



LUTON &
DUNSTABLE
UNIVERSITY
HOSPITAL



Annual Report and Accounts

for the period April 2014 to March 2015
incorporating Quality Account

Luton and Dunstable University Hospital
NHS Foundation Trust



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Presented to Parliament pursuant to Schedule 7, paragraph
25 (4) (a) of the National Health Service Act 2006

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Awards and Congratulations

Macmillan Quality Award for L&D Cancer Unit



During the year, we were delighted to receive a Macmillan Quality Environment Award which assesses how well buildings such as chemotherapy units provide support and care for people affected by cancer. The award coincided with the completion of an extensive programme of renovation to refurbish and upgrade the facility.

Patients have said how impressed they are with the improvements, and one said it was like moving up to business class because the new chairs are so comfortable that he can fall asleep while having his chemotherapy treatment.

It is well recognised that an environment where individual privacy and dignity are respected and which is welcoming, accessible and offers choice and comfort, is beneficial to patients' recovery.

The Macmillan Quality Environment Mark will help to ensure that people affected by cancer are treated and supported in physical environments of uniformly high quality.

Equality and Diversity 2014-15 NHS Employers Partners Award



We received an award from NHS Employers for our work on Equality and Diversity during the year. The team at the Trust, Angela Doak (Director of HR),

Sally Gitkin, (Head of Organisational Development and Learning) and Sally Dring (Patient Experience Manager) and the Trust the Equality lead Robert Jones (pictured left), have helped to ensure the trust has benefitted from being a NHS Partner.

This has led to the Trust successfully recruiting over 60 Personal, Fair and Diverse (PFD) champions; becoming runners up for an award for the Apprentice steps programme of work ; developing an equalities information pack, supporting the trust to make a year on year improvement in its performance against the NHS Equality Delivery System (E.D.S 2) goals.

Award Winning Apprentice Scheme at L&D



Over the past year, six young adults have been engaged in work placements at the L&D through a scheme called Apprentice Steps. Apprentice Steps is a

partnership between the L&D, Luton Borough Council's New Horizons Service and Luton Adult Learning. The project provides accredited learning and work placements for adults with learning disabilities and hopefully leads to paid work in the local area.

The pilot project was set up to improve the social and economic prospects for adults with learning difficulties. The partnership has been very successful, and has achieved local and national recognition winning prizes at the recent Adult Learners' Week and NHS Eastern region award ceremonies.

Hazel Watson from L&D's Training Department said, "Apprentice Steps has enabled people with a learning difficulty to gain credible work experience and a third of learners are now able to enrol in a mainstream apprenticeship. The learners are meticulous, detail conscious, have outstanding time keeping and reliability and many having fantastic IT skills. They have added real value to the Trust and I would strongly recommend Apprentice Steps to other potential partnership hosts."

L&D's Gastroenterology Team are national champions



A team from L&D's Gastroenterology Department led by Dr Matthew Johnson scooped a prestigious national award: The British

Society of Gastroenterology SAGE Award 2014 for the programme they developed to help patients with Inflammatory Bowel Disease (IBD).

The patients and their GPs have access to an online system offering support to help manage and monitor their disease more effectively which helps to avoid flare ups of severe illness. This in turn reduces the number of emergency hospital admissions for these patients - beneficial to both patients and to the hospital.

And not content with winning one award, Matthew and the team are also finalists for the British Medical Journal's Team of the Year 2014 and they have also made it to the finals for the EHealth Insider (EHI) national awards in October for the category Best Use of IT to support Healthcare Business Efficiency. What a team!

Photo shows IBD Project Nurse Karen Lithgow, Gastroenterology Consultant Dr Matt Johnson and Clinical Nurse Specialist Tracey Price proudly collect their 2014 SAGE award.

Governors who have completed their full terms of office

The L&D became a Foundation Trust with a Council of Governors in 2006. Each Governor is able to stay for a maximum of three terms of office and during 2014, four of our Governors, Bina Gupta, Vic Skates, Rowena Harrison and Lesley Groves, reached the end of their third term which equated to eight years service on the Council of Governors.

The Trust and the Council of Governors join in thanking them for all their hard work over the years. Their support by representing the views of the local people and staff, and helping the hospital to shape its plan for the future



Bina Gupta, Public Governor for Luton



Rowena Harrison, Public Governor for Bedfordshire

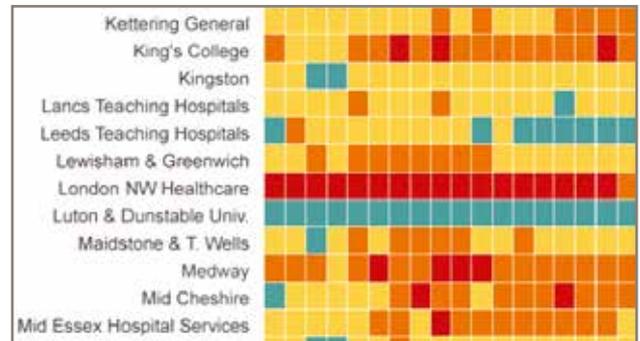


Vic Skates, Public Governor for Luton



Lesley Groves, Staff Governor for Nursing & Midwifery

A&E Performance Nationally Recognised



In March 2015, the BBC reported about the performance of Hospitals across the country at coping with this year's additional winter pressures. We are proud to have been named as the only Trust in the country to have met the 95% target of all A&E admissions being seen with four hours.

This is a fantastic achievement and is thanks to the hard work and team effort given from staff across all areas of the Hospital. Thank you to everyone for your continued hard work and support in putting patients at the heart of everything we do.

L&D Volunteer Awarded the British Empire Medal

Eileen McMahon is the L&D's longest serving Volunteer having been with us for 40 years. She offers her unique skills as a Skin Camouflage Practitioner not just to our patients solely, but also via the charity 'Changing Faces'. Eileen has received a number of awards over the years, including the Queens Medal via the British Red Cross for her Services to Volunteering, but her most recent, the British Empire Medal , or BEM (for her services to the Community



Eileen (centre) with the 4 Volunteer Managers she has worked with (L-R) Liz Bagshaw, Karen Bush, Sally Dring and Rhona Harvey

75th Anniversary Archive and History Talks



Over the 75th Anniversary year, Janet and John Graham have voluntarily supported the work of our archive and Janet, who trained and worked at the L&D as a nurse, has presented many wonderful talks about the L&D's 75 years within the community. Our thanks go to Janet and John for their dedication to the Trust.

L&D Pharmacist Awarded Clinical Doctoral Research Fellowship



Cathy Geeson has been awarded a Clinical Doctoral Research Fellowship from the National Institute for Health Research (NIHR), and is the first pharmacist to ever receive this award. The research aims to develop a prediction tool to help

hospital pharmacists identify patients at highest risk of preventable medication related problems. This will permit pharmacists to target patients, which has the potential to increase the efficiency of hospital pharmacy services, and thereby reduce NHS costs. In terms of patient benefits, the identification and resolution of medication related problems has the potential to improve health and wellbeing, improve patient experience and ultimately quality of life.

Long Service Awards



On Thursday 13th November 2014, the Chief Executive was delighted to spend time, along with other Trust Board members, in the company of staff celebrating their long service with the Trust. In recognition of this we enjoyed Afternoon Tea where many memories were shared about the hospital over the past 25 years. It was a lovely afternoon which was made even better by the enthusiasm and passion shown by these staff still today.

Staff worked for the L&D over 25 years

Hilary Adams
 Stephen Adcock
 Anne Barker
 Deborah Borland
 Charulata Chauhan
 Deborah Crosby
 Jacinta Davis
 Suzi DiFillipo
 Carolyn Ding
 Jayne Dolan
 Catherine French
 Teresa Hurley
 Flora Jackson
 Victoria Kiely
 Kevin Lane
 Christine Liburd
 Melvyn Lownds
 Helen Lucas
 Martina McIntyre
 Tracey McIntyre
 Alison McKenzie

June McMaugh
 Ann Mead
 Dorothy Michael
 Eleanor Mirzaians
 Ivor Mitchelmore
 Rohinton Mulla
 Veronica Redmond
 Lim Saw Cheng
 Tracey Scivier
 Anne Scott
 Maria Senjack
 Helen Shearman
 Phil Spencer
 Beverley Steere
 Susan Tripp
 Daniella Vincent
 Andy Walters
 Jane Ward
 Susan Young

Staff worked at the L&D over 40 years
 Heather Waller

Nursing Awards 2014



Nurse of the Year Erma Bristol-Miller Award - Grainne McDevitt
 Most Promising Graduate Nurse Aimee Varney Award - Stephanie Quantrill
 Clinical Support Worker 2014 - Cath Thompson
 Mentor of the Year - Jacqui Kenyon
 Student of the Year - James Bartlett
 Innovation Award - IBD Team
 Team of the Year - Ward 23

Postgraduate Medical Examination for Senior Doctors Recognition Award



For many years Luton and Dunstable University hospital has been an examination centre for MRCP PACES clinical examination (Postgraduate medical examination for senior doctors) which is conducted by Royal College of Physicians (RCP).

Dr Rehman, Dr Tariq, Dr Pillai, Dr Banerjee and Dr Mylvaganam were hosting this examination during this period and the hospital has been running this examination exceptionally well and none of this would have been possible without the support of our hospital

management, support staff, our patients, host examiners and regular examiners in our hospital.

In recognition of achieving a landmark as high output examination centre, a plaque was presented to Pauline Phillip Chief Executive by RCP chair examiner following the recent MRCP examination on 16/11/2014.

University College of London (UCL) Top Teacher Awards



Dr Ritwik Banerjee



Dr Parthipan Pillai

Following student nominations at UCL, two L&D consultants were singled out for praise by the Students and awarded Top Teacher certificates:

- Dr Ritwik Banerjee, Consultant Physician and Endocrinologist
- Dr Parthipan Pillai, Consultant in Respiratory Medicine

Local Community Awards



Our Integrated Discharge Team won the 'Service with a Smile' award in this year's Local Community awards and that our Respiratory Team were also finalists.



About this Report

The report follows best corporate practice reporting on the Trust's strategy and performance against the objectives. The report presents information on national targets and financial performance and also gives a review of the quality of services.

The report is structured as follows:

Introduction

Statements from the Chairman and the Chief Executive

Strategy

The Trust strategic vision, performance against 2014/15 objectives and the corporate objectives for 2015/16

Operational Performance Report

Includes performance against national targets, Research and Development and sustainability and climate change

Our Patients, Our Staff and Our Partners

Includes other information about patient care, staff, Equality and Diversity and working with partners

Governance Report

Includes details of the Board of Directors, Council of Governors and Foundation Trust membership

Financial Performance Report

Includes performance against financial targets and any risks for the future

Annual Governance Statement and Accounts

Includes the Annual Governance Statement and the annual accounts

Quality Account

Includes details of the progress against quality objectives for 2014/15, the plans for 2015/16 and the annual quality statements.

Introduction



At the very heart of the Luton & Dunstable University Hospital Foundation Trust (L&D) is a culture based on the conviction that to deliver the best clinical outcomes, the safest care and the highest standards of quality, that 'learning' and 'teamwork'

are indispensable. The commitment to learning and teamwork has shown results. For a number of years the organisation has consistently delivered against national quality and performance standards while continuing to make financial surpluses. Throughout the Hospital NHS there is a spirit of clinical ambition, as specialties grow attracting highly competent medical and clinical staff keen to implement the latest advances in medicine, provide seven day services, diagnostics at the time of need and the shortest possible inpatient admissions. Importantly, the organisation continues to demonstrate an ability to 'turn around' poorly performing services and to maintain improvement.

The commitment and expertise of our staff, has enabled us to consistently deliver against national quality and performance targets, achieving a Monitor governance rating of green for the last nine quarters and a financial surplus for the 16th successive year.

In our 2014 Strategic Plan we set out a clear vision for the future of the organisation, our ambition to transform the hospital from being a traditional District General Hospital to become a Hyper Acute Emergency Hospital, a Women's & Children's Hospital and an Elective Centre supported by diagnostics at the time of need, an Academic Unit and working with external partners to ensure the success of integrated care. Importantly, the vision is supported by an intention to re-develop the hospital building and facilities.

During 2014 we also published our 2 year Operational Plan which supported the implementation of our Strategic Plan by detailing seven corporate objectives and a number of key deliverables.

This annual report details how we successfully delivered that plan during 2014/15 despite the increasing challenges facing the NHS including escalating workforce costs, increasing numbers of patients remaining in hospital who are medically fit for discharge and the enormous implications of poorly performing organisations being paid over and above tariff to provide patient care.

Pauline Philip
Chief Executive

Chairman's Statement



I have the immense privilege of succeeding Spencer Colvin and, in an interim position, (now the Vice Chairman and Senior Independent Director), Clifford Bygrave as Chair of Luton & Dunstable University Foundation Trust Hospital. I would like to

thank them and, more significantly, the executive team and all staff, in every aspect of the hospital, for the incredible inheritance. L&D, as it is colloquially termed, undoubtedly justifies the title "one of the very best hospitals in the country".

The Health Service is inundated with clinical metrics calculated clinically and in all of these the hospital excels. It was the only hospital of any size to achieve the A&E target of 95% of patients treated within 4 hours of arrival every week over the winter of 2014/15. It is in the top 10 in cancer treatment by reference to the 2014 Patient Survey and in that situation you might expect that there was little room for improvement; yet it was judged by the National Cancer Patient Experience Programme Survey as the fourth most improved in the country. If its hospital care is the best the country can provide, L&D has also made great strides in eradicating the risks of coming into hospital - its cases of hospital induced infection are way down with only 10 cases of c diff this year, compared with 16 last. Its performance on recovering patients who have fallen and incurred the significant injury of fractured neck of femur have reduced very significantly from 84 in March 2014 to 61 in March 2015.

But what has impressed the most is not merely the metric-ranked measures of its medical achievement but the clear culture of care that permeates the totality of the hospital. In the L&D it is absolutely clear that the patient always comes first. The hospital achieves the A&E record it does not because of a target but because, from its top down, the whole hospital reacts to the fact that a critically ill patient left untreated only gets worse as well as suffering for longer - the whole hospital mobilizes to make sure such patients, all patients, leave having received the most caring care achievable. In this we are deeply indebted also to our 270 volunteers who make a major contribution complementing perfectly the 4,000 core hospital staff.

In addition to total care I have been impressed by the way in which the hospital always seeks out new ways of doing things. Two stand out for me in the year 2014/15. L&D is a teaching hospital - that need to contribute to the future of the profession is clearly very important to it. As such it is a member of ULCP (an Academic Health Partnership founded under the mothership of UCLH in London). It was surprised to discover that a review undertaken by that institution identified L&D's informatics as best in class. This

doesn't just improve the efficiency of the hospital but also the way in which patient notes and information can be made immediately available to the consultant - critical to optimal and efficient diagnostics and treatment. In similar vein, on 10th January, the hospital instituted for, we believe, the first time in the country a Super Saturday of planned elective care offered by consultants under their existing contract. This is further evidence of the extent of the commitment of all staff to ensure facilities are best used and care is most flexibly offered to the patients. On a more prosaic basis, as committed by Spencer last year, the car parking has now been reconfigured so that all patients and visitors should at all times have easy access to the hospital by car.

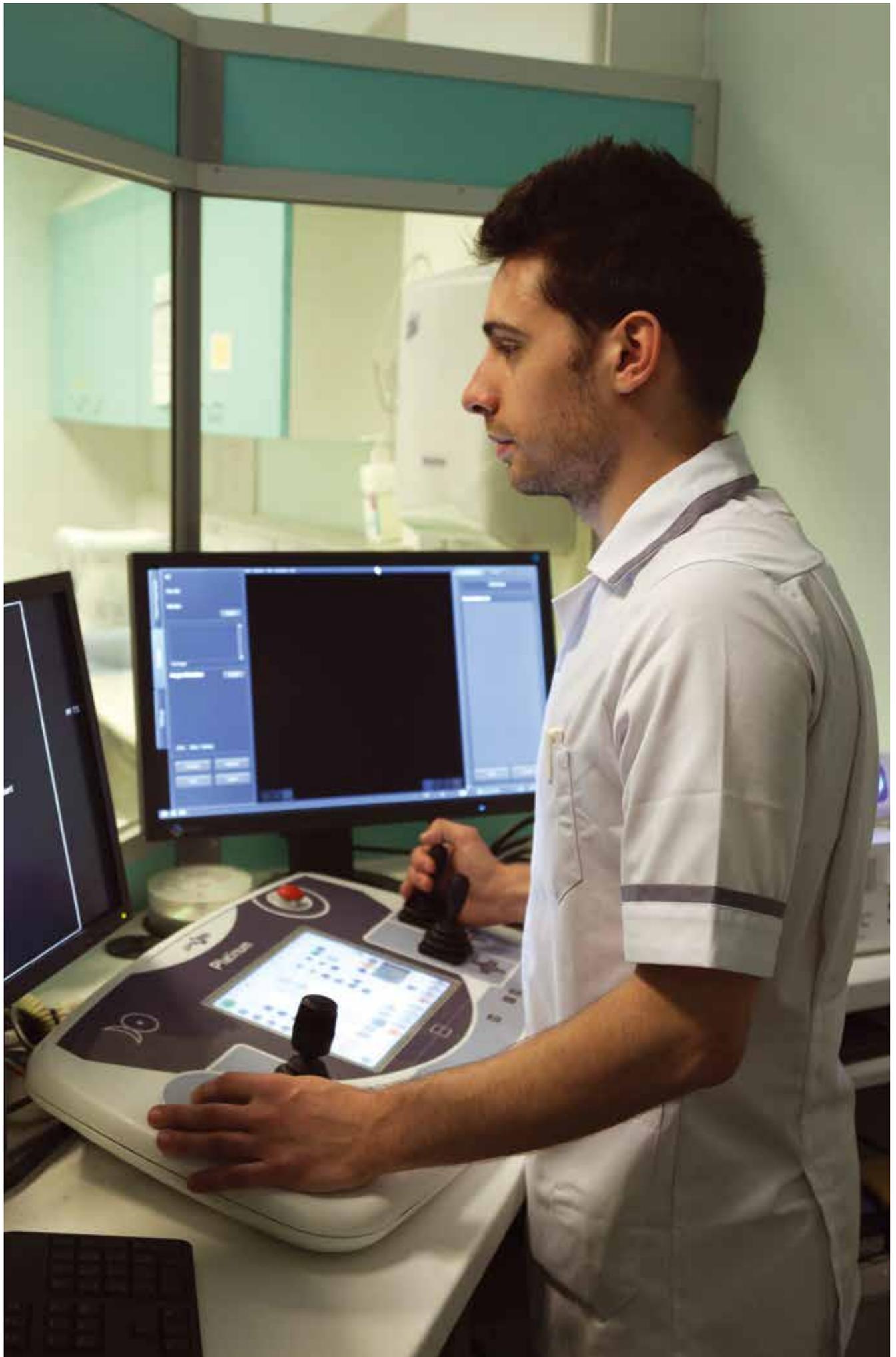
Looking ahead, anyone visiting the site will rapidly understand the constraints under which it operates. In the middle of last year the board agreed to investigate a scheme costing around £150m under which the hospital site will be refurbished. The evaluation of this programme of works is proceeding well and we have every hope that by the time I next write to you the project will have the approval of the Board, the Governors (who are closely involved in the project's development) and Monitor (our Regulator) and that the funding will have been secured. We expect this redevelopment to be concluded by 2020 but, we are already starting the process of refurbishing certain aspects of the hospital which will not be touched directly by the redevelopment.

No one can read the papers and listen to the news without understanding something of the challenges which the Health Service faces. L&D is not able to ignore them but the accounts which declare a modest surplus (the sixteenth such in a row) mean that it is in a clear minority - most are in deficit. And, with that head start, the great support of the community, Members* and Governors for a hospital that is determined to achieve the best possible outcomes. I feel very confident that L&D will go from strength to strength.

I commend these accounts, the hospital and all who strive to deliver its services for your consideration. And I add my thanks.

Simon Linnett
Chair

* If anyone reading these accounts wants to join our 15,000 Members who take overall stewardship of this incredible institution, you can sign up on www.ldh.nhs.uk



Strategic Vision

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

Vision statement

“The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise using the best technology available and with kindness and understanding from all our staff”

That vision has informed the hospital of what the L&D is and will continue to be during the next five years. Constantly striving to improve Clinical Outcome, Patient Safety and Patient Experience which is at the heart of everything we do.

The Trust has agreed a strategic vision for the next five years. The vision is the outcome of extensive work undertaken during the last three years, including:

- the development of a clinical services strategy
- detailed analysis of the local health economy's requirements
- participation in the Healthier Together project
- a thorough review of emerging national policy, including the Keogh Report into Emergency Care, the Academy of Royal Colleges report 'Seven Day Consultant Present Care' and the Better Care fund initiative
- joint working with local commissioners and other stakeholders
- an ongoing dialogue with our members and governors
- recognition that rising health care demand, rising costs and flat real funding means the Local Health Economy is facing a serious sustainability challenge.

Our vision is based on an understanding that patients will choose to receive acute hospital care from organisations that deliver:

- the best clinical outcomes
- a reputation for providing safe care
- high quality care
- care and diagnostics at the time of need

Our vision is consistent with

- the emerging findings from the Bedford / Milton Keynes Review
- the knowledge available to us regarding the strategic intention of other providers
- the financial challenges facing our local CCG's
- the business development opportunities available to us to increase market share and to establish new services
- the strengths and weaknesses of the Trust

Our vision translates into a five year strategic plan, underpinned by six priorities:

1. Delivering Integrated Care, leading the work with external partners and stakeholders to ensure success in delivering care in the best place for patients.
2. Being a Major emergency centre; delivering 24x7 consultant-led A&E, emergency surgery, and acute medicine, supported by a level 3 critical care unit, enhanced trauma services and a specialist hyper-acute hub for vascular interventions, cardiac and stroke care.
3. Expanding our Women and Children's centre, with a maternity unit providing extended consultant cover and presence, in line with Royal Colleges Guidelines and 7-day consultant led care supported by a level 3 NICU and inpatient Paediatric Services.
4. Growing our Elective Centre; attracting both complex and non-complex elective activity from across the Local Health Economy and offering a high quality and efficient service for inpatient and day patient care.
5. Providing diagnostics at the time of need to support the delivery of integrated care for outpatients and the best possible clinical outcome for inpatients.
6. Advancing our commitment to training and teaching by: developing all staff groups; drawing on our clinical case mix and areas of established excellence, such as Human Factors; enhancing our commitment to undergraduate and postgraduate training; and increasing the scope of training to educational commissioners.

Values

- To put the patient first, working to ensure they receive the best possible clinical outcome and high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.
- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.
- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.
- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.



Performance against Corporate Objectives 2014/15

This section of the annual report reviews our performance against corporate objectives set out in our Operational Plan 2014-2016. This also incorporates the work undertaken against the short term challenges facing the Trust. The progress that has been made against our quality priority objectives is reported in the Quality Account section of this document.

Objective 1: Deliver Excellent Clinical Outcomes

Year on year reduction in HSMR in all diagnostic categories

- The Mortality Board continued to oversee the scrutiny of deaths that take place in hospital, reviewing all Dr Foster reports and confirming that there were no causes for concern.
- The Board conducted studies and investigations in the following areas:
 - Death by day of the week
 - Deaths on a weekend
 - Deaths of patients admitted on a Friday
 - Syncope
 - Liver disease
 - Ulcerative colitis
 - Lower respiratory tract infection
 - Excision of stomach
 - Abdominal Hernia
 - Aspiration Pneumonia
 - Urinary Tract Infection

All of the reviews identified that the Trust has no causes for concern regarding the care that was being received by our patients. However, the studies did identify learning points that have been taken forward including: ensuring that daily board rounds are documented, a review by the Division of Medicine of our processes for the allocation of patients to consultants.

Objective 2: Improve Patient Safety

a) Year on year reduction in clinical error resulting in harm

- We have achieved a 30% reduction in hospital acquired pressure ulcers at grades 2 & 3.
- We have reduced the number of reported falls with harm from 27 during 2013/14 to 17 during 2014/15, an overall reduction of over 35%.

- We have reduced catheter usage by 4.24% therefore reducing the risk of a catheter acquired infection whilst in hospital.
- We have reduced the overall cardiac arrest rate from 1.69 to 1.44 per 1000 discharges from September 2014 to March 2015.

b) Year on year reduction in Healthcare Acquired Infection (HCAI)

- We have achieved a significant reduction in the number of C Difficile infections from 19 during 2013/14 to 10 during 2014/15.
- We have maintained a low number of MRSA bacteraemias.

Objective 3: Improve Patient Experience

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

At the L&D, the Friends and Family Test (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 in the Patient Experience Call Centre.

Previously, the results for FFT were published as a Net Promoter Score (NPS). However, the score was difficult to understand and this led to a review by NHS England. The scores are now shown as a percentage of people who would or would not recommend the Trust. From October 2014, 92- 94.6% of our patients have consistently reported that they would recommend the hospital to their family and friends.

The call centre provides us with further detailed information in real time from patients 48 hours following their discharge. This information is fed back directly to the wards and clinical areas to support the patients and change practices to improve the patient experience.

The annual national patient survey is demonstrating steady progress and improvement. We are within the normal range when benchmarked against other hospitals nationally.

Objective 4: Deliver National Quality and Performance Targets

Delivering sustained performance with all CQC outcome measures

- The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration is Registration without Conditions.
- No enforcement action has been taken against the Trust during the reporting period April 1st 2014 and 31st March 2015 and we have not participated in special reviews or investigations by the CQC during the reporting period.
- The last formal CQC inspection was in September 2013. Two areas of improvement were identified; record keeping and maternity staffing. We declared full compliance with the standards in January 2014 and the CQC conducted a follow up inspection in August 2014. To date we have not received a formal report back from the CQC against these criteria. However, correspondence indicated that we were assessed as being compliant with the standard for record keeping.
- We have established a Trust wide 'Transforming Quality Initiative' reporting to the Executive Board. The initiative is not intended to duplicate our formal governance processes but to support them in ensuring we deliver the highest possible standard of care. The initiative has three components, a core group consisting of managers/ leaders, a reference group made up of staff who are well positioned to provide 'reality checks' and a small group of champions who will initiate change and improvement across the hospital.

Delivering nationally mandated waiting times and other indicators

- During 2014/15, the L&D continued to consistently deliver against national quality and performance targets, achieving a Monitor governance rating of green throughout the year.

The L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.

- Met or improved upon the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.
- Met all of the cancer targets for the year.
- Had excellent performance against the C Difficile target threshold of 19 recording 10 cases.
- Reported 3 MRSA Bacteraemia which is under the diminimus of six for reporting to Monitor.

Objective 5: Implement our New Strategic Plan

During 2014/15 a number of key strategic developments supported the delivery of the Trust's Strategic Vision.

a) Delivering new service models:

Emergency Hospital (collaborating on integrated care and including hospital at home care)

- **Introduced Percutaneous Coronary Intervention (PCI)** - During 2014/15 the Division of Medicine introduced a PCI service in order to meet the needs of patients and commissioners, ensuring equity in diagnosis and treatment of patients with an Acute Coronary Syndrome through the provision of a local service. The target for the first year was to provide 200 treatments and this was achieved within 10 months.
- **Expanded seven day services** - To meet the increasing demands within the Division of Medicine and to support an improved patient experience, cardiology and respiratory services were extended to cover seven days which builds on clinical services already in place in our emergency department. This provides improved access to expert decision making, assessment, investigation and initiation of treatment to ensure the best patient outcomes.
- **Expanded the capacity of the Emergency Department** - To continue to meet the continued increase in demand for emergency services at the hospital, the Emergency Department was remodelled during 2014/15 to increase capacity.
- **Increased therapies staffing for stroke patients** - To further develop the Trust's ambition to be a Hyper Acute Stroke unit, the Division of Medicine agreed funding for additional therapies staff in the Division's stroke unit to bring staffing closer to the Midlands and East Gold Standard service specification.
- **Replaced CT scanners** - The Imaging Department has improved patient facilities by the replacement of both

CT scanners with high specification equipment as well as reconfiguration of the department. The investment helps pave the way for new services developments such as CT coronary angiography.

- **Implemented 7 day services** - The Trust has further increased 7 day in-patient service provision across Imaging and Therapies, supporting patient pathways to improve access to diagnostics and therapy interventions across several specialties.
- **Improved diagnostics** - Following the successful introduction of Endobronchial Ultrasound (E-BUS) last year, Cellular Pathology, in conjunction with Medicine have expanded endo-bronchial ultrasound services, providing local services to patients and facilitating faster and more effective diagnostics. The service has also appointed an additional substantive consultant Histopathologist to continue to support improved cancer pathways.
- **Further developed outpatient transformation** - To increase efficiency in Outpatient clinic utilisation and improve the use of room space across the Trust, the Diagnostics, Therapeutics and Outpatients Division invested in 'Bookwise' - an electronic room scheduling system.

Women's & Children's Hospital

- **Increased numbers of day case procedures** - Day case provision for both Women and Children has been expanded enabling less invasive options and supporting treatment closer to home especially for children with complex long term gastric problems.
- **Improved the Delivery Suite** - The delivery suite has seen improvement including improved access, additional en suite delivery rooms and better facilities for birthing partners.
- **Completed the interim improvements for Neonatal HDU and SCBU** - The Neonatal unit has been modernised and has an improved High Dependency and social care environment. This now provides a clean and bright unit better meeting the needs of developing pre term and unwell new born babies.

Elective Centre

- **Completed the restructuring of the operating timetable and introduced 6 day elective working** - Our ambitious programme of theatre re-engineering was implemented in December 2014 and for the first time introduced a model of flexible cross-cover within specialties to ensure protected operating time for 51 weeks a year. We also established the model of Saturday operating where we run a full theatre day one Saturday per month to increase the available operating time. This was a challenging implementation with far-reaching impact on timetables in the organisation, but has now embedded well with positive impact seen on start times for lists and minimised turnarounds through increasing the proportion of all day lists and fewer theatre changeovers.
- **Continued to develop highly specialised consultant services** - due to the rapidly growing demand for services, the Division of Surgery recruited its third medical retina consultant and third breast surgeon during 2014/15. Recruitment is also underway for the 5th Urologist following approval of the business case in 2014/15.
- **Continued to repatriate work from main theatres to outpatient facilities:** In 2014/15, an increased number of patients received their cystoscopy examinations in an outpatient setting (the Urology Diagnostic Centre) rather than having to go to main theatres. This service will be further consolidated through delivery of the one-stop urology clinic when it's new facilities become available in summer 2015.

Information Management and Technology

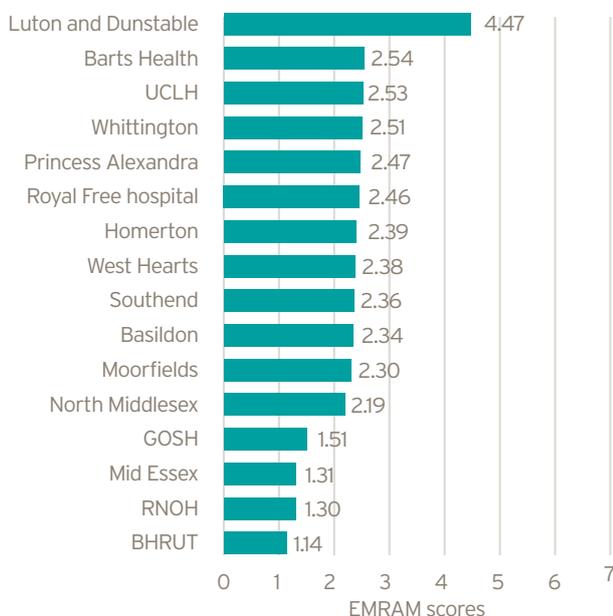
- **Further progress towards the Electronic Patient Record (ePR)** - The Trust delivered the implementation of the electronic patient record this year, where care can safely occur without the need to deliver the persistent paper record. The contract delivered an electronic document and record management system (eDRMS), with the scanning of patient's persistent paper records. We achieved a full scan on demand service for all adults in September 2014, all paediatrics in November 2014, and the final area to go live was maternity records in April 2015. The final key element of our three projects after eObs (electronic nursing observations) and eDRMS has been the successful implementation of electronic prescribing and medicines administration (ePMA). We are also part of a consortium of providers implementing a Chemotherapy prescribing system which is a major part of our patient safety agenda in

terms of safe and effective administration of cytotoxic drugs. We are scoping and building the interfaces to link all of the systems together, and are looking to implement this system in Q3 2015.

The Trust's progress with electronic records was externally benchmarked within UCLP using the internal standards organisation HIMSS's electronic medical records adoption model. This validated the high quality of our electronic patient record systems. See the graph below which shows the Trust outperforming all other providers:

EMRAM

EMRAM scores across UCLP range from range from 1.140 to 4.465 as shown below:



EMRAM scores for UCLP acute provider trusts

Reference: UCL Partners Informatics Environment Maturity Assessment - January 9th, 2015

- Reviewed the provision of PACS** - We have completed a tactical PACS project to exit from the National Programme for IT Contract which is ending this year, and have migrated all our data from the central data store onto the Trust infrastructure in preparation for the implementation of the recently procured new PACS & Vendor Neutral Archive system. We are one of the only Trusts to have successfully completed this transition.
- Investment in Unified Communication** - The Trust is investing in a new Unified Communications system, to replace our current telephony system which is 25 years old and now very difficult to maintain and support. We have upgraded much of the infrastructure, including the back-up power and network. Next year we will deploy the devices and use the system starting with voice deployment in the summer of 2015.
- Advancement of IT Infrastructure** - There have been major advances in the IT infrastructure this year with significant progress in the transition to our managed service partner (OCSL). This has resulted in enhanced resilience, stability and performance in the delivery of IT systems across the organisation. We have progressed with server modernisation, and installation of new Virtual Desktop Infrastructure into areas such as Maternity and Outpatients. This is a complete upgrade in our desktop suite resulting in faster more reliable cloud based desktop computing.
- Restructured the IT Department** - In line with the infrastructure changes, we have re-structured our IT department to a more service orientated focus. We have introduced weekly and monthly service reports detailing call levels, response times and service improvements on which the teams are working. These reports form the basis of monthly divisional meetings that are arranged with divisional leads to review service performance or highlight areas of improvement. We have also reviewed or introduced processes and procedures for change, problem or incident management to ensure IT issues are dealt with in an efficient and measured approach. These changes have resulted in a reduction in outstanding calls and the time taken to resolve IT issues or progress improvements related to IT.
- Developed Clinical Correspondence and Administration** - The transfer of clinic letters electronically to GP Practice once approved by the author has been a focus on this year with all practices with which we regular receive patients now receiving electronic letter transfer. There will be a concerted
- Implemented E-Prescribing and medicines administration** - Pharmacy has managed the introduction and roll out of electronic prescribing across the Trust, delivering efficiency benefits in medicines management, transcription and stock control and driving improved patient safety benefits.
- Implementation of electronic blood tracking** - The Trust has also implemented electronic blood tracking, a major safety initiative supporting the effective management and administration of essential blood products to our patients. The new process uses much safer intelligent bar code reconciliation linking blood products to the patient and trained clinician performing the transfusion.

focus on turnaround times as we look to revise the support structures to support the pathway focussed approach to administration.

Business Development

- **Business Development** - We have continued to market our services to GPs and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. We have also extended our outreach into bordering catchment areas and worked to promote the L&D Brand as a high quality care provider. Considerable analysis has taken place of where we could re-patriate referrals that are currently not coming to the Trust, and market analysis has continued. This has laid the foundations for real changes in referral patterns to be achieved in the future.

b) Implementation of our preferred option for the re-development of the site.

- At its extraordinary Board Meeting, held in public on the 1st October 2014, the Board of Directors ratified the Finance, Investment and Performance (FIP) Committee's recommendation to develop a detailed business case to redevelop of the L&D site. In making the recommendation FIP reviewed the various options including the development of a new hospital site, do nothing or do minimum. Upon reviewing the options and the associated financial consequences FIP agreed the wider site re-development option offered the most clinical and operational benefit and whilst the scheme requires the Trust to access a loan the associated re-payments would be affordable assuming a range of income generation opportunities and a detailed cost improvement plan. In 2015, the Board will consider the Outline Business Case for Hospital-Redevelopment.
- The option selected will cost in the region of £130 - 150m and has been designed to facilitate the Trust's clinical strategy by enabling the re-invention of the DGH into a campus of four distinct centres: Major Emergency, Women's and Children's, Elective and Teaching and Training. It will comprise both new build and refurbished accommodation. The new building will contain: an integrated Critical Care Unit, a Neonatal Unit, a Delivery Suite and a new theatre suite incorporating an ambulatory surgical facility. The existing Emergency Department will be expanded and a number of wards will be re-furbished or re-decorated. The outpatient facility will be re-organised to meet the changing needs of these services.
- Following agreement of the master plan, the Trust

conducted a procurement exercise to identify a professional services team to develop the design to support the preparation of an Outline Business Case. A consortium led by AECOM was the successful bidder for the work required. The team commenced work in February 2015.

- A Hospital Re-development Programme Board has been established, chaired by the Trust's Chair, has direct responsibility, delegated by the Trust Board, for overseeing the management and delivery of the re-development proposals. The development of the Outline Business Case will be managed on a day-to-day basis by the Programme Team. This will be chaired by the Chief Executive in her role as Programme Sponsor.
- A full time project team has been appointed by the Trust to manage the development of the design and to prepare the Outline Business Case.

Objective 6: Develop all Staff to Maximise Their Potential

a) Delivering excellence in teaching and research as a University hospital

- We continue to expand the teaching of undergraduate medical students with increased numbers and a wider range of clinical settings. In postgraduate training we are converting, with the support of the local education and training board, non-training posts to training posts in General Practice and Emergency Medicine. In areas of significant increase in service demand, such as acute medicine and obstetrics, we are working closely with the Deanery to ensure trainees receive the best training and benefit from the rich casemix which is unique to our hospital. In Research we have worked with our new research partnership area to ensure a 40% increase in research commissions.
- We are also developing plans with the Trust to support a range of expanding training needs including in simulation and human factors training, and towards establishing a clinical trials facility. There are regular presentations to the Trust Board on training and research, and teaching continues to be one of the priorities for the Board and senior staff to ensure the best and most sustainable future patient experience and safety.

b) Ensuring a culture where all staff understand and promote the vision and values of the organisation

- We have put in place a number of initiatives across the Trust in order to raise awareness and increase our

staff's understanding of the vision and values of the organisation including:

- The Corporate Induction now has a session on the vision and values lead by an Executive Director.
- Our values are a core part of the appraisal paperwork that all staff covered by Agenda for Change complete each year - staff are encouraged to recognise how they have supported the values in their own work over the previous year.
- All nurse recruitment includes an assessment based on the Trust values.
- The Preceptorship programme for newly-qualified nurses and the revised two-week Health Care Assistant induction includes a session on values and communication.
- Work with divisional clinicians to support development of excellence in clinical learning has been undertaken in two divisions.
- Human Factors training mirrors values of patient safety through collaboration and team work.
- A coaching culture is developing through workshops for line managers and training as practitioners.
- Health coaching for clinicians working with patients with long-term conditions such as diabetes and respiratory conditions continues.
- Individual managers are accessing coaching from both internal and external qualified practitioners.

c) Recruiting and retaining a highly motivated and competent workforce

- The Trust is committed to becoming an employer of choice by recruiting a highly skilled workforce in order to serve its local population in the best way possible.
- In order to continue recruiting the right staff for the right opportunities the Trust has engaged with the following:
 - Monthly recruitment open days for Nurses and other specialities
 - Overseas Recruitment
 - Increased advertising of recruitment events
 - Development of the Trust website
 - Promotion of the Trust and its vacancies/ employment opportunities by using social media
 - Creating a nursing recruitment brand for the Trust (Proud to Care)
- In order to ensure the Trust retains its most important resource (its employees) the Trust offers the following:

- All staff should have access to a personal development plan and undertake an annual appraisal
- Opportunities for staff to progress through the Trust's Talent Management Programme
- Access for all staff to undertake additional training/ learning that will benefit both the employee and the Trust
- Starter and Exit interviews in order that the Trust can engage and improve its staff experience.
- A confidential assistance service is available to all staff 24/7.

Objective 7: Optimise the Financial position

Delivering our financial plan 2014-2016 with particular focus on the implementation of Re-Engineering Programmes (REP).

