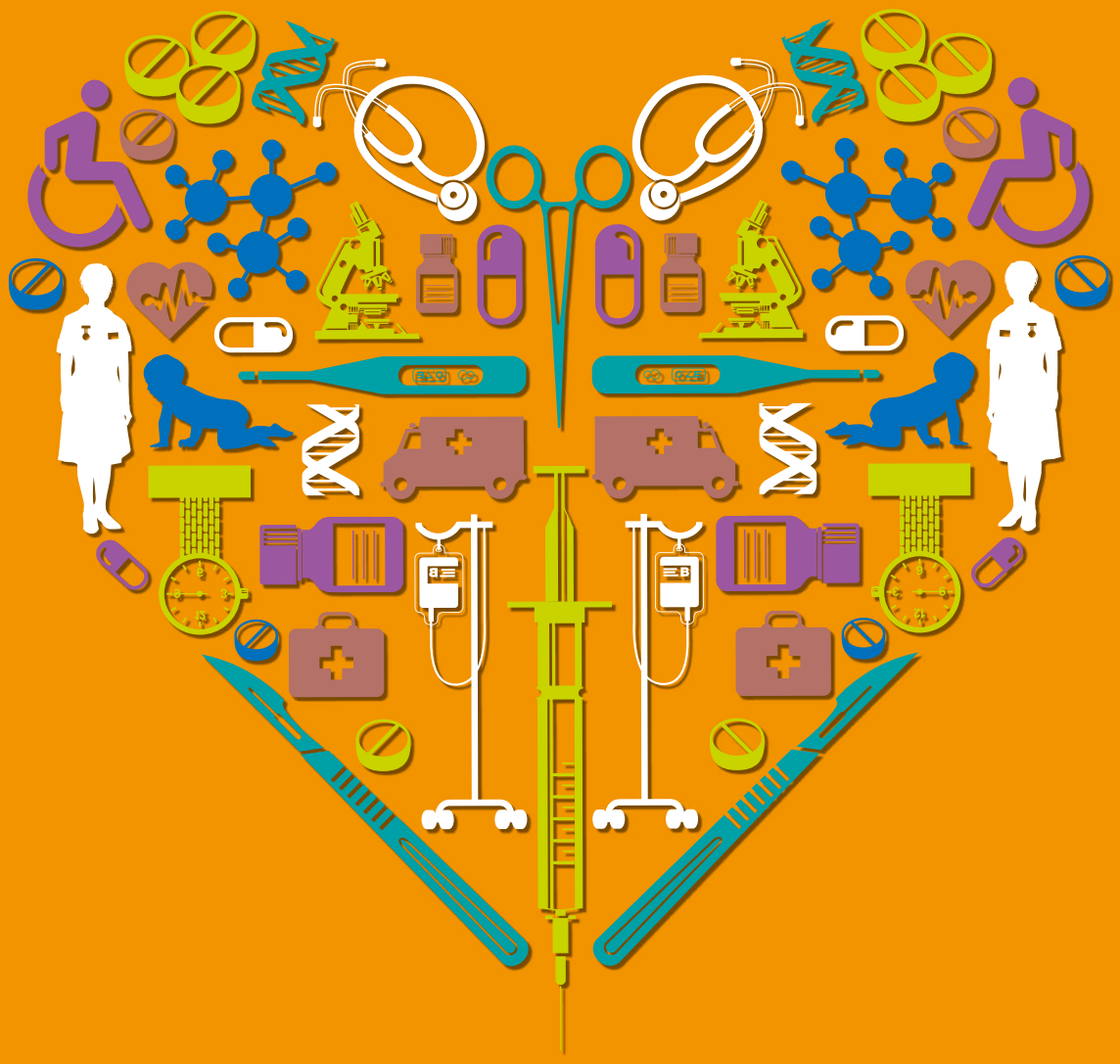
LUTON & DUNSTABLE UNIVERSITY HOSPITAL



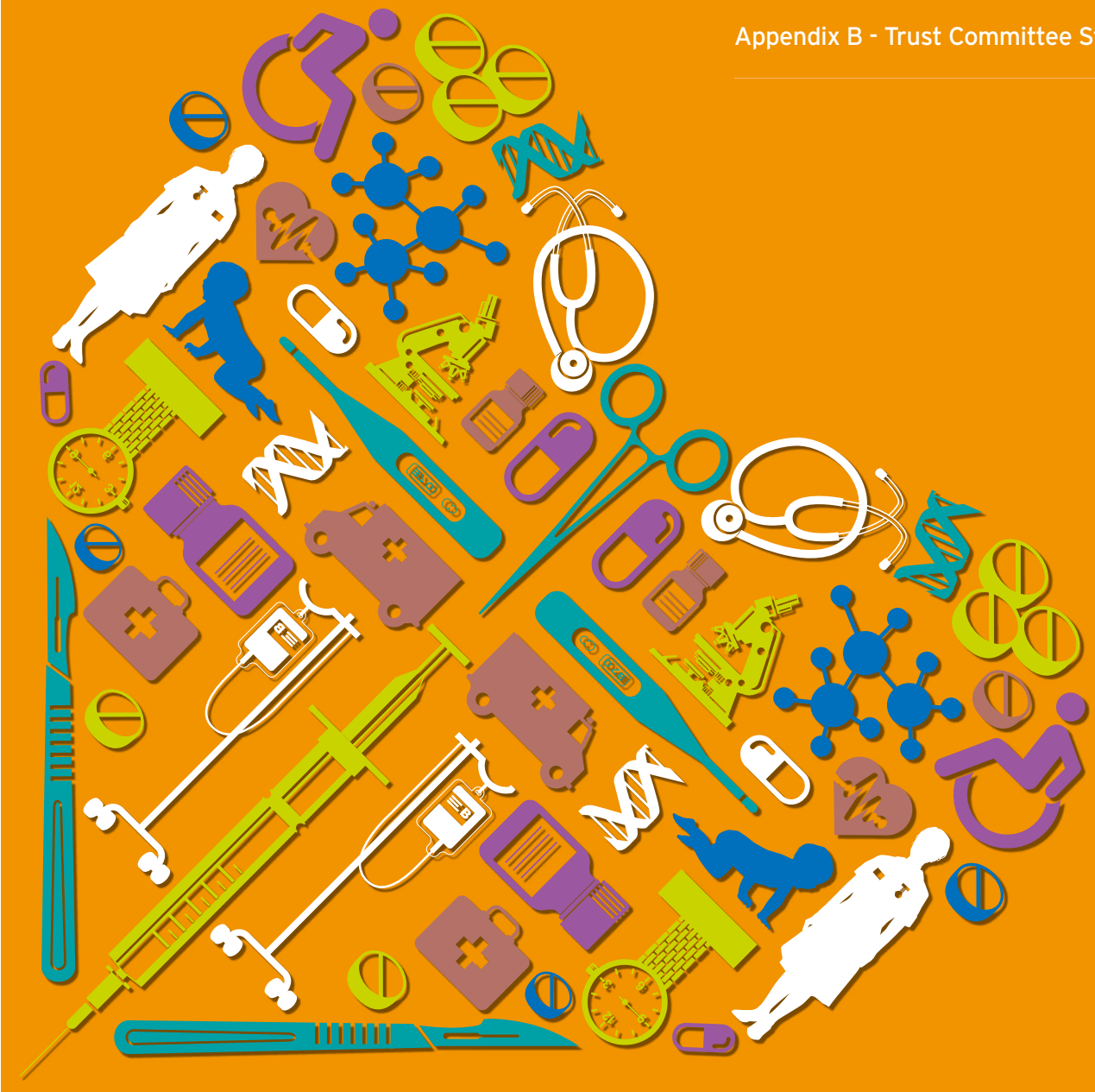
# Quality Accounts /Report

for the period April 2012 to March 2013

Luton and Dunstable Hospital
NHS Foundation Trust

# Appendix 1 Quality Account/Report





# 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 2012/13 is included in this account alongside our priorities for quality improvement in 2013/14. This report summarises how we did against the quality priorities and goals that we set in 2012/13. It also tells you those we have agreed for 2013/14 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 2013/14.

The second section looks at our performance in 2012/13 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 2013/14 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.

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

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

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

The seventh section contains comments from our external stakeholders.

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

# About Our Trust

The Luton and Dunstable Hospital NHS Foundation Trust is a medium size general hospital with approximately 641 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for the people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 70,000 admitted patients, over 300,000 outpatients and ED attendees and we delivered over 5,100 babies.

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

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

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

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

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

| Division | Specialties | |
|---|---|---|
| Diagnostics, Therapeutics & Outpatients | Pathology Services<br>- Blood Sciences<br>- Cellular Pathology<br>- Microbiology<br>- Phlebotomy<br>Haematology Care<br>Pharmacy<br>Physiotherapy and Occupational Therapy | Imaging<br>Musculoskeletal Services<br>Dietetics<br>Speech and Language Therapy<br>Clinical Psychology<br>Outpatients<br>Breast Screening |

During 2012/13 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.

# 1. A Statement on Quality from the Chief Executive

Improving clinical outcome, patient safety and patient experience is at the heart of the Vision and Aims we agreed in 2010/2011 for the Luton and Dunstable Hospital NHS Foundation Trust. In order to embed this vision into clinical practice and service delivery, clinical outcome, patient safety and patient experience continue to be key corporate objectives for 2013/2014. This Quality Account details how we will deliver and monitor our progress.

## Our Vision and Aims

### Vision Statement

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

### Aims

- To put patients first, providing the best possible clinical outcome and the highest quality to the patient experience.
- In partnership with Cambridge University, University College London and others, to be nationally respected for the provision of education and development.
- To ensure value for money and using the freedoms of Foundation Trust status, to exploit our strengths and specialisms for the benefit of patient care and clinical outcomes.
- To ensure effective governance, accountability and leadership while maintaining staff engagement and involvement.
- To ensure a full appreciation throughout the organisation of the changing environment of commissioning, competition, risk, regulation, patient choice, sustainability, QIPP and our financial position.
- To develop and maintain productive relationships with external partners and maximise opportunities for communication and joint working.
- To retain and recruit the best staff.
- To market and promote effectively the services of the Trust.

### Values

- To put the patient first, working to ensure they receive 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.

In the coming year, we will build on the work that we did during 2012/13 enabling us to further improve clinical outcome, patient safety and patient experience:

- Throughout the year we consistently delivered against all national quality and performance targets.
- Following a comprehensive Care Quality Commission (CQC) Review of Compliance undertaken over two days during 2012, it was confirmed that we are now meeting all CQC Essential Standards of Quality and Safety.
- In September we opened a Patient Experience Call Centre facilitating our ambition to gain timely feedback from patients on their care and experience.
- We continue to work as part of the University College London Partners exploring new and better ways of improving clinical outcome.
- By delivering a number of strategic and service developments, we were able to enhance the care that we provide for all our patients.

Our greatest focus in the coming year will be in tackling the quality challenges that we have yet to progress. Our key corporate objectives for the year relate to clinical outcome, patient safety and patient experience. All of our corporate objectives are detailed below. Top of our agenda during 2013/14 will be our commitment to ensuring that we have the appropriate level of clinical expertise available in a timely manner, to deliver safe and effective care 24/7.

Our Division of Medicine will continue to lead our work in improving our average length of stay, ensuring in particular, that older people remain in hospital only when it is clinically appropriate.

Last year, whilst we had a major focus on improving hospital mortality, we were disappointed that we were not able to make greater improvements with regards to fractured neck of femur. Our Division of Surgery will therefore continue to drive this work with support from across the organisation.

In recent years, our Women's and Children's Division has led the organisations work towards 24/7 Consultant Care. This year, as well as further developing their own specialist services, they will share with clinicians across the organisation their experiences in implementing new medical models.

As we learn from the Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) we plan to revolutionise how we learn from our complaints and find new ways of improving how our clinical staff communicate with our patients.

Finally, I have made a personal commitment to work with our patients, their families and stakeholders across Luton to re-design 'end of life' pathways/care in order that we can ensure that every patient receives high quality co-ordinated care at the end of their life.

To the best of my knowledge, the information in this report is accurate.

Pauline Philip
Chief Executive
22nd May 2013

## Corporate Objectives 2013/14

### Objective 1:
### Deliver Excellent Clinical Outcomes

- Improve performance by reducing average length of stay for older people
- Improve performance on overall hospital mortality across fractured neck of femur and all specialties
- Reduce avoidable emergency re-admissions
- Fully participate in national and local clinical audits

### Objective 2:
### Improve Patient Safety

- Ensure that we have the appropriate level of clinical expertise available to deliver safe and effective care 24/7
- Ongoing development of Safety Thermometer, exceeding performance year on year
- Continue to reduce HCAI rates year on year
- Increase compliance with hand hygiene year on year
- Extend electronic nursing observations to include fluid management, weight and device management

### Objective 3:
### Improve Patient Experience

- Revolutionise how we handle complaints
- Continue to implement the Outpatient Transformational programme
- Improve patient experience by establishing a framework to take forward the key messages from the listening events and the recommendations from the Francis report
- Improve the quality of professional communication with all patients and carers.
- Work with patients, their families and stakeholders in Luton to redesign end of life care
- Establish an off site facility for ophthalmology, plastics and dermatology
- Deliver additional clinical and diagnostic services during evenings and weekends
- Improve communication by rolling out the 'Perfect Day'
- Formally explore alternative ways to deliver non-clinical support services in order to improve quality and contain cost.

### Objective 4:
### Deliver National Quality & Performance Targets

- Deliver sustained compliance of all CQC outcome measures
- Deliver nationally mandated waiting times for 18 Weeks, Cancer and A&E including A&E Indicators
- Sustainability culture established across the organisation
- Achieve 40% of the Trust's Carbon Management Plan Target
- Deliver CQUIN targets year on year

### Objective 5:
### Progress Clinical & Strategic Developments

- Clinical Strategy agreed and implemented
- Agree detailed business cases for phases as laid out in Masterplan
- Deliver masterplan enabling schemes and early phases
- Care can safely and efficiently take place, without need to request a paper record
- To improve the ability of decision makers at all levels of the organisation to use information in order to improve service delivery, design, quality, efficiency and safety
- To increase levels of safety, efficiency, and flexibility delivered by transformational technology
- Work jointly with LA, CCGs and other key stakeholders

### Objective 6:
### Develop all Staff to Maximise Their Potential

- Extend education and training performance management to all staff groups through the Divisional structure to go beyond regulator and training commissioner requirements to measurably enhance patient experience and safety globally through a radical development programme
- Develop and deliver joint accredited academic programmes with our partner Universities
- Continue to increase the number of staff appraisals to 80%
- Increase mandatory training compliance
- Maintain clinical leadership development
- Establish a culture where all staff feel able to sign up to our values and have knowledge of the Trusts Quality Priorities and staff fully aware of the Trust's vision, values and objectives

### Objective 7:
### Optimise our Financial position

- Deliver our Financial Plan 2013/14
- Finalise forward capital investment plans and agreed balance between borrowing and cash financing
- Develop service line management as the key tool to drive financial efficiency and increase clinical engagement
- Increase productivity – Improved Theatre Productivity, improved outpatient productivity and establish ambulatory care model to reduce avoidable admissions and costs.

# 2. Report on Priorities for Improvement in 2012/13

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.

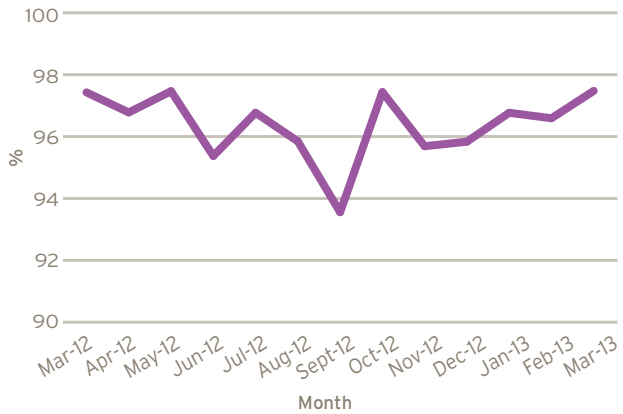
## Priority 1: Patient Safety

### Delivering the Safety Thermometer programme

During 2011/12 the Trust were a pilot site for Safety Express, and in 2012/13 the Harm Free Care programme was rolled out using the Safety Thermometer to all wards. Monthly information is collected about the proportion of patients treated who receive health care without experiencing any of the 4 harms (pressure ulcers, falls, Urinary Tract Infections associated with urinary catheters (CA-UTI) and venous thromboembolisms (VTE). The measurement includes harm that may have occurred prior to admission to the hospital.

