2013/2014 **Findings:** • 32% of standards fully compliant (100%) • 13% of standards with high compliance (91-99%) • 38% of standards categorised as moderate compliance (75-90%) • 17% of standards with low compliance (<75%) **Key Recommendations:** • Documentation at initial examination should be carefully documented, dated and timed. This should be applied to prescriptions and drug charts as well. Action: This will be discussed at the Clinical Governance Meeting and the teams will be notified

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				separately by email in order to raise awareness • All Doctors to be notified of the need to accurately enter date and time of examination. The name should be clearly noted in block capitals under the initials with bleep numbers, where relevant. Height and weight measurements to be entered by admitting nurse. Electronic discharges to contain all relevant investigation results and drugs noted. Action: This will be discussed at the Clinical Governance Meeting and the teams will be notified separately by email in order to raise awareness
OUT-PATIENT HYSTEROSCOPY CLINIC PATIENT SATISFACTION SURVEY **N = 291**	**O&G**	**Patient Survey**	**March 2016**	**Mains Aims:** • To identify levels of patient satisfaction within the Outpatient Hysteroscopy Clinic • To identify any specific areas for improving patient experience **Findings:** • Just over half of respondents (51%) felt the clarity of information sent prior to the appointment was 'excellent'; 39% felt it was 'good'; 7% felt it was 'satisfactory'; 2% felt it was 'poor' and one patient (0.5%) felt it was 'very poor' • 51% of patients felt the speed of their appointment was 'excellent'; 35% felt it was 'good'; 10% felt it was 'satisfactory' and 4% felt it was 'poor/very poor' • 39% of patients felt the waiting time in the clinic was 'excellent'; 32% felt it was 'good'; 19% felt it was 'satisfactory'; 10% felt it was 'poor/very poor' • The majority of patients (88%) felt the dignity/respect shown by staff was 'excellent'; 11% felt it was 'good'; and 1% (4 patients) felt it was 'satisfactory' • The majority of patients (89%) felt the Doctors' professionalism was 'excellent'; 10% felt it was 'good'; and 1% felt it was 'satisfactory' • 62% of patients felt the clinic surroundings/waiting area was 'excellent'; 32% felt it was 'good'; 6% felt it was 'satisfactory'; and 1 patient felt it was poor • Almost three quarters of patients (74%) felt their general overall impression of the service was 'excellent'; 22% felt it was 'good'; 3% felt it was 'satisfactory'; and 1 patient felt it was 'poor' • Additional comments from patients were generally positive **Key Recommendations:** • Review clinic letter sent out to patients to address possible confusing information sent out prior to appointment • Review appointment times/length of appointment & review Clinic start/finish times to address waiting time issues

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
TRUSTWIDE CONSENT SURVEY AND DOCUMENTATION REVIEW 2015 **NUMBER:** **PATIENT SURVEY = 75** **DOCUMENTATION REVIEW = 124** **DOCUMENTATION REVIEW (LD/DEMENTIA PATIENTS) =30** **OBSERVATIONAL AUDIT = 20**	**Corporate**	**Patient Survey & Audit**	**March 2016**	**Main Aims:** The main aim of this survey is: • To collect information about patients' experiences of providing consent for a procedure/operation during their hospital visit/stay • Identify any gaps in documentation/completion of Consent Forms • To carry out an observational audit of staff obtaining patient consent from patients with Dementia and Learning Disabilities **Findings: <u>Patient Survey:</u>** • There has been an improvement in the percentage of patients (from 91% - 96%) reporting a member of staff explaining the nature and purpose of the procedure. • There has been a slight decrease in percentage of patients (from 100% - 95%) reporting a member of staff explaining the advantages of the procedure. • The 2014 audit demonstrated 90% of patients reported that disadvantages/risks were explained to them as part of the consent process. This year 92% of patients reported that disadvantages/risks were explained. • The number of patients who were advised of the type of anaesthetic/sedation which would be used during their procedure/operation has slightly decreased from 90% to 88%. • 95% of patients felt they were able to ask further questions before giving consent. The previous audit demonstrated 91% of patients felt they were able to ask further questions. • 71% of patients felt they were given enough time to consider the information provided before being asked to sign the consent form. This has dropped from 91% in the previous audit. • There has been a decline in the percentage of patients (71%) who felt they were given enough information (verbal/written) to help them make their decision. The previous audit demonstrated 91% of patients were given enough information. • 91% of patients felt they fully understood what the operation/procedure entailed. This has improved since the previous audit (82%). • 24% of patients felt they would have benefitted by having information provided in other formats. The previous audit demonstrated this was the case in 9% of cases. • 29% of patients reported they had not been given a copy of the signed consent form. The previous audit demonstrated just under half of the patients (46%) reported they had not been given a copy of the signed consent form.

Title/Topic	Directorate Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Documentation of Consent Forms (Trustwide): • No. of standards fully compliant = 16% • No. of standards with high compliance = 35% • No. of standards with moderate compliance = 6% • No. of standards with low compliance = 43% **Documentation of Consent Forms (LD/Dementia Pts):** • No. of standards fully compliant = 55% • No. of standards with high compliance = 19% • No. of standards with moderate compliance = 6% • No. of standards with low compliance = 19% **Key Recommendations:** • To undertake a more in depth patient experience survey to better understand the issues identified and develop a more comprehensive, focussed action plan. • To include assessment of capacity and best interest training in junior doctor induction, in respect of consent. • Pre-operative checks must include a check that forms have been appropriately completed and appropriate action taken if not. • Develop an audit programme to assess the robustness of mental capacity assessment. • LD nurse to proactively monitor and provide support to the medical and nursing team caring for LD patients requiring consent to procedures • Review and reinvigorate a more comprehensive training programme for clinical staff in consent • Review and improve the consent documentation tool and re-audit in 6 months. • Presentations at the following forums: Patient Safety Breakfast, Grand Round, Governance meetings, Dementia Strategy Group

Committees of the Board of Directors