The REP was launched as formal programme in the last year, pulling together various initiatives into a coherent portfolio of projects. The REP is fundamental to the ongoing viability of the organisation as it strives to meet the twin challenges of tariff efficiency and commissioner driven demand management initiatives, in addition to providing the basis to meet the affordability of the hospital redevelopment. The overall approach is based on the analysis that suggests the Trust's systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity. The REP aims to meet the financial challenge by creating overall 'system' efficiency rather than delivering discrete cost reductions unconnected to the whole. The Corporate schemes outlined below have been the focus for this year:

- Theatre Re-Engineering
- Outpatient Re-Engineering
- Reducing length of stay
- The implementation of seven day services
- The implementation of an electronic staff rostering system
- Reviewing clinical correspondence and administration
- Business Development

The Re-engineering programme is embedded into the Division's annual plans and are reported back in this report through the corporate objective review, divisional performance review and quality accounts.

Service Developments during 2014/15

During 2014/15, the Division of Surgery:

- **Continued to improve outcomes for patients with fractured neck of femur** - The excellent progress in improving outcomes for patients with fractured neck of femur continued with ongoing improvement in the time taken to get patients to theatre and an increase in patients who qualified for best practice tariff. At March 2015 our HSMR was 61 (compared to 84 in 2014) which is significantly under the aim of 100.
- **Further reduced length of stay through delivering enhanced recovery pathways** - During the year, our first knee schools were held, with excellent feedback from patients and relatives. We have developed combined pre-assessment for hip and colorectal patients on enhanced recovery pathways, and have introduced our new patient information leaflets, explaining to patients what to expect, and how quickly they can plan to go home.
- **Replaced air handling system in theatres** - Following the significant refurbishment to theatres 1-6 the upgrading works to the air handling system in theatres were completed to improve reliability and enable remote monitoring of the system.
- **Invested in changing facilities in arrivals and introduced the concept of no-crossover** - following some improvement works to the surgical admissions area, patients are now being admitted to the area adjacent to the theatre suite in which their procedure will take place, reducing the need for patients to cross their hospital on their way to theatre. This has had significant patient experience and efficiency improvements, enabling us to more accurately predict the journey times for patients to theatres.
- **Continued to improve cancer patient experience** - The dedication of the cancer team was acknowledged when the Trust was recognised as one of the top ten hospitals in the UK for patient experience and for one of the four most improved in the country. Following completion of the refurbishment of the Macmillan Cancer Unit including the new cancer patient information centre which was achieved in partnership with Macmillan Cancer Support the Trust was one of a few organisations awarded the Macmillan Quality Environment Award.
- **Implemented Extracorporeal Shock Wave Therapy (ESWT) for orthopaedics patients:** The division has invested in equipment to be able to provide this non-invasive treatment for tendinopathy to patients. This can be delivered as a series of treatments in an

outpatient setting and is a NICE approved alternative to surgery for some patients. Training of staff has been completed and the first clinics have run in quarter 4 2014/15.

During 2014/15, the Division of Medicine:

- **Reduced Length of Stay** - The optimised usage of our ward areas has been focussed on two key interventions to reduce our hospital bed utilisation. The scaling up of our Ambulatory Care Centre (ACC), and the launch of a Hospital at Home (H@H) service. The ACC has seen steady growth in the number of conditions that can be managed effectively, and with its relocation to EAU in December there was a growth in the service. The programme has also continued to focus on process refinements, faster diagnostics, board rounds and improved consultant input. This has been delivering ongoing improvements. It has delivered a continuing ongoing reduction in our Length of Stay (LoS) for all spells and also patients with a LoS of >28 days.
- **Successfully implemented a bowel screening service** - To support timely diagnosis and intervention, the Division has successfully implemented a bowel screening service with plans for further service expansion in 2015/2016
- **Introduced partial booking in Rheumatology** - The Division implemented partial booking in response to patient feedback. This method offers an improved experience to patients and increases the efficiency of clinics by reduced rescheduling of follow-up appointments.
- **Met increasing demand for outpatient services** - The Division have recruited a number of specialist consultants to improve the service and to meet the increasing demand for services in cardiology, gastroenterology and respiratory.
- **Extended Ambulatory Care Opening Hours** - The Ambulatory Care Centre extended its opening from 09:00-17:00 to 09:00-21:00 allowing more patients the opportunity to be managed on ambulatory pathways and reducing pressure on the Division's bed base.
- **Reconfigured the Acute Medical bed base** - The Division increased its assessment unit bed capacity by reallocating Ward 4 as EAU 2. This allows patients a longer average length of stay in an assessment unit and improves flow through the hospital.

- **Increased therapies staffing for stroke patients** – the Division agreed funding for additional therapies staff in the Division's stroke unit to bring staffing closer to the Midlands and East Gold Standard service specification.

During 2014/15, the Division of Women's and Children's Division:

- **Developed an emergency Gynaecology and Early Pregnancy Unit** - The Women's division have implemented extended early pregnancy clinic provision and are offering a six day service alternating between Saturday and Sunday on a two week basis. This has enhanced patient experience and reduced avoidable admissions.
- **Developed the maternity theatre complex** - Delivery Suite Theatres under went improvements to ensure the environment meets the needs of both delivering mothers and the clinicians through effective climate control and central estates monitoring.
- **Reviewed and developed specialist midwives** - The Division has successfully recruited a specialist Diabetes midwife to support women who need additional care and a specialist midwife for mental Health has also been approved.
- **Improved access to technology to midwives** - Led by a midwife, the Women's and Children's Division are in the final stages of launching the community midwife booking App. This will mean less time completing paper records and more time with expectant Mothers. This will be a flagship product, the first of its kind.
- **Developed ante-natal services** - The community midwifery service has continued to support the slimming world healthy pregnancy project with get success with expectant mothers who have been supported through this work. Improvements in the antenatal clinic area have started and are continuing into 2015/16.
- **Further developed the Advanced Nurse practitioner roles** - The Division's first 'home grown' Advanced Paediatric Nurse practitioner has successfully completed her training and has joined the Junior Doctor Rota part time from March 2015. This has provided both enhanced care for children attending the unit and is a great opportunity for nurses to continue to develop skills as well as aiding recruitment.

- **Continued to enhance links locally and nationally** - The Division's links to specialist centres such as Great Ormond Street, Kings College and Addenbrooks have continued to flourish with more children seen and cared for locally by specialist local consultants and specialist visiting consultants.

During 2014/15, the Diagnostics, Therapeutics and Outpatients Division:

- **Replaced CT scanners** - the Imaging department has benefited from the replacement of both CT scanners with high specification equipment as well as reconfiguration of the department to improve patient facilities. The investment helps pave the way for new services developments such as CT coronary angiography.
- **Implemented PACS and VNA tactical solution** - investment in the IT infrastructure has improved the picture archive storage facility to the Imaging department, facilitating growth and protecting retrieval of images to future proof the service whilst the longer-term strategic solution is procured and implemented.
- **Implemented 7 day services** - The Division has further increased 7 day in-patient service provision across Imaging and Therapies, supporting patient pathways to improve access to diagnostics and therapy interventions across several specialties.
- **Invested in Pathology Services** - Blood Sciences have commissioned new laboratory clinical biochemistry analysers, which will improve efficiency and turn around time for blood samples and increase the clinical repertoire of tests available within the Trust and allow for rationalisation of serology testing. The department has also commenced a calprotectin and Vitamin D service, whilst Transfusion have implemented blood issuing and blood tracking systems within the Trust to improve patient safety and meet regulatory requirements.
- **Improved diagnostics** - Following successful introduction of Endobronchial Ultrasound (E-BUS) last year Cellular Pathology, in conjunction with Medicine have expanded endo-bronchial ultrasound services, providing local services to patients and facilitating faster and more effective diagnostics. The service have also appointed an additional substantive consultant Histopathologist to continue to support improved cancer pathways.

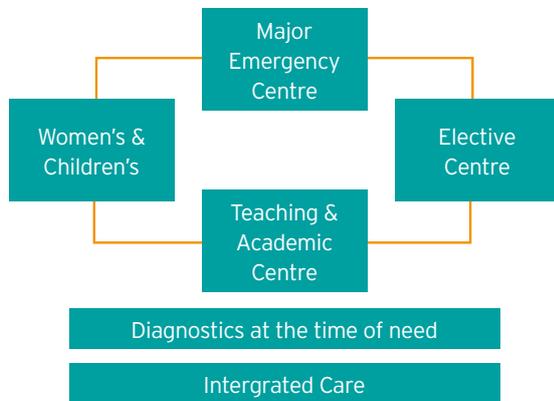
- **Further developed outpatient transformation -** Outpatients have invested in Bookwise - a room scheduling system to allow for increased efficiency in Outpatient clinic utilisation and use of room space across the Trust.
- **Implemented Partial booking -** a new Outpatient appointment booking system has been initiated in some speciality areas to better manage appointment scheduling, reduce short notice clinic cancellations and to pave the way for increased patient choice and improved access to Outpatient services across the Trust.
- **Improved the Fracture Clinic -** Implementation of changes to the scheduling system in Fracture Clinic has substantially improved patient flow during the course of clinics and reduced waiting times, as has been demonstrated by the very positive feedback received from patients.
- **Improved Outpatient Phlebotomy Service -** a designated phlebotomy service to support patients attending outpatient appointments has been established, providing a one-stop service co-located to clinics and relieving demand on the main Phlebotomy department
- **Implemented E-Prescribing -** Pharmacy has managed the introduction and roll out of electronic prescribing across the Trust, delivering efficiency benefits in medicines management, transcription and stock control and driving improved patient safety benefits.

2015/16 Strategic Approach

L&D Re-Inventing the DGH

Our Strategic Plan, published in 2014, set out our intention to transform L&D into:

- A Hyper Acute Emergency hospital - 'The Major Emergency Centre'
- A Women's & Children's hospital - 'The Women's and Children's Centre'
- An Elective Centre - 'The Elective Centre'
- A Teaching and Academic Centre



The new L&D will have four business and clinical units:

1. The Major Emergency Centre

At the heart of the new L&D will be 'The Major Emergency Centre' providing the highest standard of emergency medicine, emergency surgery and hyper acute specialist medicine. The Centre will provide the shortest possible length of hospital care by delivering 24/7 (or 7/7 if applicable) consultant care and diagnostics at the time of need. The Centre will work closely with other providers to ensure that patients receive ongoing treatment in their own place of residence or other appropriate facility.

At the core of the Major Emergency Centre will be the Emergency Department. We believe the Trust is in an excellent position to become a 'Major Emergency Department' as described in the Keogh Report 'Transforming Urgent and Emergency Care Services in England'. In recent years, our department has consistently performed amongst the top 10 nationally in the delivery of the four hour target. Our friends and family score is high, we attract high calibre consultant staff and our conversion rate is very good.

During the next two years we will increase staffing and facilities to ensure the department meets the future specifications. The Emergency Department will be supported by a comprehensive range of clinical specialities including:

Emergency and Trauma Surgery

- The Trust has a dedicated Trauma theatre and an emergency theatre (as per NCEPOD guidance) which are staffed 24 hours a day, 7 days a week.
- The emergency and trauma operating sessions are predominantly consultant-led with experienced anaesthetists.
- We are the network hub for Oral and Maxillofacial trauma, with trauma surgery centred at L&D for Milton Keynes, East and North Herts and Bedford Hospital patients delivered by specialist teams.
- Over the past two years the L&D has worked hard to successfully improve outcomes for fractured neck of femur patients and one of the cornerstones of this success has been to achieve our aim of 85% of patients going to surgery within 36 hours of admission.
- Over the next two years we are focussing on reducing our pre-operative length of stay for other key emergency pathways.
- Right-sizing our critical care bed provision to support the anticipated growth in emergency and trauma theatre activities is also believed to be essential to achieving best outcomes.

Hyper Acute Medicine

The forward vision of the Medical Division at L&D is to provide a model of hyper acute care for our in-patients. We endeavour to ensure that only those patients requiring hospital admission for on-going acute care are managed within our bed-base.

- A model of integrated care will link our geriatricians with locality based GPs, social care and mental health professionals. This model will provide multidisciplinary care crossing health care boundaries.
- Early access to specialist advice will facilitate improved patient care and experience through improved coordination.
- Early intervention and focus on chronic disease management within the community setting will prevent unnecessary hospital admissions

- Consultant delivered acute medicine, 14 hours a day, 7 days a week, has been in operation since May 2013. This model facilitates rapid and appropriate decision making and results in:
 - i. improved outcomes for our patients
 - ii. more efficient use of resources
 - iii. easier GP access to the opinion of a fully trained doctor.
- All admitted patients will be assigned a single, appropriately qualified, responsible consultant who will continue care through to discharge
- Unless a patient's care dictates otherwise, this will be delivered from a single bed base with no transfers during their admission.

Stroke

- The Trust currently provides Hyper-Acute stroke services for Luton, Bedfordshire, Hertfordshire and Buckinghamshire.
- Local CCGs are presently assessing the organisation of Hyper Acute Stroke Unit (HASU) services within the region with support from the East of England Cardiovascular Clinical Network, the likely outcome of which is a reduction in the number of commissioned HASU providers across the three counties.
- L&D is in a strong position to retain the HASU service due to the geographical location of the hospital and the local infrastructure which allows for a wide catchment area
- L&D is also the only provider in the region to offer 7 day a week urgent, high-risk TIA outpatient clinics which supports the delivery of our HASU.

Cardiology

- Our Cardiology Department provides a comprehensive elective and non-elective service for our local population, delivered by an experienced and committed multi-disciplinary team.
- The high quality of service provision is demonstrated through the Myocardial Ischaemia National Audit Project (MINAP) and patient experience data.
- A commitment to working with partner organisations to provide improved patient pathways, including care closer to home is evident in the provision of outreach arrhythmia, cardiac surgery assessment clinics

and community cardiac rehabilitation sessions and palpitation clinics.

- The recently commissioned Cardiac Centre is a state of the art, future proofed facility, delivering diagnostic coronary angiography, permanent pacemaker implantation and percutaneous coronary intervention (PCI).

Vascular

- The L&D Board of Directors will consider a business case for the development of vascular surgery during the first half of 2014/15 to provide services for Luton, Bedfordshire and Milton Keynes catchment.
- In parallel, the Radiology Department will create a plan for a network arrangement for Vascular Interventional Radiologists. It is anticipated that the service would be established during 2015/16.

Diagnostics at the time of need

- It is our intention that by the end of 2015-2016 that both Imaging and Pathology will provide comprehensive acute diagnostic services to support both inpatient and outpatient pathways 7 days a week.
- New services will be established to deliver both CT coronary angiography and interventional radiology, supporting the development of vascular surgery at the Trust.
- Having immediate access to diagnostics is imperative for the Major Emergency Centre, the Women's and Children's Centre and the Elective Centre.
- Timely diagnostics are fundamentally important for the provision of elective care, ensuring patients choose the hospital.
- Finally, without proper access to diagnostics, integrated care will fail. Our achievements and plans are detailed under the Diagnostic, Therapeutics and Outpatients Divisional reports.

2. Women's and Children's Centre

The Women's & Children's Centre will build on the present performance and reputation of the existing services in L&D. The Centre will focus on providing excellence locally. Working with tertiary providers, the ambition is to enable a developing range of treatment and care to be provided in order to avoid the need for patients to be transferred to other centres and when this is not possible to facilitate earlier returns.

Our present Women's and Children's Division provides a comprehensive range of services to the population of Luton, Bedfordshire, Hertfordshire, Buckinghamshire and further afield. The Division offers a growing gynaecology service, a busy maternity unit, a specialist level 3 Neonatal Unit and a range of paediatric services. The Division also works in partnership with other care providers, including tertiary centres such as Great Ormond Street Hospital, to ensure that people are given the most appropriate care and treatment in a setting close to their homes.

- The Gynaecology Service has been transformed by a new Ambulatory Centre, allowing the hospital to offer women an array of day case procedures in a relaxed, female-centred environment.
- The Gynaecology Service will take the opportunity to extend the catchment of its recurrent prolapsed and urinary incontinence services following the release of a new specification by Specialist Commissioners and their statement of intention to reduce the number of centres.
- Within Maternity Services, the Division has invested in staffing to ensure increased consultant presence and one to one care for women in labour.
- The Trust's level 3 Neonatal Unit has, year on year, increased consultant presence which provides rapid support and senior decision making for our highest risk infants.
- In Paediatrics, similarly, there is a growing team of acute and speciality consultants enabling consistency, early consultant assessment and rapid decision making.
- This increased level of senior cover across the division provides swift, expert support for emergencies, it reduces the length of our patients' hospital admissions and it improves patient safety and outcomes. It also provides more opportunities for supervision and training for our workforce of the future.

3. Elective Centre

Today, L&D provides a comprehensive range of elective surgery and medicine to local populations. We also provide an increasing amount of tertiary or specialist care. Our new 'Elective Centre' will aim to compete with the best Elective Care Centres providing diagnostics at the time of need, one stop clinics, elective care uncompromised by emergency care and excellent patient experience. Importantly, the Elective Centre will also focus on the provision of speciality medicine,

following the present surgical model of one patient, one consultant, one bed.

Surgical Services - Present Provision:

- a regional centre for bariatric surgery
- tertiary level services for head & neck surgery; corneal surgery; breast screening and reconstructive surgery; and some uro-gynaecology pathways
- a range of other surgical specialties including urology, upper and lower gastro-intestinal, trauma and orthopaedics
- general paediatric surgery
- 10 main operating theatres (excluding two maternity theatres) with work on-going to replace our 11th theatre

Medical Services - Present Provision:

- a variety of therapeutic endoscopy procedures
- sleep studies
- a day hospital unit that provides a variety of planned treatments

Outpatient and Diagnostic - Present Provision:

- elective outpatient services for a wide variety of surgical and medical specialties
- imaging services including x-ray, CT and MRI scanning
- diagnostic endoscopy procedures

The outpatient transformation programme has successfully delivered significant environmental improvements to our main outpatient areas. Our current aim is to provide one-stop outpatient and diagnostic services wherever possible and the introduction of the one-stop urology service during 2015/16 will be a significant development in this regard.

Our focus is on re-engineering the operating theatre structure to support increased capacity and free up theatre space for our intended developments. We are also implementing a full scheduling model which is significantly improving the booking of our operating lists and further increase the opportunity for growth.

4. Integrated Care

The delivery of the new strategic plan is dependent on a robust model of integrated care being provided to meet the need of our population. For this reason L&D has taken the unusual step of taking the leadership role to work with all stakeholders to develop a demonstration project, implementing integrated care for the South Bedfordshire catchment area.

This model will provide a health and social care integrated multidisciplinary team with a single point of contact and expert care coordination. The integrated care delivery team will focus on early intervention, a greater emphasis on chronic disease management and a more planned approach to acute care management with early supported discharge. The delivery of this project and its roll out across the Luton catchment area will be key in ensuring that both health economies are able to meet future financial challenges.

5. Teaching and Academic Centre

Teaching and evidence underpins the ethos of our organisation. The Teaching and Academic Centre will be at the hub of the new L&D, providing a focus for all teaching activities and facilitating the use of evidence in daily practice.

In teaching and training we will plan to deliver programmes at all levels to enhance the professional and personal competency of health care professionals. In medicine, both for undergraduate, Foundation and speciality training, and for the increasing number of non-training grade medical staff there will be a greater investment of time and resources. In nursing we will support up skilling to enhance skill mix, the development of specialist nurses to bridge between secondary and community care. The full apprenticeship model will be launched in the autumn 2014, to develop HCAs and enable transition to full nursing. For all professional and non-professional staff will establish systematic programmes of patient focussed staff development.

In Research we will build on an existing excellent research base to increase patient and clinician participation in Research, and increase Research income to support the financial resilience of the Trust.

6. Hospital Re-Development

At its extraordinary Board Meeting, held in public on the 1st October 2014, the Board of Directors ratified the Finance, Investment and Performance (FIP) Committee's recommendation to develop a detailed business case to redevelop of the L&D site. In 2015, the Board will consider the Outline Business Case for Hospital-Redevelopment.

Maintaining Performance

The Board of Directors recognises the importance of sustaining the level of delivery against national quality and performance targets delivered by the Trust in recent years. During the last year, the organisation has demonstrated an exceptional ability to maintain operational performance whilst also focussing on strategic planning and change. This will be particularly important in coming years.

Maintain and Develop Key Clinical Specialties

- Maintain key specialties to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear strategies for key specialties to mitigate the benefit from the re-organisation of acute services to the north of the Trust.
- Ensure that specialty plans give consideration to the 'necessary volume' to ensure give the economies of scale required for sustainability.

Exploring Opportunities for Growth

- Explore the growth opportunities across the range of services offered as a consequence of the Bedford and Milton Keynes review, either alone or in partnership.
- Actively engage other stakeholders including the CCGs and the local authorities in rethinking models of community care embedding L&D expertise services in the heart of the major localities.
- Increase the Trust's market share in the services identified in the Clinical Services Strategy as offering greatest opportunity e.g. Cardiac Services, Stroke, Trauma and Orthopaedics, Spinal Surgery, Women's & Children, Bariatrics and Ophthalmology.
- Strengthen the relationship with tertiary hospitals to enhance and develop a range of hyper-acute services, in particular paediatrics, cancer, stroke and trauma.

Ensuring Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using an electronic patient record, and decision support information systems at all levels of the organisation.
- Ensure that the delivery achieved during 2014/15 against national and local quality and performance targets is fully embedded, further improved and maintained.
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects which meet the need for tariff efficiency and the financing of the redevelopment programme.
- Review and modernise non-clinical support services including catering, cleaning and portering to ensure they are responsive to patients' needs and support clinical care, outsourcing will be considered the best option for non core services
- Further develop the Divisions to allow greater focus at specialty level in order to benefit fully from service line management and bring forward a new generation of clinical leaders.
- Continue to review and strengthen performance by the use of internal and external expert review.

Corporate Objectives 2015/16

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

1. Deliver Excellent Clinical Outcomes	<ul style="list-style-type: none">• Year on year reduction in HSMR in all diagnostic categories
2. Improve Patient Safety	<ul style="list-style-type: none">• Year on year reduction in clinical error resulting in harm• Year on year reduction in HAI
3. Improve Patient Experience	<ul style="list-style-type: none">• Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance
4. Deliver National Quality & Performance Targets	<ul style="list-style-type: none">• Deliver sustained performance with all Care Quality Commission (CQC) outcome measures• Deliver nationally mandated waiting times and other indicators
5. Implement our New Strategic Plan	<ul style="list-style-type: none">• Deliver new service models:<ul style="list-style-type: none">- Emergency Hospital (collaborating on integrated care and including hospital at home care)- Women's & Children's Hospital- Elective Centre- Academic Unit• Implementation of preferred option for the re-development of the site.
6. Secure and Develop a Workforce to meet the needs of our Patients	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Deliver our financial plan 2014-2016 with particular focus on the implementation of re-engineering programmes

Responding to the Francis Reports and Improving Quality

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

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

Mortality Board

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

Complaints Board

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

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

The Complaints Board continues to see improvements in the management of complaints by the Divisions. The

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

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

Transforming Quality Initiative

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

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

Patient Safety - Raising Concerns

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

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

Patient Safety Rules

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

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

Responding to the Cavendish Report

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



Service Developments planned for 2015/16

Strategic and Corporate:

- **Further develop the Electronic Patient Record (ePR)** - Having achieved an electronic patient record for our patients in 2014/15 using multiple systems, we will now focus on the potential consolidation of this record into a single unified ePR, and the Trust will examine options closely in the market place. This will be combined with a review of our Patient Administration Options as our current system contract expires in 2016.
- **Investment in a new Unified Communications system** - we have agreed to replace our current telephony system which is over 25 years old and difficult to maintain and support. We have upgraded the infrastructure, including the back-up power provision, of the Local Area Network. The phone deployment is planned to be completed towards the end of September 2015. We will be working concurrently to modernise our paging (bleep) system, and emergency communication during this period. Our new Telecoms platform offers additional functionality and scope for re-designing our contact centres, switchboard and other key Trust support functions.

Surgical Division:

- **Continue to work on developing Specialist Vascular Services** - As part of the Trust's 5 year strategic plan, re-establishing vascular services at the L&D was identified as a key opportunity to enhance and complete our hyper-acute portfolio. During 2015/16, the Surgical Division will be working in partnership with DTO to establish the operational model and viability of a full vascular service supported by interventional radiology. This will require the development of a comprehensive business case and work to identify any early enablers of such a development, such as the establishment of vascular lab services at the L&D to save patients having to travel to Bedford for their imaging prior to surgery.
- **Commence a Urology one-stop diagnostic clinic** - During summer 2015, works will be completed to the new Urology one-stop clinic facility, which will enable patients to have their diagnostic tests at the same time as their consultation rather than having to come back at a later date. Recruitment is also planned for a substantive 5th Urologist and will be completed during 2015/16.
- **Improving in-list turnaround in theatres** - The re-engineering of the theatres timetable has increased utilisation of theatre sessions to 51 weeks per year. During 2015/16 a programme of training in

observation and root cause of constraints is planned with theatres staff to enable them to critically evaluate the running of the lists and identify steps to reduce the time taken between cases.

- **Review of the surgical booking processes** - During 2015 the division plans to establish a new pathway for pre-assessment which improves the timeliness of pre-assessment services by bringing them earlier in the patient pathway. Implementation of same-day pre-assessment clinics linked to elective surgery clinics will follow later in 2015.
- **Review of elective surgery theatre provision** - The division has identified an urgent need for additional theatre space, and a plan for the replacement of the mobile 'Vanguard' theatre with a more cost-effective solution which provides an additional theatre is being developed for delivery during this financial year.
- **Recruitment of the 7th Oral and Maxillo-facial Consultant** - The division has developed a business case for a 7th consultant in this growing specialty to assist with the increasing amount of head and neck work that is coming to the hospital.
- **Establishing inpatient Paediatric Orthopaedics services and securing Paediatric General Surgery at the L&D** - The division has developed plans to repatriate inpatient paediatric orthopaedic work to the L&D following the cessation of services provided from Bedford Hospital as outreach. The division has successfully recruited a new General Paediatric Surgeon who will start in April 2015, and will secure the future of the service pending the retirement of the incumbent consultant. The division intends to work in partnership with tertiary providers to ensure robust and resilient services for paediatric surgery.

Medicine Division:

- **Implementation of service line management** - During 2015/16 the Division will start linking operational and financial performance that will enable clinicians to lead and develop services and support delivery of the best clinical and financial outcomes.
- **Utilise demand and capacity analysis to inform specialty strategies and service development** - The Division plans to analyse capacity and demand to appropriately guide the business planning agenda across medicine and to also evaluate the way in which services are organised under our 'reengineering' programmes of work.

- **Transcription service development** – The Division will work with clinicians to support them to provide timely, clinical correspondence to patients and their GPs following outpatient clinic appointments.
- **Roll out partial booking across medicine specialities** – Following the successful introduction of partial booking in rheumatology, the Division will develop an implementation programme to roll out all services. This methodology supports both the efficiency of clinics and significantly improves patient experience.
- **Rheumatology service transformation** – The Division is increasing the clinical capacity for early access to specialist care particularly in Early Inflammatory Arthritis. A new ultrasound service will also commence to support this particular service. In addition, the Infoflex database will be introduced for all patients to improve care management and to monitor and track compliance to meet best practice. Also a page on the hospital web-site will be developed to provide helpful information about the service for patients.
- **Repatriation of CT Coronary Angiography (CTCA)** – Working collaboratively with Imaging and supported by Harefield Hospital, the Division will aim to provide an improved patient pathway with care closer to home and offer best value to the local health economy.
- **Gaining British Society Echocardiography (BSE) Departmental Accreditation** – The Division intends to gain BSE Accreditation that will demonstrate quality and excellence through benchmarking services. This further enhances the range of cardiology services that are being developed at the hospital.
- **Collaborative working across diabetes and maternity services to develop diabetes in pregnancy services** – The Division will support work by the diabetes service to collaborate with maternity to further develop the service available for pregnant women.
- **Further development of insulin pump service** – Through the development of an insulin pump service, the Division aims to improve clinical outcomes and quality of life of our patients. This will also be supported by telephone clinics.
- **Expansion of the Nutrition Nursing Service** – The Division plans to expand the Nutrition Nursing Services following the in-sourcing of the service last year. This extension will provide support for all enteral and parenteral nutrition patients, specialist training and support for hospital teams. This will lead to better outcomes for patients throughout the hospital.
- **Continued development of Ambulatory Care** – The Division will continue to optimise the Ambulatory Care Service in order to increase the number of patients managed on alternative care pathways to hospital admission.
- **Further development of stroke services** – Following an increase in therapies staffing in 2014/15, the stroke services will continue to develop with the planned recruitment of additional stroke physicians and stroke specialist nurses.
- **Transition to Needs Based bed model** – The Division currently operates an age based bed model with patients automatically being referred to Elderly Care services if they are 78 years old and over. During 2015/16, the Division will remodel the bed base to provide needs based service that admits patients under the most appropriate specialty team, be that respiratory medicine, cardiology or complex medicine fully supported by Elderly Care consultants.

Women's & Children's Division:

- **Develop gynaecology community pathways** – The Division will continue to work with Bedfordshire and Hertfordshire services to develop effective community gynaecology pathways and services to meet the needs of the community.
- **Continue to improve the facilities in maternity** – The Division plans to further improve the delivery suite for mothers and partners by adding more ensuite facilities and providing improved rest areas.
- **Complete further pathway redesign** – During 2015/16 pathways for antenatal and post natal mothers will be reviewed and redesigned ensuring both facilities and staffing skill mix better meet their needs.
- **Employ a consultant midwife** – In order to support normalisation and natural birth, increasing midwife led delivery and community support the maternity services will seek to employ a consultant midwife. This will be in conjunction with a planned increase in midwifery staff particularly at night to improve the support and experience of mothers.
- **Provide more parents accommodation and improve facilities** – Following successful fund raising the Neonatal team are redeveloping a house on Calwood Road to provide dedicated parent's accommodation to support parents whose babies are being cared for in our neonatal intensive care unit. The unit is also improving the parents facilities on the neonatal unit.

with a refurbished kitchen and a dedicated sitting room providing much needed relaxation areas .

- **Continue close working with local community services and GPs** - To improve access to primary care and appropriate secondary care for families with children with long term conditions or complex health needs, the Division plans to continue to work extensively with local community services and GPs.
- **Work in partnership with Keech Hospice** - The Paediatric Team plan to work in partnership with Keech children's hospice to improve palliative care provision on the paediatric unit and to support staff training and rotation through Keech and the wards here to maintain and develop skills.

Diagnosics, Therapeutics & Outpatients Division:

- **Commence CT Coronary Angiography (CTCA) Service** - Commencing in April 2015, Imaging will be working collaboratively with Cardiology to repatriate CTCA services to the Trust from other health providers. The new service will provide improved patient pathways, delivering faster local diagnostics and treatment to cardiac patients.
 - **Investing in a 4th ultrasound room and expanding MSK work** - The Imaging department has seen a steady increase in the demand for MSK ultrasound and plans to invest in the provision of a 4th ultrasound room to ensure there is the physical capacity to meet this demand.
 - **Improve radiology reporting services** - The Division is planning to invest in two additional radiologists that will support CTCA service development, expanded MSK work and expanded access to imaging modalities in CT, MR, ultrasound and plain film. In line with the service strategy to meet the needs of the hyperacute Trust, these appointments will also facilitate improved delivery of same day in-patient reporting 7 days a week and improved reporting capacity and turn around for routine outpatient and direct access work. The implementation of the strategic PACs solution will further support delivery of efficient and effective radiology reporting services.
 - **Develop a combined Pathology Service** - During 2015/16 all Pathology laboratories will be involved in formulating the strategy for a combined Pathology service to best meet the needs of the hyperacute Trust. This strategy will take into account opportunities to improve efficiency with new clinical
- biochemistry analysers, plans to replace haematology analysers and the further opportunities to rationalise, modernise and automate equipment across Blood Sciences and Microbiology. This will be supported by the tender and procurement of a new laboratory information management system (LIMS) during 2015, and by the implementation of new shift pattern and improved working model across Blood Sciences and Microbiology to best support 7 day service provision.
 - **Continue outpatient re-engineering** - This Division will continue the programme of work to re-engineer outpatient services and in 2015 this will include the introduction of self check-in kiosks to facilitate improved patient booking processes, intra-clinic tracking and more efficient clinic procedures / outcome capture. Partial booking will be rolled out across further specialties, whilst the necessary demand and capacity planning work will be facilitated by working in conjunction with external specialists.
 - **Relocate and reconfigure services** - The Division will continue to review the location and configuration of services throughout 2015/16. Fracture Clinic is to be relocated to the Edwin Lobo centre in order to facilitate the expansion and improvement of the Emergency Department in line with the Trust's strategy. Community MSK therapy services will also be relocated, with services moving from Castle Street to Bushmead and Chaul End Community Centres.
 - **Develop Therapy, Dietetics and Pharmacy Services** - During 2015/16, the Division is planning to in source the Nutrition and Dietetic services to provide improved resilience and to best meet hyperacute in-patient needs. Therapy services are also being re-configured to support changing Divisional requirements, 7 day services and to meet strategic service developments. The Pharmacy service plans to progress the e-oncology prescribing initiative.



Principal activities of the Trust

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

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

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

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

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

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

Division	Specialties		
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine	Respiratory Medicine Diabetes and Endocrinology Gastroenterology Cardiology Dermatology Hepatology Neurology	Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - Colorectal - Upper Gastrointestinal - Vascular - Bariatric Surgery Urology Paediatric Surgery	Trauma & Orthopaedic Hospital at home Critical Care Plastic Surgery ENT Cancer Services Medical Oncology	Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
Women's and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology	Gynae-oncology Paediatrics Fertility Neonatal Intensive Care Unit	Uro-gynaecology Ambulatory Gynaecology
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 2014/15 Divisional Directors, General Managers and Executive Directors met weekly in the Executive Board. Twice a month the Board reviewed the operational activities and discussed the strategic issues.

The other Executive meetings were dedicated to the Clinical Operational Board and Seminars.

For detailed information on related parties see note 27 to the accounts.

Review of Operational Performance

Key performance targets 2014/15

We assess our own operational performance against external national targets published by the Care Quality Commission (CQC), the Monitor Risk Assessment Framework and other locally agreed contracts, with the support of external peer review and other external expertise.

Activity

During 2014/15, L&D continued to consistently deliver against national quality and performance targets, achieving a Monitor governance rating of green throughout the year.

The L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met or improved upon the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.
- Met all of the cancer targets for the year.
- Had excellent performance against the C Difficile target threshold of 19 recording 10 cases.
- Reported 3 MRSA Bacteraemia which is under the diminimus of six for reporting to Monitor.

The table below summarises how our operational performance described above is interpreted against the national objectives by CQC and Monitor.



The diagram below summarises how our operational performance is interpreted against the national objectives by CQC and Monitor.

L&D Performance against CQC and Monitor Targets

	Threshold	Q1	Q2	Q3	Q4
Total time in A&E - \pm 4 hours (Whole site %)	95%	Achieved	Achieved	Achieved	Achieved
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:					
Surgery	94%	Achieved	Achieved	Achieved	Achieved
anti cancer drug treatments	98%	Achieved	Achieved	Achieved	Achieved
radiotherapy	94%	Not Achieved	Not Achieved	Not Achieved	Not Achieved
Cancer: two week wait from referral to date first seen (7), comprising either:					
all cancers	93%	Achieved	Achieved	Achieved	Achieved
for symptomatic breast patients (cancer not initially suspected)	93%	Achieved	Achieved	Achieved	Achieved
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	Achieved	Achieved	Achieved	Achieved
All cancers: 62-day wait for first treatment (4), comprising either:					
from urgent GP referral to treatment	85%	Achieved	Achieved	Achieved	Achieved
from consultant screening service referral	90%	Achieved	Achieved	Achieved	Achieved
Referral to treatment waiting times - non-admitted	95%	Achieved	Achieved	Achieved	Achieved
Referral to treatment waiting times - admitted	90%	Achieved	Achieved	Achieved	Achieved
Referral to treatment waiting times - Incomplete pathways	92%	Achieved	Achieved	Achieved	Achieved
Clostridium Difficile - meeting the Clostridium Difficile objective of no more than 31 cases/year	19	Achieved	Achieved	Achieved	Achieved
MRSA - meeting the MRSA objective of no more than 1 case/year	6	Achieved	Achieved	Achieved	Achieved

■ Achieved ■ Not Achieved

CQC Performance

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

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

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

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

The last formal CQC inspection was in September 2013. Two areas of improvement were identified; record keeping and maternity staffing. We declared full compliance with the standards in January 2014 and the CQC conducted a follow up inspection in August 2014. To date we have not received a formal report back from the CQC against these criteria. However, correspondence indicated that we were assessed as being compliant with the standard for record keeping.

CQC Assessments

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

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

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.
- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.
- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

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

Intelligent Monitoring

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

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

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.

Quality of Governance

We have ongoing monitoring of quality governance through the committee structure which is detailed in the Governance section of this report. Further information about how we review quality is contained within the Quality Account section of this report. Assurance in relation to our Assurance Framework and internal control is contained within our Annual Governance Statement.

Regulatory Performance Ratings

Monitor, which regulates all NHS Foundation Trusts, allocates risk ratings for each quarter against their risk of breach of authorisation as a Foundation Trust.

During 2013/14, Monitor implemented a new system of monitoring Trusts called the Risk Assessment Framework. Therefore from April - September 2013 the Trust was judged against the Compliance Framework and from October 2013-March 2014 against the Risk Assessment Framework. For 2014/15 the whole year was against the Risk Assessment Framework.

The risk ratings are for the Compliance Framework were:

1. Financial risk rating

Rated 1-5, where 1 represents the highest risk and 5 the lowest risk of breach of authorisation/regulatory concerns.

2. Governance risk rating

Rated red, amber or green regarding compliance with governance arrangements

The risk rating for the Risk Assessment Framework are:

1. Continuity of Service risk rating

The continuity of services risk rating incorporates two common measures of financial robustness:

(i) **liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and

(ii) **capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations.

A rating of 1, 2, 2*, 3 or 4 is assigned where 1 represents the highest risk and 4 represents the lowest risk.

2. Governance risk rating

Governance ratings are derived from a number of elements including:

- Performance against nationally selected outcomes and standards
- CQC compliance
- Relevant information from third parties

Trusts are then rated red, amber or green regarding compliance with governance arrangements where red is taking regulatory action.

The Compliance Framework performance assessment criteria that Monitor applied in 2013/14 can be found at:

<http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-commissioners/guidance-founda->

The Risk Assessment Framework assessment criteria that Monitor apply can be found at:

<http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-commissioners/licensing-provi->

Further information related to the L&D can be found at: <http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/luton-and-dunstable-hospital-nhs-fou>

For 2013/14 the Trust maintained a green governance rating under the new regime. The change to the continuity of services rating saw the Trust move from a score of 3 to a 4 maintaining a low risk.

For 2014/15 the Trust maintained a green governance rating and a continuity of services rating of 4.

Summary of rating performance

1. Comparison between 2013/14 and 2014/15:

	Annual Plan 2014/15	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Financial risk rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial risk rating*	3	3	3		
Governance Risk Rating	Green	Green	Green		
Risk assessment framework					
Continuity of service rating				4	4
Governance Risk Rating				Green	Green

2. Trust performance against national targets

	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
National Target				
CQC Action	No	No	No	No
Monitor override	No	No	No	No

We had no formal interventions.