The graph indicates the percentage of harm free care within 2012/13. This data demonstrates a high level of harm free care that occurred whilst an in-patient and does not include harms that occurred prior to admission to hospital.

**% Harm Free Care in Hospital**




Our safety thermometer targeted four key areas:

1) **Continue with the implementation of care bundles to support the elimination of all avoidable hospital acquired grade 2, 3 and 4 pressure ulcers by the end of 2012.**

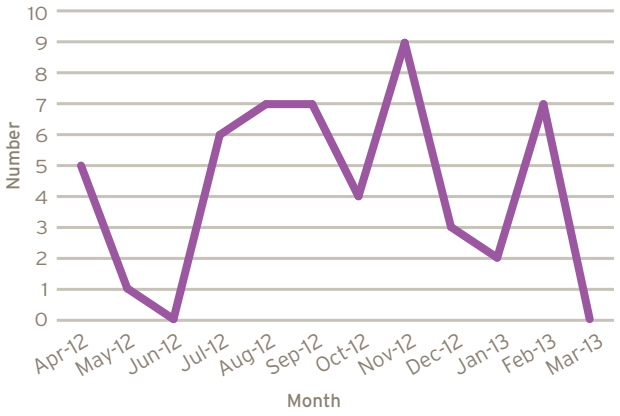
### What did we do?

- Nurses continue to undertake essential care rounding in all wards delivering a number of interventions but with a particular focus on pressure care.
- The Trust participated in the regional Pressure Ulcer Collaborative within NHS Midlands and East and have implemented the SSKIN Bundle within the hospital. Wards 17 and 23 were pilot wards for the Collaborative within the hospital and this involved implementing a number of initiatives to raise awareness of tissue damage and intervention that were put in place to help avoid tissue damage. The roll out to all clinical areas will commence in May 2013.
- Mandatory training on pressure damage prevention continued.
- The root cause analysis tool used to investigate all pressure ulcers to improve the opportunity for learning and preventing future incidents was enhanced.
- Meetings are held with the ward teams and the Chief Nurse to review the RCA and scrutinise care to determine if pressure ulcers that develop are avoidable or unavoidable.
- Performance data has been made more accessible and relevant to clinical areas and matrons.
- Intensive support to areas with a higher incidence to support quality improvements has been implemented. This has resulted in an improved performance.

### How did we perform?

- The number of avoidable grade 3 and 4 pressures ulcers that developed within 2012/13 was 51. It is not possible to compare this with 2011/12 as the criteria to determine whether a pressure ulcer was avoidable or unavoidable.

**Number of Avoidable Grade 3 and 4 Pressure Ulcers in 2012/13**




- The majority of wards have been avoidable pressure ulcer free for at least 100 days. This is celebrated and recognition given to areas where this has been achieved.

2) **Implementation of the falls care bundle in all wards leading to an overall reduction in the incidence of falls resulting in moderate or severe harm or death, by at least 25%.**

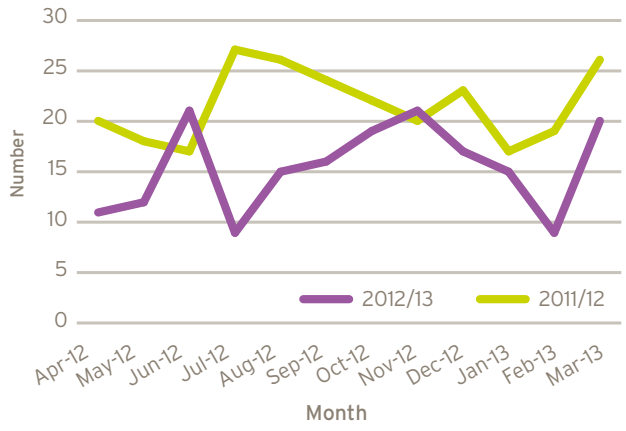
## What did we do?

- A phased implementation of the falls care bundle within the hospital has continued.
- Bed and chair sensors have been introduced to alert staff to patient moving who have been identified as a high risk of falling
- A trial of hip protectors for high risk patients on the Frail Elderly Unit has been undertaken.
- A business case has been agreed to purchase 20 low rise beds for patients that are at high risk of falling.

## How did we perform?

- There has been a 28.6% reduction in falls that have resulted in moderate or severe harm or death as a result of patients falling whilst in hospital.

**Number of falls resulting in moderate or severe harm or death**




3) **Implementation of best practice guidelines for insertion of urinary catheters**

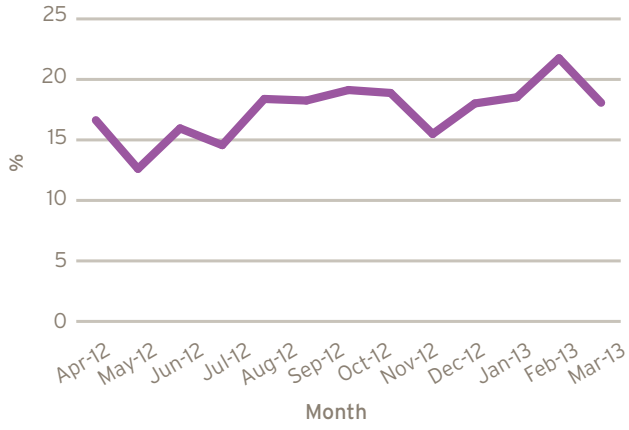
## What did we do?

- The Hospital guideline for urinary catheterisation was updated and approved by the Clinical Guidelines Committee in June 2012.
- There is an extensive training programme within the hospital on urinary catheterisation.
- An audit programme was commenced to monitor compliance with the guideline.
- The Trust has invested in bladder scanners to improve assessment of patients prior to urinary catheterisation in order to avoid unnecessary catheterisation

## How did we perform?

- The Safety Thermometer (ST) data demonstrates the number of patients during the monitoring period each month that had a urinary catheter in place. The national average within Safety Thermometer (during 2012/13) is that 12 – 16% of patients have a urinary catheter in place. The data within the ST for this hospital indicates that the range of prevalence is 12.6% - 20.3% (median 18.1%). This suggests a higher incidence of use of catheters when compared with the national average.
- Local audit has been undertaken and established that only a third of patients had a bladder scan performed prior to urinary catheterisation.
- Half of the patients had had a formal review undertaken of the need for the catheter to remain in place.
- The local audit also determined that 29% of pat.ients with a catheter in place were prescribed antibiotics for a urinary tract infection

**% Patients with a Catheter**




4) **Venous Thromboembolism (VTE) – ensuring 95% compliance with VTE risk assessment and prophylaxis for all patients by the end of 2012.**

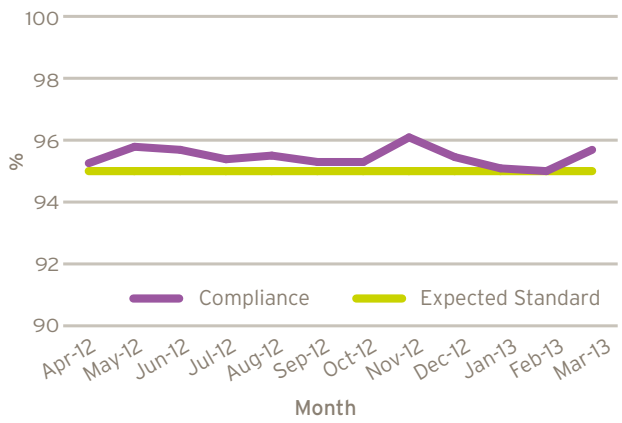
## What did we do?

The focus on the completion of VTE risk assessment has continued to identify patients at risk and enable appropriate treatment to be provided

## How did we perform?

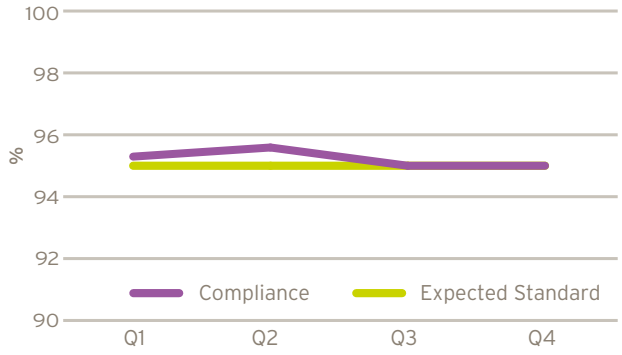
- The compliance with undertaking the VTE risk assessment exceeded the minimum standard of 95% each month in 2012/13.

### VTE Risk Assessment Compliance 2012/13




- Quarterly monitoring was undertaken ensuring that appropriate prophylaxis was given to all patients assessed to be at high risk of developing a VTE and in each quarter the Trust exceeded 95% compliance

### VTE Prophylaxis Compliance 2012/13




## Priority 2: Patient Experience

### To improve patient experience

This priority targeted seven key areas:

1) **To provide additional information to patients with their appointment letter about what to expect during their outpatient appointment.**

### What did we do?

- Information within outpatient correspondence is now included explaining what patients should expect when attending their appointment, including:
  - detailing the checking in process;
  - car parking;
  - tests, checks and examinations that may be performed when attending outpatients;
  - information relating to consent;
  - GP correspondence and follow-up appointments; and
  - questions patients may wish to ask during their appointment with the clinician.

- A new service, currently being established, has been invested in that will enable patients to receive additional specialist information relating to their medical condition or procedure to be undertaken where this is clinically appropriate.

### How did we perform?

- As from Q2 2012/13, all first outpatient appointment invitation letters have included this additional information
- Patients have reported a high level of satisfaction with the verbal information they have been provided about their medications issued to them following their appointment.

| Performance measure | Achieved | Under achieved | Nov 12 | Dec 12 | Jan 13 | Feb 13 | March 13 |
|---|---|---|---|---|---|---|---|
| % of patients given verbal information on medicines (outpatients at L&D dispensary) | | > 75% | 72% | 71% | 63% | 89% | 90% |
| % of patients who know what to expect prior to attending | > 85% | < 75% | 76% | 73% | 71% | 68% | 72% |
| % of staff treating / examining patients who introduced themselves | > 85% | < 75% | 76% | 76% | 79% | 76% | 89% |
| % waiting > 30 minutes | < 15% | ≠ 15% | 29% | 35% | 56% | 33% | 35% |
| % welcomed at reception and privacy | > 85% | < 75% | 86% | 85% | 58% | 86% | 83% |
| % Confidence / trust in the doctor | > 85% | < 75% | 86% | 88% | 71% | 80% | 95% |
| % Confidence / trust in the Nurse | > 85% | < 75% | 85% | 88% | 67% | 81% | 96% |
| % Rating service (good to excellent) | > 85% | < 75% | 90% | 89% | 85% | 97% | 90% |

**2) To offer extended outpatient clinic opening times to include evenings or weekends**

## What did we do?

- Clinicians have been surveyed to obtain their feedback on weekend and evening opening times.
- Work with HR/medical workforce to progress out of hours working in to new consultants' contracts has been undertaken.

## How did we perform?

- Some speciality areas are now providing regular weekend clinics e.g. Transient Ischaemic Attack (TIA) or 'mini stroke' clinics, and others on a Saturday morning
- Evening and weekend clinics are currently being provided on an ad hoc basis in order to support compliance with performance targets

The table below demonstrates the number of additional capacity clinics provided in 12/13. It is acknowledged that only a small proportion of these are provided out of hours (evenings and weekends), however the Trust is also keen to ensure capacity is utilised as efficiently as possible during weekdays when clinicians, staff and supporting services are more readily available.

The Trust is committed to expanding clinic provision alongside expansion of 7 day support services and is currently consulting with Clinical Divisions about what services are needed out of hours to support both inpatient and outpatient activity affordably and sustainably.

| | No. of additional temporary Clinics | Percentage of clinics in session |
|---|---|---|
| Evening | 74 | 9% |
| Weekday AM | 347 | 43% |
| Weekday PM | 342 | 43% |
| Sat AM | 16 | 2% |
| Sat PM | 19 | 2% |

**3) Ensure clinics start on time and improve clinic efficiency**

## What did we do?

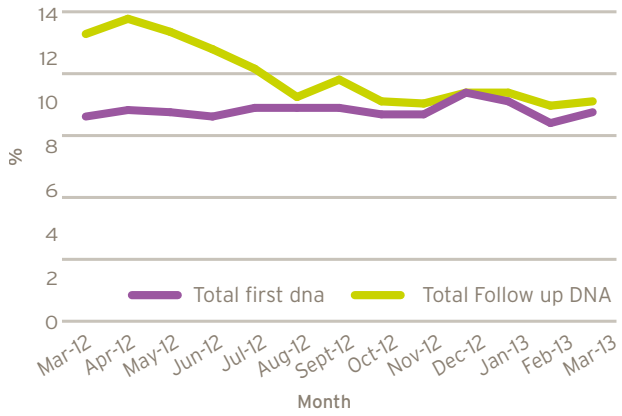
- Between June 2013 and October 2013 outpatient clinics were monitored in order to identify where clinics were starting later than their scheduled start time. This intelligence enabled the identification of bottle-necks and regular late starts.
- A regular cause for delays in start time concerned medical commitments outside outpatients (ward rounds) and conflicting meetings with clinic start times.
- At the same time the process also identified delays outside the control of the OP department such as delays due to traffic, IT system downtime, and unavailability of junior medical staff from clinics.
- The results will feed into work currently underway to review and improve medical productivity by identifying and then freeing up medical staff from competing priorities.
- A clinic capacity calculator was developed as a tool to assist in planning clinic templates and appointment scheduling.
- Key performance metrics were developed to demonstrate performance and drive improved efficiency.
- Close working alongside the Trust's medical

productivity programme is in place to improve outpatient clinic efficiency.
- GP and patient access to all Outpatient clinics via Choose and Book is facilitated.
- Advice and Guidance throughout the Trust to assist GPs in gaining access to specialist advice prior to referral was introduced.
- Clinic start times against a 30 minute standard are being measured and provide management information to improve timeliness of clinic commencement.
- Ensuring patients are better informed and made aware of any delays whilst in clinic.

## How did we perform?

- Appointments not attended (DNA) rates have reduced over the course of the last year and are anticipated to fall further this year with the introduction of interactive appointment communications. This will reduce wasted appointments, enhance clinical productivity and improve patient access.

### Trust overall DNA rate




- The analysis of clinic start times in April 2013 demonstrates 77% of Outpatient clinics started within 15 minutes of the scheduled start time. Data is being provided to Divisions by clinician to facilitate improvement where needed.

**4) Reduce the number of clinics cancelled at short notice**

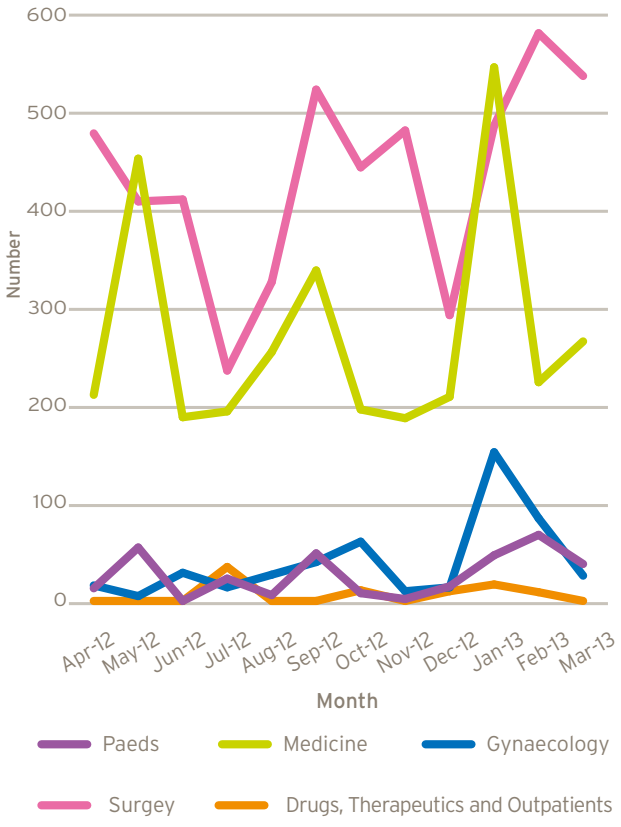
## What did we do?

- Detailed information relating to the number of patients whose appointments have been cancelled by the hospital at short notice is provided to Divisional managers each month. Progress is being made, but needs to be sustained.
- Working in tandem with the medical productivity programme is in place to minimise short notice clinic cancellations to improve patient experience, efficiency and productivity.

## How did we perform?

- Progress is variable on short notice cancellations and close working with the medical productivity programme and Divisional management is needed to drive this down.

### Patients impacted by cancellations at short notice




- Alternative Outpatient booking systems, such as partial booking in pilot service areas will be trialled during the course of 13/14 to help improve the patient experience and reduce hospital initiated cancellations.

- The proportion of rescheduled appointments compared to the total monthly volume of Outpatient appointments is 4%.

**5) Commence a programme of outpatient refurbishment**

### What did we do?

- survey of Outpatient accommodation was undertaken to prioritise a programme of refurbishment.

### How did we perform?

- Zone C outpatient waiting area has been comprehensively refurbished and air conditioning installed to each of the consulting rooms.
- A programme to upgrade the consulting rooms has commenced this year.
- Patient feedback has been very positive, with comments received from patients on how the department is now much lighter, brighter and more

**6) Provide additional training to staff and support improved team working**

### What did we do?

- Outpatient clerical staff were provided with the opportunity to participate in an NVQ programme in customer care.
- Work with nursing and admin staff across Outpatient specialties is being undertaken to develop an Outpatient customer service commitment.

### How did we perform?

- 85% of clerical staff have participated in the NVQ training programme.

**7) Provide support, information and opportunity for patients to take responsibility for their health and management of long term conditions**

### What did we do?

- More community based clinics have been established for patients with long term conditions.
- Alternative support mechanisms are being made available to patients, including telephone clinics.
- A wider range of literature is being made available to patients in pre-appointment correspondence.
- An ambulatory care unit has been established to provide support and treatment to patients with a range of conditions to avoid hospital admission.

### How did we perform?

- The Trust is proactively seeking to provide more outpatient facilities in the community to improve access and provide care and management of long term conditions closer to home.

## Priority 3: Clinical Outcomes

### To improve clinical outcome

Early in 2012/13 an overall improvement plan for improving clinical outcome for patients with fractured neck of femur was developed. The plan included the four key priority areas:

### This priority targeted four key areas:

1) **Establish a dedicated and ring-fenced unit for patients with a fractured neck of femur and other fragility fractures requiring hospitalisation.**

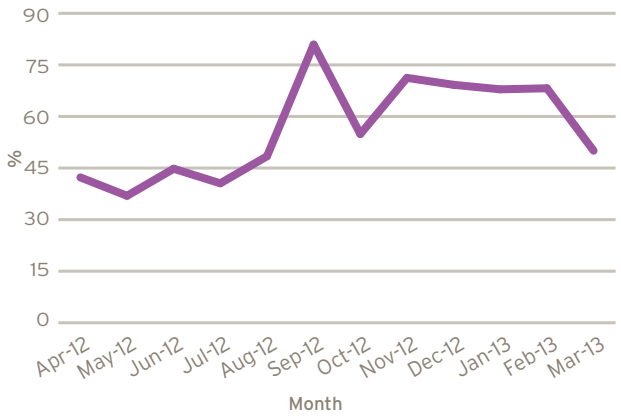
### What did we do?

- A fractured neck of femur ward was established during 2012/13 and endeavours to cohort patients within this ward; this has been increasing through the year despite significant bed pressures during difficult periods.
- A second Consultant Orthogeriatrician was appointed, junior staff allocated to the Orthogeriatric service and a formal re-organisation of Orthogeriatric consultant cover to the fractured neck of femur ward completed. A monthly multi-disciplinary team meeting to review all fractured neck of femur cases that result in death is also being established.
- The number of nurses working on the fractured neck of femur ward has been increased.
- Significant progress has been made in achieving best practice over the past year that also strengthens the financial position.
- The fractured neck of femur integrated care pathway documentation has been completely re-written. This is for multidisciplinary use and is commenced on diagnosis of the fractured neck of femur whilst in the accident ad emergency department.
- Meetings were held with high performing trusts within England to explore their management of fractured neck of femurs and endeavour to apply learning.
- An external review of the management of patients with fractured neck of femur by the British Orthopaedic Association was invited. This was undertaken in January 2013 and an improvement plan has been developed.

## How did we perform?

- An improvement in the percentage of patients admitted with a fractured neck of femur admitted directly to ward 23 as been achieved. The data includes patients who could not be admitted to the fractured neck of femur ward for clinical reasons, e.g. ITU etc.

### Fractured Neck of Femur Admissions 2012/13 - percentage admitted directly to ward 23




- The Trust met the criteria for the repair of fractured neck of femur Best Practice Tariff for 65% of the patients seen in the year 2012/13. This represents a significant improvement as the Trust did not achieve Best Practice Tariff for this procedure in 2011/12.

**2) The Orthopaedic and Anaesthetic Directorates should review the findings of the mortality review at a joint Clinical Governance Rolling Half Day session, following which both specialties should be asked to produce action plans to address the key issues raised.**

## What did we do?

- In March 2013 the data from the National Hip Fracture Database report did confirm that the Trust is an outlier in terms of mortality rate for fractured neck of femur that was identified as part of annual planning in March 2012. Teleconference consultations have been undertaken with two high-performing organisations during the year to better understand how the Trust might improve systems, and commissioned a multi-disciplinary external review of the fractured neck of femur service from the British Orthopaedic Association.
- Fluid optimisation techniques have been introduced for patients with a fractured neck of femur. This is a technique used during the operation for those patients that have a general anaesthetic.

## How did we perform?

- Following the outcome of the formal review in January 2013, the improvement plan has been updated.

**3) A multi-disciplinary group will be convened under the direction of the Divisional Director for Surgery, to review on a monthly basis, the data from Dr Foster, the National Hip Fracture database, any deaths that have occurred within 30 days of surgery for a fractured neck of femur, and to formulate and co-ordinate any appropriate audits deemed necessary by the group.**

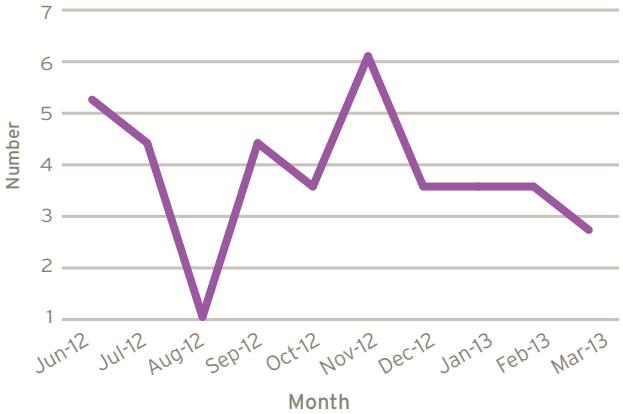
## What did we do?

- A monthly multi-disciplinary team meeting has been introduced to review all fractured neck of femur cases that result in death.
- The case note review is undertaken by a Consultant Orthogeriatrician of every patient that dies following surgery to repair a fractured neck of femur
- There is daily communication distributed widely within the hospital of information about patients with a fractured hip, including location of patients, numbers of patients awaiting surgery, number of patients that had been operated on within 36hrs of admission and number of deaths within 30 days of admission

## How did we perform?

- Significant improvements in peri operative and post-operative care have been delivered, which have seen the mortality rate for repair of fractured neck of femurs decrease from a peak of 197.4 in September 2012 to 154.0 at the end of March 2013.
- The number of actual patients that died following repair of fractured neck of femur between June 2012 to March 2013, known as crude mortality, was 33.

### Number of deaths within 30 days of admission following repair of fractured neck of femur



4) **New strategies to reduce the average length of stay would be explored of these patients in secondary care, and enable earlier, appropriate discharges to community-based rehabilitation facilities for suitable patients. Discussions about the development of a Fracture Liaison Service will be initiated, aiming to reduce the incidence of fractured neck of femur in the population we serve by 10% in three years.**

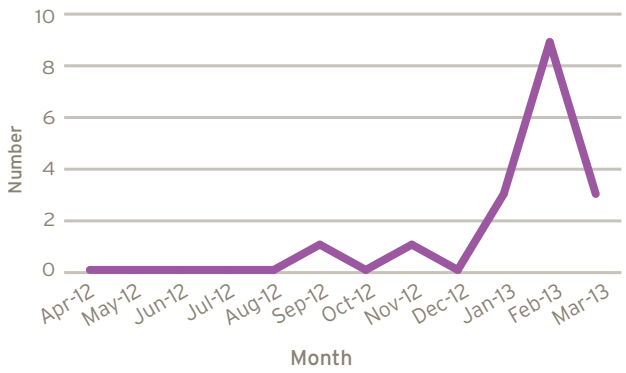
## What did we do?

- A Hospital At Home (H@H) service has been introduced which enables some patients that have suffered a hip fracture to return home sooner with the support of the Hospital At Home team.
- Commissioners have agreed that they will commit to negotiations to establish a Fracture Liaison Service in quarter three of 2013-14.
- Screening using a nationally recognised risk assessment tool will be commenced for all patients over the age of 65 that attend the A&E department that present with falls and wrist fracture or fractured vertebral body. These patients may be at risk of future falls and subsequent fractured neck of femur.

## How did we perform?

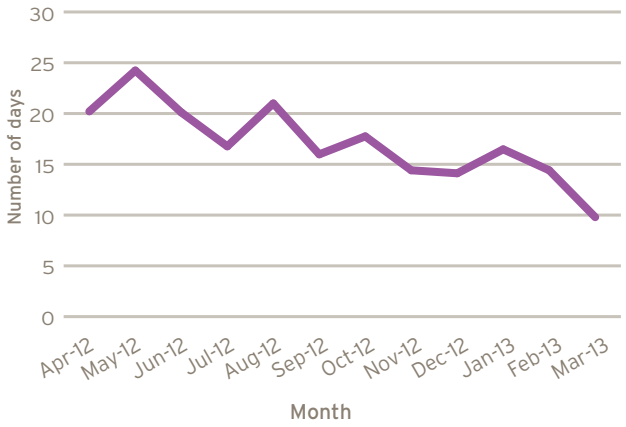
- There has been an increase in the number of patients that have had repair of fractured neck of femur that were discharged with the use of the H@H service in quarter 4.

**Number of fractured neck of femur patients discharged with the Home at Hospital service**




- There has been a significant reduction in the length of stay of patients admitted with a fractured neck of femur. In May 2012 the average length of stay was 24.4 days and in March 2013 it had significantly reduced to 9.7 days.

**Fractured Neck of Femur Admissions 2012/13 - Average Length of Stay**




# 3. Priorities for Improvement in 2013/14

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

## Priority 1: Patient Safety

### Key Patient Safety Priority 1

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

### Why is this a priority?

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

During 2012/13 a new medical model will be implemented in medicine and further increase in the number of consultants. This new model will increase the availability of a consultant led service and provide stronger senior decision making and support for junior medical staff. The impact of this work will lead to a reduction in unnecessary and avoidable admissions and a reduced length of stay.

### What will we do?

- We will implement a new medical model in medicine and further increase in the number of consultants
- We will commence a programme of work to establish changing requirements on junior medical staff on duty within medical specialties.

### How will improvement be measured and reported?

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

### Success Criteria

- Reduction in unnecessary and avoidable admissions
- Reduced length of stay for all patients
- Improve clinical outcome

### Key Patient Safety Priority 2

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

### Why is this a priority?

The NHS Safety Thermometer gives nurses a template to check basic levels of care, identify where things are going wrong and take action. It is used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, VTE and falls.

Implementation of the Safety Thermometer in 2012/13 focussed on data collection, staff training and establishing an accurate baseline. This has provided a snapshot of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. The Trust has consistently delivered 95% harm free care against these four harms. The safety thermometer objectives for 2013/14 will be to:

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

### What will we do?

- We will continue our implementation of the care bundles and other interventions described in last years report.
- Continue with infection prevention and control programme of investment and increase isolation capacity within the hospital.

### How will improvement be measured and reported?

- To measure these objectives we will collect, collate and report on the data set that has been nationally prescribed in the 'Safety Thermometer' programme. This thermometer aims to provide a snapshot of harm occurring on a particular day in the Trust (prevalence), based on the four common harm areas described above. These data are used to drive improvement at local level, as they indicate the number of patients that are receiving 'harm free care' at a given moment, as well as being submitted to the NHS Information Centre as part of the national programme. Data are reviewed monthly as part of our nursing quality assurance framework and actions to prevent future harm discussed, and are also reported to our Clinical Operational Board. Overall performance and assurance is reviewed by Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

### Success Criteria

- Improve clinical outcome
- 50% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers
- 10% reduction in the proportion of patients with harm from a fall
- 3% reduction in the proportion of patients with a urinary catheter
- 95% (minimum) patients to have had a VTE risk assessment on admission

## Priority 2: Patient Experience

### Key Patient Experience Priority 1

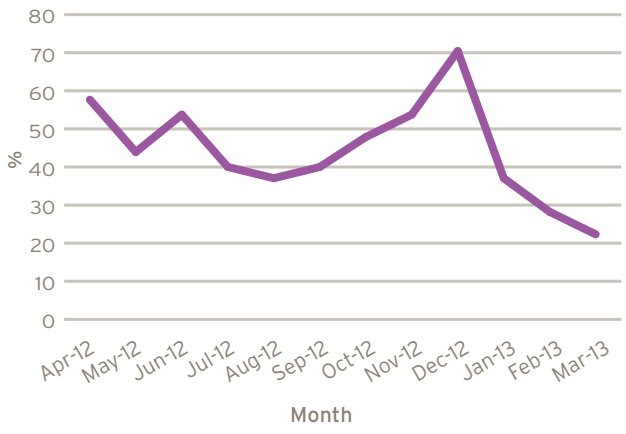
- To revolutionise how we handle complaints.

### Why is this a priority?

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

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

**Percentage of complaints responded to in the timescale agreed with the patients**




### What will we do?

- Improve the timeliness of response to complaints.
- Improve learning from complaints.
- Commence a programme of using complaints and other metrics to establish an 'early warning' mechanism.

### How will improvement be measured and reported?

The hospital will capture and monitor compliance times for each division. The hospital will report compliance with complaint response times within the quality report that is submitted to the Trust Board of Directors. Satisfaction with the timeliness and quality of the response will be sought from complainants. Triangulation of intelligence and trends within complaints and other quality information will be measured and reported within the trust committee structure. Communication skills training will be monitored and reported to the COSQ and where there is feedback about staff or departments; this will be incorporated into appraisals to deliver recognition of good practice or demand improvements in the event of poor feedback.

### Success Criteria

- Further increase in the quality of complaint responses as evidenced through
- Complainants' feedback and Ombudsman's review of responses
- Improvement in the timeliness of complaint responses without decreasing the quality of the response
- Increase in the use of local resolution meetings wherever appropriate
- Summary of learning from complaints published to the Trust website as recommended by the Francis Report

### Key Patient Experience Priority 2

- Continue to implement the Outpatient Transformational programme

### Why is this a priority?

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

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

### What will we do?

- Developing an operational sub-committee to the Transformation Board.
- Developing outpatient customer service training programme
- The achievement of a 2% reduction in the 'Did Not Attend' rates
- Reducing the number of patients experiencing hospital initiated clinic cancellations
- Reducing delays in clinics

### How will improvement be measured and reported?

Progress from the Outpatient Transformation Board will be monitored and reported to the COSQ and the Board.

### Success Criteria

- Be amongst the most improved Trusts in the National Outpatient Experience
- Survey in the East of England
- Achieve further 2% reduction of those that Do Not Attend (DNA) their appointment rates
- Expanded specialty specific pre-appointment patient information
- Achieve fit for purpose Outpatient facilities
- Reduce number of patients experiencing hospital initiated clinic cancellations
- Reduced delays in clinics and provide better intra-clinic patient communications
- Faster Outpatient call centre response times
- Alignment of Outpatient productivity to medical productivity to drive efficiency and transformation

## Priority 3: Clinical Outcomes

### Key Clinical Outcome Priority 1

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

### Why is this a priority?

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

### What will we do?

- Expand the pilot of the Frail Elderly Unit based on guidance within the 'Quality Care for Older People with Urgent & Emergency Care Needs (Silver Book)'.
- Commission an external expert review to be undertaken within the Department of Medicine for the Elderly. This will be a full review of the way in which we deliver DME services and ensuring that this is fit for the future. This will include the interface between primary and secondary care.