Activity Performance Analysis

The table below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Activity Type	Units	Plan 2014/15	Forecast 2014/15	Plan 2015/16
Activity - Acute and Specialist				
Elective inpatients	Spells	9,564	9,028	9,770
Elective day case patients (Same day)	Cases	24,931	23,532	25,465
Non-Elective (excl well babies)	Spells	34,072	35,569	38,138
Total Admitted Patients		68,567	68,129	73,373
Outpatients - first attendance	Attendances	87,431	82,174	87,960
Outpatients - follow up	Attendances	151,833	144,382	153,666
Outpatients - procedures	Procedures	42,245	41,242	45,149
Total Outpatients		281,509	267,798	286,775
A&E	Attendances	81,766	92,244	98,274
Maternity Pathway				
Ante-Natal Pathway	Patients	5,743	5,446	5,804
Births	Births	5,100	5,236	5,379
Post- Natal Pathway	Patients	5,281	4,994	5,155
Total Maternity Pathway		16,418	15,959	16,418
Critical Care				
Adult - Intensive Care	Bed Day	2,199	2,266	2,416
Adult - High Dependency Unit	Bed Day	2,685	2,614	2,697
Adult - Ward Based High Dependency	Bed Day	1,907	2,670	2,730
Neonatal -Intensive Care	Bed Day	2,641	2,322	2,438
Neonatal -High Dependency Unit	Bed Day	2,490	3,610	3,436
Neonatal -Special Care Babies	Bed Day	4,744	6,142	6,462
Neonatal -Transitional Care	Bed Day	1,192	1,310	1,316
Paediatric - High Dependency	Bed Day	2,259	1,802	1,882
Total Critical Care	Bed Day	20,117	22,736	23,377

In 2014/15 our commissioners anticipated substantial QIPP reductions. Despite their endeavours planned reductions on activity did not occur and emergency activity, in particular, has shown a significant increase.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators increasingly utilising services such as hospital at home and ambulatory care to absorb the demand. However, this activity could not be provided within existing employed staffing levels, consequently the Hospital incurred substantial temporary staffing costs, partly funded through additional winter funding.

In 2015/16, the Trust will continue to utilise the opportunity presented by the Better Care Fund, underpinned by a new model for elderly care piloted in South Beds and Luton during 2014/15, in order to see a fall in emergency activity. This, in part, is necessary to create space for elective activity which is planned to increase in 2015/16, both through increasing demand in specific areas, and through our plans to reduce its 18 week backlog and overall waiting lists.

Research Performance

The current NHS Five Year Forward View states that:- 'Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine'.

Ongoing clinical excellence at the L&D is supported by high quality research and a robust evidence base. The Trust aims to undertake high quality research that addresses issues of concern to the local population and to the NHS as a whole. High quality research provides the evidence with which to practice 'evidence based-medicine'.

The Trust's research strategy emphasises strengthening research through collaboration with the Department of Health funded UK Clinical Research Network (UKCRN), the National Institute for Health Research (NIHR) in England via the Clinical Research Networks (CRNs) [previously known as the Comprehensive Local Research Networks (CLRNs)], local Clinical Commissioning Groups and Academic links. As from 1st April, 2014, we became a member of CRN: North Thames. The remit remains the same as the CLRNs i.e. to provide researchers with the practical support to facilitate clinical studies in the NHS and increase research across England.

This practical support includes:

- Reducing the "red-tape" around setting up a study.
- Funding the people and facilities needed to carry out research "on the ground" so research activity does not drain core NHS resources.
- Helping researchers to identify suitable NHS sites to recruit patients to take part in research studies.
- Advising researchers on how to make their study "work" in the NHS environment.

The R&D department has been very busy over the past 12 months and along with some L&D specialty consultants since June 2014 has met with various Research Delivery Managers from the 6 Divisions in CRN North Thames (divided by specialty) to discuss how to increase research capacity at the L&D. The CEO, Medical Director, R&D Director and R&D Manager met with the CRN Clinical Director and CRN Chief Operating Officer, on 11th June, 2014. As a consequence of these various meetings the CRN recognised the L&D's potential and decided to invest a 40% uplift in our previous funding allocation amounting to an overall additional £167,242 funding in 2015/16. (Funding in 2014/15 was £418,131 and in 2015/16 amounts to £585,373). The additional funding is to employ research nurses up to 31st March, 2016, in the first instance into the following specialty departments - Neurology, Paediatrics, Ophthalmology, Gastroenterology / Hepatology, Respiratory Medicine, Microbiology / Infectious Diseases, Rheumatology, Orthopaedics and Reproductive Health. In addition to this allocation, CRN North Thames has asked us to assess the possibility of seconding a 1 wte haematology research nurse (to be based at the L&D and with funding provided by CRN) for 6 months in the first instance, with a review after 6 months.

Recruitment to NIHR Portfolio studies at the L&D for 2014/15 totalled 568 patients. We have agreed to the CRN North Thames 'Stretch Target' of 861 for 2015/16. With the additional research nurse support it is felt this target can be met and exceeded. Clearly in CRN North Thames the bar is set high but we are confident we are up to the challenge particularly with the additional recruitment which will ensue due to the 40% uplift in funding / additional research nurses. I look forward to the L&D becoming one of the best recruiting DGHs - if not the best - in CRN North Thames.

Research issues and studies approved to be undertaken at the Trust (via the Research & Development Department) are presented at the quarterly Division of Medical Education and Research (DMER) Committee meetings. There are 120 active research studies in which 39% of our consultants are involved.

The Trust's Annual Academic Report for 2014/15 will be available in September 2015. However, the Annual Academic Report for 2013/14 reported that, in addition to the 138 ongoing research studies during that year, publications by Trust staff included 76 Scientific Papers; 61 Abstracts and 2 Books or Chapters in Books.

Education and Performance

Medical Education

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

Undergraduate

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

Postgraduate

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

Medicine

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

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

Obstetrics & Gynaecology

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

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

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

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

Pre-Registration Education for Nurses and Midwives

We continue to provide placements for pre-registration students and undergo a yearly qualitative and quantitative assessment through the Quality Improvement Performance Framework. This framework is monitored quarterly against an action plan to ensure continuous improvement. A number of areas are reviewed including student feedback on both the Higher Education Institution and the hospital placements where each student is allocated a qualified mentor to support their clinical education. Our performance against this assessment is good and we strive to meet all the requirements of the regional Learning and Development Agreement.

To monitor quality, we undertake a formal assessment of the performance of the University of Bedfordshire and the University of Hertfordshire using nursing education quality indicators as a benchmark. Annually, 160 nurses and 60 midwives are trained in partnership with the University and the Trust.

Pre-Professional Workforce

We have complied with proposed national changes to the education and training of this group of staff based on recommendations from the Cavendish Report. It has been agreed that all clinical support staff will undertake the Care Certificate to ensure an improvement in knowledge and skills for the benefit of patients. We have opted to use the apprenticeship model to deliver this training to our clinical support workers.

Appraisal and Pay Progression

In line with revised national Agenda for Change requirements implemented on 1st April 2014, incremental pay progression is now dependent on staff having had an appraisal within the last 12 months, compliance with core mandatory training, and achievement of individual objectives.

This revised approach has led to a 9% increase in core mandatory training compliance since 31st March 2014. Our appraisal compliance rate continues to fluctuate slightly above 70%, with long term sickness, maternity leave or service pressures leading to appraisals having to be rescheduled as the primary reasons for late completion. Appraisal rates are monitored on a monthly basis and managers are informed of compliance so that they can take action in a timely fashion.

Personal and Continuous Professional Development

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

In recognition of the national move towards a more blended approach to learning, we continue to provide access to an excellent resource for leadership and management development through the Ashridge Business School. All staff can access the Virtual Ashridge website through the Intranet. We also promote e-learning and provide supported sessions for staff to undertake their mandatory training, where appropriate.

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

Every year, we produce a comprehensive training brochure offering clinical and non-clinical courses for multi-professional staff. Some of the courses are provided by our own clinical specialists and we also commission some external providers, where cost-effective and appropriate. In addition, we are able to make best use of regional funding for the benefit of all our staff including Bands 2 - 4.

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

Mentoring Schemes

As part of our 75th Anniversary celebrations, we partnered with Luton Sixth Form College to deliver a mentoring programme for a group of Year 12 students keen to pursue a career in medicine. The scheme is aimed at academically able students whose families do not have a career in a medical field or may not have been to university. Recruitment onto the scheme included completion of an application form and an interview. Each of the six students selected were matched with a doctor who will be their mentor for the 18 month programme. Students have regular meetings with their mentor to introduce them to what it is like to work in the hospital, advise them on the application process for medical school and prepare them for interviews as well as increasing their confidence. Students also have the opportunity to gain valuable work experience through work shadowing.

Overseas Nurses

During 2014/15, we recruited a large number of overseas nurses, these nurses were given a tailor-made induction period to ensure that they are fully prepared for work. The nurses then follow our internal preceptorship programme and formal competencies are assessed in practice. To ensure that all the nurses have a reasonable standard of English, they were assessed at interview and on arrival. Those that required additional English language training attended lessons provided by Luton Adult Learning which were run on-site to enable the nurses to attend.

Apprenticeships

Health Education England have reviewed each NHS job role in order to map it to an apprenticeship qualification. This financial year, 117 Trust staff have enrolled to an apprenticeship qualification. The Trust continues to broaden the frameworks (subjects) that are studied as apprenticeships, and currently people are studying towards apprenticeships in Customer Service, Business Administration, Team Leading, Management, Pharmacy, Healthcare, Maternity and Paediatric Support, Electrical Installation, Electrical Operations, Food Production and Cooking and Catering.

Apprenticeship frameworks in Project Management, Life Sciences, Dental Nursing, Haematology and Maxillofacial and Orthodontics are due to start.

The Trust continues to offer apprenticeship qualifications at levels 2, 3, 4 and 5 (GCSE to degree level) and is one of the most proactive Trusts in the East of England.

Staff Development

A number of roles have evolved and expanded using the intelligence gained from the Perfect Day project. The discharge coordinator role and ward administrator role has supported the reduction in documentation and other administrative duties enabling nurses to spend more time at the bedside. Other areas have seen further development of the housekeeper role, ensuring the ward environment is kept in line with the cleaning standards and supporting patients' nutritional requirements.

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

Leadership Development

We continue to participate in NHS Leadership Academy national programmes. We are actively promoting these to all our managers, both clinical and non-clinical, and the talent management analysis tool in our current appraisal paperwork supports discussions about future aspirations with staff at all levels.

The Leading Safe and Effective Quality Patient Care programme has been completed for Matrons and now further groups of Ward Sisters are participating with the option of external coaching for participants through a regional coaching network in Bedfordshire and Hertfordshire.

The NHS Healthcare Leadership Model has been promoted internally and we have increased the number of feedback facilitators in the Trust. Uptake of the new 360° feedback model is improving in the Trust. As part of our support for doctors undertaking Revalidation, we continue to facilitate 360° feedback in line with GMS guidance, incorporating patient feedback.

Coaching takes place regularly for senior staff, where appropriate and helpful, and we are developing our approach to Health Coaching so that we can support patients with long-term conditions to manage their health in collaboration with their clinician.

Medical Revalidation

There are 315 doctors within General Medical Council (GMC) Connect whom we are responsible for in terms of Revalidation. All doctors are supported to prepare for their individual revalidation with the GMC which is required every 5 years. In addition to providing access to 360° feedback twice in 5 years, we have also purchased a licence to a customised website to enable every doctor to prepare for their appraisal on an annual basis. This online web-based portfolio of evidence is a full record of the doctor's whole practice and provides comprehensive information for each annual appraisal.

The Revalidation Support Officer provides support for both appraisers and individual doctors to ensure that all the relevant information is included. She liaises closely with the Medical Director, who is also the Responsible Officer for revalidation and the General Medical Council. Our main focus is to ensure that doctors are made aware of their responsibilities and can confidently prepare for and successfully go through the revalidation process. We have successfully achieved the numbers for each quarter and are confident that we are on target for doctors employed by the Trust to be prepared for revalidation.

During 2014/15, we have successfully achieved the numbers for each quarter and are confident that we are on target for doctors employed by the Trust to be prepared for revalidation.

Sustainability/Climate Change Performance

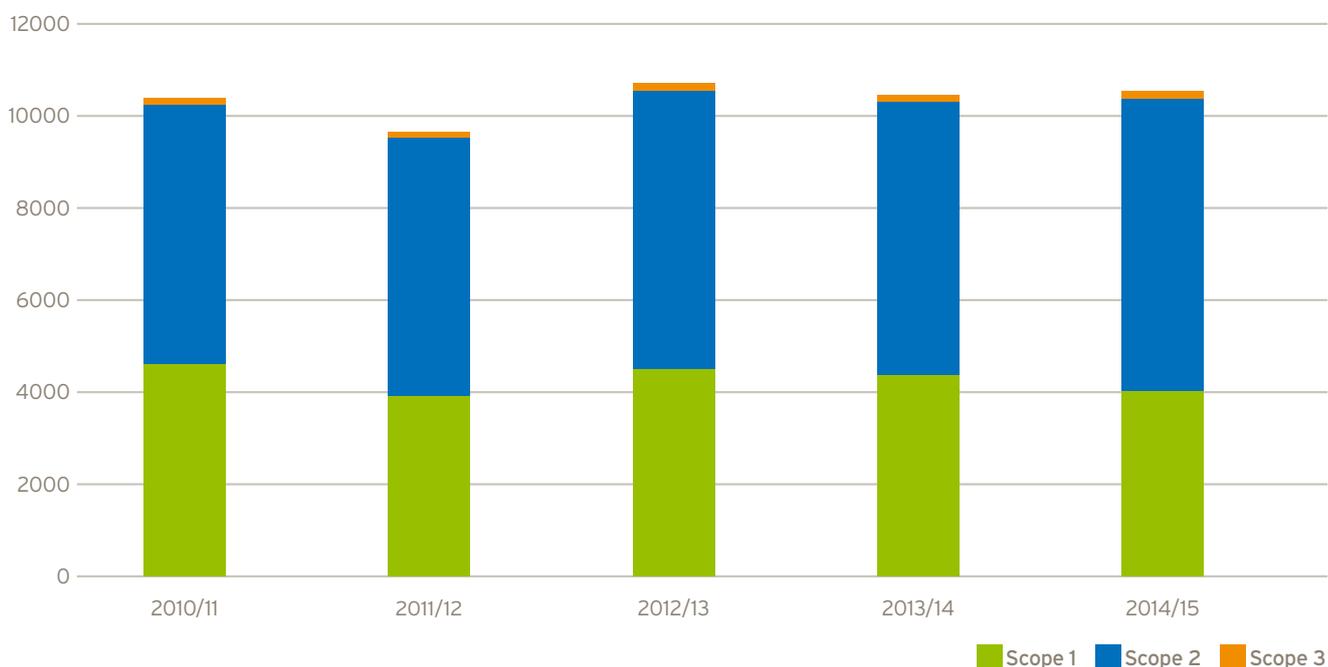
Monitor encourages NHS foundation trusts to produce a sustainability report as part of their annual report and accounts. Luton and Dunstable University Hospital NHS Foundation Trust is voluntarily disclosing their sustainability and environmental performance for the

7th year. This report has been written in accordance with HM Treasury and Defra guidance on reporting carbon emissions.

Detailed Performance

Greenhouse Gas (GHG) Emissions	2010/11	2011/12	2012/13	2013/14	2014/15
Non-Financial Indicators (tCO2e)					
Gas	4,574	3,942	4,501	4,340	3,974
Gas Oil	9	16	12	15	15
Owned vehicles	9	8	6	5	6
Total Scope 1 (Direct)	4,592	3,966	4,519	4,360	3,995
Purchased Electricity	5,658	5,569	6,059	5,936	6,402
Total Scope 2 (Energy Indirect)	5,658	5,569	6,059	5,936	6,402
Official Business Travel Emissions	148	134	136	160	159
Total Scope 3 Indirect GHG Emissions	148	134	136	160	159
Total GHG Emissions	10,398	9,669	10,714	10,456	10,556
Related Energy Consumption (million kWh)					
Gas	24.9	21.4	24.5	23.6	21.6
Purchased Electricity	11.5	11.6	12.5	13.3	13.7
Financial data (£k)					
Gas	518	542	641	785	667
Gas Oil	2	4	3	4	4
Owned vehicles	4	4 (est.)	2	6 (est.)	6
Purchased Electricity	977	1126	1218	1,407	1,394
Official Business Travel	215	204	255	300	277
Total cost	1,740	1,975	2,263	2,520	2,348

Graphical analysis (Scope 1, 2 and 3 Greenhouse Gas Emissions in tCO₂e)



Commentary

The primary measure of greenhouse gas emissions is the tonnes equivalent of carbon dioxide and these are listed under one of three categories: Scope one related to emissions arising from sources controlled by the organisation e.g. burning gas to provide heating and hot water; Scope 2 which are indirect emissions arising from the supply of energy to the organisation by a third party e.g. electricity, and Scope 3, all other emissions which arise as a consequence of our activity but which is not owned or controlled by the organisation e.g. water, waste, business travel in private cars etc. We abide by the minimum reporting requirement as stated in the HM Treasury Public sector annual reports: sustainability reporting guidance 2014/15.

Power and heating is supplied to the Trust via the consumption of electricity and gas. Both are measured in kWh.

Whilst the consumption of both utilities is influenced by the seasons, it is clear that the long term trend in gas consumption (12 month moving average) is down. The Trust consumed nearly 2 million mWh less gas (8%) in the last financial year compared to the previous year. Electricity consumption so slightly down (0.5%) compared to the previous year but cost was a little higher (3%). However, the tonnage of carbon dioxide equivalents was higher for these Scope 2 emissions due to an 11% increase in the emission scaling factor! Some of the reduction in gas consumption may have been due to the milder weather - the number of heating degree days below 18.5oC was three per cent less last year, but the boiler refurbishment project alone yielded a 1.35 million mWh saving in gas consumption.

Year	2010/11	2011/12	2012/13	2013/14	2014/15
Degree Days	3295	2901	3560	3080	2983

Gross expenditure on the CRC Energy Efficiency Scheme to cover emissions generated in 2014/15 was around £178,000.

Waste

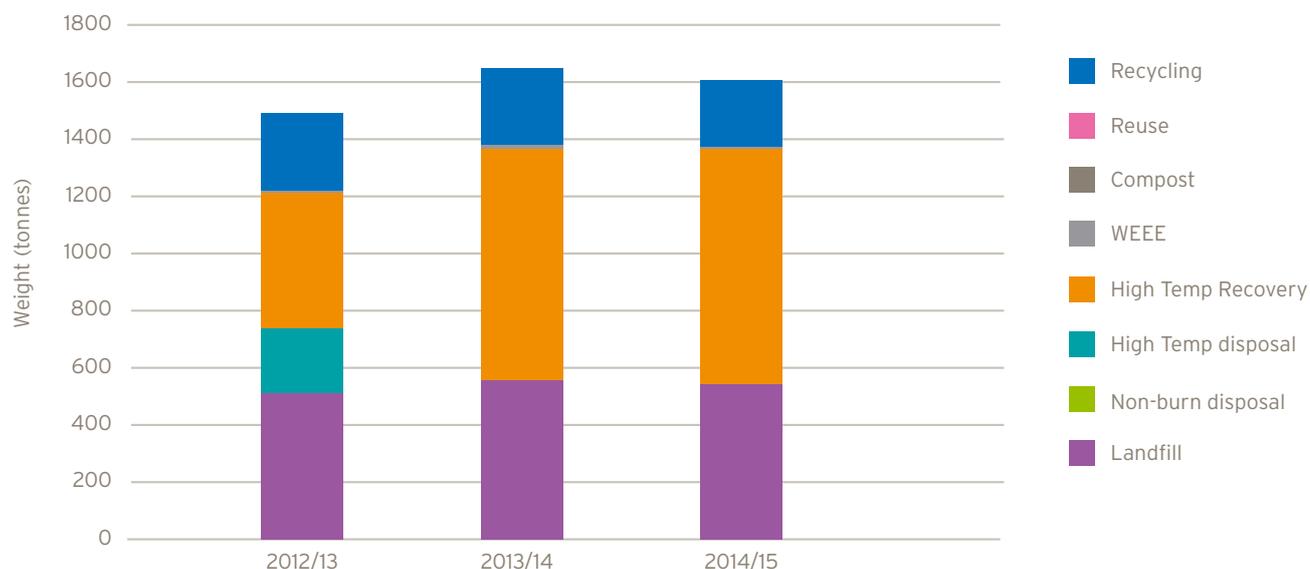
	2010/11	2011/12	2012/13	2013/14	2014/15
Non- financial indicators (tonnes)					
Total waste arising	1271	1472	1333	1638	1606
Incineration*	48	75	480	818	829
Alternative treatment	639	734	228	0	0
Offensive**	-	-	-	12	273
Domestic	443	453	507	553	543
WEEE	25	26	7	12	5
Shredding	80	116	47	194	147
Recycling***	-	-	273	267	235
Financial Indicators (£k)					
Total waste arising	347	364	433	354	358
Incineration*	46	57	190	274	266
Alternative treatment	238	234	105	0	0
Offensive**	-	-	-	2	63
Domestic	41	46	57	60	71
WEEE	9	8	0	0	0
Confidential	14	18	16	15	16
Recycling***	-	-	-	20	21

*Incineration includes infectious and non-infectious was streams and sharps disposal. Infectious waste includes items that have been in contact with body fluids from a patient with a known or suspected infection.

**Offensive waste is a human healthcare waste not presenting risk of infection, even though it may contain body fluids, secretions or excretions (including blood)

***Recycling stream includes co-mingled recyclables, confidential and waste electronic and electrical equipment.

Graphical analysis (Waste volumes in tonnes and disposal routes)



Commentary

Overall waste tonnage generated by the trust averages around 130 tonnes a month - this has been relatively static at this level for a considerable period.

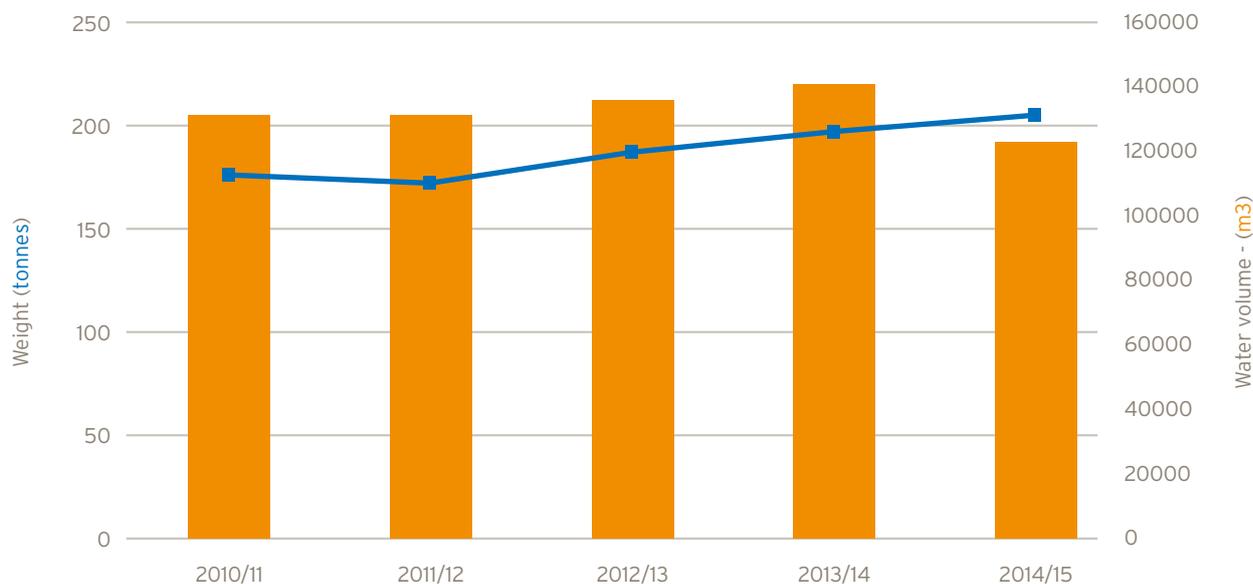
Implementation of the offensive waste stream segregation project has seen a reduction in waste disposal costs due to the lower costs of offensive waste compared to infectious waste.

Cumulative cost savings of £31k have been achieved to the end of October 2014, and the offensive waste stream as a proportion of overall waste has increased from four per cent to twenty per cent.

Looking forward, there would be a significant cost avoidance to the Trust if there was more recycling undertaken.

Finite Resource Consumption	2010/11	2011/12	2012/13	2013/14	2014/15
Non- financial indicators (m³)					
Water consumption	131,238	131,080	135,739	140,884	122,849
Financial Indicators (£k)					
Water supply costs	176	172	187	197	205

Graphical analysis (Water usage)



Commentary

The reduction in water consumption is a reflection of fewer water leak episodes, but there remains a lack of transparency with water supply information. Discussions are ongoing with the local water supplier with the aim of having automatic meter readers (half hourly) put on all the incoming water supplies so that information granularity similar to half hourly metered gas and electricity meter supplies is achieved. This will allow water leaks to be detected even earlier and should facilitate calendar month billing rather than the dysfunctional mechanism currently in place.

We continue to investigate wasteful high water use and water waste processes such as water softening/blending and are constantly on the lookout for technologies that will reduce the wastage.

We are currently reviewing all water management contracts to determine value for money for the Trust.

Sustainable Transport

Implementation of the hospital travel plan continued over the last year with delivery of the final instalment of the car parking strategy first implemented in 2011. The addition of a hundred extra spaces for patients and visitors has being broadly welcomed by everyone.

We have continued to develop our partnership working with Arriva bus and Luton Borough Council with several promotions around the Luton Busway. Our long-standing discount bus ticket promotion with Arriva continues to be popular, this was recently enhanced with the introduction of the Arriva APP, with the discount being extended to day tickets.

We have continued to enjoy opportunities offered by the Local Transport Fund and held further individualised marketing events for staff and several free Dr Bike clinics where staff have been able to get a bikes service free charge. The tax efficient cycle scheme continues to be popular with 50 staff taking advantage of this promotion.

In July 2012 the Trust Board approved the Travel Plan. The headline target for the plan is to achieve a 15% modal shift away from single occupancy vehicle use and towards sustainable modes over the next five years. A voluntary target has also been set to achieve a 5% modal shift away from the car amongst patients and visitors. Staff, and patient and visitor travel surveys are in the process of being completed as part of the transport assessment and travel plan revision required as part of the hospital redevelopment plan.

Carbon Management Plan implementation

Two schemes were successful in receiving funding from the £50 million government Energy fund. For the boiler refurbishment project, post completion evaluation has shown a saving of 1.3 million kWh of gas over a one-year period, and £68k cost avoidance made up of a combination of gas consumption and carbon reduction tax avoidance. This translates to 265 tonnes of carbon dioxide equivalent.

Boiler Refurbishment Project



In one year (to 17/01/15)

- Gas used down by 1.346 million kWh
- £69.8k cost avoidance
- 248 tonnes of CO2

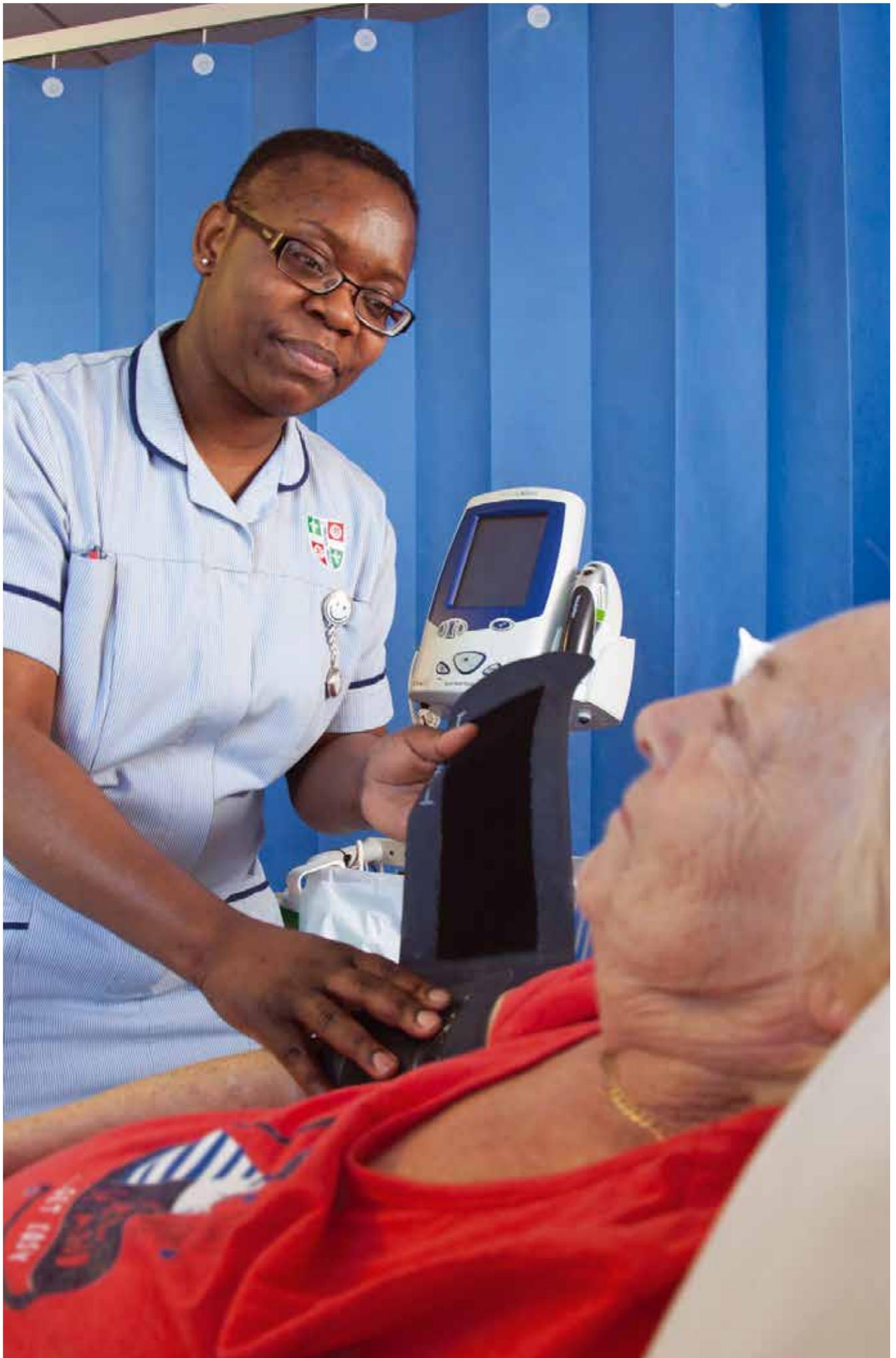
Outputs from the LED external street replacement project are more difficult to measure consumption spread across several distribution boards - none of which are metered. Anecdotally, operating hours before and after our unchanged consumption saving must have occurred given the low wattage of the LED fitting compared to the old light fitting.

In February 2015, a bid for a £30k loan from the SALIX fund to procure enhanced controls in four Boiler house plant rooms was successful. The simple but proven technology reduces dry cycling within the boilers so that they only operate when there is a genuine call for heat from the system and not just to keep the water hot within the boiler. The installation was completed on 31 March 2015 and we are now in the 12 month post project evaluation period. The project feasibility study suggested a saving of 178 tonnes of carbon dioxide equivalent to a consumption saving of just under 1,000,000 kWh of gas. Project payback is anticipated at just over one year. Further energy efficiency measures which been introduced over the last financial year include enhanced controls on the ventilation plant to the surgical block theatres which controls the temperature accurately in the operating theatres, and reduces ventilation when the theatres are unoccupied. Similar controls have been introduced for the two maternity theatres. Enhanced controls also been introduced to the ventilation plant in the pathology block.

Looking forward

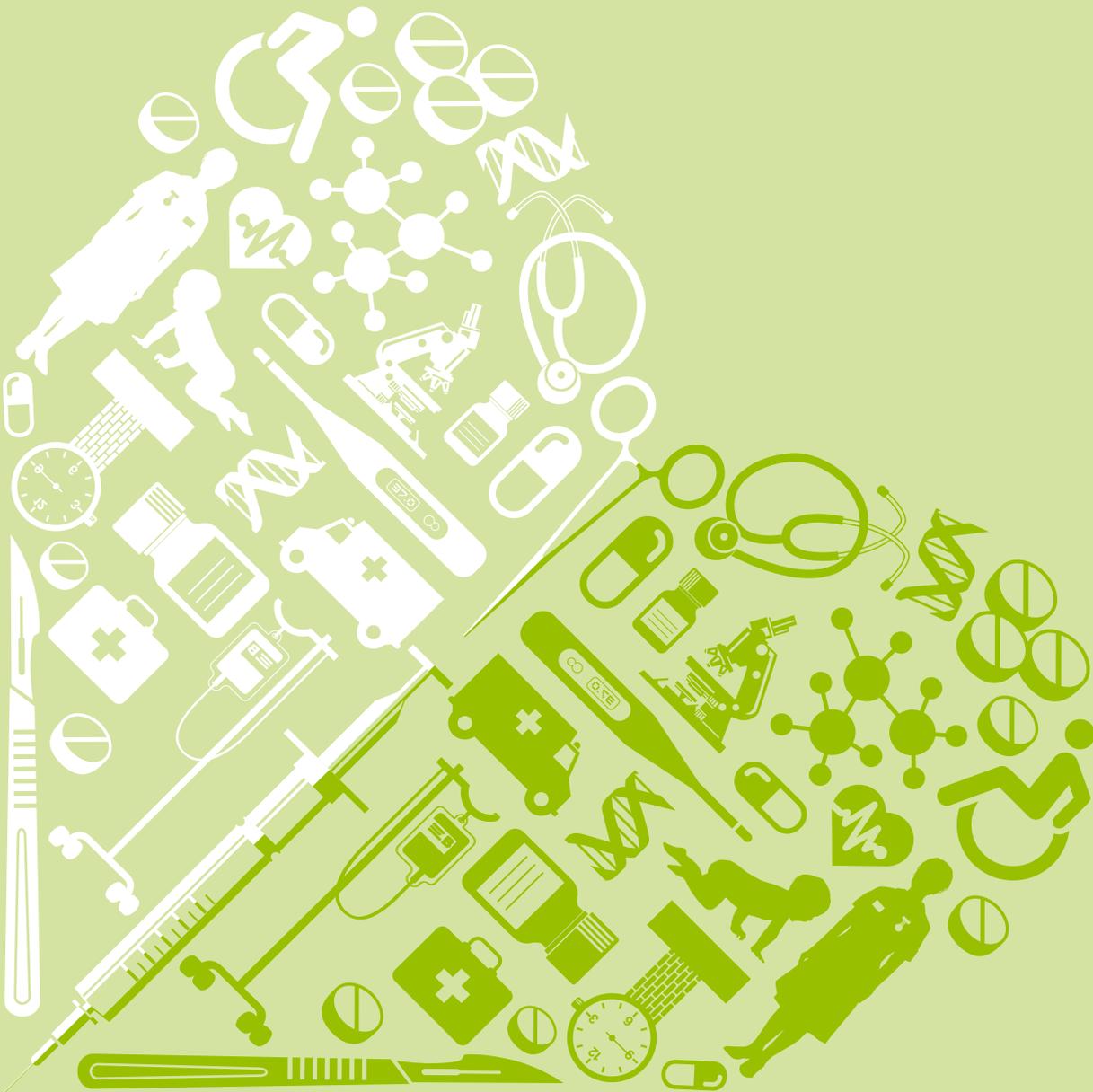
Looking forward, the following work streams are planned which will help the hospital to deliver on its sustainability obligations. Cognisant of the hospital redevelopment and any energy centre solutions it might propose:

- Further BMS interventions will be introduced to the existing boiler plant so that there are is at least some linkage to external ambient air temperature.
- Carbon reporting will be enhanced in order to raise the profile of sustainability within the organisation.
- A sub metering strategy will be developed for electricity,
- A metering strategy will be introduced for all our mains water inlets;
- there will be a concerted push on improving recycling rates, and
- the travel plan will be reviewed part of the planning for the hospital redevelopment.



Our patients, our staff and our partners

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Our Patients

This year we have expanded the opportunity for our patients to give their feedback by extending the Friends and Family Test to additional areas in Outpatients and Children's services. Staff in these additional areas are keen to hear patient concerns and experiences directly from their patients and as the feedback can be more timely than the results from other surveys, the staff have the opportunity to make changes, often in real time by contacting the patient directly to offer further support and advice. This is facilitated through the calls that we continue to make via the Patient Experience Call Centre and by gaining the patient's permission for a member of staff to call the patient back. The comments and experiences of patients can be accessed by ward and divisional managers and common themes are identified for Trust wide projects that have the potential to make improvements to services.

Our patients have provided us with information that we are extremely proud of by naming individual members of staff and teams who have made a positive difference to their care and treatment. Feedback like this is incredibly motivating for staff and provides the hospital with information on areas of good practice that can be learnt from.

Patient Experience Call Centre and Patient Advice and Liaison Service (PALS)

If patients, families or carers have any concerns about their care or treatment then the PALS staff are available to help and if requested will visit patients on the wards to help with any immediate problems. PALS can sign post to other services and arrange meetings with staff to resolve issues on the spot. The PALS desk is located in the main entrance of the hospital within the Patient Experience Call Centre and is open from 9am to 5pm with a drop in facility from 10.00 to 12.00 and 14.00 - 16.00 Monday to Friday with a message service available out of hours.

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

- An appointment system for relatives to speak to the Consultant so that the patient and relatives know that when they arrive on the ward they will be able to speak to a Doctor at that time.
- Shelves have been installed in bathrooms for patients to place their possessions.
- A range of initiatives have been implemented to support the needs of our patients living with dementia and which also help to provide a more restful

environment for all patients on the wards.

- Additional armchairs have been purchased in one ward in response to feedback about uncomfortable seating.
- Nursing safety briefings have been introduced along with a communication book for recording questions for doctors. This was in response to feedback which raised poor communication between doctors and nurses as a specific concern.

Local Involvement Networks Healthwatch

The Trust continues to work with Healthwatch Luton, Central Beds and Hertfordshire. Healthwatch Luton have conducted two surveys this year, one in outpatients during November and an Inpatient Survey in February 2015.

The Trust works with other specialist patient groups through the Information Point in St Mary's reception with regular input from Alzheimer's Association, Disability Advice Service, Carer Support, Headway, Stroke Association, Falls Service, Kingham Project, Cardiology Research and Stop Smoking. The Trust is currently working with Carers in Bedfordshire on a project to open a Carers Lounge in the St Marys Unit.

Patient and Public Participation Group

During 2014/15, the Patient and Public Participation Group met quarterly to review and monitor patient experience data. Two patient focus groups were held where feedback was gained on the Bedside Patient Information Booklet, Discharge process, Equality Delivery System and a Cultural Handbook for staff.

Listening to Patient Concerns

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

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

The majority of our complaints were resolved at local resolution level; however, seven complainants asked the Parliamentary and Health Service Ombudsman to review their complaints. Following the Case Manager's

Assessment (the first stage of the process) the Ombudsman declined to investigate one complaint; two complaints are awaiting a decision for an investigation and four complaints are currently being investigated by the Ombudsman.

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

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

- The Early Pregnancy Clinic is now able to perform scans at weekends.
- The creation of 144 additional car parking spaces for staff and an additional 100 spaces for patients and visitors.

Compliments

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

Below are some extracts from compliment letters received recently:

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

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

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

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

The Chaplaincy Service

This past year has seen the Chaplaincy growing and developing, both in the number of people involved in the team and the service we deliver.

We have been delighted in welcoming two new Chaplains who have joined the L&D's Chaplaincy Team. Fr Michael Patey as the new Roman Catholic Chaplain and the Revd Varkey Eappen into the newly created Team Chaplains' post. We have also said farewell to the Revd Julie Cox who retired after eight years as Bank Chaplain.

Working with members of staff from the Muslim community and with the support of the Charitable Funds we have been able to refurbish the Sacred Space, the Prayer Room on the ground floor of the Surgical Block to provide washing and other facilities for the many Muslim patients and staff who pray there. We continue to have Friday Prayers in the Social Club.

The support offered by the Chaplaincy Team is a partnership of care. The Chaplains, Ward Visitors and Chapel Volunteers work together (with a team of over 50 - mostly volunteers) with the local faith communities to offer spiritual, pastoral and religious care to all at the L & D. We are now offering support to over 1700 patients and staff each month and are continuing to develop our service by developing the team and the way we work. We have for example recently introduced teams of volunteers to visit Hindu and Muslim patients.

We are also working with Hospital Radio to enable people unable to attend an act of worship, to listen on L&D Radio to specially recorded programmes.

This last year has also seen the publication of the **NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care**. We are currently reviewing our service against the guidance which will provide us with a framework for developing our team, our service and the care and support we offer.

Our Staff

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

Recruitment and Resourcing

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

Nurse Recruitment

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

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

Health Care Assistants (HCAs)

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

- In line with the recommendations of the Cavendish review and the Francis Report, the Trust has implemented a revised training programme for all Health Care Assistants (HCAs) to meet the 'basic care certificate' level. All HCAs now undertake a 2 week induction followed by completion of the standardised national competencies within the first 12 weeks of commencing employment.