### How will improvement be measured and reported?

A balanced scorecard of metrics will be developed around the older persons pathway.

The scorecards will be updated monthly and distributed within the hospital. The scorecard will be reviewed by the Clinical Operational Board and the Clinical Outcome, Safety and Quality sub-committee and reported monthly to the Board.

### Success Criteria

- Reduction in the average length of stay for elderly patients from 12.4 to 11.0
- Reduction in the number of elderly patients placed in less appropriate wards
- Reduction in the number of patients medically fit for discharge but still in hospital

### Key Clinical Outcome Priority 2

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

### Why is this a priority

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

In March 2013 the data from the National Hip Fracture Database report did confirm the Trust as an outlier in

terms of mortality rate for fractured neck of femur. Mortality rate for repair of fractured neck of femurs decreased from a peak of 197.4 in September 2012 to 154.0 at the end of March 2013. Therefore a continued commitment to reduce the mortality rate amongst this group of patients remains a priority for the hospital in 2013/14.

## What will we do?

An improvement plan is in place for care of patients with a fractured neck of femur following an invited external expert review which is expected to have an impact; these actions are set out in the following objectives.

- Implement the use of fluid optimisation techniques for use with patients that have a general anaesthetic during the repair of the hip fracture.
- We will commence osteoporosis screening using a nationally recognised risk assessment tool for all patients over the age of 65 that attend the A&E department that present with falls and wrist fracture or fractured vertebral body. These patients may be at risk of future falls and subsequent fractured neck of femur.
- We will continue to undertake a case notes review of all patients that have died following hip fracture repair.
- We will develop a pathway for patients with a fractured neck of femur that do not get admitted via the A&E department with the fracture.
- A multi-disciplinary group will continue under the direction of the Divisional Director for Surgery, to review on a monthly basis, the data from Dr Foster, the National Hip Fracture database, any deaths that have occurred within 30 days of surgery for a fractured neck of femur, and to formulate and co-ordinate any appropriate audits deemed necessary by the group.
- Through our Consultant Orthogeriatrician, and our Elderly Care Physician with a particular interest in fractured neck of femur and a role which spans primary and secondary care, and discussion with the Clinical Commissioning Groups, we will continue to explore new strategies to help to reduce the average length of stay of these patients in secondary care, and enable earlier, appropriate discharges to community-based rehabilitation facilities for suitable patients.
- We will initiate discussions about the development of a Fracture Liaison Service, aiming to reduce the incidence of fractured neck of femur in the population we serve by 10% in three years.

## How will improvement be measured and reported?

A balanced scorecard of metrics that has been developed around the fractured neck of femur care pathway will continue to report on key indicators reflective of patient safety and clinical outcomes.

The scorecard will be updated monthly and distributed within the hospital. The scorecard will be reviewed by the Clinical Operational Board and the Clinical Outcome, Safety and Quality sub-committee and reported monthly to the Board.

## Success Criteria

- Significant reduction in fractured neck of femur HSMR
- Improve number of patients for which best practice tariff to 90% is achieved

## Responding to the Francis Report

Following the publication of the Francis report, the Trust set out its plan to brief and engage staff on the findings of the report. The approach taken was to hold a number of Trust wide listening events, the purpose of which was to engage and listen to as many staff as possible, identify key risks and early warning signs that the organisation face and agree and prioritise actions. The key message and aim was to create a common patient safety culture across the Trust where 'patients not numbers come first'.

In addition to the internal Trust projects, work is underway with University College of London Partners (UCLP) to accelerate improvement in light of the Francis report. Led by the Chief Nurses and Medical Directors across UCLP, a small number of carefully chosen initiatives have been prioritised;

- Understanding and measuring what matters to patients (developing a ward health check)
- Understanding what matters to patients (developing the UCLP Promise)
- Understanding and acting on what matters to staff
- Developing ward sister training and accreditation

This work can be accelerated and done more effectively by working in partnership, by sharing local work where helpful to peers in other organisations.

The Trust is committed to ensuring a consistent culture of compassionate care and following on from the listening and engaging events, the DH response and the UCLP programme, the Trust has identified many areas of action to consider. The Trust's next step is to complete a plan as to how to take the outcomes of these forward. It is essential that we build on the engagement and enthusiasm of our staff whilst also ensuring we respond to the DH recommendations as appropriate. To achieve this, the next stage will involve representation of staff from across the Trust.

# 4. Statements related to the Quality of Services Provided

## 4.1 Review of Services

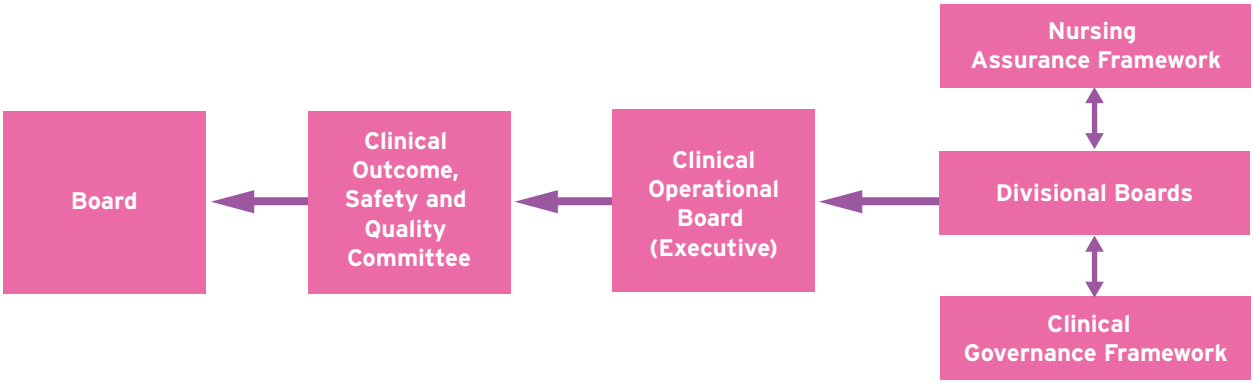
During 2012/13 the Luton and Dunstable Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers monthly performance reports 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 2012/13 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:

- Fractured neck of femur;
- Services for the elderly;
- Colorectal surgery;
- Colposcopy;
- Clinical sustainability;
- Hospital development financial strategy; and
- Whole system financial modelling

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

### Quality Assurance Monitoring




The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable Hospital NHS Foundation Trust for 2012/13.

## 4.2 Participation in Clinical Audits and National Confidential Enquiries

During 2012/13, 37 national clinical audits and 5 National Confidential Enquiries covered NHS services that Luton and Dunstable Hospital NHS Foundation Trust provides.

During the period the Trust was eligible to participate in thirty seven of the 51 national clinical audits that met the Quality Accounts inclusion criteria

The Trust participated in thirty-four (92%) of the eligible national audits

Details are provided within the tables below.

| Audits 2012-2013 | Organiser | Eligible | Participated | Target Cohort | Audit returns |
|---|---|---|---|---|---|
| Peri and Neo-natal | | | | | |
| Perinatal Mortality | MBRRACE – UK (Oxford) | ✓ | ✓ | Ongoing | Ongoing |
| Neonatal Intensive and Special Care | RCPCH | ✓ | ✓ | Ongoing | Ongoing |
| Children | | | | | |
| Paediatric Pneumonia | BTS | ✓ | ✓ | Nov. 2012 – March 2013 33 cases | All |

| Audits 2012-2013 | Organiser | Eligible | Participated | Target Cohort | Audit returns |
|---|---|---|---|---|---|
| Paediatric Asthma | BTS | ✓ | ✓ | Nov. 2012 -Jan. 2013 19 cases of 30 eligible | N = 19 (63 %) |
| Childhood Epilepsy 12 (Early Adopter) | RCPCH | ✓ | ✓ | 40 cases submitted | All |
| Paediatric Intensive Care | PICANet | ✗ | ✗ | N/A | N/A |
| Paediatric Cardiac Surgery | NICOR CHD Audit | ✗ | ✗ | N/A | N/A |
| Paediatric Diabetes | RCPCH/NPDA | ✓ | ✓ | July - Sept 2012 131 cases submitted | All |
| Paediatric Fever | CEM | ✓ | ✓ | Aug. 2012 - Nov. 2012 50 cases submitted | All |
| **Acute Care** | | | | | |
| Emergency Use of Oxygen | BTS | ✓ | ✓ | Aug. 2012 - Nov. 2012 11 cases submitted | All |
| Adult Community Acquired Pneumonia | BTS | ✓ | ✓ | Dec. 2012 - May 2013 | In progress |
| Adult Non Invasive Ventilation | BTS | ✓ | ✓ | Feb. 2013 - May 2013 | In progress |
| Adult Critical Care | ICNARC | ✓ | ✓ | Ongoing | Ongoing |
| Cardiac Arrest | NCAA | ✓ | ✓ | Ongoing | Ongoing |
| Fractured Neck of Femur | CEM | ✓ | ✓ | Aug. 2012 - Nov. 2012 50 cases submitted | 100% |
| Renal Colic | CEM | ✓ | ✓ | Aug. 2012 - Nov. 2012 50 cases submitted | 100% |
| **Long Term Conditions** | | | | | |
| In-patient Diabetes (Adult) | Diabetes UK / NHS IC | ✓ | ✓ | Sept. 2012 94 cases Submitted | 100% |
| Pain Database | British Pain Society and Dr. Foster | ✓ | ✓ | Ongoing | Ongoing |
| IBD | RCP | ✓ | ✓ | Round 4 - Jan. - Dec. 2013 | In progress |
| National Audit of Dementia | RCPsych | ✓ | ✓ | June - Oct. 2012 Submitted 40 cases | 100% |
| Adult Asthma | BTS | ✓ | ✗ | Sept. - Dec. 2012 | N/A |
| Bronchiectasis | BTS | ✓ | ✗ | Oct. 2012 - Jan. 2013 | N/A |
| Renal Registry | UKRR | Via Lister Hospital | ✗ | N/A | N/A |
| Asthma Deaths | NRAD | ✓ | ✓ | Ongoing | Ongoing |
| **Elective Procedures** | | | | | |
| Joint Replacement (Hip, Knee) | NJR | ✓ | ✓ | Ongoing | Ongoing |
| Elective Surgery PROMS | NHS Information Centre | ✓ | ✓ | Ongoing | Ongoing |
| **Cardiovascular Disease** | | | | | |
| Coronary Angioplasty | NICOR | ✗ | ✗ | N/A | N/A |
| Peripheral Vascular Surgery | VSGBI Database | ✗ | ✗ | N/A | N/A |

| Audits 2012-2013 | Organiser | Eligible | Participated | Target Cohort | Audit returns |
|---|---|---|---|---|---|
| Carotid Interventions | RCP / Vascular Society | ✗ | ✗ | N/A | N/A |
| CABG and Valvular Surgery | Adult Cardiac Surgery | ✗ | ✗ | N/A | N/A |
| Acute Myocardial Infarction and ACS | MINAP | ✓ | ✓ | Ongoing | Ongoing |
| Heart Failure Audit | National Institute for Cardiovascular Outcomes (NICOR) | ✓ | ✓ | Ongoing | Ongoing |
| Pulmonary Hypertension | NHS IC | ✗ | ✗ | N/A | N/A |
| Acute Stroke (SINAP) | RCP | ✓ | ✓ | Ongoing | Ongoing |
| Cardiac Arrhythmia Implantable Devices | NICOR | ✓ | ✓ | Ongoing | Ongoing |
| Cardiothoracic Transplant | RCS | ✗ | ✗ | N/A | N/A |
| Vascular Surgery | VSO | ✗ | ✗ | N/A | N/A |
| **Cancer** | | | | | |
| Lung Cancer | NHS IC | ✓ | ✓ | Ongoing | Ongoing |
| Bowel Cancer | NHS IC | ✓ | ✓ | Ongoing | Ongoing |
| Head and Neck Cancer DAHNO | NHS IC | ✓ | ✓ | Ongoing | Ongoing |
| Oesophago-gastric Cancer National O-G cancer Audit | RCS | ✓ | ✓ | Ongoing | Ongoing |
| **Trauma** | | | | | |
| National Hip Fracture | BOA | ✓ | ✓ | Ongoing | Ongoing |
| Severe Trauma | TARN | ✓ | ✓ | Ongoing | Ongoing |
| **Mental Health** | | | | | |
| Prescribing in Mental health | RCPsych | ✗ | ✗ | N/A | N/A |
| National Audit of Schizophrenia | RCPsych | ✗ | ✗ | N/A | N/A |
| **NHS Transplant** | | | | | |
| Audit of Blood Sampling and Labelling | NHS Blood and Transplant | ✓ | ✗ | **Abandoned with approval from NBT** | April 2012 |
| Potential Donor | NHS Blood and Transplant | ✓ | ✓ | Ongoing | Ongoing |
| Audit of Use of Anti-D | NHS Blood and Transplant | ✓ | ✓ | Planned March 2013 | Ongoing |
| Renal Transplant | NHS Blood and Transplant | ✗ | ✗ | N/A | N/A |
| Renal Registry | UK Renal Registry | ✗ | ✗ | Via Lister Hosp. | N/A |
| **Health Promotion** | | | | | |
| Health Promotion in Hospitals | nhphaudit.org | ✗ | ✗ | N/A | N/A |

**Other National and Regional Audits**

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

| Audit | Organiser | Target Cohort | Returns |
|---|---|---|---|
| Thrombosis Venous Thromboembolism Annual Survey (FOI Request) | All Parliamentary Thrombosis Group | Organisational and Performance questionnaire | Annual (submission usually Sept/October |
| National Anticoagulation Clinical Reporting System | DAWN Benchmarking | All system entries | Twice annually July 2012 Jan 2013 |
| Rare Disorders of Pregnancy | UK Obstetric Surveillance System (UKOSS) | Case submissions by UKOSS criteria | Continuous |

**Submissions to national cancer data sets:**

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

| Cancer National database / Registries | Organisation | Data submissions |
|---|---|---|
| Open Exeter: Referrals via NHS Screening Services:<br>- Breast<br>- Gynaecology<br>- Colorectal | NHS Connecting for Health | Monthly:<br>Within 25 working days of the month end. |
| Open Exeter: Two week Wait Referrals:<br>- Upper GI<br>- Pancreatic<br>- Urology<br>- Haematology<br>- Skin<br>- Lung<br>- Gynaecology<br>- Head and Neck<br>- Colorectal<br>- Breast | NHS Connecting for Health | Monthly:<br>Within 25 working days of the month end. |
| Open Exeter: Breast Symptomatic 2 week wait Referrals: | NHS Connecting for Health | Monthly:<br>Within 25 working days of the month end. |
| Open Exeter: Rare Cancer Referrals treated within 31 days of receipt of referral:<br>- Haematology<br>- Children's Cancers<br>- Testicular | NHS Connecting for Health | Monthly:<br>Within 25 working days of the month end |
| Open Exeter: Routine referrals which are upgraded by clinician & treated within 62 days:<br>- Upper GI<br>- Pancreatic<br>- Urology<br>- Haematology<br>- Skin<br>- Lung<br>- Gynaecology<br>- Head and Neck<br>- Colorectal<br>- Breast | NHS Connecting for Health | Ongoing |

**Local Clinical Audits**

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of twenty nine 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 |
|---|---|---|---|---|
| 1 | Cardiac Arrest Procedures | NCEPOD | 100% | Yes |
| 2 | Alcohol Related Liver Disease | NCEPOD | (1/3) 33% | Yes |
| 3 | Subarachnoid Haemorrhage | NCEPOD | (3/4) 75% | Yes |
| 4 | Bariatric Study | NCEPOD | (7/8) 83% | Yes |
| 5 | Maternal, Still births and Neo-natal deaths | CEMACH | 100% | Yes |

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

## 4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton & Dunstable University Hospital in 2012/2013 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 606. This research can be broken down into 144 research studies (113 Portfolio and 31 Non-Portfolio).

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

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

A proportion of Luton and Dunstable Hospital income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work. Through discussions with our commissioners we agreed a number of improvement goals for 2012/13.

**Goals and Indicators**

| Goal no. | Description of goal | Quality Domain(s) | Indicator name | Indicator weighting |
|---|---|---|---|---|
| 1 | To ensure that providers have real time systems in place to monitor patient experience. | Patient Experience | Patient Revolution | 20% |
| 2 | Collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument (developed as part of the QIPP Safe Care national work stream) to survey all relevant patients in all relevant NHS providers in England on a monthly basis | Patient Safety | NHS Safety Thermometer | 25% |
| 3 | National goal to reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE). | Patient Safety | VTE | 11.25% |

| Goal no. | Description of goal | Quality Domain(s) | Indicator name | Indicator weighting |
|---|---|---|---|---|
| 4 | National goal to improve responsiveness to the personal needs of patients. | Patient Experience | Personalisation | 2.5% |
| 5 | Reduce the amount of time that patients wait to be physically admitted to an actual Critical Care area (ITU,HDU, combined unit, or appropriate L3 or L2 facility (Intensive Care Society 2009 Levels of Care). | Clinical Effectiveness | Critical Care Network | 30% |
| 6 | Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting | Patient Safety and Clinical Effectiveness | Dementia Screening Question | 6.25% |
| | | | Dementia Risk Assessment | |
| | | | Specialist Referral | |
| 7 | Improving care for adults with learning disability | Innovation | 10% improvement from LD Organisational audit | 5% |

All the CQUINs were achieved with minor exceptions in quarter 1 related to goal number 1 patient experience.

The Trust monetary total for the associated CQUIN payment in 2012/13 was £4,461,155.

## 4.6 Care Quality Commission Registration

The Care Quality Commission (CQC) is the organisation which 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 which 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 Care Quality Commission (CQC) and its current registration is **Registration Without Conditions**.

No enforcement action has been taken against the Trust during the reporting period April 1st 2012 and 31st March 2013. The CQC assessed the Trust on the 18th June 2012 and assessed compliance against ten essential standards. Based on their comprehensive assessment undertaken over two days, the CQC were satisfied that the Trust was meeting all 10 of the essential standards of quality and safety that were assessed (Outcome 02 - Consent to care and treatment; Outcome 04 - Care and welfare of people who use services; Outcome 06 - Cooperating with other providers; Outcome 07 - Safeguarding people who use services from abuse; Outcome 08 - Cleanliness and infection control; Outcome 09 - Management of medicines; Outcome 13 – Staffing; Outcome 16 - Assessing and monitoring the quality of service provision; Outcome 20 - Notification of other incidents; Outcome 21 – Records).

The CQC undertook a review as part of a targeted inspection programme to services that provide the regulated activity of terminations of pregnancy. The focus of their visit on the 21st March 2012 was to assess the use of the forms that are used to certify the grounds under which a termination of pregnancy may lawfully take place. The CQC published their findings in June 2012 and the Trust was judged to be fully compliant.

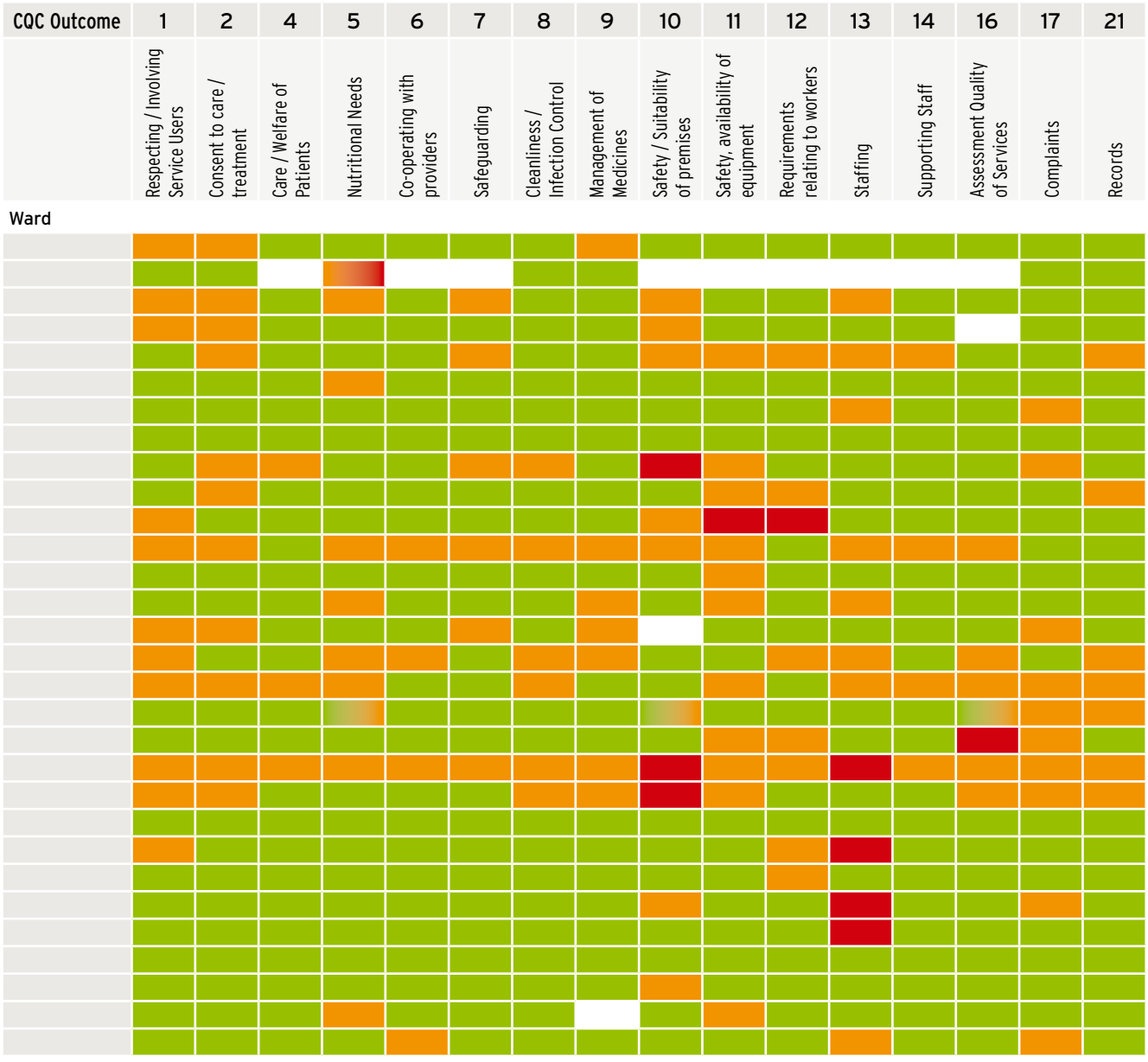
The Luton and Dunstable NHS Foundation Trust has not participated in special reviews or investigations by the CQC during the reporting period.

The Trust developed an internal process to support staff in their ongoing work to deliver care standards (as outlined by the CQC); it is called the Nursing and Midwifery Assurance Framework. The report above relates to self assessment for month 1 of the cycle of the Framework (April). External peer review assessment for March took place covering 8 wards with positive (green)

findings in most wards for most outcomes. Assessors recommended clarity about the use of staff to interpret and improvements to knowledge of MCA/DOLS. they found some evidence of poor documentation in some areas. To address ambers or reds, discussions take place at the monthly quality monitoring meetings with the Chief Nurse, corporate team and Matrons and Sisters.

Improvement plans have been developed and are being monitored through the ward quality meetings, however issues outside of the remit of the ward sisters are being escalated directly to the applicable departments.

The self assessment tool is completed on a quarterly basis and reviewed by the Trust Executive and the Clinical Outcomes, Safety and Quality committee monthly. It is also discussed at the Board of Directors. An example of the self assessment tool is shown below.




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.

We maintained NHS Litigation Authority Risk Management Standards Level 2 for the Trust and achieved Clinical Negligence Scheme for Trust's Standards for Maternity services at level 1 in October 2012.

## 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 2012/13 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 the data warehouse established February 2011 to provide timely alerts and increase the visibility of any data and data quality problems.
- Continued to work with Commissioners to monitor and improve data quality in key areas.

### NHS Code and General Medical Practice Code Validity

Luton and Dunstable Hospital NHS Foundation Trust submitted records during 2012/13 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:

- 99.2% for admitted patient care; 99.6% for out patient care and 95.7% for A&E care.

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

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

### Clinical coding error rate

The Luton and Dunstable Hospital NHS Foundation Trust was subject to a Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

The error rates reported for diagnosis and treatment coding (clinical coding) were 8.1% against a national average of 9.1%.

### Information Governance toolkit attainment levels

The Luton and Dunstable Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2012/13 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

## 5.1 Progress 2012/13

### 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 | 2010* or 2010/11 | 2011* or 2011/12 | 2012* or 2012/13 | National Average | What does this mean? |
|---|---|---|---|---|---|---|
| Number of hospital acquired MRSA Bacteraemia cases (n) | Patient Safety Trust Board Reports (DH criteria) | 1 | 2 | 2 | N/A | We exceeded the threshold of 1 case that we had been set for the year |
| Hospital Standardised Mortality Ratio* (n) | Patient Safety Dr Foster / Trust Board Report | 97.4* | 94.6* | 97.2* | 100 | Lower than 100 is positive. |
| Number of hospital acquired C.Difficile cases (n) | Patient Safety Trust Board Reports | 36 | 34 | 17 | N/A | Good performance with a significant reduction since last year |
| Incidence of avoidable hospital acquired grade 3 or 4 pressure ulcers | Patient Safety Trust Board Report | N/A | N/A | 51** | N/A | The data represents the number of avoidable pressure ulcers. The Trust's strategy is to reduce all avoidable pressure ulcers by 50% |
| Number of Central line infections < 30 days (Adults) | Patient Safety Trust Internal Report | 2 | 0 | 4 | N/A | There has been an increase in incidence compared to last year |
| Cardiac arrest rate per 1000 discharges | Patient Safety Trust Board Report | 1.63 | 1.5 | 1.8 | N/A | An increase when compared to last year |
| Average LOS (excluding healthy babies) | Clinical Effectiveness Trust Patient Administration Information Systems | 3.9 days | 4.2 days | 3.7 days | N/A | We have seen a slight improvement on length of stay |
| Rate of falls per 1000 bed days | Clinical Effectiveness Trust Board Report | 6 | 5.92 | 5.5 | N/A | A further reduction n 2012/13 noted |

| Performance Indicator | Type of Indicator and Source of data | 2010* or 2010/11 | 2011* or 2011/12 | 2012* or 2012/13 | National Average | What does this mean? |
|---|---|---|---|---|---|---|
| % of stroke patients spending 90% of their inpatient stay on the stroke unit (n) | Clinical Effectiveness | 81.3% | 77.7% | 78.3& | Target of 80% | An increase when compared to last year |
| Rate of fractured neck of femur to theatre in 24hrs (n) | Clinical Effectiveness<br><br>Dr Foster | 69%* | 70% | 83.6% | N/A | An improving picture is noted |
| In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n) | Clinical Effectiveness<br><br>Dr Foster | 58.7* | 66.5* showing green on Dr Foster systems | 52.5* | 100 | This remains an excellent result – a lower number reflects less deaths than expected |
| In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n) | Clinical Effectiveness<br><br>Dr Foster | 93.7* | 78.7* | 87.7* | 100 | The Stroke service performs well with an HSMR consistently less than 100 |
| Readmission rates*: Knee Replacements Trauma and Orthopaedics (n) | Clinical Effectiveness<br><br>Dr Foster | 5.3% | 5.5% | 11.4% | N/A | The data is a concern and this will be investigated and confirmed. |
| % Caesarean Section rates | Patient Experience<br><br>Obstetric dashboard | 24.7% | 26.5% | 25.5% | Trust goal <23% | This is proving difficult to reduce however we have pathways in place to promote vaginal delivery whenever possible |
| % patients who would rate the service as excellent, very good or good (out-patients) | Patient Experience<br><br>National out patients survey response to question 48 | N/A | 89 | N/A | N/A | National survey not undertaken in 2012 (biennial) |
| Patients who felt that they were treated with respect and dignity*** | Patient Experience<br><br>National in patient survey response to question 75 | 8.9 | 8.7 | 8.7 | Range 8.2 - 9.7 | Same performance as previous year |

| Performance Indicator | Type of Indicator and Source of data | 2010* or 2010/11 | 2011* or 2011/12 | 2012* or 2012/13 | National Average | What does this mean? |
|---|---|---|---|---|---|---|
| Complaints rate per 1000 discharges ( in patients) | Patient Experience<br><br>Complaints database and Dr Foster number of spells for the year | 3.2 | 3.56 | 3.62 | N/A | This result indicates an increase in the rate of complaints however, we have encouraged patients to speak up |
| % patients disturbed at night by staff (n) | Patient Experience<br><br>CQC Patient Survey | 7.9* | 7.8* | 8.0* | Range 7.0 – 9.2 | Similar compared to last year |
| Venous thromboemolism risk assessment | Patient Experience<br><br>Commissioning for Quality National Goal since 2011 | Achieved >90% | Achieved >95% by Q4 | Achieved >95% all year | N/A | Sustained and improved performance above 2012/13 CQUIN target of >95% |

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

* Denotes calendar year

** The pressure ulcer metrics have changed for the last 3 years so the data is not comparable year on year. The figure in the 2010/11 quality account was for all pressure ulcers. 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.

### Stroke

In 2012/13 we struggled to meet the stroke target of ensuring that 90% of patients spending 80% of their time on a stroke ward due to bed pressures. However, this position greatly improved towards the end of the year and we will be looking to maintain this as we develop its services to act as the hyper acute hub.

## 5.2 Major quality improvement achievements within 2012/13

### Hand Hygiene Campaign

To ensure true compliance with hand cleansing at the right times, every time during patient contact on an ongoing basis, a hand hygiene campaign was launched in January 2013 by the CEO, *'Hand Hygiene in Partnership'*. A Trust-wide hand hygiene assessment has been undertaken by the Infection Control Team and an action plan created and background work undertaken. This features a three-pronged approach;

1. The development of public facing messages to explain to patients and our community our commitment to ensuring clean hands when caring for patients, through the use of a virtual assistant hologram unit which will be introduced in 2013 and can be used at various entrance points in the hospital;

2. The introduction of a new and novel electronic hand hygiene compliance monitoring system, one of the first sites in the UK to use this, alongside staff perception and knowledge surveys to drive targeted improvement action plans, refreshed education and training and awareness raising going forward; and

3. The introduction of a process whereby patients are actively given permission by staff to ask if they have cleaned their hands before touching them (this is the hospital recommended Moment 1 for hand hygiene; before touching a patient) and to address how this partnership working can enhance patient confidence and make them feel genuinely listened to. All of this

is in support of national recommendations for hygiene standards and based on the Chief Medical Officer for England citing hand hygiene as contributing to infection prevention success, while many infection issues continue to exist, including antimicrobial resistance.

## Patient Experience Call Centre

In August 2012 we set up the patient experience call centre so that we could phone patients within 48 hours of leaving hospital to ask them about their experience of our care and services. Clinical and non-clinical staff are encouraged and supported to participate in making these calls so that they can hear feedback from patients first hand. The Centre has been a success and provides wards, divisions and departments with clear and comprehensive feedback to inform action planning about what works well and what needs to be improved. For example patients helped us to identify gaps in post operative patient information and to understand the circumstances in which they find they receive conflicting information. We are already seeing improvements directly related to the feedback obtained.

In January 2013 the Trust received a National Patient Experience Award (PENNA) for excellence in collecting and using patient feedback. Judges commented that our Patient Experience Call Centre was the first of its kind and they commended the work. We believe that it is important that we speak to as many patients as possible after their discharge from hospital so they have opportunity to give feedback and to ask any questions they might have thought of after going home. We will continue to develop the patient experience centre over the coming year.

## Wardware

We are continuing to collaborate with Kings College Hospital to design and implement an electronic clinical observation system called Wardware. This system is used when the clinical staff undertake vital sign observations such as blood pressure, temperature and heart rate amongst others and then enter the results into an electronic hand held device instead of on a paper observations chart. The observations are then uploaded to the system, and a weighted scoring system is applied to patient's vital signs. The system will then calculate a score depending on the severity of illness of the patient, thus the sickest patients will trigger the highest score. The highest risk patients are differentiated from the medium and low risk patients to enable prioritisation of the patients in most need of urgent care. The Wardware system also provides guidance to the clinical staff undertaking the observations about who they should contact and when to repeat the observation based on the condition of the patient. The observations recorded within the Wardware system are transmitted via wireless technology and can be viewed by senior clinical staff on any computer in the Trust. Thus it is also possible to obtain an overview of all the patient's observations completed in the system at ward view or trust wide and identify those that are the sickest.