- All HCAs are offered a permanent position upon successful completion of the 'higher care certificate', within their first year. This will ensure all support workers have a generic basic training and can choose to progress to senior support worker roles.

Medical Agency Locums

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

Medical Productivity

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

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

Sickness Absence Project

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

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

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

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

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

eRostering

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

The implementation of the new rostering solution not only focuses on maximising the governance, qualitative and financial benefits associated with the technology but has acted as a catalyst to develop the Trusts culture ultimately changing the fundamental way the Trust approaches rostering. The project commenced in January 2014 and as at March 2015 41 areas are successfully using the system for rostering. All nursing bank shifts and payments are managed within the system and employees can view their roster and manage annual leave from home via the internet. The programme will continue into the 2015/16 financial year, with a view to including other staff groups, for instance medical staff and Allied Healthcare Professionals.

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

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

to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability"

Employee Relations and Staff Engagement

Staff Engagement and Consultation

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

Staff Involvement Group

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

Joint Staff Management Council (JSMC)

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

Staff Recognition

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

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

- On 22nd December 2014, the Trust recognised the long service given by volunteers who had devoted their time to the Trust over a time span of 40 years.

Communication

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

- Town Hall meetings with the Chief Executive to share information in respect of strategic plans and also operational issues
- Weekly Executive Briefings are undertaken to share key operational issues
- Divisions, departments and wards have established newsletters in their areas to share good practice and learning
- The nursing team have established a fortnightly nursing newsletter
- A bi-monthly L&D Staff Newsletter developed by the Staff Involvement Group but very much involving staff in ensuring stories
- The Intranet/E-mail system is used to communicate key message to staff in a timely way
- Regular meetings with Divisional representatives to share information and to receive feedback.
- Monthly meetings of Trust Board members with the Council of Governors which includes elected staff representatives
- Staff Governors actively speak directly to staff about their thoughts and ideas
- The CEO conducted a communication survey with staff and held meetings to understand directly from staff how they would like to be communicated with
- The Trust commissioned a piece of work during the summer of 2014 to explore how easy staff felt it was to (safely) raise concerns in the workplace. In addition, information gathered from the 2013 survey results and feedback from other sources, suggested that bullying and harassment may be taking place in some areas of the Trust. All staff were invited to participate either face to face by telephone or via survey monkey (online) questionnaire. Also, former employees were written to and given the opportunity to participate. During the period May to August 2014, we received feedback from 32 staff/former staff/governors in total. Feedback from this piece of work has been considered and actions taken as appropriate.

Staff Involvement Group Newsletter

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

Voluntary Services

We are extremely grateful to all of our volunteers for the services that they provide and we are happy to be in a position to provide opportunities for people in the local area to engage with their hospital.

The Trust currently has 252 volunteers supporting patients and staff and providing a very diverse service. Nearly 60% of these are over the age of 60yrs, 19.44% are aged 40yrs to 59yrs, 12.7% aged 25yrs to 39yrs and only 10.31% aged 18yrs to 24yrs. 34% are from a BME background, which is slightly under representative of our local community.

During 2014/2015 107 new volunteers were recruited and there were a total of 90 leavers. 7.7% of these leavers have proven that volunteering can be a route to paid employment as they secured either full time or bank roles within the Trust. This is an increase of 5.4% from 2013.

Of the other volunteers who left during this period, 6.7% went on to health related education, using volunteering as an insight into a healthcare setting and gaining valuable experience to enhance their CV and support University applications. 18.8% left due to a change in personal circumstances.

In order to reduce time spent on the recruitment process, the department has now trialled group rather than individual interviews and these have so far proven successful. We have been able to reduce the time taken to interview by up to 50%, and we have also seen a reduction in the number of people who do not attend for their interview. We therefore now have a better capacity to schedule an increased number of interviews when required.

The report on the investigation into matters relating to Savile at Leeds Teaching Hospital NHS Trust was published during 2014. The Trust has considered the impact of this report and its findings in respect of hospital volunteers.

During the year we have introduced some new volunteer roles, for instance within Medical Education, we now have volunteers who role play to assist with the mock OSCE student exams. The Macmillan Unit have also gained an Information Support Volunteer who has a wealth of experience having worked with the first Maggie's Centre when it opened in 1996. She helps provide support and strengthen the physical and emotional wellbeing of people with cancer and their families and friends. In June 2014, Volunteers week was celebrated with support from Mecca Bingo.

We held our annual Long Service awards event in December which was attended by 24 Volunteers and their guests. The awards were presented once again by Clifford Bygrave, Senior Independent Director and this year saw our first 40 year award presented to Eileen McMahon, our Skin Camouflage Practitioner. Alongside Suzanne Boet who has been arranging the chapel flowers for 30 years.

Health and Wellbeing/ Occupational Health

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

During 2014/15 the Trust has introduced a number of initiatives to promote opportunities for staff to adopt a healthier lifestyle either onsite or by promoting external facilities that are conducive to good health.

The Occupational Health and well being Service has focussed on providing information on health promotion topics and activities, by acting as a signpost for staff to obtain information and advice on a variety of health and fitness related initiatives. This has been achieved through the continued development of a health and well being section on the staff intranet, various electronic communications, newsletters, and awareness raising events.

In June 2014, a health and well being awareness raising day was held, which proved to be very popular entitled 'Spring into summer'. Awareness raising stands and activities included: -laughter yoga, smoking cessation, Active Luton, smoothie bikes, Heights/weights and Body Mass Index, British Heart Foundation representatives, healthy eating, a nutritionist performing health snacks demonstrations, Zumba taster sessions and other keep fit demos. Our Employment Assistance programme providers CiC were also present. A similar event is currently being planned for 2015.

This year, 66.3% of our frontline staff were vaccinated against flu, which was a 7.5% higher uptake than the year previous and higher than the national average uptake amongst other NHS Acute Trusts.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine.

SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

The Trust continues to provide an Employee Assistance Programme, which is available to all staff. This provides access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. Advice is available on The service is available 24 hours a day, 365 days of the year. The provision of this support during the past two years has proved to be valued greatly by staff with an excellent utilization rate. Monthly help/awareness raising sheets are also provided, which not only remind our staff of the availability of this important support but also give information about a number of health/life issues.

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years. With in excess of 2000 staff who are over the age of 40, the Trust has actively engaged with this initiative. A company commissioned by Luton Borough Council provided free health checks to those over the age of 40 and up to the age of 74. Whilst this was a national scheme we were able to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 300 members of staff seen. Each check included height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.

National NHS Staff Survey

The eleventh National Staff Survey was undertaken between September and December 2014. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark Reports across all NHS Acute Trusts. For the seventh year, the survey report has been structured around four of the seven pledges to staff in the NHS Constitution, which was published in March 2013, plus three additional themes.

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All Staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme : staff satisfaction

- Additional theme : Equality and diversity
- Additional theme : Patient experience measures

This year the Trust opted to survey all staff (for the last 2 years we had opted for a sample survey of 850 staff). Questionnaires were distributed by a mixed mode of electronically via work email or in paper format. Completed questionnaires were sent directly to the Trusts independent survey contractor, Quality Health, for analysis by age, staff groups and work and demographic profile.

This report gives a high level overview of the survey findings. A summary report of the complete results is available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust. As in previous years, there are two types of key finding:

- Percentage scores, i.e., percentage of staff giving a particular response to
- one, or a series of survey questions.
- Scale summary scores, calculated by converting staff responses to
- particular questions into scores. For each of these summary scores, the
- minimum score is always 1 and the maximum score is 5.

Response Rates

2014 National NHS Staff Survey		2013 National NHS Staff Survey		Trust Improvement/ Deterioration
Trust	National Average*	Trust	National Average*	
35%	42%	53%	50%	18% deterioration

* Acute Trusts

The official sample size for our trust was 3608. 1207 completed questionnaires were returned. 6 members of staff returned their questionnaires without filling them in. A group of 151 staff were excluded from the official sample as ineligible. E.g. having left the Trust or on long term sick leave.

There was a decrease in the response rate, which whilst obviously much lower than last year's final response rate is in line with the overall trend across all NHS Trusts nationally (not just those using Quality Health). Quality

health had stated that they believed the decline in response rates could be attributable to the introduction of the Staff Friends and Family test where in a majority of cases, all staff will already have been surveyed on two separate occasions prior to the national survey.

Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

	2014 National NHS Staff Survey		2013 National NHS Staff Survey		Change since 2013 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.79	3.74	3.90	3.74	Decrease (worse than)	Above (better than) average
KF 22 Staff ability to contribute towards improvements at work	74%	68%	75%	68%	No significant change	Highest (best) 20%
KF 24 Staff recommendation of the Trust as a place to work or receive treatment	3.70	3.67	3.81	3.68	Decrease (worse than)	Average
KF 25 Staff motivation at work	3.90	3.86	4.04	3.86	Decrease (worse than)	Above (better than) average

Key Findings

A summary of the key findings from the 2014 National NHS Staff Survey are outlined in the following sections:

Top Ranking Scores

Top 5 Ranking scores	2014 National NHS Staff Survey		2013 National NHS Staff Survey		Change since 2013 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 8 % of staff having well structured appraisals in last 12 months	47%	38%	38%	38%	Increase (better than)	Highest (best) 20%
KF 6 % of staff receiving job relevant training, learning or development in last 12 months	84%	81%	86%	81%	Decrease (worse than)	Highest (best) 20%
KF 22 % of staff able to contribute towards improvements at work	74%	68%	75%	68%	No significant change	Highest (best) 20%
KF 4 Effective Team working	3.82	3.74	3.88	3.74	Decrease (worse than)	Highest (best) 20%
KF 21 % of staff reporting good communication between senior management and staff	34%	30%	39%	29%	Decrease (worse than)	Highest (best) 20%

Bottom Ranking Scores

Bottom 5 Ranking Scores	2014 National NHS Staff Survey		2013 National NHS Staff Survey		Change since 2013 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 5 % of staff working extra hours***	77%	71%	76%	70%	No significant change	Highest (worst) 20%
KF 17 % of staff experiencing physical violence from staff in last 12 months	3%	3%	2%	2%	No significant change	Above (worse than) average
KF 28 % of staff experiencing discrimination at work in last 12 months	13%	11%	15%	11%	No significant change	Above (worse than) average
KF 16 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	16%	14%	18%	15%	No significant change	Above (worse than) average
KF19 % of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	23%	25%	24%	No significant change	Average

*** Whilst KF 5 is an amalgamation of both paid and unpaid hours, a further breakdown indicates the following:-

Response -unpaid extra hours	National	L&D
0 hours per week	42%	38%
Up to 5 hours per week	45%	47%
6 - 10 hours per week	9%	10%
11 or more hours	4%	5%

Where Staff Experience has improved (largest changes since 2013)

Improvements	2014 National NHS Staff Survey		2013 National NHS Staff Survey		Change since 2013 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 7 % of staff appraised in last 12 months	88%	85%	74%	84%	Increase (better than)	Above (better than) average
KF 8 % of staff having well structured appraisals in last 12 months	47%	38%	38%	38%	Increase (better than)	Highest (best) 20%
KF 10 % of staff receiving health and safety training in last 12 months	79%	77%	68%	76%	Increase (better than)	Average
KF 26 % of staff having equality and diversity training in last 12 months	68%	63%	55%	60%	Increase (better than)	Above (better than) average

Where Staff Experience has deteriorated (largest changes since 2013)

Deteriorated	2014 National NHS Staff Survey		2013 National NHS Staff Survey		Change since 2013 survey	RRanking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 25. Staff motivation at work	3.90	3.86	4.04	3.86	Decrease (worse than)	Above (better than) average
KF 3 Work pressure felt by staff	3.08	3.07	2.98	3.06	Increase (worse than)	Average
KF 24 Staff recommendation of the trust as a place to work or receive treatment	3.70	3.67	3.82	3.68	Decrease (worse than)	Average

The Staff Survey results for 2014 are positive. We maintained an above average staff engagement score and also demonstrated improvements in four areas. These improvements reflect the enormous amount of work and focus in the last year in relation to appraisal and statutory training:

- % of staff appraised in last 12 months
- % of staff having well structured appraisals in last 12 months
- % of staff receiving health and safety training in last 12 months
- % of staff having equality and diversity training in last 12 months
- The Trust has also been ranked as the best performing (top 20% of all acute Trusts) in five key areas:
- % of staff having well structured appraisals in last 12 months
- % of staff receiving job relevant training, learning or development in last 12 months
- % of staff able to contribute towards improvements at work
- Effective Team working
- % of staff reporting good communication between senior management and staff

Whilst we are very pleased with the outcomes within the staff survey there are areas where further action is required. One finding was placed in the bottom 20% (% of staff working extra hours).

A communication programme of the results was undertaken to inform the Board, Executive Team, Council of Governors and Divisions of the results.

An action plan is in place to address the areas of poorer performance including Awareness days where relevant managers/staff/external representatives will provide more information in relation to work that is being done to address some of the areas where improvements could be made, for instance staff experiencing physical violence from staff in the last 12 months.

Equality and Diversity

Equality and diversity is core to all Trust activities and during 2014 we have continued to build on work done in previous years.

All policies & procedures, guidelines and service changes take into account equality implications in line with the 'Protected characteristics', as described within the Equality Act 2010.

During 2014 the following policies have been Equality Impact assessed:

- Bereavement policy
- Translation & Interpreting
- Strategy for patient & public engagement
- Privacy & dignity guidelines
- Routine HIV testing
- Patient experience strategy
- Management of friends and family policy
- Premedication of neonatal intubation

From February 2014 all new staff receive face to face equality training as part of the Trust's Induction programme. Equality, diversity and human rights training is provided for all other staff.

A series of Equality Delivery System 2 workshops were held during 2014 and the Trust's rating has improved from the previous year.

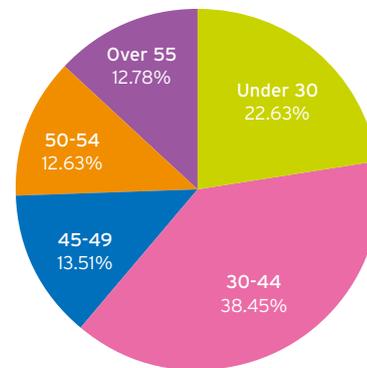
The Trust's Equality, Diversity and Human Rights Steering Committee (EDHRSC) continues to meet quarterly to support improvements in the experience of patients and

staff, by strengthening and maintaining an approach to equality, fair treatment and inclusion. An Executive Committee, which includes the Chief Nurse, the Director of Human Resources and a non-Executive Director, steers the work of the EDHRSC and both groups are accountable to the Executive Board.

An Equality, Diversity and Human Rights strategy is in the consultation phase and there will be a formal launch once finalised.

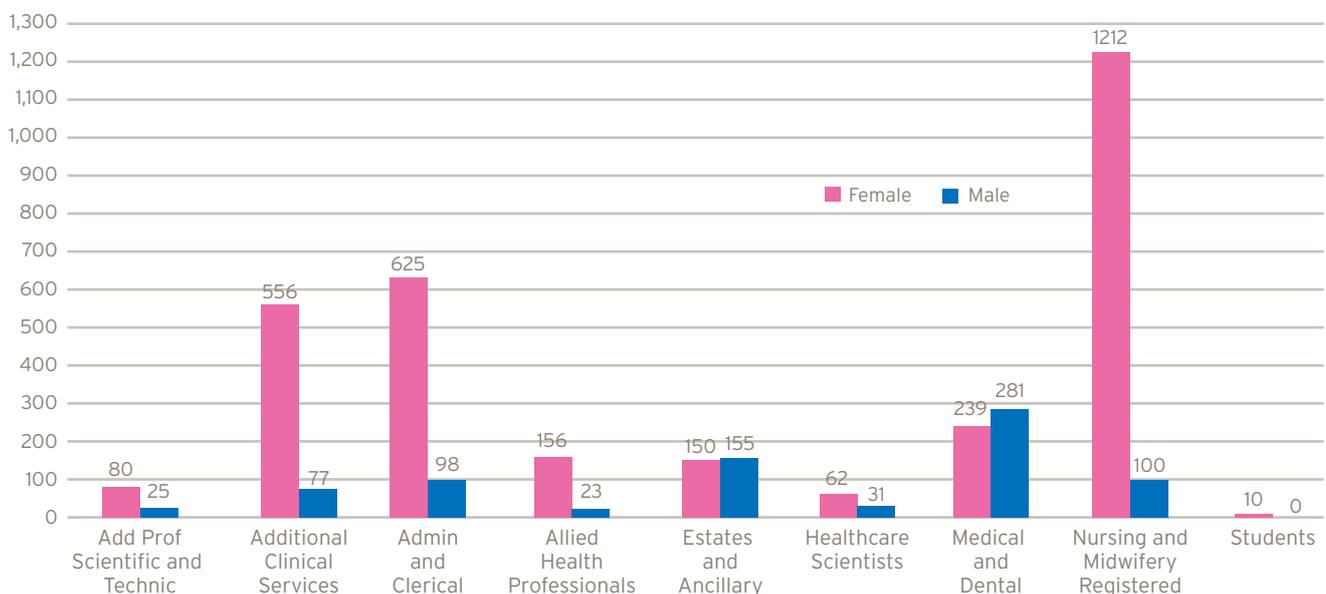
Workforce Profile Reporting

Workforce by age band



The majority of Trust staff fall between the 30 to 44 age band. 25.41% are over 50 years old which indicates that a sizeable percentage of staff may currently be considering retirement.

Gender by staff group



Overall, female staff make up the majority of the workforce, this is with the exception Estates and Facilities and Medical and Dental staff.

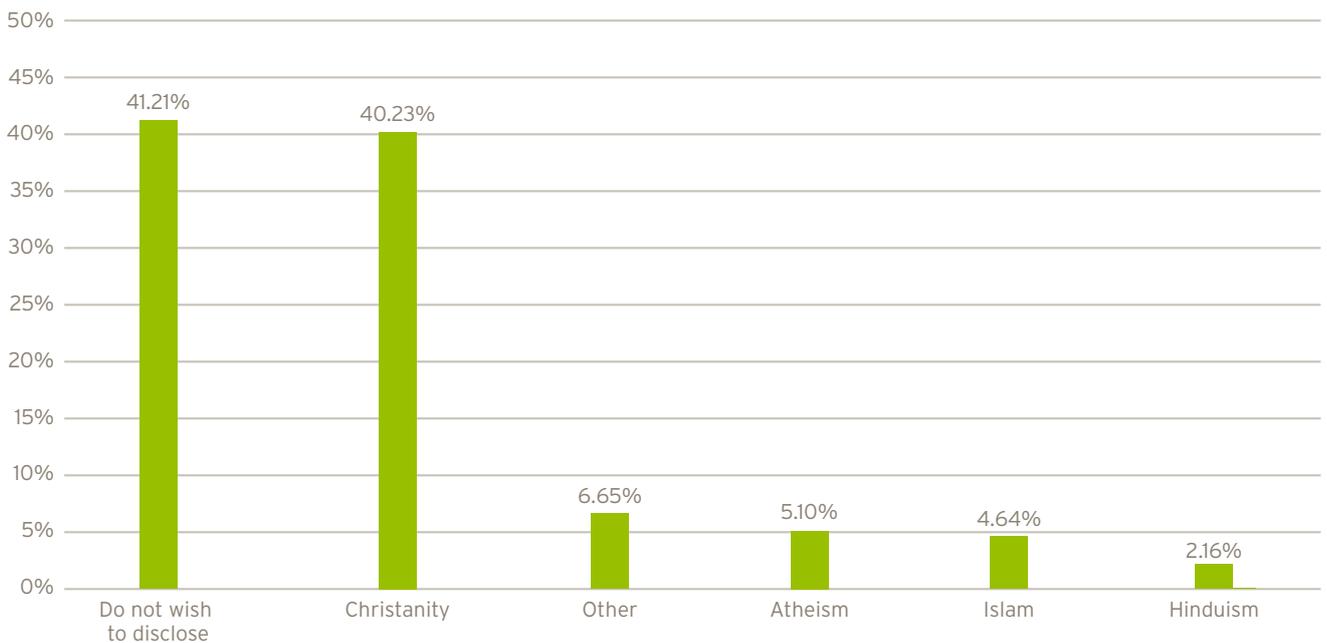
Gender pay gap

AFC Band	Female	Male	Total	% of females
Band 7	308	37	345	89.28%
Band 8A	61	13	74	82.43%
Band 8B	23	16	39	58.97%
Band 8C	8	6	14	57.14%
Band 8D	6	3	9	66.67%
Band 9	3	2	5	60.00%
Grand Total	409	77	486	84.16%

There are more female than male staff represented across middle to senior grades. However, the proportion is more evenly spread between male and female staff at Band 8B and above.

Religious belief

Workforce by religion or belief

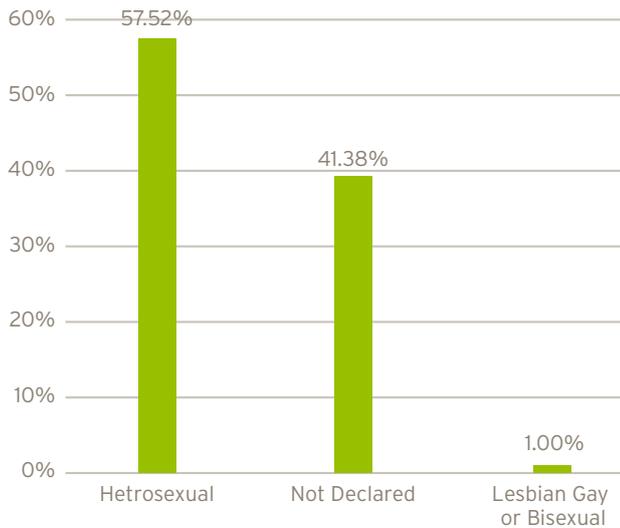


A significant number of staff do not wish to disclose their religious belief and the number of staff who disclose that they are Muslim seems low in comparison to the population profile. The EDHRSC will explore this further.

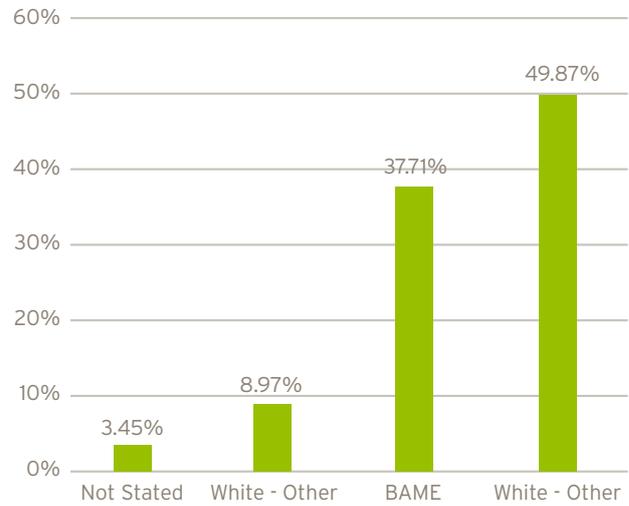
Sexual Orientation

Our monitoring information does not adequately identify the number of people who are 'other than' heterosexual due to lack of disclosure. Improvements to how this information is collected will be made.

Workforce by Sexual Orientation

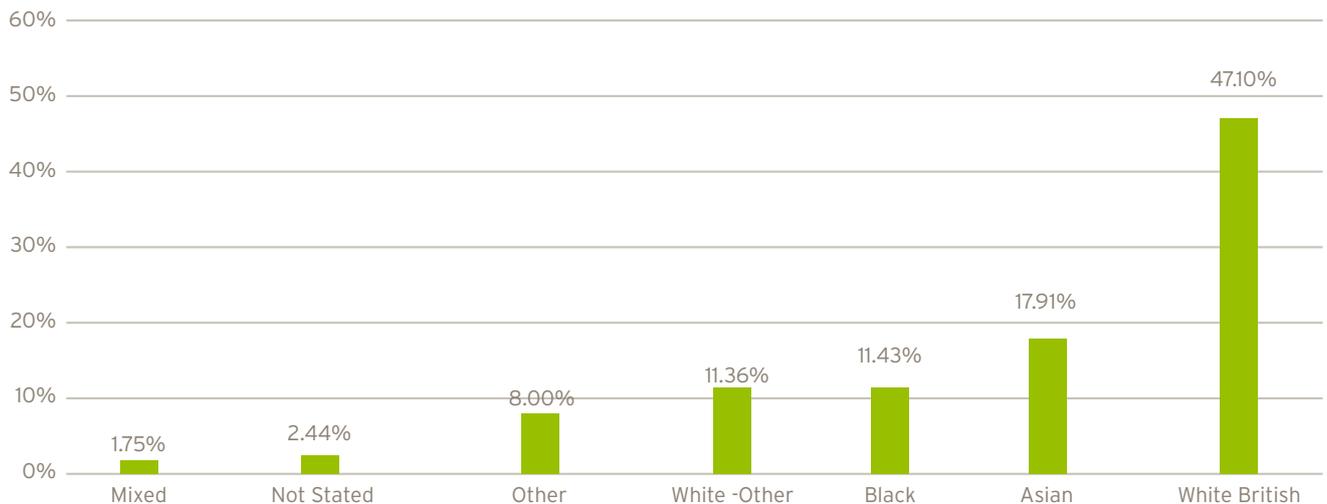


Workforce by ethnicity



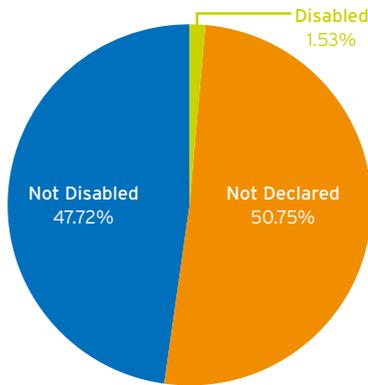
Just under half of the workforce are classed as White - British and over a third come from BAME communities. A small percentage of staff did not provide the information, though this was relatively small and indicates that people are more comfortable about disclosing their ethnic origin than religion or sexual orientation. This remains the challenge for the Trust to develop a picture of workforce representation across all protected characteristics.

Nursing & midwifery ethnicity



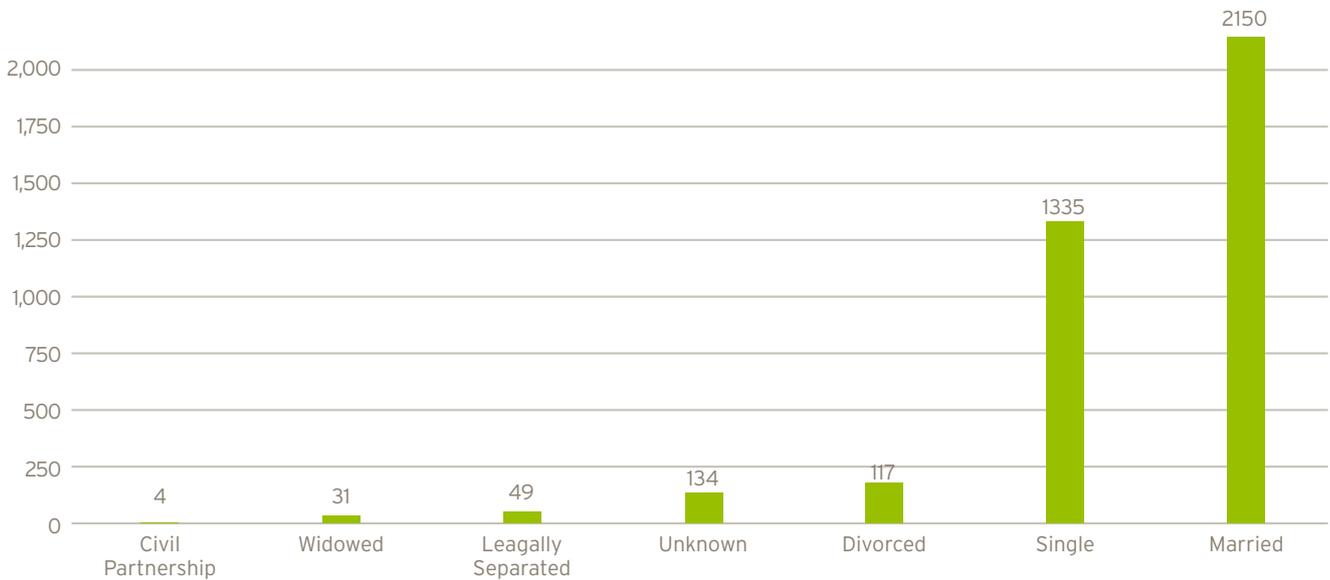
The nursing and midwifery workforce has over 40% of staff who declare themselves as other than white. This is a significant proportion of our frontline carers who work directly with patients.

Disability



Just over 50% of staff have not declared if they are disabled, therefore our figures may not give an accurate picture of disability within the workforce.

Workforce by Marital Status



Pregnancy and Maternity

As at 31st March 2015 we had 93 employees on maternity leave this equates to 3.01% of our female workforce.

Leavers

At 31st March 2015 the Trust employed 3880 staff and 79.64% of the total are female.

Division	Total Leavers
Corporate	86
Diagnostics	92
Medicine	213
Surgery	131
W&C	107
Total	629

Top Reasons For Leaving

Voluntary Resignation - Other/Not Known	26.59%
End of Fixed Term Contract	21.82%
Voluntary Resignation - Other Reasons	15.61%
Voluntary Resignation - Relocation	13.85%
Retirement Age	9.08%
Voluntary Resignation - Work Life Balance	7.48%

Working with Our Partners

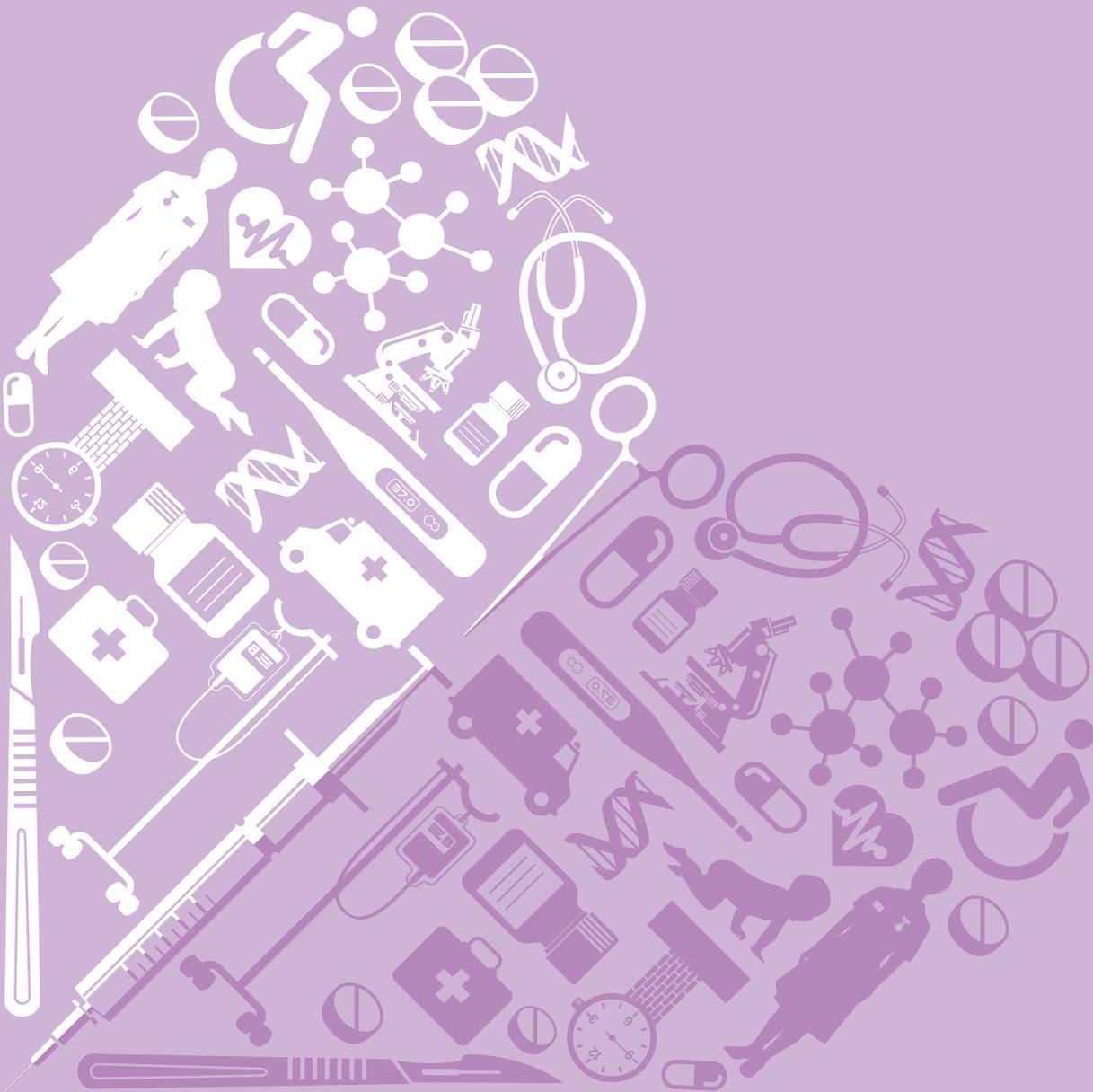
Good relations with commissioners have continued to be maintained during 2014/15 and have worked to develop a sound foundation with new personnel as the CCG's are established.

The Trust contributes to nationally recognised and statutory partnerships through:

- Cross system networks to support high quality care and Choosing Health priorities such as cardiac network, diabetes network, mental health partnership arrangements and prevention of teenage pregnancy in maternity services.
- Local strategic partnerships such as Local Area Agreement and Bedfordshire and Luton Local Resilience Forum.
- Local Safeguarding Children's Boards (LSCB) - Luton LSCB and Bedfordshire LSCB.
- Local Safeguarding Vulnerable Adult Boards for Luton and Bedfordshire.
- East of England meetings and events.
- Regular CEO meetings with Clinical Commissioning Groups (CCG) Chief Officers, Directors of Social Care and the Chief Officer of the Local Area Team.
- Bedfordshire and Luton integrated care programme working with the Local Authority, Community Providers, Mental Health, CCG and Social Care.



Board of Directors	74
Committees of the Board of Directors	82
Council of Governors	86
Foundation Trust Membership	90



Board of Directors

The affairs of the Foundation Trust are conducted by the Board of Directors in accordance with the NHS Constitution and the Foundation Trust's Authorisation.

The Board manages the business of the hospital and is the legally responsible body for making decisions relating to the strategic direction, performance and overall running of the Foundation Trust. The Board has in place a schedule of decisions reserved for the Board and a delegation of powers document, setting out nominated officers to undertake functions for which the Chief Executive retains accountability to the Board.

The Board delegates its duties for the day to day operational activities of the hospital to the Executive Board which includes finance, activity, performance, safety, clinical quality and patient care. The Board comprises seven executive and seven non-executive directors and meetings are in a public setting every two months. In addition the Non-Executive and Executive Directors meet bi-monthly in a seminar session and attend monthly Council of Governors meetings or seminars.

As far as the Directors are aware there is no relevant audit information of which the auditors are unaware and the Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Independent Professional Advice

The Board has access to independent professional advice, where it is judged that it is necessary to discharge their responsibilities as Directors.

The Role of the Chairman of the NHS Foundation Trust

The Chairman is pivotal in creating the conditions for cohesion between Board members and the executive roles of the directors. Specifically it is the responsibility of the Chair to ensure the effectiveness of the Board of Directors and to:

- Run the Board, taking account of the issues and concerns of Board members, be forward looking, and concentrate on strategic matters.
- Ensure that members of the Board receive accurate, timely and clear information to enable them to take sound decisions, monitor effectively and provide advice to promote the success of the Trust.

- Preside over formal meetings of the Council of Governors, and ensure effective communication between Governors and the Board of Directors and with staff, patients, members and the public.
- Arrange regular evaluation of the performance of the Board of Directors, its committees and individual Directors.

The Role of Non-Executive Directors (NEDs)

Our NEDs work alongside the Chairman and Executive Directors as equal members of the Board of Directors. The distinct roles of a Non-Executive Director are to:

- Bring independence, external skills and perspectives, and challenge to strategy development and Trust performance.
- Hold the Executive to account for the delivery of strategy; offer purposeful, constructive scrutiny and challenge; and chair or participate as member of key committees that support accountability.
- Actively support and promote a positive culture for the organisation and reflect this in their own behaviour; provide a safe point of access to the Board for whistle-blowers.
- Satisfy themselves of the integrity of financial and quality intelligence and that the system of risk management and governance are robust and implemented.
- Ensure the Board acts in best interests of the public; a Senior Independent Director (SID) is available to members and governors if there are unresolved concerns.
- NEDs including the Chair appoint the Chief Executive.
- As members of the Remuneration and Nomination Committee, determine appropriate levels of remuneration for Executive Directors; support the Chair in appointing and, where necessary removing executive directors, and in succession planning.
- Meet annually with the Chair to review the Chair's performance. The Senior Independent Director takes soundings from Governors.
- Consult with the Council of Governors to understand the views of governors and members and accounts to the Council of Governors in terms of the Statutory and NHS Foundation Trust Code of Governance requirements.

Information regarding the appointment and removal of Non-Executive Directors can be found in the Council of Governors section.

Remuneration and Interests

The remuneration of individual Directors can be found in note 4.5 to the accounts.

Board of Directors 2014/15

Name	Post Held	Year Appointed	Term of Appointment	Status
Mrs Pauline Philip	Chief Executive	2010	Permanent	
Mr Andrew Harwood	Director of Finance	2000	Permanent	
Mr David Carter	Managing Director	2011	Permanent	
Mrs Pat Reid	Chief Nurse	2012	Permanent	
Dr Mark Patten	Medical Director	2012*	Permanent	
Ms Angela Doak	Director of Human Resources	2010	Permanent	
Mr Mark England	Director of Re-Engineering and Informatics	2014	Permanent	Voting from 22nd October 2014
Mr Spencer Colvin	Chairman	2010**	3 Yr Fixed Term	To 30th June 2014
Mr Simon Linnett	Chairman	2014	3 Yr Fixed Term	From September 24th 2014
Mr Clifford Bygrave	Non-Executive Director	2006+	Annual	Interim Chair from 1st July -24th September 2014
Ms Alison Clarke	Non-Executive Director	2006+	Annual	To July 2015
Mr Jagtar Singh	Non-Executive Director	2009	3 Yr Fixed Term	To 30th December 2014
Mr John Garner	Non-Executive Director	2012	3 Yr Fixed Term	To May 2015
Dr Vimal Tiwari	Non-Executive Director	2012	3 Yr Fixed Term	To May 2015
Mr Mark Versallion	Non-Executive Director	2014***	3 Yr Fixed Term	From 22nd October 2014
Mr David Hendry	Non-Executive Director	2014	3 Yr Fixed Term	From 22nd October 2014
Mrs Jill Robinson	Non-Executive Director	2014	3 Yr Fixed Term	From 5th December 2014

* Appointed as Medical Director (Consultant at the L&D since 1998)

** Term renewed 2013

*** Interim Non-Voting to October 2014

+ Reflects appointment to Board of Foundation Trust

A declaration of interest register is available for viewing in the Trust Offices

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable University Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non-Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the NEDs are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

Independent Evaluation of Board Performance both Collectively and Individually

The Board continuously analyses its performance, duties and role on an ongoing basis and employs a Board Secretary to observe the board activity and report findings into the Board of Directors. The Board analyses its own performance at the end of each Board meeting and also requests feedback from Governor Observers at each meeting that is subsequently reported to the Council of Governors.

Board Evaluation

During 2012/13 an assessment of the Trust's governance arrangements was undertaken through the Institute of Directors. The Institute of Directors has no connection to the Trust.

The effective functioning of the governance arrangements of the board is key to the success of the organisation. Board evaluation is extremely valuable in contributing to board effectiveness which has been recognised through various governance codes over the years particularly Monitor's Code of Governance that suggests an external Board Evaluation every three years. Periodic and rigorous board evaluation process represents best-practice and should be considered as part of any governance review.

The review found that the Board and Governance structures were robust and there was a good spread of knowledge across the Board members. The feedback did include the following recommendations that were supported by the Board and continue to be progressed:

- development of a succession planning framework;
- further involvement of stakeholders in the development of our future strategy;
- development of a communication programme for staff about the annual plan;
- ongoing involvement of the Divisional Directors in the Board Seminars;
- development of an outline of 'Board Director responsibilities' as part of Executive Director job descriptions; and
- complete a review of risk appetite.