One of the main benefits of using this system is that it is possible for the nurse in charge, the critical care outreach team and doctors to identify the patients giving cause for concern, allow them to prioritise their workload, and make decisions based on accurate and live information, without requiring the nurse who has done the observations to inform them of their concerns. This has the capacity to facilitate quicker 'rescue' of deteriorating patients.

A year long pilot of an electronic observation system demonstrated a significant reduction in length of stay and a reduction in mortality on the ward where the pilot was carried out and provided the evidence base for Trust-wide roll out of the system.

So far the system is in use as the primary form of recording observations, on three of the medical wards, and the roll out plan for the system to the remaining medical wards will be April to August 2013. The system also has further capability to capture and improve fluid balance monitoring which will result in improved accuracy. A devices module is also available and will improve compliance with best practice guidance for in-dwelling devices such as urinary catheters and IV cannulas.

It is envisaged that the implementation of this product will have a significant impact on delivering quality care to patients as it can facilitate more timely intervention helps prevent avoidable harm, prevent cardiac arrests and reduce avoidable deaths. It is anticipated that a pilot of the new modules will commence in April 2013.

## Perfect Day Project

At the Luton and Dunstable University Hospital we believe it is important to put the nurse at the bedside. Nurses have been trained to provide expert care and management but over the years the role has become cluttered with nurses taking on other responsibilities which take them away from the bedside. In November 2012 the Trust initiated an innovative and groundbreaking project to design a sustainable model of nursing care that meets the needs of patients, staff and regulators.

The model is built around the need to put the nurse back at the bedside and reduce unnecessary paperwork. In order to make this happen we reorganised the daily workload of the whole ward team to allow nurses to focus on essential nursing care with support staff taking on some of the activities that took nurses away from the bedside. It has been tested using a series of "Perfect Days" followed by a "Perfect Week" pilot in February 2013. To help us understand what a "perfect experience" looks and feels like for our L&D patients and what stops our staff from having a "perfect day work experience" we engaged a wide range of patients and staff through a series of focus groups.

The model has been well received by staff and patients and we are confident this is the way forward in improving essential nursing care as well as improving patient and staff experience.

Success measures have been agreed and are currently being monitored. Further work is being undertaken to understand the financial and HR implications of the model before a final proposal for roll out is presented

The project group is made of a range of ward based staff with a wider staff and patient representative group being consulted through focus groups.

## Frail Elderly Unit

An increasing number of older people are attending emergency departments and accessing urgent health and social care services. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals compared to other patient groups. At the Luton and Dunstable Hospital we have launched a pilot project to improve the care and treatment of our frail elderly patients.
Frail elderly patients attending the Accident and Emergency Department (A&E) or the Emergency Assessment Unit (EAU) at the L&D are often transferred to an inpatient ward before they are reviewed by a Geriatrician. The most recent guide produced by the Royal College of Physicians makes clear recommendations for the care of the Frail Elderly accessing hospital care. It recommends a Comprehensive Geriatric Assessment (CGA) take place within 24hrs of admission. This is defined as 'a interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.
The pilot project is led by two of our Consultant Geriatricians and senior staff from our multidisciplinary teams looking at a small cohort of frail elderly patients.

The project seeks to identify the patients when they come through the front door and following a comprehensive assessment a decision is made about discharge and appropriate support services are mobilised so that whenever possible patient are able to go home without unnecessary delay. Key success measures have been agreed and once we have evaluated the data we hope to role this out to all our frail elderly patients.

## Opening of the Cardiac Unit

A new Cardiac Centre opened to patients in June 2012, benefitting over 800 patients a year who can now have specialist treatment closer to home. The £5.5 million Cardiac Centre was officially opened by His Royal Highness, The Duke of Edinburgh on the 19 February 2013 and serves a population of over 350,000 people in an area with a high incidence of coronary heart disease. Local demand is high and thousands of people with heart complaints are cared for at Luton and Dunstable University Hospital by a team of Cardiac specialists.
In an imaginative redevelopment at the heart of the main hospital building which was opened in 1939 by Her Majesty Queen Mary, the new Cardiac Centre offers a range of specialist investigations and treatment, including Coronary angiography, cardioversion, echo-cardiography and cardiology clinics. Specialist staff at the Cardiac Centre aim to be able to provide other coronary interventions including stenting within 2013/14.

Around one third of all preventable deaths in Luton and the surrounding area are due to Cardiac problems and prior to the unit opening, people had to travel to other specialist centres for investigations which can be very stressful for patients and their families. Now such investigations and treatment will be delivered locally.

Local people have donated over £41,000 in the last year to the hospital's Cardiac Centre charity appeal to pay for enhancements and additional medical equipment including an echocardiogram (ECHO) machine.

## Learning Disabilities (LD)

The Trust has made significant improvements in care for patients with a learning disability. The Learning Disability Action Plan, incorporating the East of England NHS Learning Disability QIPP: 'Improving Acute Hospital Patient Pathways for Adults with a Learning Disability and Adults with Autism' has been progressed through the LD Task Group.

The LD Nurses have developed guidance for Carers of Patients who have a Learning Disability and a number of easy read leaflets and information has also been developed for complaints, discharge and patient feedback.

This work is complimented by the LD Patient Experience coffee mornings that are held quarterly, facilitated by the LD Nurses and attended by the Chief Nurse, Deputy Chief Nurse and Safeguarding Lead Nurse. The coffee morning is an opportunity for LD patients to share their experiences and feed into the Trust Patient Experience Group in a non threatening, supportive environment and representatives of POWhER and MENCAP to share the experiences of their service users and clients who are unable to communicate their experiences personally.

Improvements in care of LD patients include a daily email alert from the Trust's patient information system to Matrons, LD Nurses and Corporate Nursing Team with details of all registered LD patient admission/discharges over the previous 7 days. Matrons then visit all learning disability patients within 24 hours of admission with ongoing daily feedback from ward managers to allow any reasonable adjustments to be made as necessary. Ward staff can also refer LD patients to the LD Nurses via Extramed, an electronic data management system used in the Trust.

A weekly email alert is also sent to the LD Nurses informing them of all planned outpatient activity for LD registered patients in the forthcoming 2 weeks. This allows the LD nurses to contact any patients who are not already being supported in advance of their appointments to offer them support. LD Nurses send easy read post discharge questionnaires to all LD patients and responses are collated and forwarded to the Patient Experience Lead/PALS quarterly

A number of LD Patient Pathways, as per the LD East of England QIPP recommendations, are in place in Pre-Assessment, Accident & Emergency, X-Ray/Imaging, Outpatients, and Medicine & GUM to guide and support staff in providing the best care for patients with an LD.

### Human Factors

The aim of the Human Factors (HF) project is to improve teamwork and communication within and across disciplines, in order to enhance patient safety and the experience of both staff and patients. Following on from successful work in the maternity department a Human Factors (HF) project was designed for the department of emergency medicine.

The strategy initially involved training, combined with follow up coaching in HF skills and implementation of HF interventions in the workplace. We are evaluating our work through the use of a validated patient safety survey and through evaluation of the individual interventions we develop.

Our achievements in 2012/13 are training, implementation of HF interventions in the workplace and development of leaders. The training plans are below:

- To start the project in May 2012 we ran a four hour immersion event for a critical number of staff from all disciplines and grades to introduce the concepts of safety through teamwork skills;
- To support the delivery of monthly training days in HF and crisis resource management through simulation we trained a group of multi-disciplinary trainers in the skill of de-briefing; and
- Since July 2012 we have delivered a team training day every month for 10 members of staff from the areas of EAU and ED. The training days have covered in greater depth the inherent fallibilities of the human, aspects affecting individual human and team performance and how to improve safety through improved leadership and teamwork behaviours. Using high fidelity simulation we have provided experiential learning for training in the use of teamwork behaviours.

By using an HF expert working alongside clinical and nursing leaders in the workplace we have made progress on the following interventions:

- Board Rounds in ED; and
- Reliable ward round.

Leaders from nursing, clinical and general management backgrounds are self reporting enhanced cognisance of the importance of HF and changes to their own leadership behaviours.

Plans for 2013/2014 include further training and coaching, and further implementation of HF interventions within the general wards

## 5.3 Friends and Family Test

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

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

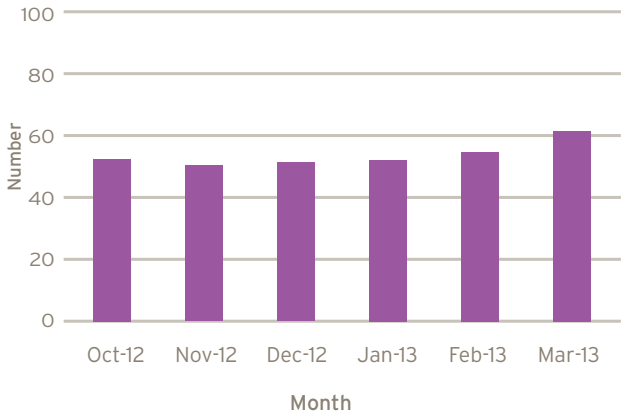
The Friends and Family test is a simple comparable test which, when combined with follow up questions, provides us with a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations.

We offer a variety of ways in which we seek feedback from patients and these include postcards that can be filled out and left in the hospital. Patients can also go

onto the hospital website to complete a survey. The patient experience call centre contacts patients within 48 hours of leaving hospital to ask them about their experience of our care and services and this includes the Friends and Family test. This successful innovation was recognised nationally and was a winner in the National Patient Experience Award (PENNA) for excellence in collecting and using patient feedback.

We started to collect this information from patients during August 2012 and we have seen gradual and consistent improvements in the score.

**Friend and Family Score**




## 5.4 National Inpatient Survey 2012

As a Trust we continually seek to improve the patient experience and see evidence in the results below of progress in the right direction.

Our composite score for patient experience comes from the results of answers to five particular questions within the national in-patient survey. The hospitals 2012 score is 67.5 and this is an improvement from 64.0 and 65.6 in 2011 and 2010 respectively.

**Results of the national in-patient survey 2012**

| Category | 2010 | 2011 | 2013 | Trust year on year comparison | Comparison other NHS hospitals |
|---|---|---|---|---|---|
| The emergency / A&E department, answered by emergency patients only | 7.3 | 7.1 | 8.4 | Increased | The same |
| Waiting lists and planned admission, answered by those referred to hospital | 6.7 | 6.3 | 9.0 | Increased | The same |
| Waiting to get to a bed on a ward | 7.3 | 6.6 | 7.0 | Increased | The same |
| The hospital and ward | 8 | 7.8 | 8.1 | Increased | The same |
| Doctors | 8.4 | 7.9 | 8.2 | Increased | The same |
| Nurses | 8.3 | 7.9 | 8.1 | Increased | The same |
| Care and treatment | 7.3 | 7.1 | 7.5 | Increased | The same |
| Operations and procedures, answered by patients who had an operation or procedure | 8.1 | 8.3 | 8. | Increased | The same |
| | 6.5 | 6.8 | 6.8 | Same | The same |
| | 8.3 | Increased | The same | Reduced | The same |
| Leaving hospital | 6.8 | 6.8 | 7.0 | Increased | The same |
| Overall views and experiences | 6.5 | 6.0 | 5.5 | Reduced | The same |

Note all scores out of 10

A patient experience improvement plan has been developed and this will enable the hospital Patient Experience Group to gain assurance of the improvements put in place.

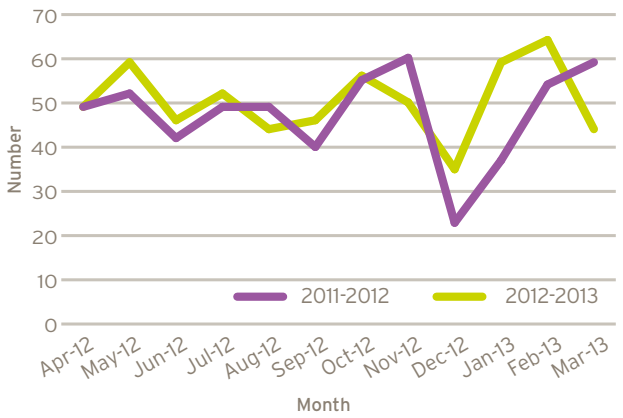
## 5.5 Other Surveys

One of our local LINks (Luton) conducted an independent survey of 500 patients during July with 276 responding. Luton LINk reported finding high levels of satisfaction with an overall score of 8.2 out of 10 which was the same as in 2011. Findings in relation to food were similar to the previous year with patients reporting that they were receiving help with feeding when needed but were sometimes dissatisfied with temperature, taste or amount of food. They found no significant discrepancies between the quality of care for planned and emergency admissions or between ethnicity, gender and disability but noted that some patients would appreciate more assistance when English is not their first language.

## 5.6 Complaints

During 2012/13 we had a continual drive to encourage patients to "speak up" and tell us about their concerns; we have therefore seen a rise in the total number of complaints received. In 2011/12 we received 565 complaints and 2012/13 we received 604 complaints.

### Complaints per Month




**Complaints by subject and in comparison to last year:**

| | 2011 - 2012 | 2012-2013 |
|---|---|---|
| Administration | 39 | 24 |
| Appointments | 39 | 82 |
| Attitude | 112 | 85 |
| Communication | 79 | 55 |
| Confidentiality | 8 | 7 |
| Discharge Arrangements | 33 | 47 |
| Facilities | 68 | 29 |
| Lost Property | 10 | 18 |
| Medical Care | 237 | 311 |
| Nursing Care | 104 | 112 |
| Staffing Levels | 0 | 2 |
| Waiting List | 31 | 5 |
| Waiting Time | 35 | 17 |

(The number of subjects is greater than the number of complaints received as some complaints include more than one issue).

During 2012/13 we have seen a reduction in the number of complaints relating to Administration, Attitude, Communication, Confidentiality, Facilities, Waiting Lists and Waiting Times.

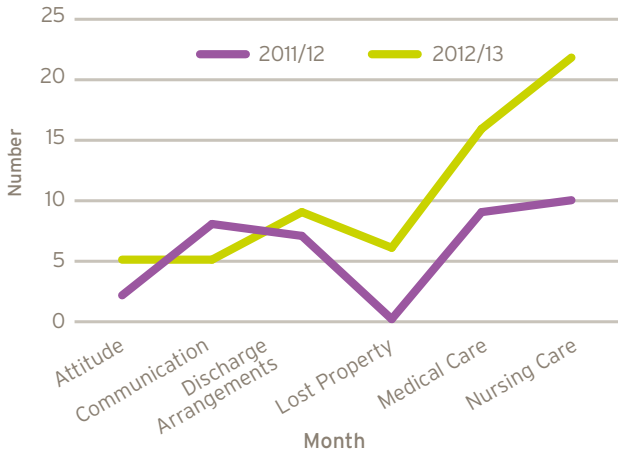
**Complaints related to patients who have a learning disability**

There have been 3 complaints in 2011/12 and 2013 related to the care of patients with a learning disability. The use of the Learning Disability care pathway is embedded in practice to support individual patients' needs whilst they undergo investigations and procedures. Effective use of this is overseen and monitored by the Learning Disability Liaison Nurse.

**Complaints about the Care of the Older Person**

Whilst there has been an increase in the number of complaints from DME patients or their families in 2012/13, this remains a low number. Practice within DME is that the consultants and ward sisters meet with patients and relatives to address questions or concerns and commit to resolving them at the time. We believe that the low complaint numbers are a result of this active process.