A programme of implementation was commenced and the actions have been completed with the review of risk appetite planned for June 2015. The Board of Directors continued to hold a number of seminars throughout the

year and held a Board Awayday in December 2014 to assess the strategic direction of the Trust.

During 2014/2015, the Council of Governor's recruited a new Chairman and three Non-Executive Directors. As part of this process, an experienced external organisation conducted a Board skills evaluation to identify the requirements to compliment the current Board. This evaluation of the Board enabled the appropriate Non-Executive Director recruitment.

From the 1st November 2014, the Fit and Proper Persons regulations were made into statute. The Trust already complies with NHS Employers recruitment regulations. However, the Board of Directors agreed a programme of work to strengthen evidence of compliance against the regulations:

- The Chief Executive, in consultation with the Director of Human Resources, determined to whom the non-board senior posts the Fit and Proper Persons Test applied.
- Amendments were made to Conflict of Interest, Anti-Bribery, Recruitment and Advertising and Appraisal Policies to include the Fit and Proper Persons Test.
- The Chairman via the Trust Board Secretary will ask members of the Trust Board to confirm that they continue to meet the requirements of the Fit and Proper Persons Test as part of the Trust Board's annual review of interests.
- The requirements of the Fit and Proper Persons Test now forms part of the Executive Directors and Non-Executive Directors appraisal process.
- The HR Department reviews the insolvency and bankruptcy register and register of disqualified directors on appointment and annually.

As previously reported, in recent years the Trust also implemented a Divisional Management Structure which is now fully embedded and facilitated by service line management. The Divisional Structure is supported by performance review, ongoing governance expertise and independent review from PricewaterhouseCoopers (PwC - internal audit). During 2014/2015 the Division of Medicine governance structures were reviewed to increase the clinical accountability at specialty level. A new structure was developed to deal with the particular pressures inherent in the larger clinical division. A priority for 2015/2016 is to consider a similar clinical directorate structure for the surgical division.

All Trusts must be subject to an external Board review following the Monitor Well Led Framework every three years and we are planning a review during 2015/2016.

Trust Directors: Expertise and Experience

Executive Directors

Mrs Pauline Philip

Chief Executive

Pauline joined the L&D as Chief Executive on 1st July 2010. With a strong clinical background, together with a number of highly successful Chief Executive positions, she brings a unique combination of skills and experience to the Trust.

Her vision is to create an organisation that puts patients first every time and that constantly strives to ensure that every patient receives safe care and the best clinical outcomes available in the NHS.

Pauline has an enviable track record in healthcare having spent over eight years in key Chief Executive positions at NHS Trusts in London, followed by her appointment as Director of Mental Health for the London Region of the Department of Health.

In 2002, she was seconded to the World Health Organisation (WHO) to establish a department dedicated to global patient safety. Pauline's appointment at the L&D follows her success at WHO and her proven expertise in leading and driving positive change through complex organisations.

(Membership of Committees - CF, FIP, COSQ, HRD)

Mr David Carter

Managing Director

David Carter has twenty years experience as a Board Director for various NHS organisations including mental health, community and primary care trusts and in the acute sector at Barnet & Chase Farm Hospitals NHS Trust. David's background is in finance and prior to joining the NHS he spent seven years at KPMG in London working in audit and consultancy where he qualified as an accountant.

David has overall responsibility for operational and estates, performance and contracting.

David acts as Deputy CEO in Pauline's absence.

(Membership of Committees - CF, FIP, COSQ, HRD)

Mr Andrew Harwood

Director of Finance

Andrew has been the Director of Finance since February 2000, with overall responsibility for the Trust's finances. He is responsible for procurement and contractual arrangements including with our commissioners.

Andrew's robust approach to financial management has helped to ensure that the L&D has successfully balanced its books in each of the last 15 years. With over 20 year's finance experience in the NHS, gained in health authorities and individual Trusts, he co-ordinated the Trust's financial strategy for our application for NHS Foundation Trust.

(Membership of Committees - CF, FIP, HRD)

Dr Mark Patten

Medical Director

Mark has worked at the L&D since 1998 as a Consultant in Critical Care & Anaesthetics and has held numerous managerial positions, including being a Clinical Director from 2008-2010, Associate Medical Director from 2010-2011 and Divisional Director of Surgery since April 2011. During the last 12 years Mark has taken a particular interest in patient safety and has found time to undertake a number of tours of duty as a Royal Navy Reservist.

(Membership of Committees - CF, FIP, COSQ, HRD)

Ms Angela Doak

Director of Human Resources

In November 2010 Angela took up post as the Director of Human Resources in an acting capacity, after initially joining the Trust in July 2010 as Associate Director of Human Resources.

Angela has over 20 year's experience in human resources and organisational development in acute NHS trusts. Just prior to joining the Trust Angela held the post of Director of HR in a Foundation Trust. She has a strong track record in providing high quality HR services and her particular areas of interest and expertise include dealing with major organisational change, complex employee relations cases and also employment matters concerning medical staff.

(Membership of Committees - COSQ, CF, FIP, HRD)

Mrs Patricia Reid

Chief Nurse

Pat was previously the Deputy Chief Nurse at Cambridge University Hospitals NHS Foundation Trust. Pat trained as a nurse at University College Hospital London and had numerous senior nurse posts before moving into publishing as Editor of the Nursing Times. She was also the very first nurse on the board of the BMJ.

Pat has a broad experience in the NHS having also undertaken General Management and service redesign roles.

(Membership of Committees - COSQ, CF, HRD)

Mr Mark England

Director of Re-Engineering and Informatics

Mark joined the Trust in 2008 from the London Borough of Croydon where he had been a Chief Information Officer for Children's Services for four years. There he delivered high-quality, commercially competitive technology services to almost 150 schools, whilst leading multiple high profile eGovernment projects. Many of these were Pan-London, including leading the technical delivery of the award winning shared eAdmission portal used by 100,000's of parents each year. By enabling electronic channels of payment Croydon was also the first authority to take cash transactions out of all schools, releasing considerable financial and quality benefits. His first exposure to the NHS was working to develop an early Children's Index with local NHS providers in South London.

Prior to that he spent five years working as a Project Manager on the development, and global implementation, of a web-based multilingual Enterprise Resource Planning (ERP) system. This was focussed on supporting the delivery of Reproductive Health services in the developing world, and was implemented in 140 countries in 4 languages. Qualified as a software engineer, specialising in multi-lingual application design, he worked across multiple sectors on commercial internet based applications for many years.

(Membership of Committees - CF, FIP, HRD)

Non-Executive Directors**Mr Spencer Colvin**

Chairman (Left June 2014)

Spencer is a local businessman whose career started in the legal profession transferring at an early stage to

the Transport and Logistics services sector. He spent 30 years with blue chip companies Exel plc (now part of Deutsche Poste) and Hays plc providing a range of services to UK industry winning an award for service excellence in home delivery services in 1996.

During the past 15 years Spencer has been Director of a management recruitment consultancy and Chairman or Chief Executive of companies operating in the European and international freight markets and the Healthcare sector.

He has been a governor in education for a period of over 17 years and is currently Chairman of a special needs school in Hertfordshire. Spencer has been involved with Variety (a charity for underprivileged children) for many years.

(Membership of Committees - CF, RNC, COSQ, FIP)

Mr Simon Linnett

Chairman (From September 2014))

Simon Linnett is an Executive Vice Chairman at Rothschild in London. He has devoted a large part of his professional life to working within the public/private interface both nationally and internationally and is responsible for the bank's relationship with the UK government. He has had a long association with the health dialogue including the health reform process and the health debate generally and has engaged with various government bodies and other health institutions on this subject. Simon has previously headed Rothschild's global transport group and remains closely involved with its initiatives. He has a strong personal interest in the "green" debate, seeking to influence discussion on auctioning emissions and chairing Rothschild's Environment Committee. Simon graduated from Oxford in Mathematics in 1975 and joined N. M. Rothschild & Sons Ltd where he has been ever since. Simon's external roles include: on the Council and Treasurer of Queen Mary University London; Trustee of the Science Museum Group; Chairman of the Independent Transport Commission; and Trustee of Exbury Garden Trust (a Rothschild family garden). He is now a Trustee of NESTA.

(Membership of Committees - CF, RNC, FIP, HRD)

Mr Clifford Bygrave

Vice Chairman and Senior Independent Director
Interim Chairman July-September 2014

Clifford Bygrave is a Fellow of the Institute of Chartered Accountants in England and Wales, a Chartered Tax Adviser and a Member of the Society of Trust and Estate Practitioners. He is the Senior Independent Director

and Vice Chairman of the Board. Clifford has been a Non-Executive Director at the L&D since 2001. He also served as Non-Executive Director of Bedfordshire Health Authority until its merger with the East of England Strategic Health Authority and is now Chairman of the L&D's Audit and Risk Committee.

Following his retirement as a partner at Ernst & Young, Clifford is now the National Finance Director of the Boys' Brigade. He has served on the Council of the Institute of Chartered Accountants in England and Wales for 23 years. He also represented the UK Accounting bodies on the International Federation of Accountants Ethics Committee for five years. In addition he represented his Institute in Brussels for a number of years. In view of his seniority on the L&D Board and his extensive governance experience Clifford was appointed as L&D's Senior Independent Director with effect from July 2007.

(Membership of Committees - AC, CF, FIP)

Ms Alison Clarke

Non Executive Director

Prior to being appointed as Non-Executive Director in 2002 Alison held Chief Officer and Assistant Director posts in several London local authorities. Her special areas of interest and expertise are performance management, quality management and human resources. She was awarded an MBA in 2000.

(Membership of Committees - COSQ, CF, RNC, AC)

Mr Jagtar Singh OBE

Non Executive Director (left December 2014)

Jagtar worked for the fire service in Birmingham for 24 years before moving to Bedfordshire as Deputy Chief Fire Officer in 2001.

In 2003 Jagtar received both the Public Servant of the Year Award at the Asian Achievement Awards ceremony in Birmingham and was awarded an OBE for his work on equality and diversity in the Fire Service.

In 2006 Jagtar was appointed Non-Executive Director of East of England Ambulance Service and moved to Luton and Dunstable Hospital in October 2009. Jagtar is keen to encourage greater ethnic minority representation in all public services and to remove inequalities in service delivery and ensure all communities receive the highest level of services.

He is active in voluntary work being a Trustee for the Healing Foundation, Employment Opportunities for the

Disabled and Bedford Race Equality Council. Until recently Jagtar was also President of the West Midlands Fire Service Romania with Aid. Jagtar has also helped to develop and establish a number of minority support groups in the fire service and is now supporting the Asian members of the fire service to set up a new national group and also the BME network in the Ambulance Service to be a more strategic and effective critical friend.

(Membership of Committees - AC, CF, RNC, COSQ)

Mr John Garner OBE

Non Executive Director

John began life in HM Forces serving overseas and then coming out to become a Police Officer, Teacher and Education Officer HMP Preston. From this point he entered local government to become a Chief Officer in a number of authorities in the North Department Community Services (Environmental Health, Leisure and Housing).

After a career in local government he became the Chief Executive of the National Union of Students and progressed from there to become Controller for Sport and Entertainment at Wembley Stadium Ltd.

John has been the Chair of integrated governance, Deputy Chair of the Audit Committee, NED with South Beds PCT and Chair of Beds Shared Services Board. He has also been the Chair of Beds Children's Safeguarding Board. In addition to this John has been a NED and Audit Committee member for the Football Licensing Authority DCMS and Chair of Audit for the Government Office NW and Member Dept Communities and local Government Dept Audit and Risk Management Committee.

John was also awarded an OBE for his services to children with special needs.

(Membership of Committees - AC, CF, RNC, FIP, HRD)

Dr Vimal Tiwari

Non Executive Director

Dr Vimal Tiwari was educated at Aberdeen University Medical School and St Mary's Hospital London, and also has a Master's Degree in Medical Education from the University of Bedfordshire. She has worked as a GP in Hertfordshire for over 30 years and as a Named Safeguarding GP for 8 years, with parallel careers over the years in Mental Health, Community Paediatrics, Medical Education and more recently Clinical Commissioning. She maintains a strong interest in Child Health, while being committed to securing the best quality compassionate, modern and comprehensive

health care for all ages.
(Membership of Committees - AC, CF, RNC, COSQ)

Mr Mark Versallion

Non Executive Director (voting from October 2014)

Mark was appointed to the Board in December 2013. He has twenty years experience in the commercial sector, with companies such as BAE Systems plc and Capgemini plc, as well as having worked for U.S. Senators and U.K. Government Ministers in the 1990s. He was a non-executive director at NW London NHS Hospitals Trust from 2008-13.

A naval officer in the reserves for seventeen years he was a Councillor at the London Borough of Harrow for nine years. He has been a Councillor at Central Bedfordshire Council since 2011, in charge of children's services and schools.

(Membership of Committees - AC, FIP, CF, RNC)

Mr David Hendry

Non Executive Director (from October 2014)

David was born in Luton and qualified as a Chartered Accountant with Whittaker & Co in Castle Street before gaining further professional experience with KPMG.

Following 8 years in the profession he moved into the retail sector. Firstly with BHS plc, where he went through a series of promotions ultimately heading the Finance Directorate and contributing to the company's significant turnaround. He was then recruited by TK Maxx as the US retailer's European Finance Director, helping them adapt and profitably grow the concept from 4 UK stores to 212 operating in 3 countries over the 11 years he was there. Wanting to gain experience in the public sector, he then spent 6 years with Transport for London as Surface Transport Finance Director, the division which facilitates 80% of all journeys through the capital's streets and rivers, contributing to significant improvements in service and efficiency over this period.

In 2014 David decided to pursue a portfolio career, giving him more personal flexibility and opportunity to utilise his skills. He sees the Non-Executive role at L&D

as a significant opportunity helping support the right to health and treatment for all, and to do so in an area that has been home to him throughout his life.

(Membership of Committees - AC, CF, HRD, COSQ, RNC)

Mrs Jill Robinson

Non Executive Director (from December 2014)

Jill has a background in Financial Services and qualified as a certified accountant with Prudential plc. Having gained extensive financial, management and project accounting experience Jill moved into operational roles to use her accountancy skills and progressed to become Operations Director of Prudential Europe and then Operations Transformation Director for Prudential UK. Jill moved to Equitable Life Assurance Society as Operations Director where she was responsible for delivering two regulated projects allowing release of reserves of £540m, restoring stability to the servicing through the elimination of backlogs and resolving complaints within two days. From there she moved to Mercer as Partner, Head of Customer Service Delivery. Jill was responsible for the development of a new operational model, resulting in cost reduction of 30% and improvement of service level standards to 98%. Jill is currently Outsourcing and Finance Director for Marine & General Mutual, setting strategy and effecting the sale of the company. Jill is passionate about enthusing teams to deliver improved services, at reduced cost, for the benefit of customers and considers it a privilege to be able to use her skills in the NHS for the benefit of patients and staff alike.

(Membership of Committees - AC, CF, FIP, COSQ, RNC)

Key to committees:

- COSQ - Clinical Outcomes, Safety and Quality Committee
- CF - Charitable Funds Committee
- RNC - Remuneration & Nomination Committee
- AC - Audit and Risk Committee
- FIP - Finance, Investment and Performance Committee
- HRD - Hospital Re-Development Programme Board

Record of committee membership and attendance

Total Meetings	Public Board Meetings	Private Board Meetings	Audit & Risk	Remuneration and Nomination	Charitable Funds	COSQ	HRD FROM OCT2014	FIP
Pauline Philip	7/7	6/6			2/3	6/8	8/8	9/10
Spencer Colvin (to June 14)	1/1	1/1		1/1	1/1	2/2		3/3
Simon Linnett (from Sept 14)	4/4	3/3		3/4	2/2		8/8	5/6
Andrew Harwood	7/7	6/6			3/3		8/8	10/10
David Carter	7/7	6/6			0/3	7/8	8/8	10/10
Pat Reid	6/7*	5/6*			1/3	8/8	8/8	
Mark Patten	7/7	6/6			3/3	7/8	8/8	10/10
Angela Doak	6/7**	5/6**			2/3**	5/8 **		10/10
Mark England	6/7	5/6			2/3		8/8	10/10
Clifford Bygrave	7/7	6/6	4/4	5/5	3/3			10/10
Alison Clarke	6/7	5/6	4/4	5/5	3/3	8/8		
Jagtar Singh (to Dec 2014)	4/5	4/4	2/2	1/4	1/1	4/6		
John Garner	7/7	6/6	4/4	4/5	3/3		8/8	10/10
Vimal Tiwari	6/7	6/6	4/4	5/5	3/3	7/8		
Mark Versallion	5/7	4/6	1/4	4/4	1/3			7/10***
David Hendry (from Oct 14)	3/3	3/3	3/3	4/4	2/2	4/4	7/7	
Jill Robinson (from Dec 14)	2/2	2/2	1/2	3/3	1/2			2/2

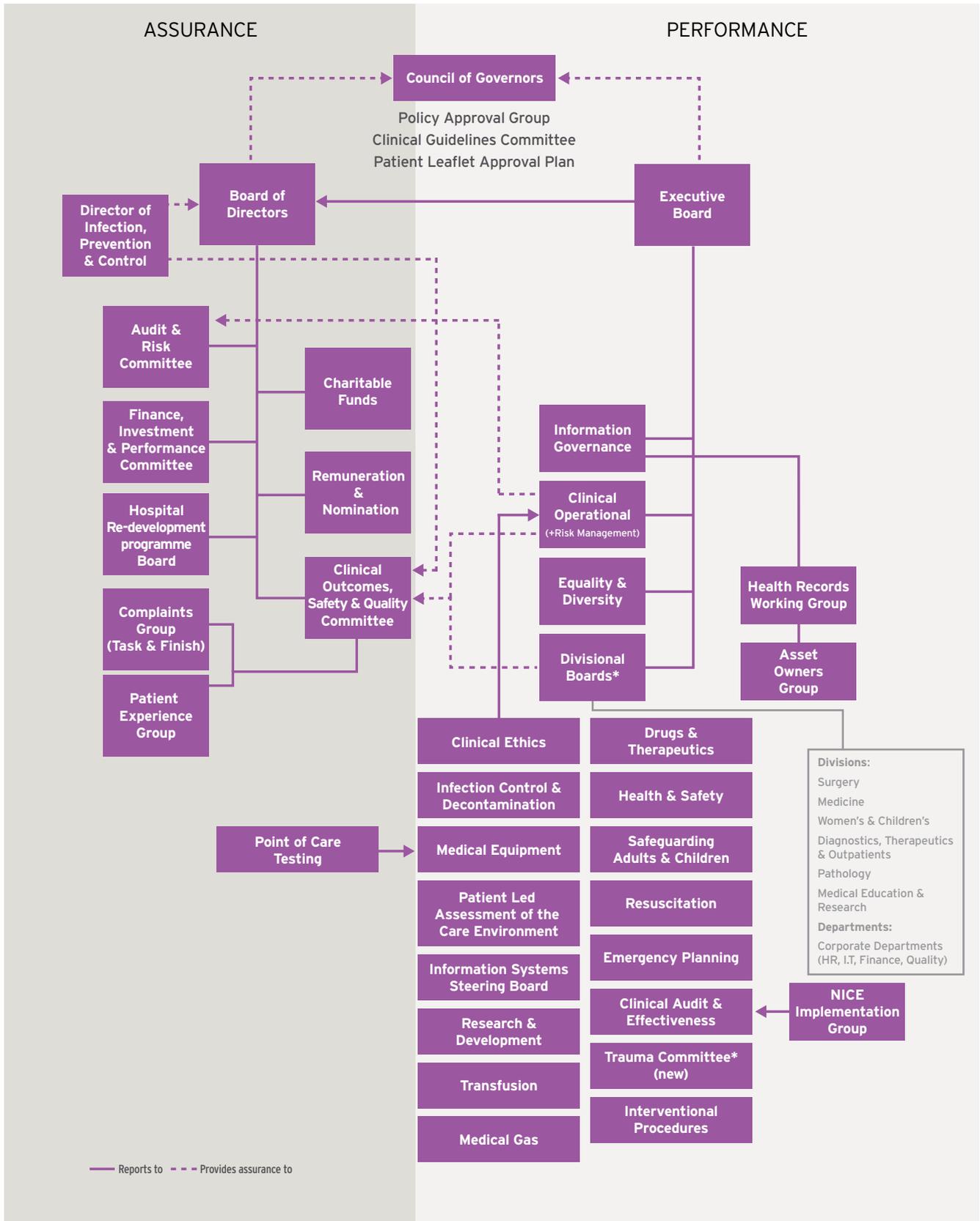
* Denotes that S Oke deputised for P Reid

** Denotes that J Rosenblatt deputised for A Doak

*** One meeting date had to be moved that prevented attendance

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and committee structure



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

Audit and Risk Committee

The function of the Audit Committee has been to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

Key responsibilities delegated by the Board to the Audit and Risk Committee are to:

- Ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- Monitor and review compliance with Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Review the annual financial statements and Annual Report for compliance with accounting standards and legal requirements before submission to the Board of Directors.
- Review the annual Counter Fraud programme and ensure the Trust is adequately resourced to meet the requirements of the Directorate of Counter Fraud;
- Ensure cost-effective external audit.
- Appoint, monitor and review Internal Audit service.
- Report to the Council of Governors on any matters that require immediate action and make recommendations on steps to be taken.

Membership of the Audit and Risk Committee:

The Audit Committee membership has been drawn from the Non-Executive Directors and has been chaired by Mr Clifford Bygrave (Non Executive Director and Senior Independent Director (SID)).

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards, through scrutiny and sign-off of the quarterly Monitor reporting returns. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability. In depth reviews of operational risks on the register, including Activity Recording, Financial Control, Divisional Governance, Information Technology, Estates, CIPs and Risk Management have further supported the Committee's understanding and review of the key issues facing the Trust. In relation to CQC compliance with care standards, the Committee reviews regular reports from the Clinical Outcome Safety and Quality Committee.

Internal Audit

The Audit & Risk Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and positive approach to identifying, assessing and mitigation planning to risks. This was supported by in year and year end internal audit reviews of the Board Assurance Framework and Corporate Risk Register.

External Audit

The Audit & Risk Committee engages regularly with the external auditor throughout the financial year, including holding private sessions with Non Executive Directors.

The Audit & Risk Committee considers the external audit plan, technical updates, any matters arising from the audit of the financial statements and the Quality Account and any recommendations raised by the external auditor.

The External Audit programme is scheduled to focus on key areas of risk and for 2014/15 the areas of audit risk were:

- Valuation of tangible assets and the impact on the financial statements of the independent revaluation exercise that was undertaken for all land and buildings as at 31 March 2015;
- The appropriate recognition of revenue from NHS Commissioners including the consideration of any contract negotiations, challenges and changes as well as the associated fraud risk; and
- Management overriding controls and the focus on any areas of management judgement or those outside of routine business such as the property revaluation.

The ISA260 report presented on the 20 May identified that there were no material concerns or control weakness identified during the year.

The appointment of the auditor was made in 2012 as a result of a competitive process under a procurement compliant framework. The appointment was extended in 2014 on the same terms. Each appointment is subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit & Risk Committee to assess the effectiveness of the external audit programme. External Audit confirmed they were able to complete the required testing against the controls in the fee agreed with the Trust.

Organisation going concern status has been specifically discussed with the External Auditors in relation to the financially challenging environment the Trust faces. Assurance on the accounts review of the "going concern" opinion is based on risk to service continuity and that the Trust is able to confirm service continuity and therefore going concern status over the medium term.

KPMG LLP have also provided tax advice on an ad hoc basis during 2014/15 totalling £11,000. Each assignment was subject to an individual engagement letter and undertaken by a separate division within the organisation thereby avoiding any objectivity or independence issues.

Remuneration and Nominations Committee

This Committee reports to the Board of Directors and acts as defined in the Standing Financial Instructions, Standing Orders and Code of Governance documents.

The Committee has delegated responsibility from the Trust Board for the appropriate remuneration for the Chief Executive, other Executive Directors employed by the Trust and other senior employees on locally agreed pay arrangements, including:

- All aspects of salary.
- Provisions for other benefits, including pensions and cars.
- Arrangements for termination of employment and other contractual terms;
- Review the composition of the Board of Directors and make recommendations as to the appropriate make-up of the Board.
- Make recommendations to the Nomination Committee of the Council of Governors in respect of Non-Executive Director positions.

Membership of the Remuneration and Nominations Committee:

The Remunerations and Nominations Committee has been drawn from the Board members and was chaired by Jagtar Singh (NED) to December 2014 and Mark Versallion (NED) from January 2015.

Charitable Funds Committee

The L&D is a Corporate Trustee. The Charitable Funds Committee on behalf of the Corporate Trustee agrees proper use of charitable funds and approves fundraising schemes.

Key responsibilities are to:

- Keep proper accounting records and prepare accounts in accordance with applicable law.
- Safeguard the assets of the charity.
- Take reasonable steps for the prevention and detection of any fraud and other irregularities.
- Determine operating procedures for the administration of charitable funds.
- Appoint investment advisors.
- Appoint independent auditors.

Membership of the Charitable Funds Committee:

The Charitable Funds Committee membership has been drawn from Board members and is chaired by Mr Clifford Bygrave (NED and SID).

Clinical Outcome, Safety and Quality Committee

The Clinical Outcome, Safety and Quality Committee provide assurance to the Board of Directors that the Trust is compliant with legislation and guidance on clinical, patient safety and quality issues.

The Clinical Outcome, Safety and Quality Committee monitors the implementation of strategic priorities and the organisations performance in relation to clinical outcome and research and development. It ensures compliance with regulatory requirements and best practice within the patient safety and quality improvement agenda.

Membership of the Clinical Outcome, Safety and Quality Committee:

The Clinical Outcome, Safety and Quality Committee membership includes Board members, and is chaired by Alison Clarke (NED).

Finance, Investment and Performance Committee

The purpose of the Finance, Investment and Performance Committee has been to lead the strategic direction of the Trust's finance work, approving capital bids and plans and monitoring performance.

Membership of the Finance, Investment and Performance Committee:

The Finance Investment and Performance Committee membership included Board members, senior managers and clinicians and is chaired by Mr Clifford Bygrave (NED).

Hospital Re-Development Programme Board

The purpose of the Hospital Re-Development Programme Board has been to lead the progression of the Outline Business Case following approval of the Strategic Business Case at the Board of Directors on the 1st October 2014.

Membership of the Hospital Re-Development Programme Board:

The **Hospital Re-Development Programme Board** membership included Board members, senior managers and clinicians and is chaired by Mr Simon Linnett

Council of Governors

The constitution defines how we will operate from a governance perspective and it is approved by the Board and the Council of Governors. The basic governance structure of all NHS Foundation Trusts includes:

1. The Membership;
2. The Council of Governors; and
3. The Board of Directors

In addition to this basic structure, Board and Council of Governor committees and working groups, comprising both Governors and Directors, are used as a practical way of dealing with specific issues.

The specific statutory powers and duties of the Council of Governors are:

- Appoint and, if appropriate remove the Chair.
- Appoint and, if appropriate remove the other Non-Executive Directors.
- Decide the remuneration and allowances and the other terms and conditions of office of the Chair and the other Non-Executive Directors.
- Approve the appointment of the Chief Executive.
- Appoint and, if appropriate remove the NHS Foundation Trust's auditor.
- Receive the NHS Foundation Trust's annual accounts, any report of the auditor on them and the annual report.
- Hold the Non-Executive Directors to account for the performance of the Board
- Approve significant transactions as defined in the Trust's Constitution.

In addition:

- In preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

The Monitor Code of Governance determines that every NHS Foundation Trust will have a Board of Governors which is responsible for representing the interests of NHS Foundation Trust members and partner organisations in the local health economy in the governance of the NHS Foundation Trust. Governors must act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct. The Board of Governors should hold the Board of Directors to account for the performance of the Trust, including ensuring the Board of Directors acts so that the Foundation Trust does not breach the terms of its authorisation. Governors are responsible for regularly feeding back information about the NHS Foundation Trust, its vision and its performance to the constituencies and stakeholder organisations that

either elected them or appointed them. The Code of Governance states that one of the independent Non-Executive Directors should be appointed by the Board of directors as the "Senior Independent Director", or SID, in consultation with the Board of Governors. The SID should act as a point of contact if governors have concerns which contact through normal channels has failed to resolve or for which such contact is inappropriate. Mr Clifford Bygrave is the appointed SID for the Trust.

The constitution provides that the Board of Directors appoint a vice chairman from one of our Non-Executive Directors. The vice chairman should deputise for the chair as and when appropriate. Mr Clifford Bygrave is the Vice Chairman of the Trust.

It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS Foundation Trust.

From 1st January 2010 to June 2014, the Council of Governors was chaired by Mr Spencer Colvin. Mr Clifford Bygrave (SID and NED) was appointed Interim Chairman from July - September 2014 until Mr Simon Linnett took over as Chairman on the 24th September 2014. Council of Governor meetings are held at least three times in each financial year and are open to the public and representatives of the press. Since September 2009 these meetings have been held every two months.

In October 2013 the Council of Governors elected Mr Roger Turner as Deputy Chair/Lead Governor of the Council of Governors for a term of two years. The Deputy Chairman or Lead Governor of the Council of Governors presides as chair of any meeting of the Council of Governors where the Chairman presiding at that meeting in terms of a conflict of interest (section 12.29 of the Constitution). The Lead Governor is also the nominated person that Monitor would contact in the event that it is not possible to go through the Chair or the Trust's Secretary.

The Council of Governors met six times during 2014/15 and the attendance is recorded.

Register of Interests of the Council of Governors' Members

A declaration of interest register is available for viewing in the Trust Offices.

Elections

Our annual elections to the Council of Governors were held during May - July 2014. UK Engage were our independent scrutiniser to oversee the elections, which were held in accordance with the election rules as stated in our constitution.

The following constituency seats were filled by uncontested candidates

- Staff: Medical and Dental

The following constituency seats were filled by election

- Public: Luton
- Public: Bedfordshire
- Public: Hertfordshire
- Staff: Nursing and Midwifery

Analysis of Annual Election Turnout:

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of Candidates	Election turnout %
July 2014	Public: Luton	6195	3	13	16.9%
July 2014	Public: Bedfordshire	2700	2	6	22.4%
July 2014	Public: Hertfordshire	1487	1	3	18.4%
July 2014	Staff:Nursing and Midwifery (including HCAs)	1867	3	4	14.9%

Governors in post - April 2014 to March 2015

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Appointed Governors					
Luton CCG	Carole Hill	Appointed to Apr 2016		3 years	4/7*
Bedfordshire CCG	Dr Chris Quartly	Appointed to Apr 2016	Resigned December 2014	3 years	2/5
Hertfordshire CCG	Vacant				
Central Bedfordshire Council	Cllr Norman Costin	Appointed to 2015		3 years	1/7
Luton Borough Council	Cllr Mahmood Hussain	Appointed to 2016		3 years	1/7
Luton Chamber of Commerce	Ms Cheryl Smart	Appointed to 2015		3 years	1/7
University College London	Prof Brian Davidson	Appointed to 2016		3 years	3/7
University of Bedfordshire	Professor Mike Cook	Appointed to 2016	Resigned February 2015	3 years	3/6
Public Governors					
Hertfordshire	Mr John Harris	Elected to 2017	Start of 3rd term	3 years	5/7
	Mr Malcolm Rainbow	Elected to 2015		3 years	5/7
	Mr Guy Thomas	Elected to 2015		3 years	3/7
Bedfordshire	Ms Janet Curt	Elected to 2015		3 years	7/7
	Mr Bob Shelley	Elected to 2016		3 years	7/7
	Miss Dorothy Ferguson	Elected to 2015		3 years	7/7

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
	Mr Ray Gunning	Elected to 2015		3 years	7/7
	Mr Bart Hanley	Elected to 2015		3 years	2/7
	Ms Rowena Harrison	Elected to 2014	Ended term	3 years	1/4
	Mr Roger Turner	Elected to Sept 2017	Start of 2nd term	3 years	7/7
	Mrs Sandra Bowden	Elected to Sept 2017	Start of 1st term	3 years	2/3
Luton	Mr Keith Barter	Elected to 2016		3 years	6/7
	Ms Tracee Cossey	Elected to 2014	Ended term	3 years	3/4
	Ms Marie-France Capon	Elected to 2015		3 years	5/7
	Mrs Bina Gupta	Elected to 2014	Ended term	3 years	4/4
	Mr Amer Hussain	Elected to 2016		3 years	5/7
	Mr Anthony Scropton	Elected to 2016		3 years	7/7
	Mr Tariq Shah	Elected to 2016		3 years	2/7
	Mr Derek Brian Smith	Elected to 2015		3 years	7/7
	Mr Vic Skates	Elected to 2014	Ended term	3 years	2/4
	Ms Shamim Ulzaman	Elected to 2016		3 years	4/7
	Mr Jack Wright	Elected to 2015		3 years	6/7
	Mr John Young	Elected to 2015		3 years	3/7
	Mrs Geraldine Tassell	Elected to Sept 2017	Start of 1st term	3 years	3/3
	Mrs Judy Kingham	Elected to Sept 2017	Start of 1st term	3 years	3/3
	Mrs Susan Doherty	Elected to Sept 2017	Start of 1st term	3 years	3/3
Staff Governors					
Staff					
Admin, Clerical and Management	Mr Jim Machon	Elected to 2015		3 years	5/7
	Mrs Ros Bailey	Elected to 2016		3 years	6/7
Nursing and Midwifery (including Health Care Assistants)	Ms Lesley Groves	Elected to 2014	Ended term	3 years	2/4
	Mrs Mel Grocock	Elected to 2016	Resigned May 2014	3 years	1/1
	Mrs Christina Lieberman	Elected to 2014	Ended term	3 years	2/4
	Ms Jackie James	Elected to 2017	Start of 1st term	3 years	1/3
	Mrs Pamela Vasallo-Todaro	Elected to 2017	Start of 1st term	3 years	2/3
	Mrs Carmel Deveraux	Elected to 2017	Start of 1st term	3 years	3/3
Volunteers	Mrs Pam Brown	Elected to 2015		3 years	7/7
Medical and Dental	Mr Chi-Hwa Chan	Elected to 2014	Ended term	3 years	0/4
	Dr Ritwik Banajee	Elected to 2017	Start of 1st term	3 years	2/3
Ancillary and Maintenance	Mr Gerald Tomlinson	Elected to 2016		3 years	5/7
Professional and Technical	Ms Barbara Turner	Elected to 2015		3 years	4/7

Anyone wishing to contact Governors can write to the Governors' email address governors@ldh.nhs.uk or to the Board Secretary. The Members' Newsletter can be found on the L&D's website.

Council of Governors Sub Committees

There are three sub-committees of the Council of Governors

Remuneration and Nomination Committee

The Remuneration and Nomination Committee assists the Council of Governors in carrying out the following of its functions:

- To appoint and if appropriate remove the Chair.
- To appoint and, if appropriate remove the other Non-Executive directors.
- To appoint and, if appropriate remove the Vice-Chairman of the Board of Directors.
- To decide the remuneration and allowances and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.
- To approve the appointment of the Chief Executive.
- To agree the outcome of the annual appraisals of the Non-Executive Directors by the Chair.
- To agree the outcome of the annual appraisal of the Chair by the Senior Independent Director.

During 2014/15 the committee met four times and has completed the following activities:

- Approved the remuneration and allowances for the Non-Executive Directors.
- Agreed the outcomes of the Non-Executive Directors appraisals.
- Agreed the outcome of the annual appraisal of the Chair by the Senior Independent Director.
- Completed the process to be able to recommend to the Council of Governors the new Chair and three Non-Executive Directors

Membership and Communication Committee

The Membership and Communications Committee assists the Council of Governors in carrying out the following of its functions:

- To implement the Trust Membership Strategy.
- To be a contact for the Trust to encourage membership.
- To represent the Council of Governors and visit locations around the Trusts' constituencies to encourage membership.
- To support the publication of the Ambassador Newsletter to members.
- To support the Annual Member's meeting.
- To ensure the Trust's Membership Strategy is reviewed yearly and remains fit for purpose.

During 2014/15 the committee met six times and has completed the following activities:

- Issued two Ambassador Newsletters.
- Reviewed the Membership Strategy.
- Supported the two Medical Lectures on Anticoagulation and Elderly Care.
- Supported the Annual Member's Meeting.
- Visited locations across the catchment to increase membership.

Constitutional Working Group

The Constitutional Working Group assists the Council of Governors in carrying out the following of its functions:

- To ensure that the Constitution is up to date with new developments.
- To review the Constitution at least annually.
- Recommend amendments to the constitution to the Council of Governors;
- Liaise with Monitor and legal representatives when required.
- Report to the Annual Members Meeting to approve any Constitutional amendments.
- During 2014/15 the committee met once and agreed a number of improvements to the current constitution that were agreed by the Council of Governors in February 2015 and the Board of Directors in March 2015. None of the amendments affected the powers of the governors.

Foundation Trust Membership

The Trust's Governors and Members continue to play a vital role in our Constitution as a Foundation Trust. There are two broad categories of membership constituency namely public and staff (including volunteers). The public constituency is further divided into three:

- i. Luton
- ii. Bedfordshire
- iii. Hertfordshire

As at 31 March 2015 there were 16,145 registered FT members comprising 4,249 staff (including volunteers) and 11,641 public members. Our FT public membership numbers showed an upward trend by 307 during 2014/15 which is a 2.7% increase as compared to corresponding period of the previous year.

The Governors agreed a Membership Strategy through the Council of Governors in June 2014. Our strategy outlined six objectives and progress on each is outlined below.

1) To increase the membership

The strategy outlined more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership. This has been achieved and ongoing recruitment Bedfordshire is required.

2) To ensure membership diversity

A review of the diversity of the membership identified that an increase the number of younger members was required. We have made links with the Youth Parliament and Apprenticeship schemes. The aim to increase the membership from 131-150 in the 16-24 category has been achieved successfully achieving 160.

3) To develop the membership database

In order to increase communication, the aim to maintain the number of recorded e-mails at 30%. For 2014/15, 31% was achieved. An annual review of those members that need to be removed was also conducted and the database updated.

4) To provide learning and development opportunities to the membership

The plan for 2014/15 was to hold two medical lectures and two further events within the year. This year, two medical lectures were held - one on anticoagulation and one on Elderly Care both held at Luton Sixth Form College. Both events were attended by over 120 members of the public at each. Engagement events were also supported across the catchment area and each proved

a popular experience for the membership and provided excellent opportunity to learn about our services and speak to the medical team.

5) To communicate with the membership and encourage them to stand in elections

Our strategy for this year involved continuing with our Ambassador newsletter. Two were issued in 2014/15. This has proved a worthwhile and effective means of communicating our achievements and developments among our members and local stakeholders. For 2014/15, an Annual Review was produced that was issued to the membership at the Annual Members Meeting in September 2014. A programme to provide more information to members on becoming a Governor was implemented at the beginning of 2014 and resulted in an increased number of candidates standing for election in Luton from 3 to 13.

6) Effective use of resources

The Council of Governors Membership and Communication Sub-Committee reviews the budget on behalf of the Governors. This year the Foundation Trust Department has performed well against the budget.

Strategy for 2015/16

The strategy will be reviewed in June 2015 by the Membership and Communication Sub-Committee to identify the plans for 2015/16. The main objectives will remain the same and plans to:

- Forecast an increase of the membership to 16,609 for period ending 31 March 2016.
- Further increase the membership and hold engagement events in Bedfordshire.
- Target key membership groups to discuss becoming Governors.
- Encourage members to vote for their preferred candidates in the elections.

Elections for the Council of Governors will be held in June/July 2015 for 14 seats (nine public and five staff). The services of an external provider have been engaged to assist with the electoral process as the independent scrutineer.

Membership size and movement:

Public constituency	2014/15 (Plan)	2014/15 (Actual)	2015/16 (Plan)
At year start (April 1)	11,334	11,334	11,641
New members	600	593	600
Members leaving	200	286	200
At year end (March 31)	11,734	11,641	12,041
Staff constituency*			
At year start (April 1)	4,249	4,249	4,504
New members	893	933	715
Members leaving	698	678	651
At year end (March 31)	4,444	4,504	4,568
Total Members	16,178	16,145	16,609
Patient constituency			
Not applicable			

* The Staff Constituency in line with the Trust Constitution and includes volunteers and bank staff that are not part of the Trust headcount.