### Themes of Complaints received within the Division of Medicine for the Elderly



## 5.7 Performance against Key National Priorities 2012/13

| | | 2010/11 | 2011/12 | 2012/13 | Target 12/13 |
|---|---|---|---|---|---|
| Target 1: Clostridium Difficile | To achieve contracted level of no more than 31 cases per annum (hospital acquired) | 36 | 34 | 17 | 31 |
| Target 2: MRSA | To achieve contracted level of no more than 1 cases per annum | 1 | 2 | 2 | 1 |
| Target 3: Cancer | Maximum waiting time of 31 days from decision to treat to treatment start for all cancers | 98.6% | 98.3% | 99.6% | 96% |
| Target 4: Cancer | Maximum waiting time of 62 days from all referrals to treatment for all cancers | 88.5% | 87.5% | 90.3% | 85% |
| Target 5: Cancer | Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment | 97.4% | 96.7% | 95.6% | ***93%*** |
| Target 6: Cancer | Maximum waiting time of 31 days for second or subsequent treatment | | | | |
| | Surgery | N/A | 98% | 98.9% | 94% |
| | Anti-cancer Drugs | N/A | 98.2% | 99.8% | 98% |
| Target 7: Patient Waiting Times | Referral to treatment -percentage treatment within 18 weeks - admitted * | N/A | NA | Target achieved in all 12 months of the year | 90% |
| Target 8: Patient Waiting Times | Referral to treatment -percentage treatment within 18 weeks - non admitted ** | N/A | NA | Target achieved in all 12 months of the year | 95% |
| Target 9: Patient Waiting Times | Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways *** | NA | NA | Target achieved in all 12 months of the year | 92% |
| Target 10: Accident & Emergency | Maximum waiting time of 4 hours in A & E from arrival to admission | 98.2% | 96.6% | 98.5% | 95% |
| Target 11: Learning Disability | Compliance with requirements regarding access to healthcare for people with a learning disability | N/A | Achieved | Achieved | Achieved |

* Patient waiting times - Referral to treatment waiting times admitted 95th percentile is no longer a national target. Now replaced with Referral to treatment -percentage treatment within 18 weeks - admitted

** The new target for referral to treatment -percentage treatment within 18 weeks - non admitted – has been added

*** The new target for referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways – has been added

### Stroke

In 2012/13 we struggled to meet the stroke target of ensuring that 90% of patients spending 80% of their time on a stroke ward due to bed pressures. However, this position greatly improved towards the end of the year and we will be looking to maintain this as we develop its services to act as the hyper acute hub.

## 5.8 Performance against Core Indicators 2012/13

### 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 Jul 12 Jul 11 – Jun 12 | 108.32 | 100 | 69.01 | 124.73 | *2* |
| | Published Oct12 Apr 11 – Mar 12 | 105.28 | 100 | 71.02 | 124.75 | *2* |
| | Published Jan 13 (Jul 11 – Jun 12) | 102.47 | 100 | 71.08 | 125.59 | *2* |
| The percentage of patient deaths with palliative care coded at either diagnosis or speciality level *(The palliative care indicator is a contextual indicator* | Published Jul 12 Jul 11 – Jun 12 | 15.7% | 17.2% | 0% | 41.7% | *N/A* |
| | Published Oct12 Apr 11 – Mar 12 | 16.0% | 17.9% | 0% | 44.2% | *N/A* |
| | Published Jan 13 (Jul 11 – Jun 12) | 14.6% | 18.4% | 0.3% | ***46.3%*** | *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 2012/13.

### 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 (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| Patients aged 0 – 14 years | 2010/11 | 13.28% | 10.15% | 14.34% | 0.0% |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| Patients aged 15 years and over | 2010/11 | 10.13% | 11.42% | 15.33% | 0.0% |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |

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

- This is based upon clinical coding and the Trust is audited annually

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- This is based upon clinical coding and the Trust is audited annually.
- The hospital participated in a 2 day system wide audit with GP's, consultants and other clinical staff to review hospital readmissions and establish causes of the readmissions.
- The Trust does not routinely gather data on 28 day readmission rates

The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:
- It is recognised that due to the types of paediatric inpatient services provided, this results in repeated attendances and requirement for readmissions
- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission avoidance services available for patients to access. These include the Short Stay Medical Unit (SSMU), development of an Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team and the expansion of the Hospital at Home service.

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

## Indicator: Patient Reported Outcome Measures (PROMs) scores

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

| | Reporting period | L&D Score | National Average | Highest score (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| Groin hernia surgery | 2010/11 | 0.110 | 0.085 | 0.156 | -0.020 |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| Varicose vein surgery | 2010/11 | Not avail** | 0.091 | 0.155 | -0.007 |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| Hip replacement surgery | 2010/11 | 0.405 | 0.405 | 0.503 | 0.264 |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| Knee replacement surgery | 2010/11 | 0.325 | 0.299 | 0.407 | 0.176 |
| | 2011/12 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- Results are monitored by the Clinical Audit and Effectiveness Group
- Results are monitored and reviewed within the surgical divisions

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- Reviewing these results in both high level committees and within the surgical division
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

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

** 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 | 65.6 | 67.3 | 82.6 | 56.7 |
| | 2011/12 | 64.0 | 67.4 | 85.0 | 56.5 |
| | 2012/13 | 67.5 | 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:

- We will be introducing an Electronic Prescribing system and this will improve timeliness of available medications for patients to take home and will allow more time for nurses and pharmacists to explain medications to patients and their families.
- The hospital will be implementing the Perfect Day structure to wards and this will result in more nurses based at the bedside and improve experience of patients an their families.

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

## Indicator: Staff recommendation

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

| | Reporting period | L&D Score | National Average | Highest score (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| Percentage of staff who would recommend the Trust as a provider of care to family and friends. | 2010/11 | 57% | 66% | 95% | 38% |
| | 2011/12 | 57% | 65% | 96% | 33% |
| | 2012/13 | 61.5% | 63.3% | 94.2% | 35.3% |

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

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

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

- The hospital runs with a clinically led, operating structure
- launching a programme to support identification of cultural strengths and weaknesses and organisational values
- The Chairman and Non-Executive Directors have a programme of 3 x 3 clinical visits [3 hours every three months] and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee
- The ward buddy system has been launched in which all Executive Directors are linked to a buddy ward and undertake visits during which they talk to the staff and patients every month.

## Indicator: Risk assessment for venous thromboembolism (VTE)

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

| | Reporting period | L&D Score | National Average | Highest score (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| Percentage of patients who were admitted to hospital and who were risk assessed for VTE. | 2010/11 – Q4 | 90.3% | 80.8% | 100% | 11.1% |
| | 2011/12 - Q4 | 96.1% | 92.5% | 100% | 69.8% |
| | 2012/13 – Q4 | 95.3%+ | Not Avail* | Not Avail* | Not Avail* |

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

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

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

- The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching.
- There is daily clinical review and for any patient that have not been risk assessed, there is a follow up action to ensure that this is undertaken; this has resulted in achieving 95% and above compliance throughout 2012/13.
- We have audited compliance with use of appropriate prophylaxis and this has been 95% and above throughout 2012/13
- We will undertake root cause analysis on all patients that develop a VTE.

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

+Local Data

## 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 (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| 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 | 8.38+ | 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 thoroughly prior to submission. The data is also cross checked with laboratory data, and an external audit team supplied by KPMG has recently checked the accuracy of the Infection Control data and the data checked was correct with one transposition error that did not affect the score.



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
- An excellent improvement in performance during 2012/13 is noted with 17 cases of C.difficile in 2012/13

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

+ Local Data

### Indicator: Patient safety incident rate

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

| | Reporting period | L&D Score | National Average | Highest score (best) | Lowest score (worst) |
|---|---|---|---|---|---|
| Total number and rate of patient safety incidents (per 100 admissions) | 2010/11 | 7.51 | 5.67 | 1.61 | 29.71 |
| | 2011/12 | 8.56 | 6.13 | 0.94 | 21.71 |
| | 2012/13 | 9.3+ | 6.7+ | Not Avail* | Not Avail* |
| Total number and rate of patient safety incidents resulting in severe harm or death (per 100 admissions) | 2010/11 | 0.03 | 0.05 | 0.50 | 0 |
| | 2011/12 | 0.03 | 0.05 | 0.50 | 0 |
| | 2012/13 | Not Avail* | Not Avail* | Not Avail* | Not Avail* |

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

- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System
- 47 Serious incidents were reported in 2012/13.
- 70 avoidable and unavoidable grade 3 and 4 pressure ulcers were reported through the serious incident process during 2012/13.
- One never event was reported.

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

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

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

+ local data relating to March 2013 National Reporting Learning System Report for data 1st April 2012 – 30 September 2012

## 5.9 Embedding Quality – Workforce factors

Our 3,400 staff continue to be our most valuable asset when it comes to delivering a high quality, safe and efficient service to the patients we serve. Therefore, we must continue the drive to ensure that we have the right staffing levels, together with ensuring that we have a skilled, motivated and appropriately rewarded workforce. We understand that in order to achieve this it is necessary for us to invest in our staff and during 2012/13 one of our key corporate objectives focussed on developing staff to maximise their potential.

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

### 5.9.1 Providing staff with rewarding jobs

#### Recruitment

All new staff receive an induction to the Trust to ensure their health, wellbeing, information and knowledge-base adheres to the standard required for an organisation delivering healthcare services to the community. Our standards for both induction and statutory training comply with the requirements laid down by the NHS Litigation Authority.

During 2012/13 we recruited 105 qualified nurses and 81 HCAs. This recruitment activity has driven down established nursing vacancies to more manageable levels and more in line with natural turnover. As a result of this

recruitment we are starting to see a reduction in the use and cost of agency workers which in turn leads to improving the continuity of care delivered to patients.

## Staff Education Performance

The new University Hospital status is now embedded in the hospital, and has extended medical student training to new areas. This has enhanced the development of training skills in junior doctors, and we continue to work with UCLH to further develop the programme.

The delivery of Postgraduate Education has been formally assessed by the Deanery Performance and Quality Review (February 2013) with a successful outcome, supporting the high standards of training, the educational leadership and the Trust Board's support through the Division of Medical Education and Research. Most important is the feedback given by the trainees to the Dean that they would recommend the Trust to colleagues as a place for training which reflects the enthusiasm and training expertise of the trainers.

## Pre-Registration Education for Nurses and Midwives

We continue to provide placements for pre-registration students and undergo a yearly qualitative and quantitative assessment through the Performance and Quality Assurance Framework, monitored quarterly against an action plan to ensure continuous improvement.

## Appraisal and Personal Development Plans

The current appraisal system has been in place for the last two years and is seen as a valuable developmental tool for staff as well an effective way of reviewing individual performance. The new system continues to be externally audited and we now aim to further strengthen the links between performance and incremental progression in line with national amendments to Agenda for Change agreed from April 2013.

## Personal and Continuous Professional Development and Training

All staff are able to access education and training in The Centre of Multi-Professional Education and Training (COMET), which has a lecture theatre, seminar rooms, clinical device training rooms, a room with computers and library facilities. In addition, we run training in other venues around the hospital, as required, and sometimes hire external premises for seminars and team development events.

We ask all service managers to contribute to a training needs analysis annually which then feeds into our bid for regional funds for Continuing Professional Development. This also complements discussions at appraisal when individual personal development plans should be produced with each member of 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.

We work closely with clinical leads to ensure that updates in knowledge and skills are incorporated into the education and training that we offer. We consider that it is our role to support improvements in patient care through the development of staff competency.

In recognition of the national move towards a more blended approach to learning providing increased flexibility that does not always require staff to attend classroom-based training, we have 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 where there is a comprehensive range of materials in a variety of formats including ground-breaking research in the field of leadership.

To ensure that registered staff continue to update their knowledge and skills, 157 staff have attended higher education modules at three universities contracted to deliver courses through the Local Education and Training Board. In addition, 32 staff have attended a number of specialised courses linked to their professional development for the benefit of patients.

We continue to focus on providing staff with the opportunity to complete the European Computer Driving Licence (ECDL) with 9 completions at Level 1 and 7 completions at Level 2. There have been 32 new entrants indicating the continuing importance of supporting staff to develop their computer competencies.

We have substantially increased the interest in and uptake of qualifications for Bands 1 – 4 with 122 learners enrolled to an Apprenticeship in the last year. In addition to Team Leading, Business Administration and Customer Service, we have Health Care Assistants enrolled on a specialist healthcare qualification and catering staff starting a Hospitality Apprenticeship. The provision of Apprenticeships benefits staff that may not have been given educational opportunities previously.

We are also pleased to be engaged in a ground-breaking programme called 'Apprenticeship Steps' offering a group of adults with learning disabilities the opportunity to develop their work-based skills in partnership with Luton Borough Council. Following an intensive skills development programme, the participants will undertake a placement for 6 hours a week in the Trust.

### Clinical Leaders Programme

We have gone through a period of change in clinical leadership over the last 12 months with the roles and structure having changed. There have been a number of new appointments. We have committed to provide high quality learning and development opportunities to support these roles.

In doing so a programme has been agreed which includes skills workshops, knowledge seminars and expert speaker, all covering a wide range of themes.

The programme will be delivered by a mixture of external and internal facilitators

### Staff Health and Well Being

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

During 2012/13 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 Wellbeing 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 wellbeing section on the staff intranet, various electronic communications, newsletters, and awareness raising events.

'Lunch and learn' sessions continue to be popular as they give employees the opportunity to look at various topics that are conducive to good health. This year the topics covered areas such as Yoga, Skin Camouflage, Kettlecise and Nutrition and the dangers of shisha.

Particular highlights from this year include:

- Between October and December 2012 we vaccinated 52.9% of our frontline staff against flu, which was slightly higher than the year previous and higher than the National average uptake amongst NHS acute trusts. We were amongst the top 10 out of 40 NHS providers within the East of England.
- 12 NHS Trusts took part in the East of England Pedometer challenge 2012, with a total of 111 teams taking part. Our very own 'Catering Crawlers' came overall fifth, with 3 other L/D teams featuring in the top 20.

- Following on from information gleaned from the 2011 staff survey and subsequent feedback sessions the Trust chose to employ the services of an Employee Assistance Programme (EAP), to compliment existing support arrangements for staff within the Trust. The EAP offers all Luton and Dunstable staff access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. Advice is available on debt, legal, family and more general issues, and staff can call as often as they like and talk for as long as is needed. The service is available 24 hours a day, 365 days of the year.

## 5.9.2 Sickness Absence

The Trust recognises the impact of high levels of absence, both on quality of patient care, patient safety and the health and wellbeing of staff. To support proactive management of sickness absence across the Trust, investment was made at the beginning of 2013 to provide a particular focus on this issue and two senior Project Leads were appointed to facilitate this.

The aims of this project are:

- To develop a better understanding of the financial impact of sickness absence across the Trust.
- To develop a coaching approach to the management of sickness absence.
- To increase/improve the support and guidance available to managers.
- Shift attitudes and organisational culture around the management of sickness absence.

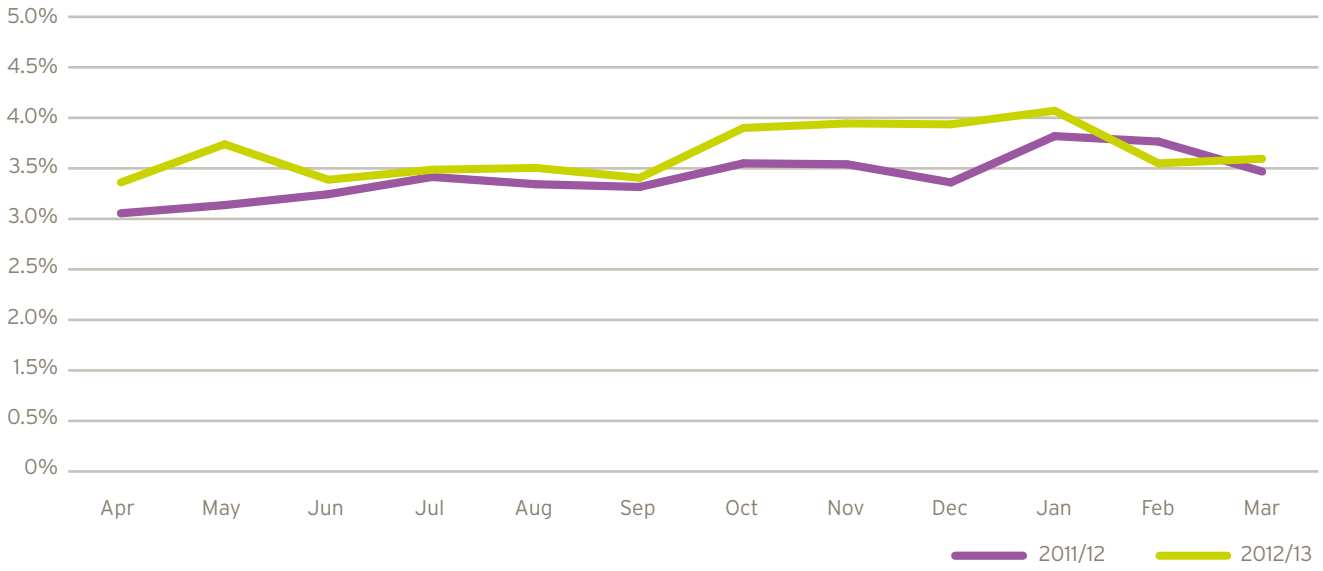
It is anticipated that this project will result in a reduction in a reduction in the number of staff with high rates of sickness absence.