Analysis of current membership:

Public Constituency	Number of members	Eligible membership
Age (years):		
0-16	2	351,959
17-21	90	93,757
22+	8,409	1,176,404
Unknown	3,140	
Ethnicity:		
White	5,902	1,327,296
Mixed	84	40,567
Asian or Asian British	1,622	139,935
Black or Black British	468	54,924
Other	301	10,922
Unknown	3,264	
Socio-economic groupings: *		
AB	2,943	132,796
C1	3,373	154,585
C2	2,514	94,527
DE	2,773	94,885
Unknown	38	
Gender analysis		
Male	6,901	799,161
Female	4,700	822,959
Unknown	40	
Patient Constituency		
Not applicable		

Analysis excludes: 3140 members with no date of birth, 40 with no stated gender, 3264 with no stated ethnicity, and 38 with no stated socio-economic grouping.

* Socio-economic data should be completed using profiling techniques (eg: post codes) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.

Notes:

TOTAL - Eligible members:

AGE:	1,622,120
Ethnicity:	1,573,644 **
Socio-economic:	476,793 ***
Gender:	1,622,120

The figures for Ethnicity and Socio-economic do not add up to 1,622,120.

The reasons provided by **Membership Engagement Services** are listed below:

The overall **Ethnicity figure for **Eligible members** is often lower than the other figures purely because it is based on a projection from the 2001 Census data so unable to provide a perfectly accurate representation.

***The overall **Socio-economic** figure for **Eligible members** is lower due to the fact that it only takes into account those between the ages of 16-64 leaving out those outside of that range.

Membership Recruitment and Engagement

Governors, supported by our membership team have continued to recruit and interact with members through initiatives such as recruitment drives and events such as medical lectures and events at GP surgeries (see the Membership and Communication Committee). In many instances these activities also included "meet your Governor" sessions to ensure the membership can contact their Governor. In this regard several of our local GPs opened their surgery doors to facilitate discussions between our hospital Governors and patients. This enabled our governors to hear at first-hand some of the views and suggestions that patients have about NHS Services. In the 12 months ahead further meetings are planned in community settings to engage with the people that are harder to reach and to work with schools and colleges to encourage members from age 16 to 18.

Anyone wishing to enquire about becoming a member of the Luton & Dunstable Hospital NHS Foundation Trust can contact the membership team at the address shown below.

Contact Details

The L&D Foundation Trust's Membership Department

can be contacted on: 01582 718333

or by email:

foundationtrustmembership@ldh.nhs.uk

or by writing to:

Membership Department
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

The L&D Foundation Trust's Governors

can be contacted by email:

governors@ldh.nhs.uk

(please indicate which Governor you wish to contact)

or by writing to:

(Name of Governor)*
c/o Board Secretary
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

*Full list of Governors available on: www.ldh.nhs.uk

Review of Financial Performance

A financial surplus for the sixteenth successive year was achieved for 2014/2015 with a surplus of £0.1m. Our performance was behind the planned surplus of £1m forecast within our Annual Plan and reflects the challenging environment in which the Trust operates.

Our staff successfully handled a range of financial pressures and challenges throughout the year. This included delivering savings to accommodate efficiency targets inherent within the national tariff system, meeting the costs of pay reform from Agenda for Change, and activity related pressure caused by both the four hour emergency care target and the 18 week elective care targets.

Furthermore the Hospital was significantly challenged during the winter by record emergency attendances, a lack of community bed provision and increased demand for services that put pressures on staff and bed availability.

The table below illustrates our income and expenditure (I&E) performance since 2005/06.

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Turnover	143.6	153.2	169.1	189.3	204.9	211.6	220.8	230.6	244.3	259.2
Surplus	0.4	2.0	2.9	4.3	3.1	2.6	2.5	0.9	0.4	0.1
Cash	1.9	18.8	35.4	45.4	43.7	50.9	47.6	37.5	24.8	11.7

All figures £m

Cash balances continued to be monitored closely, ending the year with a balance in excess of £11m. Given the level of cash accrued since achieving Foundation Trust status our working capital borrowing facilities remain unused.

£13m was invested to strengthen the capacity to deliver modern NHS services. Significant expenditure items included more than £4m on new medical equipment and £5m on IT projects (predominantly on ensuring a robust underlying infrastructure to support the numerous IT initiatives implemented to assist in delivering core healthcare activities). The Trust has also invested significant resources into site redevelopment plans whilst financing substantial improvements to the existing site including Neonatal Intensive Care, Emergency Department, and Ophthalmology facilities.

As the new Trust strategy emerged it was underpinned by an updated in June 2014, flexible and transparent 5 year business plan.

This plan reflects the changing ways in which the FT will be working, acknowledging influences and expectations such as the Better Care Fund, 7 day working and the

delivery of truly integrated care. It will also be responsive to the means that will be adopted in rising to the associated financial challenges, abiding by the principles of economy, efficiency and effectiveness - all with the intention of protecting the resources that are available to ensure that the L&D continues to be able to deliver the highest possible level of quality healthcare in the most appropriate environment.

Looking forward, it is expected that the new financial year to be significantly more challenging and it is vital that sound financial management continues to be exercised as a year in which the NHS faces a substantial resource challenge is entered.

Going Concern

After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

Key Variances from the Plan in 2014/15

The Board of Directors reviewed the position of the Hospital site developments in 2014/15. In order to achieve increased value for money, operational efficiency and effectiveness, it was determined that a more considered approach to major investment was required - particularly in light of the challenges facing the NHS. Accordingly the Board will receive a final business case in 2015/16 to take forward a major development of the Lewsey Road site.

During 2014/15 the Board became aware that the anticipated demand management initiatives identified by commissioners were not materialising as expected. This meant that the Hospital was required to increase staffing to accommodate patient need. This led to a substantial unplanned agency pay bill (which was only partly mitigated by extra Government funding for winter pressures). Accordingly this unplanned cost reduced the level of planned surplus in 2014/15.

Principal Risks and Uncertainties facing the Trust

In 2014/15 the Trust was disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem required the Hospital to improve efficiency by 4.5% per annum (£10m). The position for 2015/16 will be similar.

During 2014/15 the Trust was successful in treating substantially more patients. This increase in patients has been contrary to CCG expectations and undermined CCG QIPP plans. In 2015/16 the CCGs have again identified substantial ambition to reduce patient numbers attending the Hospital. The Trust will need to be flexible to ensure that capacity is responsive to both planned and unplanned demand.

The mis-match between CCG anticipated patient number reductions and growth in patient activity in 2014/15 gave rise to substantial over-performance. The impact of contract over-performance forced our main commissioner into financial deficit and in turn to challenge a variety of billed items in an attempt to mitigate their financial loss. This greatly delayed agreement of the 2014/15 contract value, with resolution only achieved in April 2015.

Luton CCG (our main commissioner) has identified a significant deficit. This deficit, in part, has been caused by acknowledged underfunding. The impact of CCG allocation realignment will, in time, increase the CCG allocation. Notwithstanding the ultimate benefit of 'fair shares' funding the CCG will seek downward pressure on providers as it seeks to redress the short term funding challenge and to contribute to the Better Care Fund.

The impact of the 2014/15 disputes has delayed the 2015/16 contract negotiations. There is now an agreed plan to conclude discussions by the end of May 2015.

A plan designed to deliver our financial strategy has been developed. This contains more risk than has been evident in previous years and places emphasis on the abilities of the Hospital Management Team to deliver improved financial performance whilst maintaining operational targets.

The belief that appropriate clinical outcomes, patient experience and safety remain the highest priorities has continued to be maintained and that this must be balanced with the requirement to achieve year-on-year efficiency savings.

Another risk for us is the lack of community provision of nursing, intermediate care and rehabilitation beds. This impacts on our ability to safely discharge patients from hospital to appropriate facilities. The Trust is working with Clinical Commissioning Groups to resolve these issues as soon as possible.

Commissioning aspirations for the provision of care closer to home provides us with challenges and opportunities but uncertainty with regards to the potential tendering of services.

Remuneration report

The Remuneration Committee is a Standing Committee of the Board of Directors which is appointed in accordance with the constitution of the Trust to determine the remuneration and any other associated payments or terms of service of the Executive Directors. This also includes reimbursement of travelling and other expenses incurred by Directors. The Committee meets, as a minimum, twice yearly.

The membership of the Committee includes the Trust Chairman and all Non-Executive Directors. The Chief Executive and the Director of Human Resources are also in attendance. The Director of Human Resources, is present to provide advice and services to the Committee that materially assist them in the consideration of the matters before them, other than consideration of their own remuneration or performance.

Strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and an ongoing appraisal process.

The remuneration of individual Directors can be found in note 4.9 to the accounts.

There were no pay inflation increases for 2014/2015.

The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Council of Governors at a separate Remuneration Committee.



Pauline Philip
Chief Executive
Date: 27th May 2015

Fundraising and Charitable Donations

During the 2014/15 financial year the Luton and Dunstable Hospital Charitable Fund received £579,612 from 1220 donations from grant-giving trusts, companies, individuals, community groups and legacies.

Of this total income of £579.612- 60.3% was from individuals, 32.2% of income was from Charitable Trusts, 4.3% was from companies and 3.2% was from community groups.

Included in the income from individuals is £179,663 received from six separate legacies gifted to benefit the Chest Unit, Cardiac Centre, Intensive Care Unit, the Neonatal Intensive Care Unit and the hospital's general fund. Legacies play a key part in shaping the Hospital for future generations. Most people that want to leave the Hospital a gift in their Will specify the ward or department that they want it to benefit. This is something we encourage people to do so they feel confident that their gift will be used towards something they think is important. We have had a number of enquiries this year about how to leave a gift to the hospital in a Will.

This year, we have finished fundraising for the prostate biopsy machine. We have raised over £145,319 (£121,292 this financial year) towards the machine. This includes a very generous donation from The Amateurs Trust, who are long term supporters of the hospital.

The Friends of the Hospital have continued their kind support towards the hospital and donated £53,754. This has been used to buy medical equipment for various wards and departments including an ECG machine, baby resuscitation training equipment and digital blood pressure machines.

The NICU (Neonatal Intensive Care Unit) Appeal has again been extremely well supported by families of babies in the unit and the local community. It has received 218 donations during 2014/2015 totalling £81,560. An additional £31,470 has been donated specifically to improve the facilities for parents with a baby on in NICU. This project includes new parents accommodation on site and a renovated kitchen for parents on the unit.

The NICU Appeal has raised over £899,000 since the Appeal was launched in 2008.

All of the 2014 Christmas campaigns fundraising befitted the Parents Facilities. Light up a life raised £3,260 in 2014 which is more than previous years. We also ran the Give a Gift campaign where people donate presents for patients through our online wish lists. Over 400 gifts were bought in total and a number of companies also came in with additional presents for patients.

On behalf of all the staff, patients and their families the Trust would like to say a huge thank you to everyone who has supported the Hospital by making a donation, giving gifts or volunteering their time. Your support makes a real difference to our patients and their families and helps make a difficult time more comfortable and less distressing.

For more details about how to get involved with fundraising or to find out more about specific projects and what donations are spent on please contact the Fundraising Team on 01582 718 043 or email fundraising@ldh.nhs.uk

The Luton and Dunstable Hospital Charitable Fund is a registered charity in England and Wales number: 1058704

Property Plant and Equipment and Fair Value

As stated in note 1.5 to the accounts, Property Plant and Equipment are stated at Fair Value which is defined as the lower level of replacement cost and recoverable amount. A review is carried out each year for any potential impairment, with a formal revaluation every five years. A full property valuation as at 31 March 2015, was undertaken by Gerald Eve LLP. The Directors' opinion is that there are no fixed assets where the value is significantly different from the value included in the financial statements.

External Auditor

KPMG LLP (UK) is our external auditor. The appointment was made and approved following a presentation by the Chair of the Audit Committee to the Council of Governors.

KPMG LLP (UK) may, from time to time, be asked to carry out non-audit work. The cost of these other services is shown in note 5.5 to the accounts. It is important to ensure that any additional services provided by the external auditors do not impact on their ability to be independent of management, and that conflicts with

objectivity do not arise. We will develop a protocol through the Audit and Risk Committee to address this. This protocol will need to be approved by the Council of Governors.

Private Finance Initiatives (PFI Schemes)

We have two capital schemes arranged under the PFI:

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 15 years remaining.
2. The electronic patient record scheme is a 10 year scheme that has now completed.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

Better Payment Practice Code

We are continuing to maintain progress in this area, settling 93% of non-NHS invoices within 30 days of receipt of a valid invoice.

2014/15	Number of invoices	Value £000s
Total Non-NHS trade Invoices paid in the year	73782	£100,487
Total Non-NHS trade Invoices paid within target	68515	£91,519
Percentage of Non-NHS trade Invoices paid within target	93%	91%

Off Payroll Engagements

NHS Foundation Trusts are required to disclose the information in the tables below about off-payroll engagements.

Table 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2014	6
Of which...	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	2
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	5
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	5
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	-
No. for whom assurance has not been received	-
No. that have been terminated as a result of assurance not being received.	-

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	17

Counter Fraud

The Trust has a counter fraud policy for dealing with suspected fraud and corruption and other illegal acts involving dishonesty or damage to property. Nominated staff who Trust staff can contact confidentially are the Director of Finance and the Local Counter Fraud Specialist (LCFS). The LCFS provides reports quarterly to our Audit and Risk Committee.

Level 1 = Confirmed IG Serious Incident but no need to report using the IG Toolkit.

Level 2 = Confirmed IG Serious Incident that must be reported to ICO, DH and other central bodies by reporting it on the IG Toolkit. A level 2 IG SIRI can be defined as a personal data breach (as defined in the Data Protection Act), so reportable to the ICO, or high risk of reputational damage.

Data Loss

From July 2013 all NHS organisations are required to use the Information Governance Incident Reporting Tool for reporting a level 2 IG Serious Incident. This tool is part of the online Information Governance (IG) Toolkit system. The level of an IG incident is determined by sensitivity factors.

Internally level 2 incidents are reported to the Trust's Clinical Operational Board with assurance provided to the Clinical Outcomes, Safety and Quality Committee that action has been taken and lessons learned.

As part of this new reporting requirement all Health, Public Health, Adult Social Care services and commissioned NHS service providers are required to complete and publish the tables below with information in relation to level 1 and level 2 IG incidents.

Level 1 Serious Incident Table:

Summary of incident requiring investigations involving personal data as reported to the information commissioner' office in 2014/15

Date of Incident (Month)	Nature of Incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
December 2014	Inappropriate access to patient information	Personal and sensitive data.	Three	Logged on IG Toolkit as IG SIRI
Further action on information Risk	Investigation on-going			

Summary of other personal data related incidents in 2014/15

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	3
C	Lost in Transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal - hardware	0
G	Non-secure Disposal - paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	0
K	Other	0

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Luton and Dunstable University Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS **Foundation Trust Accounting Officer Memorandum** issued by Monitor.

Under the NHS Act 2006, Monitor has directed Luton and Dunstable University Hospital NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of directed Luton and Dunstable University Hospital NHS foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the **NHS Foundation Trust Annual Reporting Manual** and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's **NHS Foundation Trust Accounting Officer Memorandum**.

Signed



Pauline Philip
Chief Executive
Date: 27th May 2015

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Luton and Dunstable University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is accountable for managing risk and leads the Executive Board, attends each of the Sub-Committees of the Board and the Clinical Operational Board to ensure that the Trust has robust processes in place to manage risk.

The Board leads for Risk Management are the Medical Director and the Chief Nurse. The Managing Director is the Board lead for non-clinical (including Health and Safety) risk management. The Medical Director leads on clinical risk management and chairs the Clinical Operational Board where all aspects of clinical risk management are discussed. Assurance is then provided to the Clinical Outcome, Safety and Quality Committee and the Audit and Risk Committee. The Clinical Operational Board includes a high level Executive membership and includes the clinical medical consultant leadership through the Divisional Directors. The Divisional

Directors are accountable for ensuring risk is embedded within their Divisional Boards.

All risks are reviewed by an Executive Risk Review Group monthly that demonstrates top level leadership to risks by considering and approving all new risks to the risk register.

At induction, new joiners to the organisation undergo basic training in risk management (clinical and non-clinical).

Risk management training sessions are provided to staff as required.

Liaison with Divisional Directors ensures that when practice is changed as a result of integrated learning from the risk management process, this is cascaded to Divisions. This takes place through the Clinical Operational Board and the Divisional Board meetings.

The Trust Risk Register is developed from risks identified at the Board of Directors and its sub committees and at divisional and department level plus from those identified from other sources e.g. external reports. The Board ensures action is taken to mitigate any risks to quality. Risks and benefits to quality and safety are assessed for all reviews of efficiency related initiatives. The Board receives the Board Assurance Framework every four months and reviews a summary of the risk register every two months in order to be able to maintain understanding of the current and future risks. The Board has participated in seminars which help in the identification of future external risks to quality such as new national guidance, new technologies and business continuity.

The risk and control framework

Risk continues to be managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Board and the Clinical Operational Board lead the review of risk through the Divisional, Information Governance and Equality and Diversity sub Boards. The Board of Directors lead the review of board level strategic risk seeking assurance from the Audit and Risk, Clinical Outcome, Safety and Quality; and Finance, Investment and Performance Committees.

The Risk Management Strategy continues to provide an integrated framework for the identification and management of risks of all kinds, whether clinical, organisational or financial and whether the impact is internal or external. This is supported by a Board

Assurance Framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management.

There is a Risk Review process under the leadership of the Executive Directors, who are consulted to approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). The relevant Executive Director agrees whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The closed risks are also monitored to ensure the Executive Team is aware of risk amendments. The Trust has in place a weekly Senior Staff Committee that oversees operational risk.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management

Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review Group and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors every two months. Actions and timescale for resolution are agreed by the risk leads and monitored by the Board of Directors and relevant sub-committee. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

The organisations major risks are detailed on the Trust Risk Register and Assurance Framework. Through the annual planning, the risks are formulated into five elements and the risks linked to those and their mitigating action are documented below. The Risk Register is reviewed by the Board of Directors, Audit and Risk Committee, Clinical Outcome, Safety and Quality Committee, FIP, and Executive Board, it contains in year and future risks.

L&D Top 5 Risks 2015 - 2016 (Summary)

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures	High	High	Workforce plans in place	Weekly Senior Team and Executive meetings
	2. Increased emergency pressures			Board approved action plans with Trust partners where appropriate	Monthly Clinical Outcomes, Safety & Quality Committee
	3. Implementation of integrated care			Re-engineering programme managed by an Executive Director	
	4. The need for robust and whole system working				
Finance	Delivering the financial challenge in 2015/16 including Commissioner plans, agency spend, CQUIN and Re-engineering programmes	High	High	Monthly review of key income & expenditure metrics	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action.
				Monthly performance review meeting with Divisions led by Executive Directors	
				Monthly Re-engineering Boards	Monthly Finance, Investment & Performance committee review
				Enhanced process for business case preparation and evaluation	Executive oversight group to monitor re-engineering milestones

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Present Hospital Campus	Trust site may not be consistent for optimum patient care	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project	Board review of OBC in Summer 2015
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff	Ongoing review and testing of Business Continuity plan relevant adaptation of plans Oversight by Board Sub group

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' / 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions.

Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board.

Risk Management is an embedded activity of the organisation and can be demonstrated through a number of examples:

- Each Divisional Board reviews reported incidents on a quarterly basis and are required to report to the Clinical Operational Board a CLIP report (Complaints, Litigation, Incidents and Patient Affairs) to triangulate and reflect on the issues raised, develop any further controls to manage the principal risks and to minimise, as far as reasonably practical, the incident occurring again. If there is a persistent risk issue identified from the incident, the issue is evaluated through the Risk Register and also subjected to independent scrutiny (for example: internal audit, external accreditation).
- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Impact Assessment Form. If there are any negative impacts on a particular group

of people/equality group following the completion of this form, the Trust will record any changes to the service and/or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.

- Business cases include a risk analysis both financially and clinically.

During the coming year the Trust will continue to embed a culture of external review and engagement of independent expertise to facilitate greater objectivity and learning;

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned. This practice will continue in 2015/16 and include an independent Board Evaluation.
- An external review of the Trust Medical Equipment provision was undertaken to identify actions for improvement to take forward.
- The value of benchmarking and learning from others has been greatly enhanced through membership of UCL Partners and the McKinsey Hospital Institute.

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

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

investigations by the CQC during the reporting period. The last formal CQC inspection was in September 2013. Two areas of improvement were identified; record keeping and maternity staffing. We declared full compliance with the standards in January 2014 and the CQC conducted a follow up inspection in August 2014. To date we have not received a formal report back from the CQC against these criteria. However, correspondence indicated that we were assessed as being compliant with the standard for record keeping.

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

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

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

Intelligent Monitoring

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

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

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients are represented on the following committees:

- Equality and Diversity Committee
- Clinical Audit and Effectiveness Committee
- Patient and Public Participation Group
- PLACE (Patient Led Assessment of the Care Environment)
- Ethics Committee
- Transforming Outpatients
- Outsourcing Project Board
- Hospital Re-Development Board
- Car Parking Working Group
- Re-Engineering Group
- Safeguarding Adults
- Carbon Management

Healthwatch monitor the services provided by the Trust and report directly to the Chief Executive and these are then referred to appropriate Directorate for consideration and action. Representatives from Luton Healthwatch are members of the Trusts Patient and Public Participation Group. The National Patient Survey action plan is also progressed and monitored through this group. Healthwatch have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in

their constituency, appointing and holding to account the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representatives from other key stakeholders such as the CCG's, Local Government Councils and Universities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Delivery of the Carbon Management Plan is ongoing: the Trust reports on progress with carbon reduction within the Operational Performance section of this report.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to Monitor and the monthly financial information provided to all budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include the below departments and groups. The Trust has governance arrangements for the Finance, Investment and Performance Committee with Divisions presenting directly to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- Oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.
- Monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.
- Support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 94 (based on 2013/14 accounts and activity published November 2014) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the Luton and Dunstable.

Information Governance

The Trust has had one serious information governance incident in relation to a confidentiality breach. The Trust identified from an access audit report, that Electronic Health Records were accessed inappropriately. This was reported to the Information Commissioner's Office (ICO) and they have undertaken to investigate.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 in the ***NHS Foundation Trust Annual Reporting Manual***.

The Quality Account is the responsibility of the Chief Nurse supported by all of the Executive Team and is written following guidance issued by Monitor. Processes put in place via the Information Governance Toolkit, led by the Director of Information Technology, as Senior Information Risk Owner (SIRO), provides assurance that the Trust's Data Quality is reviewed and monitored.

For 2014/15 the Chief Executive and Chief Nurse engaged with Trust staff and Trust Governors to review the indicators and priorities that the Trust should focus on and develop indicators on into next year.

Through the Information Governance Toolkit, the Trust has a number of key information policies in place including data quality that sets out the roles and responsibilities.

The Trust has three reports that feed data into the Board of Directors; the Quality and Performance Report, Finance Report and Workforce Report. Each of these contains data that is tracked over months and years to identify variances.

The Trust monitors Dr Foster alerts through the Mortality Board, Clinical Operational Board and Clinical Audit and Effectiveness Committee. Clinical Audit forward plans detail the work undertaken to review the data quality of these alerts. Annually the Trust has an external audit of clinical coding that demonstrated excellent practice and an internal audit of Information Governance that demonstrates assurance against the Information Governance Toolkit that includes Data Quality.

The Trust reviews directorate dashboards e.g. maternity to collect data at source and monitors the effectiveness of central data through the SUS reports. The Trust monitors key performance indicators in relation to data quality that demonstrates improving practice across the Trust.

18 week data is generated by the Information Department on a weekly and monthly basis and then actively used by key departments to manage the patient's pathways so that patients receive treatment within 18 weeks of referral. Although initial checks are made by the Information Department, this data is further validated by our separate 18 week team who interrogate the files and physically track the patient's pathway on our current IT systems and record comments regarding the progress of the pathway. Inputting of the 18 week data is restricted to a core team to reduce the risk of inaccurate data entry and the further weekly validation allows for any errors to be rectified immediately. Weekly graphs are produced which are cascaded to a wider senior team both specifically around waiting list demand and 18 week performance, both which are able to highlight data discrepancies should they arise. A fortnightly meeting also interrogates the Flash report which details the 18 week patients at specialty level.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical

leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Clinical Outcome, Safety and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control during 2014/15 was monitored by the following:

- The Board of Directors - The Board places reliance upon the Audit and Risk Committee for assurances that the system of internal control is sound.
- The Audit and Risk Committee - The function of the Audit and Risk Committee is to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.
- The structure of the Board of Directors meetings during 2014/15 allows the appropriate time to ensure matters regarding Performance and Quality would be managed through the whole Board.
- The Clinical Outcome, Safety and Quality Committee focus on assurance issues relating to clinical and corporate governance, risk management and assurance framework and report monthly to the Board. It also manages achievement of the annual Governance Plan. This committee is supported by the Clinical Operational Board that ensures divisional clinical leadership. The COSQ committee also receive assurance against the Care Quality Commission Quality Outcomes on a monthly basis.
- The Clinical Audit and Effectiveness Committee reports to the Clinical Operational Board. The committee ensures clinical leadership through the divisions, monitors the implementation of NICE guidance and reviews the Dr Foster benchmarking data sets to review trends. This process is reported to the Executive Board and assurance provided to the Clinical Outcome, Safety and Quality Committee.

- The Finance, Investment and Performance Committee takes an overview of operational activity and performance against national and local targets.
- Internal Audit – Internal Audit review the system of internal control during the course of the financial year and report accordingly to the Audit and Risk Committee.
- A Provider Licence Assurance Framework was reviewed by the Audit and Risk Committee. The Trust has reviewed Governance arrangements through the assessment of the Healthy Board 2013 and the Monitor Code of Governance. These assessments have been cross referenced against the Licence requirements laid out in condition 4 of the FT Governance.

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the Non-Executive Directors are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

My review is also informed by:

Internal Audit, who have conducted reviews of Information Governance, Key Financial Systems, the Assurance Framework and Risk Management and Activity Reporting. A review of Cost Improvement Plans and Information Technology is in progress. Internal Audit reviews are conducted using a risk-based approach covering areas agreed as being the priority for review based on a risk assessment agreed between the Audit and Risk Committee, Management and the auditors. The Head of Internal Audit reports that they have completed the programme of internal audit work for the year ended 31 March 2015 as amended with the agreement of the Audit and Risk Committee, with the exception of the review of CIPS which is currently underway. Their work identified low, moderate and high rated findings. There were no critical risk rated reports in 2014/15, nor any individual findings rated critical. Based on the work we have completed, they believe that there

is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

The key factors that contributed to this opinion are summarised as follows:

- High risk report in relation to Activity Reporting, within which was one individual finding rated high risk concerning chargeable activity in Outpatients not being completely recorded within relevant systems as a result of staff not inputting all additional activity recorded on "18 weeks" forms. There were also a number of other medium risk findings from this review and a number of medium risk reports and medium risk findings in other areas.

All recommendations arising from Internal Audit's work are considered by managers and an action plan agreed. The report, action plan and subsequent progress in implementing those actions are reviewed and monitored by the Audit and Risk Committee, and where relevant also by the Clinical Outcome, Safety and Quality Committee.

The Trust has taken action throughout the year to address the issues raised through the Internal Audit process. This included:

- A programme of work to strengthen the review of information governance risks as part of the Information Governance Toolkit
- Completing training for information system asset owners and administrators
- Improvements in the recording of risk discussions at Divisional meetings
- Commencing actions to respond to the issues identified concerning completeness of clinical activity recording in Outpatients

Conclusion

The generally sound system of internal control is supported by a robust governance structure that reviewed any identified weaknesses regularly. Some areas for action were identified during the year and immediate action taken to mitigate and resolve the concerns.



Pauline Philip
Chief Executive
Date: 27th May 2015

Independent Audit Opinion

Independent auditor's report to the council of governors of Luton and Dunstable University Hospital NHS Foundation Trust only

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2015 set out on pages C14 to C55. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2015 and of the Group's and the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings - £81 million

Refer to page 98 (Audit & Risk Committee Report), pages C19 to C22 (accounting policy) and pages C38 to C40 (financial disclosures).

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

Our response: In this area our audit procedures included:

- Assessing the qualifications, objectivity and expertise of the external valuer, taking into account their sector experience, to perform the full revaluation exercise;
- Considering the terms of engagement of the valuer to check its consistency with the Group's accounting policies for property, plant and equipment, including the treatment of VAT in depreciated replacement cost valuations;

- Confirming that the basis of the valuation and whether it was in line with Treasury Guidance (FRM) and RICS Valuation Professional Standards (Red Book);
- Confirming whether there were any assets identified as no longer required for operational use or surplus;
- Challenging with the assistance of our own valuation specialist the rationale for the alternative site valuation; and
- Undertaking work to understand the basis upon which any revaluations to land and buildings have been recognised in the financial statements and determining whether they complied with the requirements of the ARM.

NHS Income Recognition - £235 million

Refer to page 98 (Audit & Risk Committee Report), page C18 (accounting policy) and pages C29 to C30 (financial disclosures).

The risk: The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 97% of income. The Group participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated when the consolidation exercise takes place to report the Department's Consolidated Resource Account. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Group and its counter parties at 31 March 2015.

Mis-matches can occur for a number of reasons, but the most significant arise where the Group and commissioners have not concluded the reconciliations of healthcare spells completed within the last quarter of the financial year, which have not yet been invoiced, or there is not final agreement over proposed contract penalties as activity data for the period has not been finally validated.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgment. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- Reconciling the income recorded in the financial statements to signed contracts with the five most material counter parties which accounted for 71% of the income recorded from NHS commissioning

bodies and reviewing material variations supported by explanations from the Trust;

- Assessing whether the Trust was in formal dispute or arbitration in relation to any material income balances and examining the supporting correspondence, including - if appropriate - any legal advice, for consistency with the treatment of these balances within the financial statements;
- Inspecting third party confirmations from other NHS counter parties and comparing the values disclosed within their financial statements to the values recorded in the Trust's financial statements through the English AoB exercise.
- Carrying out testing of invoices raised around the financial year-end to determine whether income had been recognised in the appropriate period.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the Group financial statements was set at £5 million, determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the Audit and Risk Committee any corrected and uncorrected identified misstatements exceeding £250,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components which are subject to audits for group reporting purposes performed by the Group audit team at one location in Luton and Dunstable Hospital. The audit performed for group reporting purposes was performed to group materiality levels.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or
- the Audit & Risk Committee Report does not appropriately address matters communicated by us to the Audit and Risk Committee.
- Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources

We have nothing to report in respect of the above responsibilities.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Luton and Dunstable University Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 121 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full

and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.



Fleur Nieboer
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square, London, E14 5GL
28 May 2015

Foreword to the Accounts

These accounts for the year ended 31st March 2015 have been prepared by the Luton and Dunstable University Hospital NHS Foundation Trust under schedule 7 paragraph 24 and 25 of the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.



Pauline Philip
Chief Executive
Date: 27th May 2015

Statement of comprehensive income

	note	Parent		Group	
		(L&D NHSFT)		(L&D NHSFT & NHS Charitable Funds)	
		2014/15	2013/14	2014/15	2013/14
		£000	£000	£000	£000
Operating Income from continuing operations	2.5	259,342	244,322	259,682	244,453
Operating Expenses of continuing operations	3	(255,811)	(240,739)	(256,138)	(241,266)
Operating surplus		3,531	3,583	3,544	3,187
Finance Costs					
Finance income	6.1	65	87	148	178
Finance expense - financial liabilities	6.2	(751)	(760)	(751)	(760)
Finance expense - unwinding of discount on provisions		(11)	(20)	(11)	(20)
PDC Dividends payable		(2,768)	(2,447)	(2,768)	(2,447)
Net finance costs		(3,465)	(3,140)	(3,382)	(3,049)
Movement in fair value of investment property and other investments	11	0	0	238	100
Surplus from continuing operations		66	443	400	238
Surplus for the year		66	443	400	238
Surplus for the year		66	443	400	238
Other comprehensive income					
Revaluations impact	23	(2,218)	0	(2,218)	0
Total comprehensive income for the year		(2,152)	443	(1,818)	238

Note: Allocation of profits for the period: This surplus is wholly attributable to the owner of the parent.

Statement of financial position

	note	Parent		Group*	
		31-Mar-15 £000	31-Mar-14 £000	31-Mar-15 £000	31-Mar-14 £000
Non-current assets					
Intangible assets	7	334	404	334	404
Property, plant and equipment	8	103,027	100,192	103,027	100,192
Other investments	11	0	0	3,208	3,369
Trade and other receivables	14	1,203	1,248	1,203	1,248
Other assets	15	2,848	3,109	2,848	3,109
Total non-current assets		107,412	104,953	110,620	108,322
Current assets					
Inventories	13	2,515	2,556	2,515	2,556
Trade and other receivables	14	24,888	18,831	24,848	18,813
Cash and cash equivalents	25	11,655	24,974	12,325	25,258
Total current assets		39,058	46,361	39,688	46,627
Current liabilities					
Trade and other payables	16	(24,456)	(25,344)	(24,486)	(25,381)
Borrowings	18	(185)	(183)	(185)	(183)
Provisions	22	(1,822)	(3,364)	(2,066)	(3,704)
Other liabilities	17	(1,851)	(2,246)	(1,851)	(2,246)
Total current liabilities		(28,314)	(31,137)	(28,588)	(31,514)
Total assets less current liabilities		118,156	120,177	121,720	123,435
Non-current liabilities					
Borrowings	18	(11,777)	(11,959)	(11,777)	(11,959)
Provisions	22	(749)	(780)	(954)	(1,013)
Total non-current liabilities		(12,526)	(12,739)	(12,731)	(12,972)
Total assets employed		105,630	107,438	108,989	110,463
Financed by					
Taxpayers Equity					
Public Dividend Capital		61,512	61,168	61,512	61,168
Revaluation reserve	23	11,522	13,740	11,522	13,740
Income and expenditure reserve		32,596	32,530	32,596	32,530
Others' Equity					
Charitable Fund Reserves	24	0	0	3,359	3,025
Total taxpayers & others' equity		105,630	107,438	108,989	110,463



Pauline Philip
Chief Executive
27 May 2015

The notes on pages C18 to C55 form part of the financial statements.

Statement of changes in equity

	Parent - Pre Consolidated				Group Consolidated				
	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Charitable Funds Reserves £000	Total £000
Taxpayers' and Others' Equity at 1 April 2014 - as previously stated	61,168	13,740	32,530	107,438	61,168	13,740	32,530	3,025	110,463
Surplus/(deficit) for the year	0	0	66	66	0	0	(186)	586	400
Revaluation Impact	0	(2,218)	0	(2,218)	0	(2,218)	0	0	(2,218)
Public Dividend Capital received	344	0	0	344	344	0	0	0	344
Other reserve movements - charitable funds consolidation adjustment	0	0	0	0	0	0	252	(252)	0
Taxpayers' and Others' Equity at 31 March 2015	61,512	11,522	32,596	105,630	61,512	11,522	32,596	3,359	108,989
Taxpayers' and Others' Equity at 1 April 2013 as previously stated	60,149	13,740	32,087	105,976	60,149	13,740	32,087	3,230	109,206
Prior Period Adjustment	0	0	0	0	0	0	0	0	0
Taxpayers' and Others' Equity at 1 April 2013 - restated	60,149	13,740	32,087	105,976	60,149	13,740	32,087	3,230	109,206
Surplus/(deficit) for the year	0	0	443	443	0	0	169	69	238
Public Dividend Capital received	1,019	0	0	1,019	1,019	0	0	0	1,019
Transfers between reserves	0	0	0	0	0	0	0	0	0
Other reserve movements - charitable funds consolidation adjustment	0	0	0	0	0	0	274	(274)	0
Taxpayers' and Others' Equity at 31 March 2014	61,168	13,740	32,530	107,438	61,168	13,740	32,530	3,025	110,463

Statement of cash flows

	Parent		Group	
	2014/15 £000	2013/14 (restated) £000	2014/15 £000	2013/14 (restated) £000
Cash flows from operating activities				
Operating surplus from continuing operations	3,531	3,583	3,544	3,187
Operating surplus	3,531	3,583	3,544	3,187
Non-cash income and expense:				
Depreciation and amortisation	8,200	7,091	8,200	7,091
(Gain) / Loss on disposal	(96)	154	(96)	154
Non-cash donations/grants credited to income	(210)	(232)	0	0
(Increase)/Decrease in Trade and Other Receivables	(6,012)	(6,637)	(5,993)	(6,640)
(Increase)/Decrease in Inventories	41	28	41	28
Increase/(Decrease) in Trade and Other Payables	(619)	(2,060)	(619)	(2,060)
Increase/(Decrease) in Other Liabilities	(396)	8	(396)	8
Increase/(Decrease) in Provisions	(1,584)	(1,414)	(1,584)	(1,414)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	0	0	(128)	(89)
Other movements in operating cash flows	9	0	10	(1)
Net Cash Generated From Operations	2,864	521	2,979	264
Cash flows from investing activities				
Interest received	65	87	65	87
Purchase of Intangibles	(83)	(126)	(83)	(126)
Purchase of Property, Plant and Equipment	(12,914)	(10,795)	(13,124)	(11,026)
Sale of Property, Plant and Equipment	102	0	102	0
NHS Charitable funds - net cash flows from investing activities	0	0	482	33
Net cash generated used in investing activities	(12,830)	(10,834)	(12,558)	(11,032)
Cash flows from financing activities				
Public dividend capital received	344	1,019	344	1,019
Capital element of Private Finance Initiative obligations	(183)	(202)	(183)	(202)
Interest paid	(2)	0	(2)	0
Interest element of Private Finance Initiative obligations	(749)	(760)	(749)	(760)
PDC Dividend paid	(2,763)	(2,508)	(2,763)	(2,508)
Net cash used in financing activities	(3,353)	(2,451)	(3,353)	(2,451)
Increase/(decrease) in cash and cash equivalents	(13,319)	(12,764)	(12,932)	(13,219)
Cash and Cash equivalents at 1 April 2014	24,974	37,738	25,258	38,477
Cash and Cash equivalents at 31 March 2015	11,655	24,974	12,326	25,258

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

The NHS Foundation Trust is the corporate trustee to Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Prior to 2014/15, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund and has applied this as a change in accounting policy requiring the 2013/14 statements to be restated.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Trust does not have any other subsidiaries, associates, joint ventures or joint operations as defined under International Financial Reporting Standards.

Unless otherwise stated the notes to the accounts disclose the group position.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The trust also has employees who are members of the NEST pension scheme. This is a defined contribution

scheme and employers pension cost contributions are charged to operating expenses as and when they become due.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has an individual cost of at least £5,000; or
- the item forms a group of assets which individually have a cost of more than £1,000, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. All property (land and buildings, excluding infrastructure assets) are restated to current value using

professional valuations in accordance with IAS16 every five years. An interim valuation is also carried out.

The Trusts properties were valued on 31 March 2015 by an external valuer, Richard Ayres MRICS of Gerald Eve LLP. The total proportion of fees payable by the client during the preceding year relative to the total fee income of the firm during the preceding year are minimal. The valuations were in accordance with the requirements of the RICS Valuation – Professional Standards, January 2014 edition and the International Valuation Standards. The valuation of each property was on the basis of market value, subject to the following assumptions:

- for owner-occupied property: the property would be sold as part of the continuing business;
- for investment property: the property would be sold subject to any existing leases; or
- for surplus property and property held for development: the property would be sold with vacant possession in its existing condition.

The valuer's opinion of market value was primarily derived using:

- comparable recent market transactions on arm's length terms and;
- the depreciated replacement cost approach, because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the business or entity.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The land value for existing use purpose is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use (if of a significant value).

PFI scheme assets have been valued in accordance with the policy above.

Operational equipment is valued at depreciated historic cost. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential

deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised

in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; the sale must be highly probable i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and

is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle costs i.e. those costs anticipated to be incurred to maintain the asset to a specified standard, within the scheme form part of the liability of the Trust and consequently have been recognised as a separate asset within the Statement of Financial Position. The asset is amortised each accounting period in accordance with the lifecycle costs incurred in respect of the PFI scheme asset.

1.6 Intangible assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as

current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Financial Assets

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial Liabilities - Other financial liabilities

All other financial liabilities are recognised initially at fair

value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The bad debt provision comprises of specific bad debts for known disputed items, debtors greater than one year, debtors where there is a history of non-payment and a general provision for other debtors.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust,

the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. For charitable funds decisions made by the Charitable Fund Committee for which there is a constructive obligation to undertake activities are recognised at the point the decision is made.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in

return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded

assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The majority of the Trust's activities are related to core healthcare and are therefore not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the £50,000 corporation tax threshold, as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM, see Note 25.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and special payments register which reports on a cash basis with the exception of provisions for future losses, see Note 32.

2.1 Operating income (by classification)

	2014/15 Total £000	2013/14 Total £000
Income from Activities		
Elective income	37,541	36,870
Non elective income	70,454	69,081
Outpatient income	37,153	35,721
A & E income	10,344	9,332
Other NHS clinical income	85,308	74,046
Private patient income	1,845	1,799
Other clinical income	741	690
Total income from activities	243,386	227,539

2.2 Commissioner Requested Services

The Trust's provider licence specifies the Commissioner Requested Services, for details see www.monitor.gov.uk. This note analyses income from activities between Commissioner Requested Services and Non Commissioner Requested Services.

	2014/15 £000	2013/14 £000
Commissioner Requested Services	240,800	225,050
Non Commissioner Requested Services	2,586	2,489
	243,386	227,539

2.3 Operating lease income

	2014/15 Total £000	2013/14 Total £000
Operating Lease Income		
Rents recognised as income in the period	701	657
Total	701	657
Future minimum lease payments due on leases of Buildings expiring		
- not later than one year;	67	192
- later than one year and not later than five years;	188	188
- later than five years.	207	254
Total	462	634

2.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2014/15 £000	2013/14 £000
Income recognised this year	137	193
Cash payments received in-year	26	84
Amounts added to provision for impairment of receivables	29	110
Amounts written off in-year	537*	7

* Due to information governance concerns the Trust had been unable to refer overdue debts to a debt collection agency. This issue was resolved in 2014/15. As a result these write-offs relate to 2006/07 to 2014/15 overseas patients treatment where the debt collection agency have been unable to locate the individual.

2.5 Operating income (by type)

	Parent		Group	
	2014/15 £000	2013/14 £000	2014/15 £000	2013/14 £000
Income from activities				
NHS Foundation Trusts	729	494	729	494
NHS Trusts	1,250	1,254	1,250	1,254
CCGs and NHS England	232,702	220,728	232,702	220,728
Local Authorities	1,843	1,884	1,843	1,884
NHS Other	485	498	485	498
Non NHS: Private patients	1,845	1,799	1,845	1,799
Non-NHS: Overseas patients (non-reciprocal)	137	193	137	193
NHS injury scheme (was RTA)	741	689	741	689
Non NHS: Other*	3,655	0	3,655	0
Total income from activities	243,387	227,539	243,387	227,539
Other operating income				
Research and development	541	529	541	529
Education and training	8,811	7,798	8,811	7,798
Charitable and other contributions to expenditure	210	232	0	0
Received from NHS charities: Other charitable and other contributions to expenditure	42	42	0	0
Rental revenue from operating leases	701	657	701	657
Income in respect of staff costs where accounted on gross basis	986	1,273	986	1,273
Profit on disposal of other tangible fixed assets*1	96	0	96	0
NHS Charitable Funds: Incoming Resources excluding investment income	0	0	592	405
Other*2	4,568	6,252	4,568	6,252
Total other operating income	15,955	16,783	16,295	16,914
TOTAL OPERATING INCOME	259,342	244,322	259,682	244,453

*2 This includes car parking income of £1,456k (2013/14 £1,430k). This is strictly an income generation activity whereby income exceeds cost and the surplus is invested in the provision of patient care. There are other Trust objectives delivered through this activity including a contribution to the patient and staff safety and experience agenda (additional security and maximising the availability of car parking spaces).

3.1 Operating Expenses (by type)

	Parent		Group	
	2014/15 £000	2013/14 £000	2014/15 £000	2013/14 £000
Purchase of healthcare from non NHS bodies	130	130	130	130
Employee Expenses - Executive directors	1,013	1,173	1,013	1,173
Employee Expenses - Non-executive directors	130	121	130	121
Employee Expenses - Staff	166,969	156,813	166,969	156,813
Supplies and services - clinical (excluding drug costs)	25,992	22,548	25,992	22,548
Supplies and services - general	5,038	6,273	5,038	6,273
Establishment	5,724	4,807	5,724	4,807
Transport	87	106	87	106
Premises	9,091	8,748	9,091	8,748
Increase / (decrease) in provision for receivable impairments	82	(10)	82	(10)
Drug costs (non inventory drugs only)	1,253	318	1,253	318
Drugs Inventories consumed	21,830	20,158	21,830	20,158
Rentals under operating leases - minimum lease receipts	1,739	1,662	1,739	1,662
Depreciation on property, plant and equipment	8,130	7,021	8,130	7,021
Amortisation on intangible assets	70	70	70	70
Audit fees				
audit services- statutory audit ¹	57	55	57	55
other auditor remuneration (external auditor only)	11	9	11	9
Audit fees payable re charitable fund accounts	0	0	3	3
Clinical negligence (Insurance Premiums)	6,547	6,177	6,547	6,177
Loss on disposal of other property, plant and equipment	0	154	0	154
Legal fees	91	151	91	151
Consultancy costs	1,481	1,528	1,481	1,528
Training, courses and conferences	448	1,174	448	1,174
Patient travel	1,284	1,257	1,284	1,257
Car parking & Security	606	573	606	573
Redundancy - (not included in employee expenses)	149	116	149	116
Early retirements - (not included in employee expenses)	26	0	26	0
Hospitality	13	17	13	17
Publishing	45	61	45	61
Insurance	114	111	114	111
Other services, eg external payroll	293	315	293	315
Grossing up consortium arrangements	94	94	94	94
Losses, ex gratia & special payments	88	9	88	8
NHS Charitable funds: Other resources expended	0	0	324	524
Other * ²	(2,814)	(1,000)	(2,814)	(999)
TOTAL	255,811	240,739	256,138	241,266

*1 Excluding non-recoverable VAT.

*² Negative value as a result of reversing unused provisions and accruals during 2013/14 and 2014/15.

4.1 Employee Expenses (excluding non-executive directors)

	2014/15 Permanent £000	2014/15 Other £000	2014/15 Total £000	2013/14 Permanent £000	2013/14 Other £000	2013/14 Total £000
Salaries and wages	115,237	16,219	131,456	110,936	13,441	124,377
Social security costs	10,094	1,283	11,377	10,389	671	11,060
Pension costs - defined contribution plans						
Employers contributions to NHS Pensions	13,241	605	13,846	12,573	504	13,077
Agency/contract staff	0	11,739	11,739	0	10,485	10,485
Costs capitalised as part of assets	(353)	(83)	(436)	(304)	(593)	(897)
TOTAL	138,219	29,763	167,982	133,594	24,508	158,102

4.2 Average number of employees (WTE basis)

	2014/15 Permanent Number	2014/15 Other Number	2014/15 Total Number	2013/14 Permanent £000	2013/14 Other £000	2013/14 Total Number
Medical and dental	491	84	575	488	76	564
Administration and estates	589	93	682	565	82	647
Healthcare assistants and other support staff	649	227	876	628	219	847
Nursing, midwifery and health visiting staff	1,171	153	1,324	1,100	128	1,228
Nursing, midwifery and health visiting learners	5	0	5	6	0	6
Scientific, therapeutic and technical staff	446	61	507	438	54	492
Other	3	0	3	3	0	3
Number of Employees (WTE) engaged on capital projects	(10)	(16)	(26)	(8)	(10)	(18)
TOTAL	3,344	602	3,946	3,220	549	3,769

4.3 Employee benefits

There were no employee benefits during either 2014/15 nor 2013/14.

4.4 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were 1 (2013/14: 2) retirements, at an additional cost of £89k (2013/14: £127k). This information has been supplied by NHS Pensions.

4.5.1 Senior Managers Remuneration

2014/15

Name	Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman					
Spencer Colvin	Chairman (left 30/06/2014)	10 to 15			10 to 15
Clifford Bygrave	Interim Chair (1/07/2014 to 23/09/2014)	10 to 15			10 to 15
Simon Linnett	Chairman (started 24/09/2014)	20 to 25			20 to 25
Non Executive Directors					
Clifford Bygrave	Non-Executive Director (excl 1/07/2014 to 23/09/2014)		10 to 15		10 to 15
Alison Clarke	Non-Executive Director	10 to 15			10 to 15
Ninawatie Tiwari	Non-Executive Director	10 to 15			10 to 15
John Garner	Non-Executive Director	10 to 15			10 to 15
Mark Versallion	Non-Executive Director	10 to 15			10 to 15
Jagtar Singh	Non-Executive Director (left 30/12/2014)	5 to 10			5 to 10
David Hendry	Non-Executive Director (started 22/10/2014)	5 to 10			5 to 10
Jill Robinson	Non- Executive Director (started 5/12/2014)	0 to 5			0 to 5
Executive Directors					
Pauline Philip	Chief Executive	205 to 210		n/a	205 to 210
David Carter	Managing Director	130 to 135		17.5 to 20	150 to 155
Andrew Harwood	Director of Finance	125 to 130		17.5 to 20	145 to 150
Mark Patten	Medical Director	160 to 165		20 to 22.5	180 to 185
Patricia Reid	Director of Nursing	115 to 120		15 to 17.5	130 to 135
Angela Doak	Director of Organisational Development	120 to 125		15 to 17.5	135 to 140
Mark England	Director of Reengineering and Informatics ¹	120 to 125		65 to 67.5	185 to 190

Name	Title	2013/14		
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Pension Related Benefits (bands of £2,500)
Chairman				
Spencer Colvin	Chairman	40 to 45		40 to 45
Non Executive Directors				
Clifford Bygrave	Non-Executive Director	15 to 20		15 to 20
Alison Clarke	Non-Executive Director	10 to 15		10 to 15
Denis Mellon	Non-Executive Director (left 30/08/2013)	0 to 5		0 to 5
Ninawatie Tiwari	Non-Executive Director	10 to 15		10 to 15
John Garner	Non-Executive Director	10 to 15		10 to 15
Mark Versallion	Non-Executive Director (started 23/12/2013)	0 to 5		0 to 5
Jagtar Singh	Non-Executive Director	10 to 15		10 to 15
Executive Directors				
Clifford Bygrave	Non-Executive Director	15 to 20		15 to 20
Alison Clarke	Non-Executive Director	10 to 15		10 to 15
Denis Mellon	Non-Executive Director (left 30/08/2013)	0 to 5		0 to 5
Ninawatie Tiwari	Non-Executive Director	10 to 15		10 to 15
John Garner	Non-Executive Director	10 to 15		10 to 15
Mark Versallion	Non-Executive Director (started 23/12/2013)	0 to 5		0 to 5
Jagtar Singh	Non-Executive Director	10 to 15		10 to 15
Executive Directors				
Pauline Philip	Chief Executive	205 to 210		n/a 205 to 210
David Carter	Managing Director	130 to 135		25 to 27.5 155 to 160
Andrew Harwood	Director of Finance	125 to 130		27.5 to 30 155 to 160
Mark Patten	Medical Director	125 to 130	30 to 35 ²	30 to 32.5 155 to 160
Patricia Reid	Director of Nursing	115 to 120		52.5 to 55 165 to 170
Sarah Wiles	Director of Business Development (left 15/07/2013)	25 to 30		0 to 2.5 25 to 30
Angela Doak	Director of Organisational Development	120 to 125		22.5 to 25 140 to 145

¹ Voting Director from 22/10/2014

² Remuneration for clinical role

For the purpose of this note Senior Managers are defined as being the Chief Executive, Non Executive Directors and Executive Directors. I.e. Those individuals with voting rights.

Senior Managers have not received any taxable benefits, annual performance-related bonuses or long-term performance related bonuses in either 2014/15 or 2013/14.

4.5.2 Pension benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2015 (bands of £2,500)	2014/15		
			Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value £000
Pauline Philip ¹ Chief Executive	-	-	-	-	-
David Carter Managing Director	2.5 to 5	115 to 117.5	473	435	26
Andrew Harwood Director of Finance	0 to 2.5	180 to 182.5	840	789	30
Mark Patten Medical Director	0 to 2.5	160 to 162.5	704	655	31
Patricia Reid Director of Nursing	2.5 to 5	97.5 to 100	550	502	34
Angela Doak Director of Organisational Development	0 to 2.5	170 to 172.5	762	715	28
Mark England Director of Reengineering and Informatics	2.5 to 5	12.5 to 15	155	105	47

¹No longer contributing to pension scheme

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2014 (bands of £2,500)	2013/14		
			Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real Increase in Cash Equivalent Transfer Value £000
Pauline Philip ¹ Chief Executive	-	-	-	-	-
David Carter Managing Director	7.5 to 10	110 to 112.5	435	394	41
Andrew Harwood Director of Finance	7.5 to 10	172.5 to 175	789	732	57
Mark Patten Medical Director	7.5 to 10	152.5 to 155	655	603	52
Patricia Reid Director of Nursing	10 to 12.5	90 to 92.5	502	424	78
Sarah Wiles Director of Business Development	0 to 2.5	72.5 to 75	285	275	10
Angela Doak Director of Organisational Development	27.5 to 30	162.5 to 165	715	567	148

4.5.3 Median Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes

salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

	2014/15	2013/14
Band of Highest Paid Director's Total Remuneration	205 to 210	205 to 210
Median Total	25,783	25,783
Ratio	8.0	8.0

Neither the highest paid director's remuneration nor the Trust's median salary have changed during 2014/15.

4.5.4 Staff Exit Packages

Exit package cost band (including any special payment element)	2014/15		2013/14	
	Total number of exit packages	Total cost of exit packages £'000	Total number of exit packages	Total cost of exit packages £'000
<£10,000	14	28	9	27
£10,001 - £25,000	0	0	1	17
£25,001 - 50,000	1	40	0	0
£50,001 - £100,000	0	0	2	147
£100,001 - £150,000	1	109	0	0
>£150,000	0	0	0	0
Total	16	177	12	191
	2014/15	2014/15	2013/14	2013/14
	Payments agreed	Total value	Payments agreed	Total Value
	Number	£'000	Number	£'000
Voluntary redundancies including early retirement contractual costs	2	149	2	67
Contractual payments in lieu of notice	14	28	11	76
Non-contractual payments requiring HMT approval	0	0	1	48
	16	177	14	191

All staff exit packages were in respect of non-compulsory departures in both 2013/14 and 2014/15.

4.5.5 Expenses of Governors and Directors

The Foundation Trust had a total of 46 (42 in 2013/14) governors in office in 2014/15. 9 (10 in 2013/14) of these governors received expenses in 2014/15, with aggregate expenses paid to governors of £1,100 (£1,900 in 2013/14).

The Foundation Trust had a total of 17 (15 in 2013/14) directors in office in 2014/15. 8 (5 in 2013/14) of these directors received expenses in 2014/15, with aggregate expenses paid to directors of £4,100 (£5,200 in 2013/14).

5.1 Operating leases

	2014/15 £000	2013/14 £000
Minimum lease payments	1,739	1,662
TOTAL	1,739	1,662

5.2 Arrangements containing an operating lease

	2014/15 £000 Land	2014/15 £000 Buildings	2014/15 £000 Other	2014/15 £000 Total	2013/14 £000 Total
Future minimum lease payments due:					
- not later than one year;	72	248	802	1,122	857
- later than one year and not later than five years;	290	5	443	738	801
- later than five years.	863	0	0	863	915
TOTAL	1,225	253	1,245	2,723	2,573

The Trust does not have any significant leasing arrangements.

5.3 Limitation on auditor's liability

There is £1m limitation on the auditors liability.

5.4 The late payment of commercial debts (interest) Act 1998

£2k was paid in respect of the late payment of commercial debts (interest) Act 1998 (£0k in 2013/14)

5.5 Other Audit Remuneration

£11k expenditure was incurred with the external audit provider in respect of tax advice in 2014/15. (£9k 2013/14)

5.6 Impairment of assets (PPE & intangibles)

No impairments have been charged to expenditure in either 2013/14 nor 2014/15.

6.1 Finance income

	Parent		Group	
	2014/15 £000	2013/14 £000	2014/15 £000	2013/14 £000
Interest on instant access bank accounts	65	87	65	87
Interest on held-to-maturity financial assets	0	0	0	0
NHS Charitable funds: investment income	0	0	83	91
Total	65	87	148	178

6.2 Finance costs - interest expense

	Parent		Group	
	2014/15 £000	2013/14 £000	2014/15 £000	2013/14 £000
Interest on late payment of commercial debt	2	0	2	0
Finance Costs in PFI obligations				
Main Finance Costs	749	760	749	760
Total	751	760	751	760

7.1 Intangible Assets 2014/15

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2014 as previously stated	536	536
Additions - purchased	0	0
Cost or valuation at 31 March 2015	536	536
Amortisation at 1 April 2014 as previously stated	132	132
Provided during the year	70	70
Amortisation at 31 March 2015	202	202
Net book value		
NBV - Owned at 31 March 2015	334	334
NBV total at 31 March 2014	334	334

7.2 Intangible Assets 2013/14

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2013 as previously stated	536	536
Additions - purchased	0	0
Cost or valuation at 31 March 2013	536	536
Amortisation at 1 April 2013 as previously stated	63	63
Provided during the year	69	69
Amortisation at 31 March 2014	132	132
Net book value		
NBV - Owned at 31 March 2014	404	404
NBV total at 31 March 2014	404	404

8.1 Property, plant and equipment 2014/15

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2014 as previously stated	14,100	82,549	947	1,341	23,252	2,953	9,276	230	134,648
Additions - purchased (including donated)	0	1,709	0	3,630	3,015	862	3,972	0	13,188
Reclassifications	0	2,986	0	(3,050)	0	0	64	0	0
Revaluations	(3,450)	(17,406)	(541)	0	0	0	0	0	(21,397)
Disposals	0	0	0	0	(1,172)	(6)	(162)	(10)	(1,350)
Cost or valuation at 31 March 2015	10,650	69,838	406	1,921	25,095	3,809	13,150	220	125,089
Accumulated depreciation at 1 April 2014 as previously stated	0	15,052	62	0	14,935	695	3,494	218	34,456
Provided during the year	0	4,031	34	0	2,295	368	1,400	2	8,130
Revaluations	0	(19,083)	(96)	0	(0)	0	0	0	(19,179)
Disposals	0	0	0	0	(1,167)	(6)	(162)	(10)	(1,345)
Accumulated depreciation at 31 March 2015	0	0	0	0	16,063	1,057	4,732	210	22,062
Net book value									
NBV - Owned at 31 March 2015	10,650	57,527	406	1,921	8,664	2,752	8,418	10	90,348
NBV - PFI at 31 March 2015	0	10,539	0	0	0	0	0	0	10,539
NBV - Donated at 31 March 2015	0	1,772	0	0	368	0	0	0	2,140
NBV total at 31 March 2015	10,650	69,838	406	1,921	9,032	2,752	8,418	10	103,027

8.2 Property, plant and equipment 2013/14

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013 as previously stated	14,100	78,575	552	1,654	21,208	861	5,854	258	123,062
Additions - purchased (including donated)	0	3,561	17	3,595	2,815	269	2,288	0	12,545
Revaluation Impact	0	0	0	0	0	0	0	0	0
Reclassifications	0	413	378	(3,758)	10	1,823	1,134	0	0
Disposals	0	0	0	(150)	(781)	0	0	(28)	(959)
Cost or valuation at 31 March 2014	14,100	82,549	947	1,341	23,252	2,953	9,276	230	134,648
Accumulated depreciation at 1 April 2013 as previously stated	0	11,186	29	0	13,516	618	2,647	244	28,240
Provided during the year	0	3,866	33	0	2,196	77	847	2	7,021
Disposals	0	0	0	0	(777)	0	0	(28)	(805)
Accumulated depreciation at 31 March 2014	0	15,052	62	0	14,935	695	3,494	218	34,456
Net book value									
NBV - Purchased at 31 March 2014	14,100	55,344	885	1,341	7,981	2,258	5,782	12	87,703
NBV - PFI at 31 March 2014	0	10,300	0	0	0	0	0	0	10,300
NBV - Donated at 31 March 2014	0	1,853	0	0	336	0	0	0	2,189
NBV total at 31 March 2014	14,100	67,497	885	1,341	8,317	2,258	5,782	12	100,192

8.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	2	49
Dwellings	21	40
Assets under Construction & POA	0	0
Plant & Machinery	5	15
Transport Equipment	5	15
Information Technology	5	10
Furniture & Fittings	5	10
Intangible Software Licenses	5	10

9 Other Property Plant & Equipment Disclosures

The Trust received £210k of donated property, plant and equipment from the charitable funds associated with the hospital.

The Trust entered into a 10 year contract for the provision of medical records in February 2013. Due to the length of the contract, the expected life of the equipment in question and, on the basis that the equipment is solely used by this Trust, the Trust has recognised this equipment as property plant and equipment. The value of this equipment as at 31 March 15 was £2,096k.

The Trust's estate, encompassing land and buildings was revalued as at 31 March 2015. This valuation was completed by Gerald Eve LLP, professional valuers in accordance with the RICS Valuation - Professional Standards published by the Royal Institution of Chartered Surveyors.

Land was valued using existing use value methodology at £10,650k using the concept of economic substitution of the service utility of the asset.

Given the specialised nature of the buildings the majority of the estate has been valued using depreciated replacement cost based on modern equivalent assets at a value of £70,245k. There are various small assets which are temporarily idle, although not for sale, where the period for which the asset is idle is uncertain these have had their depreciation accelerated and are held on the Statement of Financial Position at values reflecting their short remaining economic lives.

10.1 Non-current assets for sale and assets in disposal groups

The Trust held no non-current assets for sale nor assets in disposal groups in 2013/14 or 2014/15.

10.2 Liabilities in disposal groups

The Trust held no liabilities in disposal groups in 2013/14 nor 2014/15.

11 Investments

	Parent		Group	
	31-Mar-15 £000	31-Mar-14 £000	31-Mar-15 £000	31-Mar-14 £000
NHS Charitable funds: Other investments				
Carrying value at 01 April 2014	0	0	3,369	3,240
Acquisitions in year - other	0	0	666	901
Fair value gains (taken to I&E)	0	0	251	100
Fair value losses (impairment) [taken to I&E]	0	0	(13)	0
Disposals	0	0	(1,065)	(872)
Carrying value at 31 March 2015	0	0	3,208	3,369

12 Associates & Jointly Controlled Operations

2014/15 is the second year that the Luton & Dunstable Hospital Charitable Funds have been consolidated into the Luton & Dunstable University Hospital NHSFT's accounts in accordance with IAS 27. Until April 2013, the Treasury had directed that IAS 27 should not be applied to NHS charities. However, that direction has now been removed and IAS 27 requires that consolidated accounts are prepared. This is because Luton & Dunstable University Hospital NHSFT is the corporate trustee of Luton & Dunstable Hospital Charitable Funds and the charity's objectives are for the benefit of Luton & Dunstable University Hospital NHSFT's patients.

The main financial statements disclose the NHS organisation's financial position alongside that of the group (which is the NHS organisation and the NHS charity). The NHS charity's accounts, which have been prepared in accordance with the Charities SORP, can be found on the Charity Commission website and are summarised in note 24 to these accounts.

As the accounting policies applicable to both the Trust and the Charitable Funds are consistent no adjustment other than intra-group transactions has been required.

The Trust had no other associates nor jointly controlled operations in 2013/14 nor 2014/15.

13.1 Inventories

	31-Mar-15 £000	31-Mar-14 £000
Drugs	702	767
Consumables	1,813	1,789
Total inventories	2,515	2,556

13.2 Inventories recognised in expenses

	2014/15 £000	2013/14 £000
Additions	40,739	38,321
Inventories recognised in expenses	(40,780)	(38,349)
Movement in inventories	41	(28)

14.1 Trade receivables and other receivables

	Parent		Group	
	31-Mar-15 £000	Restated 31-Mar-14 £000	31-Mar-15 £000	Restated 31-Mar-14 £000
Current				
NHS Receivables	14,157	14,158	14,157	14,158
Other receivables with related charitable funds	43	24	0	0
Other receivable with related parties	417	523	417	523
Provision for impaired receivables	(1,085)	(1,689)	(1,085)	(1,689)
Prepayments	2,781	2,266	2,781	2,266
Prepayments - Lifecycle replacements	44	44	44	44
Accrued income	4,699	793	4,699	793
VAT receivable	953	888	953	888
Other receivables	2,879	1,824	2,879	1,824
NHS Charitable funds: Trade and other receivables	0	0	3	6
Total Current Trade And Other Receivables	24,888	18,831	24,848	18,813
Non-Current				
Prepayments	508	482	508	482
Accrued income	695	766	695	766
Total Non Current Trade And Other Receivables	1,203	1,248	1,203	1,248

14.2 Provision for impairment of receivables

	31-Mar-15 £000	31-Mar-14 £000
At 1 April 2014	1,689	1,690
Increase in provision	82	58
Amounts utilised	(686)	9
Unused amounts reversed	0	(68)
At 31 March 2015	1,085	1,689

14.3 Analysis of impaired receivables

	31 March 2015 £000	31 March 2014 £000
Ageing of impaired receivables		
0 - 30 days	44	52
30-60 Days	26	45
60-90 days	30	38
90- 180 days	82	150
over 180 days	903	1,404
Total	1,085	1,689
Ageing of non-impaired receivables past their due date		
0 - 30 days	1,538	1,161
30-60 Days	1,228	314
60-90 days	4,406	2,537
90- 180 days	3,985	5,583
over 180 days	1,510	990
Total	12,667	10,585

14.4 Finance lease receivables

During 2014/15 the Trust did not have any finance lease receivables.

15 Other assets (Non Current)

	31 March 2015 £000	31 March 2014 Restated £000
PFI Scheme - lifecycle costs	2,848	3,109
Total	2,848	3,109

16.1 Trade and other payables

	Parent		Group	
	31-Mar-15 £000	31-Mar-14 £000	31-Mar-15 £000	31-Mar-14 £000
Current				
NHS payables	2,242	919	2,242	919
Amounts due to other related parties - revenue	2,001	1,867	2,001	1,867
Trade payables - capital	1,435	1,709	1,435	1,709
Other trade payables	4,426	3,153	4,426	3,153
Social Security costs	3,344	3,291	3,344	3,291
Other payables	702	296	702	296
Accruals	10,299	14,107	10,299	14,107
PDC Dividend Payable	7	2	7	2
NHS Charitable funds: Trade and other payables	0	0	30	37
Total Current Trade & Other Payables	24,456	25,344	24,486	25,381
Non-Current				
Other trade payables - capital	0	0	0	0
Total Non Current Trade & Other Payables	0	0	0	0

NHS payables do not include any outstanding pension contributions due to NHS Pensions Agency as at 31 March 2015.

17 Other liabilities

	31-Mar-15 £000	31-Mar-14 £000
Current		
Deferred Income	1,851	2,246
Total other current liabilities	1,851	2,246

There are no other non current liabilities in 2012/13 nor 2013/14.

18 Borrowings

	31-Mar-15 £000	31-Mar-14 £000
Current		
Obligations under Private Finance Initiative contracts	185	183
Total current borrowings	185	183
Non-current		
Obligations under Private Finance Initiative contracts	11,777	11,959
Total other non current liabilities	11,777	11,959

19 Prudential borrowing limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2014 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

20 Finance lease obligations

The Trust had no finance lease obligations during 2014/15 other than the PFI scheme arrangement.

21.1 PFI obligations (on SoFP)

	31-Mar-15 £000	31-Mar-14 £000
Gross PFI liabilities	19,082	20,010
of which liabilities are due		
- not later than one year;	925	932
- later than one year and not later than five years;	4,656	4,271
- later than five years.	14,422	15,744
Finance charges allocated to future periods	(7,868)	(8,633)
Net PFI liabilities	12,142	12,343
- not later than one year;	183	202
- later than one year and not later than five years;	1,808	1,346
- later than five years.	10,151	10,795

21.2 The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31-Mar-15 £000	31-Mar-14 £000 (Restated)
Within one year	752	752
2nd to 5th years (inclusive)	3,008	3,008
Later than 5 years	7,520	8,2726
Total	11,280	12,032

22 Provisions for liabilities and charges

Parent	Current		Non-current	
	31-Mar-15	31-Mar-14	31-Mar-15	31-Mar-14
	£000	£000	£000	£000
Pensions relating to other staff	64	65	749	780
Other legal claims	516	985	0	0
Agenda for Change	981	1,491	0	0
Restructuring	0	502	0	0
Redundancy	180	180	0	0
Other	81	141	0	0
Total	1,822	3,364	749	780

Group	Current		Non-current	
	31-Mar-15	31-Mar-14	31-Mar-15	31-Mar-14
	£000	£000	£000	£000
Pensions relating to other staff	64	65	749	780
Other legal claims	516	985	0	0
Agenda for Change	981	1,491	0	0
Restructuring	0	502	0	0
Redundancy	180	180	0	0
Other	81	141	0	0
NHS charitable fund provisions	244	340	205	233
Total	2,066	3,704	954	1,013

	Pensions - other staff £000	Other legal claims £000	Agenda for Change £000	Restructuring £000	Redundancy £000	Other £000	NHS charitable fund provisions £000	Total £000
At 1 April 2014 restated	845	985	1,491	502	180	141	573	4,717
Arising during the year	20	85	0	0	0	41	0	146
Utilised during the year	(63)	(83)	0	(163)	0	0	0	(309)
Reversed unused	0	(471)	(510)	(339)	0	(101)	0	(1,421)
Unwinding of discount	11	0	0	0	0	0	0	11
NHS charitable funds: movement in provisions	0	0	0	0	0	0	(124)	(124)
At 31 March 2015	813	516	981	0	180	81	449	3,020
Expected timing of cashflows:								
- not later than one year;	64	516	981	0	180	81	244	2,066
- later than one year and not later than five years;	263	0	0	0	0	0	205	468
- later than five years.	486	0	0	0	0	0	0	486
TOTAL	813	516	981	0	180	81	449	3,020

Provisions for legal claims represents the gross estimated liability from employer and public liability cases. These cases are managed by NHS Litigation Authority through the LTPS scheme, the amount of the provision recoverable from NHS Litigation Authority is included within debtors.

£72,043k is included in the provisions of the NHS Litigation Authority at 31/03/2015 in respect of clinical negligence liabilities of the Trust (31/03/2014 £47,874k).

Other provisions relate to various provisions for trading and employment contractual issues (all less than £1m).

23 Revaluation reserve

	Revaluation Reserve -property, plant and equipment £000	Total Revaluation Reserve* £000
Revaluation reserve at 1 April 2014	13,740	13,740
Revaluation Impact	(2,218)	(2,218)
Other Movements	0	0
Revaluation reserve at 31 March 2015	11,522	11,522
Revaluation reserve at 1 April 2013	13,740	13,740
Revaluation Impact	0	0
Other Movements	0	0
Revaluation reserve at 31 March 2014	13,740	13,740

* The Trust held no revaluation reserve in respect of intangible assets.

24 Charitable Funds Summary Statements

As per Note 12, below summarises the NHS Charity's accounts which have been consolidated within the Group's accounts in accordance with IAS 27.

	Subsidiary	
	2014/15 £000	2013/14 £000
Statement of Financial Activities/ Comprehensive Income		
Incoming resources	592	405
Resources expended	(579)	(801)
Net resources expended	13	(396)
Incoming Resources: investment income	83	91
Fair value movements on investments	238	100
Net movement in funds	334	(205)
	31-Mar-15 £000	31-Mar-14 £000
Statement of Financial Position		
Non-current assets	3,208	3,369
Current assets	673	290
Current liabilities	(317)	(401)
Non-current liabilities	(205)	(233)
Net assets	3,359	3,025
Funds of the charity		
Endowment funds	1	1
Other Restricted income funds	790	646
Unrestricted income funds	2,568	2,378
Total Charitable Funds	3,359	3,025

25 Cash and cash equivalents

	Parent		Group	
	31-Mar-15 £000	31-Mar-14 £000	31-Mar-15 £000	31-Mar-14 £000
At 1 April	24,974	37,738	25,258	38,477
Prior period adjustment	0	0	0	0
At 1 April (restated)	24,974	37,738	25,258	38,477
Net change in year	(13,319)	(12,764)	(12,933)	(13,219)
At 31 March	11,655	24,974	12,325	25,258
Broken down into:				
Cash at commercial banks and in hand	142	172	142	172
NHS charitable funds: cash held at commercial bank	0	0	670	284
Cash with the Government Banking Service	11,513	24,802	11,513	24,802
Cash and cash equivalents as in SoFP	11,655	24,974	12,325	25,258
Cash and cash equivalents as in SoCF	11,655	24,974	12,325	25,258

The Trust held £525 cash at bank and in hand at 31/03/15 which relates to monies held by the Trust on behalf of patients.

26.1 Contractual Capital Commitments

The Trust had contractual capital commitments totalling £0.7m at 31 March 2015.

26.2 Events after the reporting period

There have been no events after the reporting period end requiring disclosure.

The Director of Finance authorised the financial statements for issue on 27 May 2015.

27. Contingent (Liabilities) / Assets

	31-Mar-15 £000	31-Mar-14 £000 Restated
Gross value of contingent liabilities	35	40
Net value of contingent liabilities	35	40
Net value of contingent assets	0	0

Contingent liabilities relate to claims that the NHS Litigation Authority is aware of and has requested that we disclose.

28 Related Party Transactions

The Luton & Dunstable Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

All bodies deemed to be within the remit of the United Kingdom 'Whole of Government' are regarded as related parties. During the year the Trust has had significant transactions with the bodies disclosed in this note.

The Trust is the Corporate Trustee for the Charitable Funds, the transactions for which have been consolidated within these financial statements in accordance with IAS 27.

	Income 2014/15 £000	Expenditure 2014/15 £000	Income 2013/14 £000	Expenditure 2013/14 £000
NHS and DH				
Aylesbury Vale CCG	2,273	0	2,034	0
Bedfordshire CCG	57,387	0	55,894	0
Department of Health	0	2,786	34	2,447
Health Education England	8,316	9	8,091	3
Herts Valleys CCG	17,323	0	15,664	0
Luton CCG	114,295	139	106,891	139
NHS England: East Anglia Area Team	25,994	0	25,793	0
NHS England: Hertfordshire & the South Midlands Area Team	9,053	0	9,578	0
NHS Litigation Authority	0	6,562	28	6,812
Central Government				
HM Revenue and Customs	0	11,377	0	11,069
National Health Service Pension Scheme	0	13,846	0	13,077

Related Party Balances	Receivables 31 March 2015 £000	Payables 31 March 2015 £000	Receivables 31 March 2014 £000	Payables 31 March 2014 £000
NHS and DH				
Aylesbury Vale CCG	337	0	154	0
Bedfordshire CCG	5,163	0	2,933	0
Department of Health	0	60	0	67
Health Education England	202	0	45	0
Herts Valleys CCG	986	0	883	0
Luton CCG	8,049	20	5,563	20
NHS England: East Anglia Area Team	0	44	0	501
NHS England: Hertfordshire & the South Midlands Area Team	0	0	496	0
NHS Litigation Authority	0	0	0	0
Central Government				
HM Revenue and Customs	953	3,344	888	3,291
National Health Service Pension Scheme	0	1,991	0	1,851

29.1 For PFI schemes deemed to be off-SoFP

The Trust ended the off SoFP PFI scheme relating to the provision of the electronic patient record system in 2011/12. There are no transactions within either 2013/14 or 2014/15 relating to an off-SoFP PFI scheme.

29.2 Further narrative on PFI schemes

The Trust had two capital schemes arranged under PFI arrangements, one of these ended in 2011/12.

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 15 years remaining. The operator is responsible for maintaining the building during this period and ownership reverts to the Trust at the end of the contract. There are no break clauses nor re-pricing dates (On-SoFP)
2. The contract for the electronic patient record scheme has now finished. This contract was for 10 years.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

30.1 Financial assets by category

	Parent		Group	
	Loans and receivables £000	Total £000	Loans and receivables £000	Total £000
Assets as per SoFP				
Trade and other receivables excluding non financial assets (at 31 March 2015)	25,006	25,006	23,327	23,327
Cash and cash equivalents (at bank and in hand (at 31 March 2015))	11,655	11,655	11,655	11,655
NHS Charitable funds: financial assets (at 31 March 2015)	0	0	673	673
Total at 31 March 2015	36,661	36,661	35,655	35,655
Trade and other receivables excluding non financial assets (at 31 March 2014)	18,110	18,110	18,115	18,115
Cash and cash equivalents (at bank and in hand (at 31 March 2014))	24,974	24,974	24,974	24,974
NHS Charitable funds: financial assets (at 31 March 2014)	0	0	290	290
Total at 31 March 2014	43,084	43,084	43,379	43,379

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS receivables	Low	Low	Low
Accrued income	Low	Low	Medium
Other debtors	Low	Low	Medium
Cash at bank and in hand	Low	Medium	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

The Trust has a robust, audited, debt management policy that mitigates against the debtor liquidity risk. The Trust mitigates the cash credit risk by investing only in line with the Monitor compliant Treasury Management Policy.

30.2 Financial liabilities by category

	Parent		Group	
	Other financial liabilities £000	Total £000	Other financial liabilities £000	Total £000
Liabilities as per SoFP				
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2015)	11,962	11,962	11,962	11,962
Provisions under contract (at 31 March 2015)	2,571	2,571	2,571	2,571
NHS Charitable funds: financial liabilities (at 31 March 2015)	0	0	449	449
Total at 31 March 2015	14,533	14,533	14,982	14,982
Obligations under Private Finance Initiative contracts (31 March 2014)	12,142	12,142	12,142	12,142
Provisions under contract (at 31 March 2014)	4,144	4,144	4,144	4,144
NHS Charitable funds: financial liabilities (at 31 March 2014)	0	0	573	573
Total at 31 March 2014	16,286	16,286	16,859	16,859

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS creditors	Low	Low	Low
Other creditors	Low	Low	Low
Accruals	Low	Low	Low
Capital creditors	Low	Low	Low
Provisions under contract	Low	Low	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

All major contractors are credit checked prior to the awarding of the contract, thus limiting credit risk.

The Trust mitigates the liquidity risk via 12 month forward cash planning.

30.3 Maturity of Financial Liabilities

	31 Mar 2015 £000	31 Mar 2014 £000
In one year or less	2,252	3,887
In more than one year but not more than two years	665	249
In more than two years but not more than five years	2,137	2,055
In more than five years	9,928	10,668
Total	14,982	16,859

30.4 Fair values of financial assets at 31 March 2015

The fair value of the Trust's financial assets were the same as the book value as at 31 March 2015 (and 31 March 2014).

30.5 Fair values of financial liabilities at 31 March 2015

	Parent		Group	
	Book Value £000	Fair value £000	Book Value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	0	0	0	0
Provisions under contract	2,571	2,571	749	749
PFI Scheme Borrowing	11,962	11,962	11,777	11,777
NHS Charitable funds: non-current financial liabilities	0	0	205	205
Total	14,533	14,533	12,731	12,731

Note 31.1 On-Statement of Financial Position pension schemes

The Trust has no on Statement of Financial Position Pension Scheme transactions.

31.2 Off-Statement of Financial Position pension schemes.

NHS Pension Scheme

See Note 1.3 for details of the accounting treatment of the NHS Pension Scheme.

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:"

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015. The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained: The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

National Employment Savings Trust (NEST)

The Trust offers employees an alternative pension scheme, NEST. This is a defined contribution, off statement of financial position scheme and the number of employees opting in and the value of contributions have been negligible (£5k employers contribution costs in year.)

32 Losses and Special Payments

	2014/15 Total number of cases Number	2014/15 Total value of cases £000's	2013/14 Total number of cases Number	2013/14 Total value of case £000's
Losses:				
1.a. Losses of cash due to theft, fraud etc.	3	1	2	1
1. c. other causes	9	1	0	0
2. Fruitless payments and constructive losses	1	73	0	0
3.a. Bad debts and claims abandoned in relation to private patients	7	1	0	0
3.b. Bad debts and claims abandoned in relation to overseas visitors	211	537	2	7
3.c. Bad debts and claims abandoned in relation to other	118	73	49	45
Total Losses	349	686	53	53
Special Payments:				
5. Compensation under legal obligation	1	1	0	0
7.a. Ex gratia payments in respect of loss of personal effects	17	8	21	6
7.b. Ex gratia payments in respect of clinical negligence with advice	2	0	4	1
7.c. personal injury with advice	2	3	0	0
7.d. Ex gratia payments in respect of other negligence and injury	3	1	3	1
7.g. Ex gratia payments in respect of other	0	0	0	0
Total Special Payments	25	13	28	8
Total Losses And Special Payments	374	699	81	61

33 Discontinued operations

There were no discontinued operations in 2014/15.

34 Corporation Tax

Corporation Tax is not due as the Trust is below the de minimis threshold as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

35 Accounting standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted or amended by the European Union but are not required to be followed until 2015/16, at the earliest. None of them are expected to impact upon the Trust's financial statements.

- IFRS 13 Fair Value Measurement
- IFRS 15 Revenue from contracts with customers
- IFRS 9 Financial Instruments
- IAS 36 (amendment) - recoverable amount disclosures
- IAS 19 (amendment) - employer contributions to defined benefit pension schemes
- IFRIC 21 Levies
- Annual Improvements 2012
- Annual Improvements 2013

36 Other Financial Assets and Other Financial Liabilities

The Trust did not hold any 'Other Financial Assets' nor 'Other Financial Liabilities' during 2013/14 nor 2014/15.

37 Key Areas of Judgement & Estimation Uncertainty

The following have been identified as key areas of judgement and estimation uncertainty:-

- review of operating leases to determine whether the significant risks and rewards of ownership of the leased assets have transferred. To mitigate the risk of incorrect conclusions an external advisor's opinion was obtained.
- allocation of lives to acquired plant and equipment (excluding buildings for which a valuer's opinion is obtained) to calculate the depreciation charge. This is estimated based on the lives of similar assets and knowledge of the procurer.
- income generated from partially completed spells and non contract income. These are estimated assuming that patterns of provision of service are consistent from year to year.
- various accruals and provisions relating to employee expenses are estimated by rigorously applying the NHS employment contracts' terms and conditions.

38 Segmented Operations

The Trust operates in one segment, that of the provision of healthcare.

What is a Quality Account?

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

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

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

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

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

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

About our Quality Account

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

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

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

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

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

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

The seventh section contains comments from our external stakeholders.

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

About Our Trust

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

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

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

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

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

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

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

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

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

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



1. A Statement on Quality from the Chief Executive

Part 1

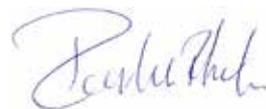
Each year, improving clinical outcome, patient safety and patient experience underpins everything that is done in L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

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

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

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

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



Pauline Philip
Chief Executive
27th May 2015

Corporate Objectives 2015/16

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

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

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in HSMR in all diagnostic categories

2. Improve Patient Safety

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

3. Improve Patient Experience

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

4. Deliver National Quality & Performance Targets

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

5. Implement our New Strategic Plan

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

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

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

7. Optimise our Financial Plan

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

2. Report on Priorities for Improvement in 2014/15

Part 2

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

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

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

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

Why was this a priority?

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

What did we do?

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

How did we perform?

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

Key Clinical Outcome Priority 2

Implement a new model of integrated care for older people

Why was this a priority?

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

What did we do?

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

How did we perform?

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

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

Key Patient Safety Priority 2

Roll out the Perfect Day across the hospital

Why was this a priority?

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

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

What did we do?

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

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

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

How did we perform?

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

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

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

Key Patient Safety Priority 3

Ongoing development of Safety Thermometer, improving performance year on year

Why was this a priority?

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

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

What did we do?

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

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

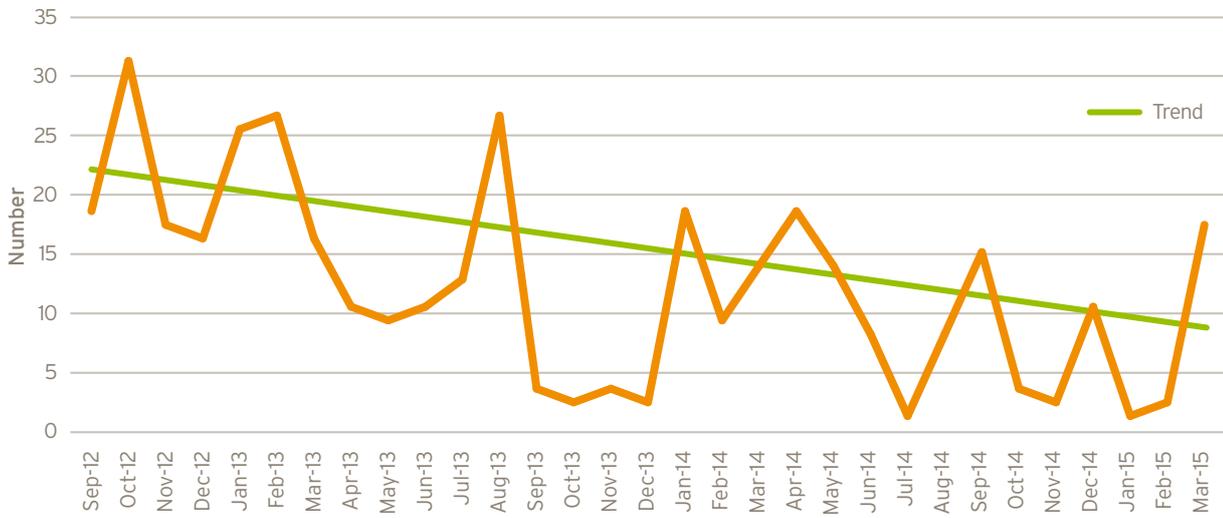
Collaborative working continues between the Falls, Dementia and Continence Nurse specialists to support ward staff in recognising and reducing risk in this particularly vulnerable group of patients.

- **Catheter related Urinary Tract Infections.** Throughout the year we have strived to reduce the use of urinary catheters across the Trust. This focused effort has resulted in An overall reduction in catheter usage of 4.24%. Our work has been assisted by the continued development of the Enhanced Recovery Programme although the number of catheters used varies according to the complexity of the surgical procedures. In partnership with the Countywide Harm Free Care group we have also co authored a 'Urinary Catheter Passport' for healthcare professionals to use aiming to improve the patient's catheter management across the health sector.
- **VTE.** Hospital acquired Venous Thromboembolism (VTE) remains an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. VTE manifests as either deep vein thrombosis (DVT) or pulmonary embolism (PE), and can be difficult to diagnose. All relevant patients have been risk assessed, prescribed and administered appropriate preventative treatment. A root cause analysis (RCA) has been undertaken on all hospital associated thrombosis. Engaging clinicians in the root cause analysis process has supported shared learning across the organisation.
- The Trust has actively participated in a Countywide 'Harm Free Care' and 'Pressure Ulcer' groups which aim to share learning to enable a further reduction in patient harms.

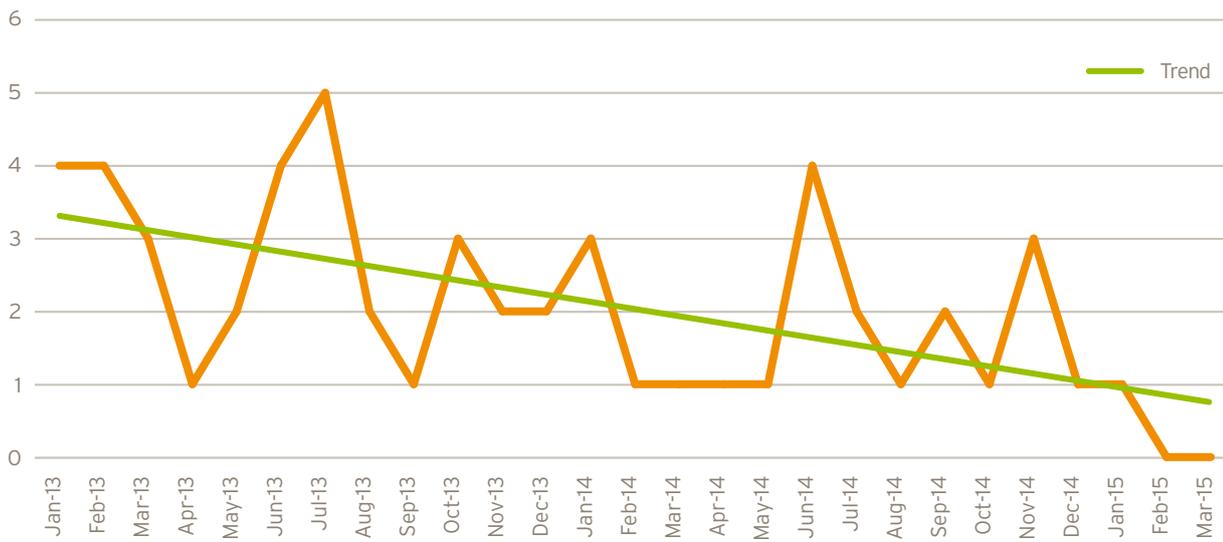
How did we perform?

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

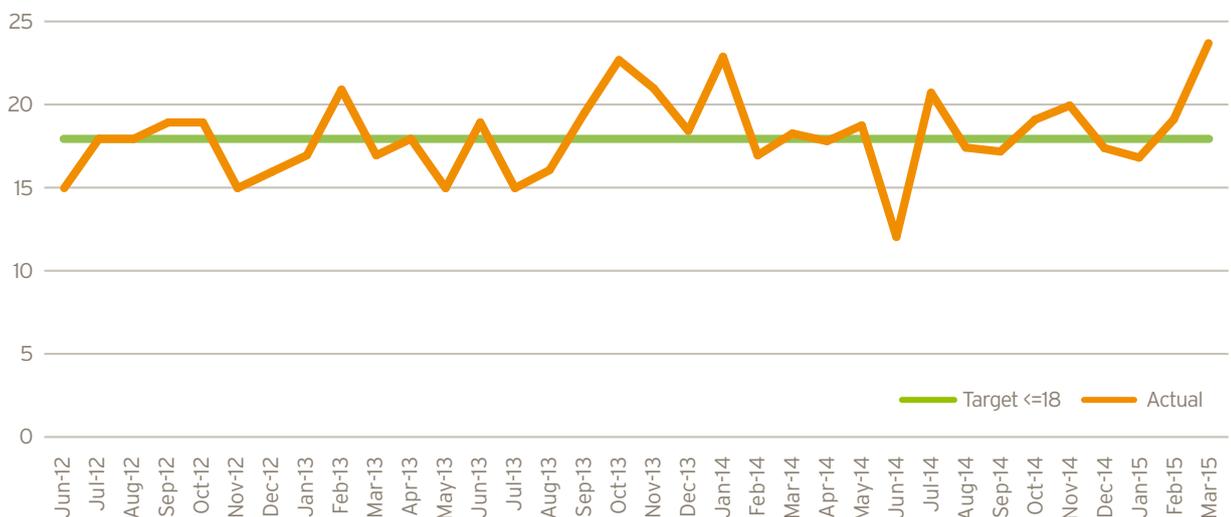
Incidence of Hospital Acquired Grade 2,3 and 4 Pressure Ulcers



Falls prevalence - number of falls with harm



Use of Urinary Catheter



Key Patient Safety Priority 4

Improve the management of the deteriorating patient

Why was this a priority?

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

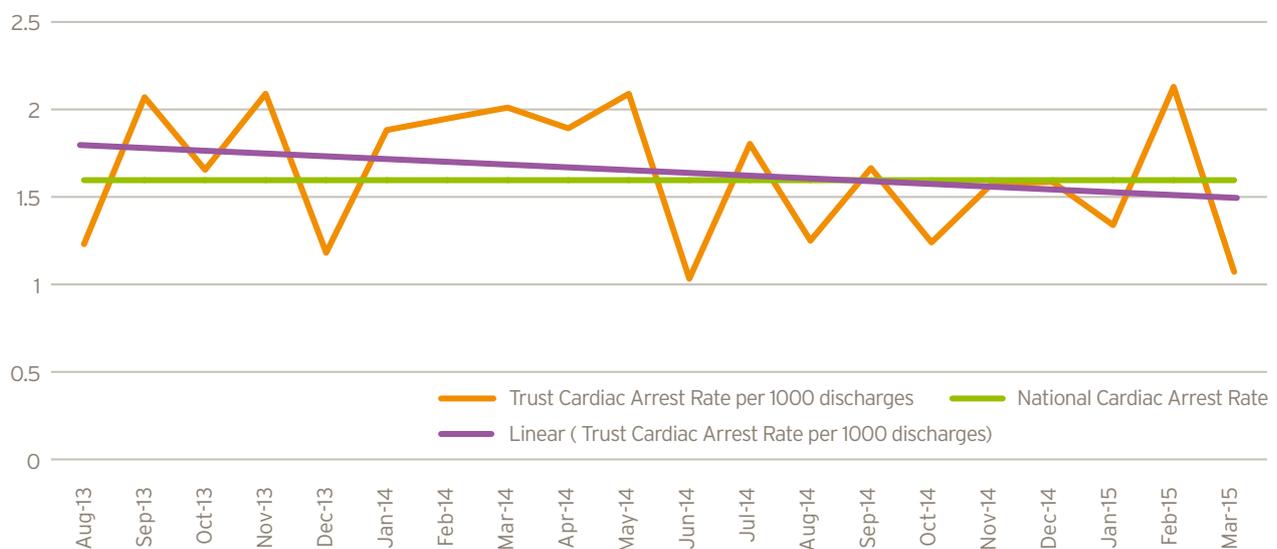
What did we do?

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

How did we perform?

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

Cardiac Arrest Rate



Key Patient Safety Priority 5

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

Why was this a priority?

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

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

What did we do?

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

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

How did we perform?

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

Priority 3: Patient Experience

Key Patient Experience Priority 1

Revolutionise the outpatient experience for our patients

Why was this a priority?

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

What did we do?

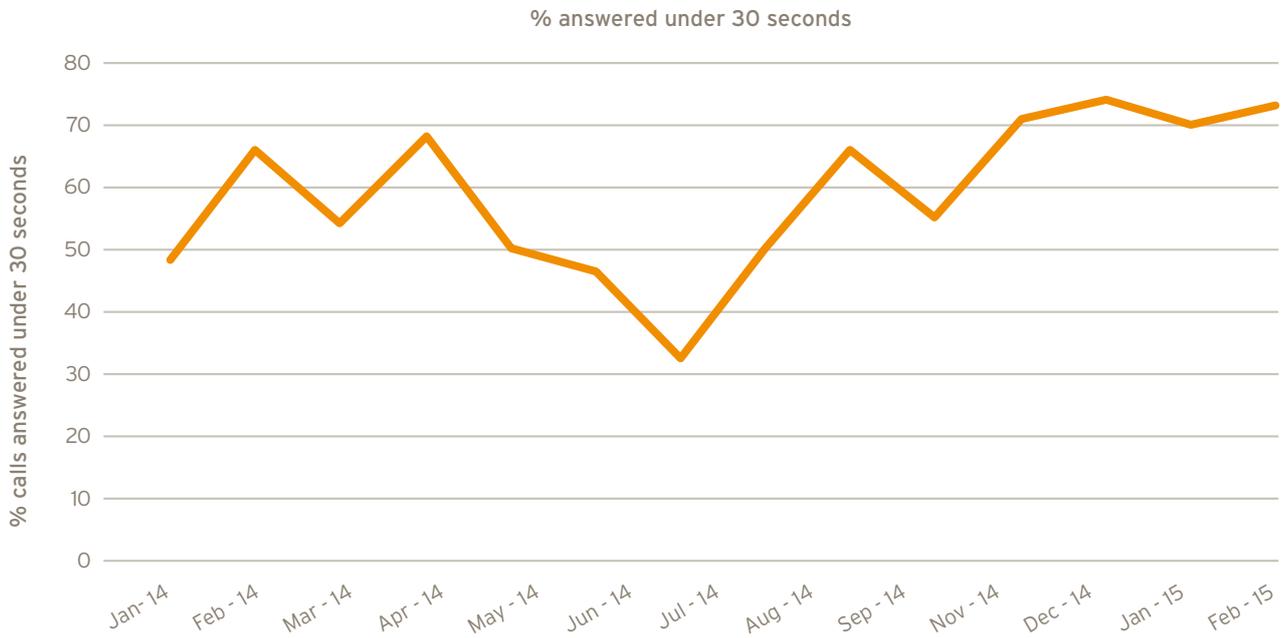
- We commenced the tender to procure remote check-in
- We implemented Bookwise, a room scheduling system to improve access and utilisation of outpatient clinic rooms across the Trust

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

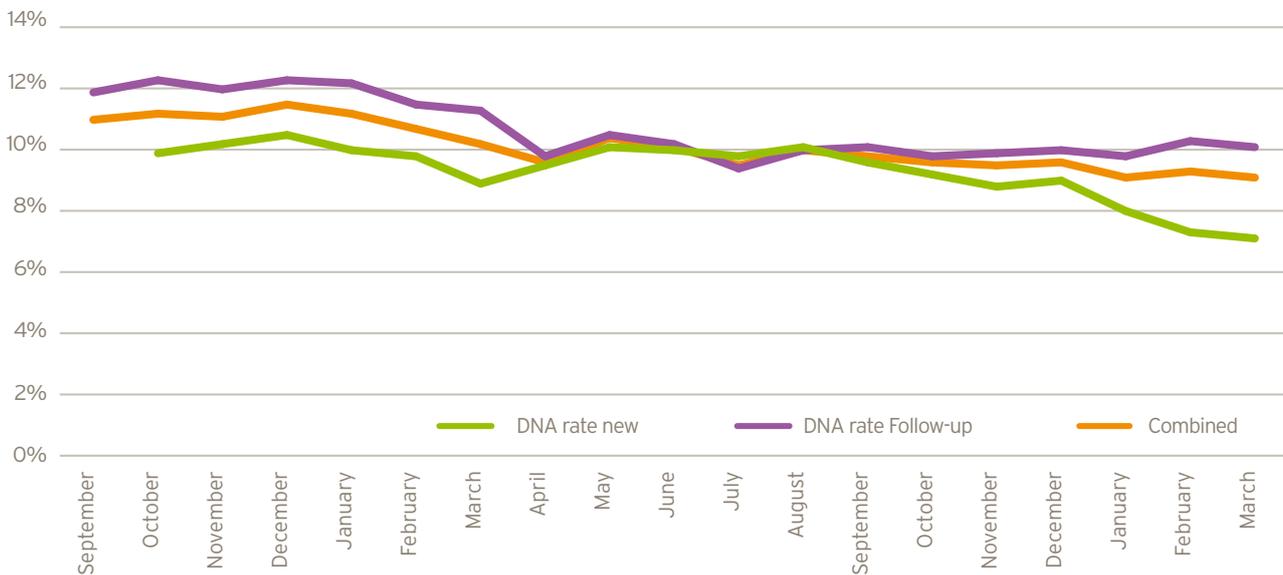
How did we perform?

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

Outpatient Department Call centre performance:



Outpatient DNA rates:



Outpatients Friends and Family score 2014/15 -

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

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

Key Patient Experience Priority 2

Decrease diagnostic wait times

Why was this a priority?

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

What did we do?

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

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

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

How did we perform?

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

Key Patient Experience Priority 3

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

Why was this a priority?

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

What did we do?

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

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

How did we perform?

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

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

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

3. Priorities for Improvement in 2015/16

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

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

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

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

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

Why is this a priority?

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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

Key Clinical Outcome Priority 2

Implement a new model of integrated care for older people

Why is this a priority?

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

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

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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

Key Clinical Outcome Priority 3

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

Why is this a priority?

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

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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

Priority 2: Patient Safety

Key Patient Safety Priority 1

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

Why is this a priority?

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

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

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

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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

Key Patient Safety Priority 2

Ongoing development of Safety Thermometer, improving performance year on year

Why is this a priority?

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

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

What will we do?

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

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

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

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

How will improvement be measured and reported?

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

Success Criteria:

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

Key Patient Safety Priority 3

Improve the management of the deteriorating patient

Why is this a priority?

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria:

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

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

Key Patient Safety Priority 4

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

Why is this a priority?

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

What will we do?

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

How will improvement be measured and reported?

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

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

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

Priority 3: Patient Experience

Key Patient Experience Priority 1

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

Why is this a priority?

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

What will we do?

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

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

How will improvement be measured and reported?

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

Success Criteria

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

Key Patient Experience Priority 2

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

Why is this a priority?

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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

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

Key Patient Experience Priority 3

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

Why is this a priority?

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

What will we do?

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

How will improvement be measured and reported?

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

Success Criteria

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



4. Statements related to the Quality of Services Provided

4.1 Review of Services

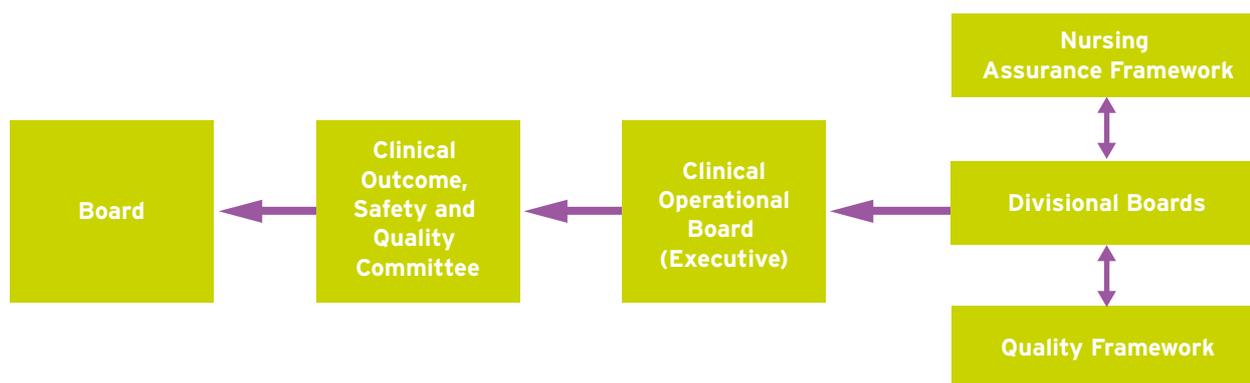
During 2014/15 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes.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

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

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

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

Quality Assurance Monitoring



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

4.2 Participation in Clinical Audits and National Confidential Enquiries

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

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

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

Details are provided within the table 1 below.

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

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

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

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

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

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

Local Clinical Audits

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

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

4.3 National Confidential Enquiries

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

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

** This study is still open and returns being made

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

4.4 Participation in Clinical Research

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

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

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

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

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

Goals and Indicators

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

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

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

4.6 Care Quality Commission Registration

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

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

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

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

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

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

CQC Assessments

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

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

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

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

Intelligent Monitoring

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

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

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

Non-Executive Assessments (3x3)

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

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

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

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

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

NHS Code and General Medical Practice Code Validity

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

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

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

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

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

Clinical coding error rate

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

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

Information Governance toolkit attainment levels

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

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

5. A Review of Quality Performance

Part 3

5.1 Progress 2014/15

A review of clinical indicators of quality

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

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

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

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

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

* Denotes calendar year

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

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

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

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

5.2 Major quality improvement achievements within 2014/15

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

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

Mortality Board

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

Complaints Board

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

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

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

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

Transforming Quality Initiative

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

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

Patient Safety - Raising Concerns

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

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

Patient Safety Rules

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

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

Responding to the Cavendish Report

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

5.3 Friends and Family Test

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

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

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

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

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

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

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

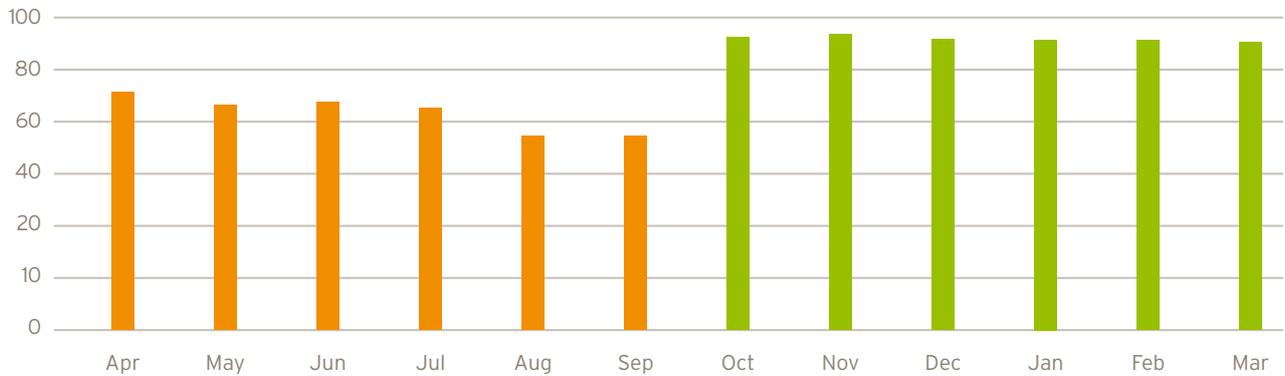
In March 2015 the Trust achieved a response rate of 44.6% for inpatients, 17.1 % for A&E and 33.6% for Maternity. In response to the lower response rates in A&E, the Trust implemented a number of actions to improve:

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

Table 1 Inpatients

Inpatient FFT Scores 2014/15

From April to September show NPS Score. From October to March shows % Recommend

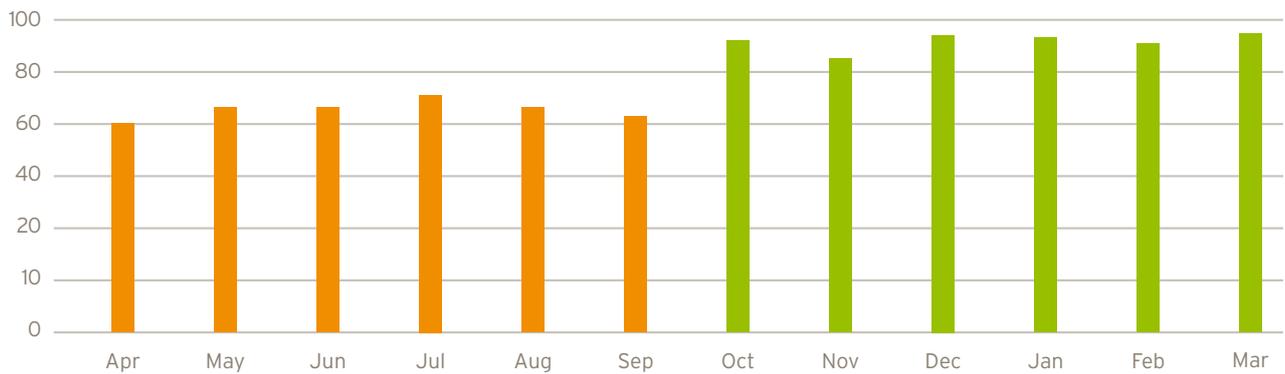


* Tables 1 shows the monthly headline score, reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

Table 2 Accident and Emergency

A/E FFT Scores 2014/2015

From April to September shows NPS Score. From October to March shows % Recommend.

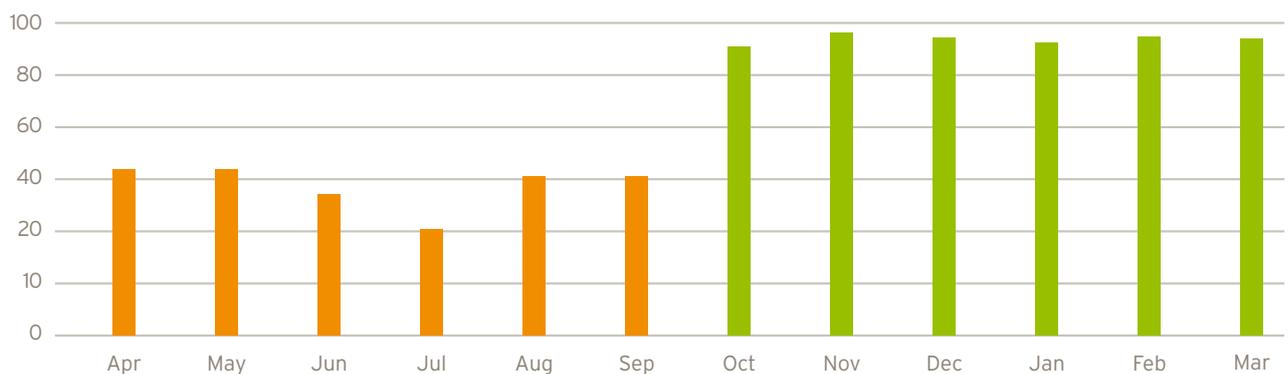


* Tables 2 shows the monthly headline score, reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

Table 3 Maternity

Maternity FFT Scores 2014/15

From April to September shows NPS Score. From October to March shows % Recommend.



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

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

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

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

National Inpatient Survey 2014

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

Results of the national in-patient survey 2014

Results of the national in-patient survey 2014

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

Note all scores out of 10

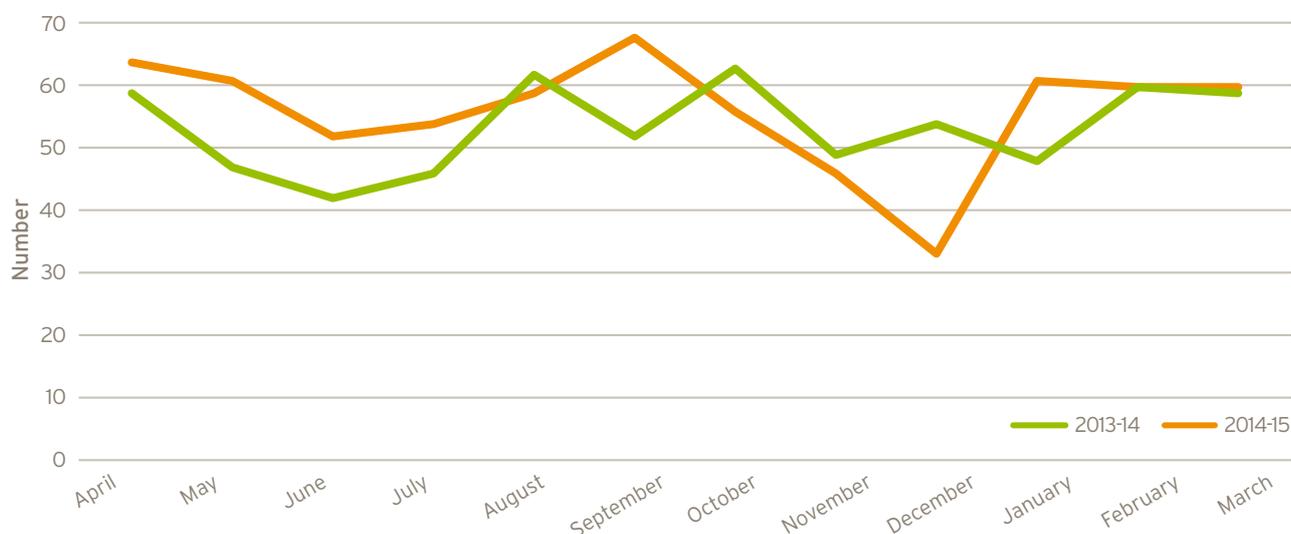
Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.

5.5 Complaints

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

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

Complaints per Month



Listening to Patient Concerns

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

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

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

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

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

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

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

Compliments

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

Below are some extracts from compliment letters received recently:

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

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

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

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

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

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

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



5.6 Performance against Key National Priorities 2014/15

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

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

5.7 Performance against Core Indicators 2014/15

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

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

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

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

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

Indicator: Readmission rates

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

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

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

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

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

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

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

Indicator: Patient Reported Outcome Measures (PROMs) scores

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

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

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

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

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

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

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

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

** Score not available due to low returns

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

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

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

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

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

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

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

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

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

Indicator: Staff recommendation

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

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

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

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

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

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

Indicator: Risk assessment for venous thromboembolism (VTE)

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

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

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

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

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

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

Indicator: Clostridium difficile infection rate

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

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

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

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

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

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

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

Indicator: Patient safety incident rate

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

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

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

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

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

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

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

*Data not available on Health and Social Care Information Centre

5.9 Embedding Quality - Workforce factors

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

Recruitment and Resourcing

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

Nurse Recruitment

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

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

Health Care Assistants (HCAs)

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

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

Medical Agency Locums

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

Medical Productivity

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

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

Medical Education

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

Undergraduate

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

Postgraduate

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

Medicine

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

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

Obstetrics & Gynaecology

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

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

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

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

Sickness Absence Project

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

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

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

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

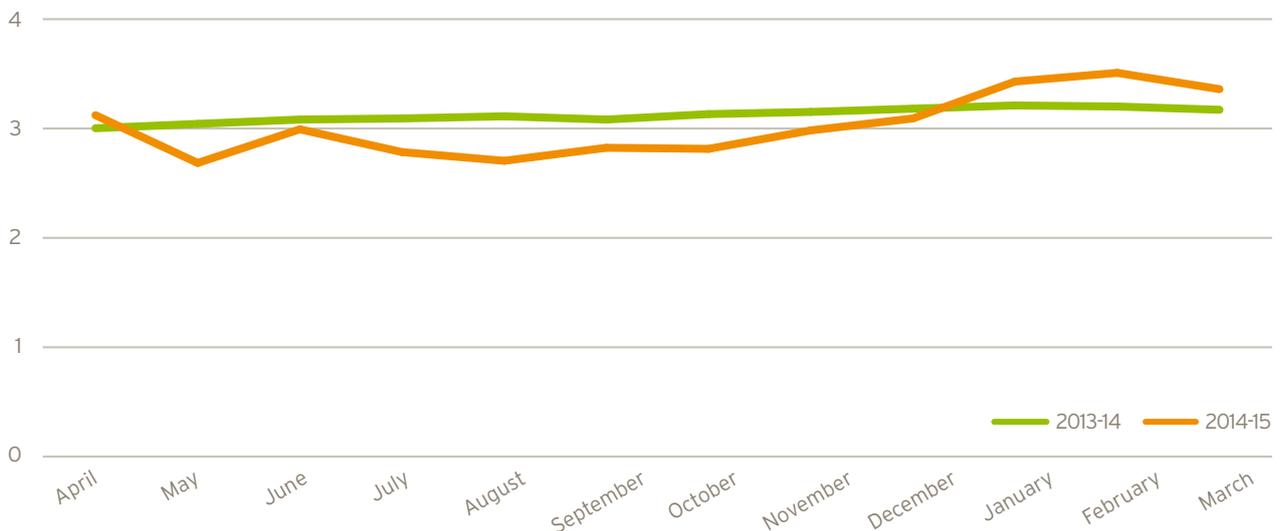
to sickness absence rates.

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

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



Percentage Sickness Absence Rates 2013/14 and 2014/15



eRostering

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

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

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

Publishing of nursing and midwifery staffing data

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

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

Employee Relations and Staff Engagement

Staff Engagement and Consultation

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

Staff Involvement Group

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

Joint Staff Management Council (JSMC)

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

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

Staff Recognition

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

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

Communication

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

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

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

Staff Involvement Group Newsletter

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

5.10 Improving the Quality of our Environment

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

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

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

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

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

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

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

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

5.11 Quality and Business Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By order of the board

27th May 2015



Chairman

27th May 2015



Chief Executive

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

7. Comments from stakeholders

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

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

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

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

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

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

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

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

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

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

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

Healthwatch Luton



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

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

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

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

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

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

2014/15 Priorities

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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



Carol Hill
Chief Officer
Luton Clinical Commissioning Group

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

Comments from Overview and Scrutiny Committees

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

Comments received from the Trust Stakeholders

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

8. Independent Auditor's Assurance Report

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

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

Scope and subject matter

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

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

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

Respective responsibilities of the directors and auditors

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

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

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

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

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

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

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

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

Assurance work performed

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

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

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

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

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

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

Conclusion

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

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

KPMG LLP

KPMG LLP
Chartered Accountants
London
28 May 2015

9. Glossary of Terms

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

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

Research - Glossary of terms

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

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

Appendix A - Local Clinical Audits

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

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

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

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

Key recommendations:

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

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

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

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

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

Key recommendations:

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

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

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

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

Key recommendations:

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

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

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

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

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

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

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

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

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

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

Key recommendations:

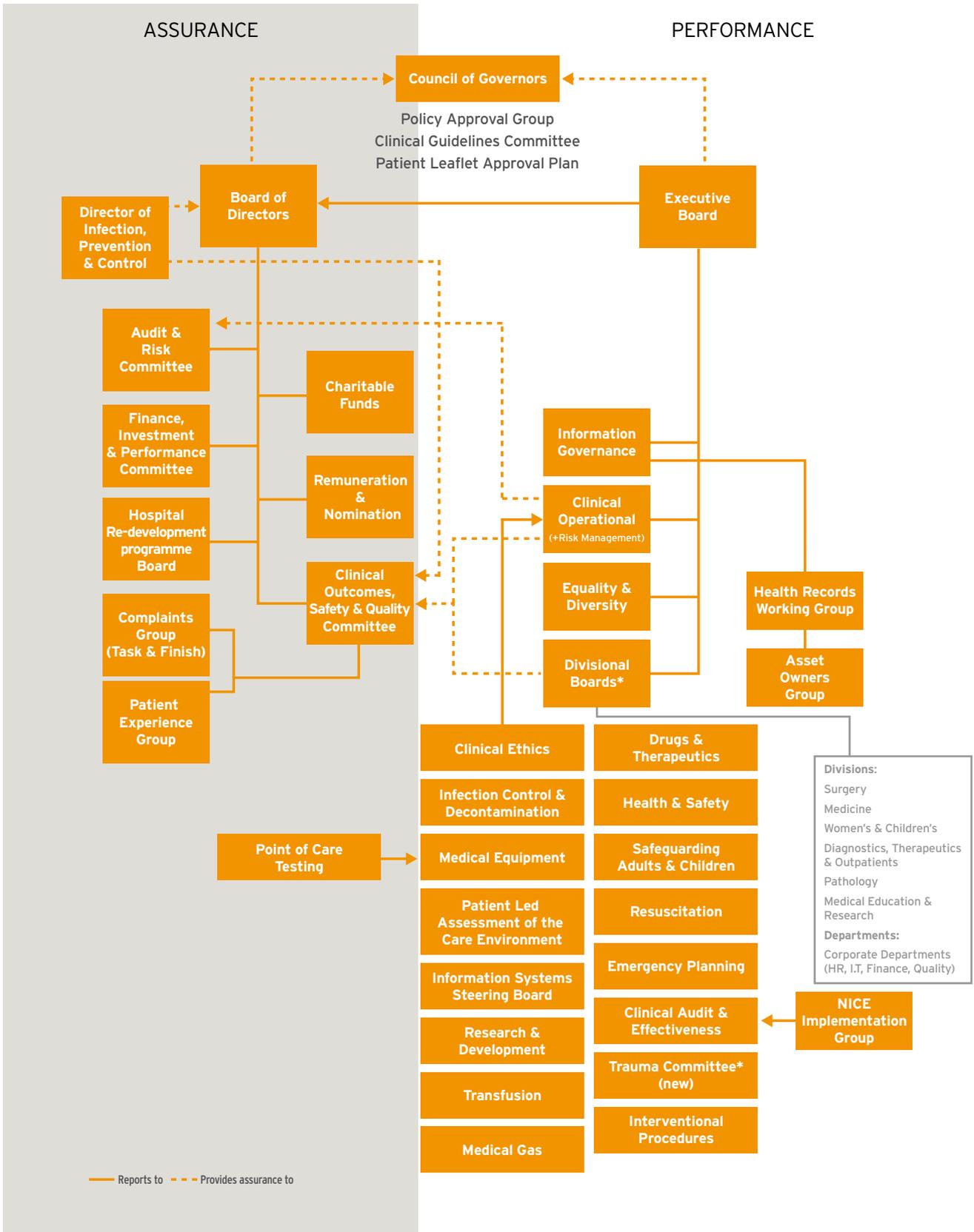
- Roll out EOL education to nurses within Critical Care, DME and Medicine division
- Implement the Individualised Plan of Care documentation and nursing care plan
- Run documentation review in Q3 and Q4 as part of the EOL CQUIN

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

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

Appendix B - Trust Committee Structure

Luton and Dunstable Hospital Governance and committee structure



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



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