Also, during 2012/13 the Trust has been implementing a new integrated, real-time web based absence management system across the Trust.

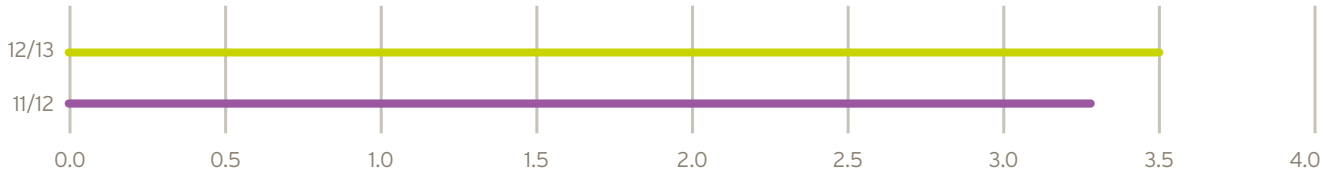
Some of the benefits of this system are:

- Improved absence visibility for managers and employees.
- A single point of entry for all absence data.
- Near real time reporting.
- Reduced cost of absence through improved visibility and controls.
- Integration with ESR.

**Actual Sickness Absence 11/12 vs 12/13**




**Full Year Sickness Absence 11/12 vs 12/13**




## 5.9.3 Staff Engagement and Consultation

The Trust prides itself in having a healthy and productive relationship with its staff and this is reflected in the staff engagement scores in the Staff Opinion Survey. Partnership working is demonstrated in many varied ways:

### Staff Involvement Group

This group focus 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 active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

### Staff Recognition

The L&D Staff Thank you day, held in July, was an opportunity to thank all staff for their hard work and commitment. Hundreds of staff attended the event, which was held in a marquee setting where a wonderful lunch and tea were served courtesy of the Trust's catering team.

This was followed by an impressive evening of dinner and awards where special recognition was given to those members of staff who had been nominated by managers and staff alike and who had made a real difference in their work at the Trust. Awardees came from across many staff groups and were recognised for going the extra mile to achieve extraordinary results and deliver high standards. The event included a series of videos highlighting some of the special developments and achievements in the previous two years.

In addition, as a thank you to staff and volunteers for all their hard work, the Trust provided a free Christmas lunch. This was very well attended and the Chief Executive used this opportunity to give her personal thanks and that of the Board of Directors.

## 5.10 Improving the Quality of our Environment

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

- **Outpatients** – We have begun to upgrade the main outpatient areas including new décor, furnishing and new sanitary facilities.
- **Endoscopy** – We have recently completed the first phase of a 2 phase scheme to both expand the Endoscopy Unit but also to upgrade and refurbish patient changing and recovery areas, thereby significantly improving dignity issues. The second phase will also seek to address ventilation issues in endoscopy rooms which will enhance infection prevention and control measures for patients and staff.
- **Theatres** – W have recently completed a significant refurbishment of the main theatre complex. This not only ensures the area is technically fit for purpose, but has significantly improved the environment for patients undergoing surgery and has improved the environment for staff.
- **Car parking** – We expanded the number of spaces in excess of 100 and whilst the new facility has expanded the number of spaces for staff initially, it will enable the number of spaces for patients and visitors in car parks closer to the hospital to increase, thereby improving patient experience.

During 2012/13 the hospital has been participating in the new monitoring programme PLACE (Patient Led Assessments of the Care Environment). This new system for assessing the quality of the hospital environment has come into effect since April 2013. Like PEAT inspections, patient representatives and Governors are included in the inspection teams.

## 5.11 Quality and Business Strategy

The Trust's quality and business strategies are aligned. The Trust has a commitment to quality and patient-centred services and the belief that higher quality services are ultimately less costly and generate more income underlines the approach taken to the commercial activities of the organisation. This means that the challenge of achieving the cost efficiency savings inherent in the national tariff is not delivered through reducing the quality or patient experience but by driving forward initiatives which will ensure that both corporate objectives are delivered. This includes investing in electronic solutions such as e-prescribing to reduce drug errors; investing in infrastructure to ensure carbon efficiency; developing our electronic document management to reduce costs and increase clinical effectiveness; and looking to reduce the length of stay in hospital

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

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

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

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

Quality is discussed and monitored at quarterly monitoring meetings with our local commissioning Primary Care Trust and agreement of Commissioning for Quality and Innovation goals for the coming year revolve around agreed areas for improvement. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

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

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 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) and on the arrangements that 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 2012/13;

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 2012 to March 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
- Feedback from the commissioners dated – yet to be received as at 22nd May 2013
- Feedback from Governors dated [17/4/13 and 15/05/2013];
- Feedback from Local Healthwatch organisations -yet to be received as at 22nd May 2013
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [April 2013];
- The 2012 national patient survey 16/04/2013;
- The 2012 national staff survey 28/02/2013;
- The Head of Internal Audit's annual opinion over the trust's control environment dated as received 15/5/2013 –; and
- CQC quality and risk profiles dated [April 2012 to March 2013].

The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

The performance information reported in the Quality Report is reliable and accurate;

We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

There is also clinical judgement in the classification of an incident as "severe harm" as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

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; and

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-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.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

22nd May 2013  Chairman

22nd May 2013  Chief Executive

# 7. Comments from stakeholders

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

Comments from Healthwatch Luton
01.05.2013

It is extremely positive to see the new developments and changes that have taken place throughout the previous year and we are pleased to see Luton and Dunstable Hospital University Foundation Trust (L&D) developing new models and structures to ensure that patients are receiving the standard of care that they deserve.

Healthwatch Luton would like to commend the L&D for their groundbreaking and innovative measures including the award winning patient call centre to interview discharged patients and to record ideas for improvements. By taking the initiative around implementing such a well received and pro active service, L&D has evidenced its commitment to putting patients at the forefront of care.

Similarly the introduction of the interactive appointment tools have demonstrably reduced the level of "Did not attend" patients missing appointments. We will continue to monitor this trend with interest in a hope that similar models can be implemented by other service providers. The decision to extend clinic opening times to weekends and evenings is also welcomed and will be monitored with interest.

Whilst there are many positive changes and improvements from the previous year it is disappointing to note that the response to complaints is far below an acceptable standard. This needs drastic and immediate improvement as there have been highlighted issues around communication at the L&D in the past. Healthwatch Luton would like to work closely with L&D to establish a new mechanism and framework to ensure this can be resolved as a matter of urgency.

We appreciate the transparency that L&D has demonstrated by highlighting the number of patients impacted by short notice clinic cancellations. In order to provide greater clarity it would be helpful if more information could be provided as to why these cancellations occurred, for example staff shortages.

It is reassuring to note that reducing avoidable pressure ulcers will continue to be a priority for the following year as there is clear evidence that more work needs to be done in this area. The procedures that have been suggested to address this seem promising and we look forward to receiving regular updates on the progress in this priority area.

A breakdown of complaints data has been provided which is very helpful and provides valuable insight into areas that are concerning patients. It has been mentioned that a total of three complaints have been received from patients with learning disabilities. Whilst it is important that this information is made available, it would greatly assist us if you can also provide statistical data regarding the total number of patients with learning disabilities that have been treated at L&D. This will allow for clear comparative analysis in relation to complaints.

Overall the L&D has had a very positive year. There have been many exciting and new developments including the opening of the highly anticipated cardiac unit. The successful acquisition of University status has also created new opportunities for training and development of staff and it is positive to see that this is being utilised effectively. Healthwatch Luton firmly believes that providing continued development for staff is vital to maintaining a high level of patient care and we are pleased that this is an ethos shared by L&D.

Finally, Healthwatch Luton would like to take this opportunity to thank all staff at L&D for their continued dedication and efforts. We look forward to working closely with the L&D in the coming year and hope that through partnership working we can continue to put patients first.

## Healthwatch Central Bedfordshire's Response to the Luton & Dunstable Hospital Trust's Quality Account 2012/13

Firstly, Healthwatch Central Bedfordshire thanks the Trust for the opportunity to comment on the L&D Hospital Trust Quality Account. As Healthwatch countrywide has only been operational since the beginning of April 2013, we will make a response based on legacy information handed to us by Bedfordshire LINk (Covering Central Bedfordshire).

The Quality Account is a well presented and very readable document ; we are particularly pleased to note the inclusion of a glossary of terms used.

Healthwatch Central Bedfordshire is only able to respond in terms of patients experiences and the feedback we have received. We fully endorse the measures the Hospital has used to gauge success in terms of patient experience and its vision:

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

In light of the findings of the Francis Report, it may helpful for the Hospital to include "listening" to the patients, not just "putting them first".

Before the end of the LINk's period in office, we were fortunate to have your Clinical Governance Lead attend the last LINk Health Working Group in March 2013, and members were able to relay both positive feedback as well as where patients felt improvements could be made. The positive comments were in relation to the new patient experience call centre where hospital personnel and governors contact patients 48 hours after discharge from hospital to see if everything is in order. The LINk had recorded a small number of cases where the discharge from hospital process for older patients at the Hospital had not gone well, and, in two cases patients had to be readmitted to Hospital, but we were assured that all was being done to ensure a safe and quality discharge for the patient.

It is reassuring to learn that emphasis will be placed on staff training, and that the Perfect Day Project where nursing staff spend some time at a patients bedside is being given more emphasis and focus. The care and attention received by nursing and auxillary has always been of huge importance to patients when recovering from surgery or illness in hospital.

Ruth Featherstone, Chair, Healthwatch Central Bedfordshire

June 2013

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

Luton and Bedfordshire Clinical Commissioning Groups (CCGs) have received the Quality Account 2012/2013 from Luton & Dunstable University Foundation Trust (L&D). The Quality Account was shared with Luton and Bedfordshire CCGs, and reviewed at the Patient Safety and Quality Committee and at Board level as part of developing our assurance statement.

We have reviewed the information provided within the Quality Account and checked the accuracy of data which was submitted as part of the L&D's contractual obligation. All data provided corresponds with data used as part of the ongoing contract monitoring process.
The L&D is required to rate their performance against national quality indicators within the Quality Account. The L&D has included this data. The rate of patient safety incidents for March 2013 is 6.7 (rate of patient safety incidents per 100 admissions, a high score indicates a good reporting culture) and this is in the highest (best) quartile of similar hospitals and is an improvement on March 2012 which was 6.3, we will continue to monitor progress in 2013/14. Luton and Bedfordshire CCGs have noticed an improvement in the Serious Incident report process and would like to see this continue and embed across all service areas. The L&D reported two Never Events which were both investigated appropriately and action plans, based on the learning from the investigations, were implemented to prevent reoccurrence.

Luton and Bedfordshire CCGs note that the L&D significantly achieved the 2012/13 CQUIN (Commissioning for Quality and Innovation) with the final position still being validated. Significant improvements were made in relation to dementia screening of their patients and onward referral.

Further work is required in 2013/14 to improve patient experience feedback. The L&D increased the number of patients asked to 10%. This is the nationally set minimum number of patients to ask for the net promoter score during 2012/13. However the L&D did not achieve their CQUIN as the positive patient response did not improve. It is recognised that the national inpatient survey identifies areas for improvement which have been included within the quality account and this will be monitored closely via the regular clinical quality review meetings.

The L&D has focused on reducing mortality related to fractured neck of femur and this is evident through the Quality Account. There are early signs that the work is beginning to have an impact and Luton and Bedfordshire CCGs will continue to support by monitoring actions to further improve outcomes for these patients. There has been good clinical engagement and leadership demonstrated and Luton and Bedfordshire CCGs would welcome this approach being replicated in other service areas, such as stroke care. Stroke care has seen some variations in service during 2012/13 and would benefit from a renewed focus on leadership, delivery and outcomes.

The L&D has worked on improving privacy and dignity for patients by ensuring the guidance for eliminating mixed sex accommodation has been carried out. Luton and Bedfordshire CCGs would like to see no breaches for non-clinical reasons now the estate works have been completed and will continue to monitor closely.

We welcome the L&D's commitment to participation in national and local audits and we will continue to support the Trust in ensuring its services use the outcomes of these audits to drive further quality improvements and a reduction in variation in clinical care.

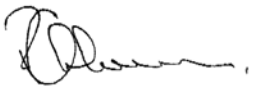
The Trust's overall management of infection prevention and control is good. Unfortunately the L&D has exceeded the ceiling for MRSA bacteraemia, by one case; however it achieved a significant reduction in clostridium difficile infections. Luton and Bedfordshire CCGs hope that the L&D will continue to work collaboratively to reduce the risk of healthcare associated infection.

The quality priorities for 2013/14 are supported by Luton and Bedfordshire CCGs and we look forward to working with the L&D to achieve targets set out within the account.

Luton and Bedfordshire CCGs acknowledge that the L&D has unconditional registration with the CQC (Care Quality Commission).

The recommendations from the Francis Report and ongoing actions will form a key part of Luton and Bedfordshire CCGs assurance monitoring in 2013/14. Luton and Bedfordshire CCGs support the L&D's rationale and indicators for 2013/14 and we look forward to working collaboratively to achieve good quality outcomes for the people of Luton and Bedfordshire.

Carol Hill ,Chief Officer
Luton Clinical Commissioning Group



Paul Hassan, Accountable Officer
Bedfordshire Clinical Commissioning Group

## Comments from Luton Scrutiny: Health and Social Care Review Group

The Luton Scrutiny: Health and Social Care Review Group (HSCRG) welcomes the opportunity to comment on the Luton & Dunstable (L&D) Hospital's Quality Account 2012-13 and their priorities for 2013-14.

During the last year, HSCRG has developed working relationships with NHS and adult social care partners. Members are pleased the L&D Hospital is fully committed to engage with the health overview and scrutiny process. A couple of examples of their practical involvements with health scrutiny are provided below.

In March 2013, Trust's representatives, including its Chair took part in the scrutiny of Coroner's Procedure, an end of life issue. As a result of evidence obtained from numerous witnesses, the committee identified problems with the release of bodies for burial caused by delays at various points in the death certification process. It made a number of recommendations for services, including the hospital Trust, to address the problems. The committee was grateful for the positive attitude of the Trust's representatives. Members note with interest and welcome the Trust's focus on re-designing end of life care to improve patients and relatives' experience.

At the time of writing (9th May 2013), a scrutiny Task & Finish Group was reviewing 'discharges from hospital', a topic involving all NHS partners and the Council's adult social care. The hospital's Director of Operations and other senior officers were fully engaged supporting the review, an excellent example of the Trust's willingness to work with the Council's health overview and scrutiny to improve patients' experience.

Members welcome the Trust's focus on measures to reduce length of stay for older people and reducing avoidable emergency re-admissions. They also welcome the introduction of the Patient Experience Call Centre, to obtain timely feedback from patients of their experience of the care and services received. They note the increase in the number of complaints about discharge arrangements from 33 last year to 47 in 2012-13, recognising this may be partly due to active encouragement for patients to speak up.

Members note the improvement the Trust has achieved against most of its 2011-12 priorities and its continued focus on them in the coming year. They are encouraged to see the steady improvement from 53.3% to 62.6% in Friends and Family Score, relating to how likely patients were to recommend the ward to friends and family. They also note the Trust compliance with the Care Quality Commission's quality standards and its continued unconditional registration.

In conclusion, Members of the HSCRG are content with the overall performance of the Trust against its Quality Accounts 2012/13 priorities and endorse its corporate objectives for 2013/14, around clinical outcome, patient safety and patient experience. Members look forward to the Trust continuing to meet the needs of service users in the forthcoming year and beyond, and maintaining its engagement with health overview and scrutiny.

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

There is no response from Central Beds Health Overview and Scrutiny Committee to the Quality Account 2012-13.

## Comments received from the Trust Stakeholders

| Comment | Response |
|---|---|
| Ensure that the graphs reflect the commentary | Graphs amended |
| Clarification on the graphs in the Outpatient section | Further commentary added |
| Additional wording on stroke and learning disabilities | Wording added |
| Clarification on serious incidents and never events | Added to page 55 |

# 8. Independent Auditor's Assurance Report

## Independent Auditor's Report to the Council of Governors of Luton and Dunstable Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Luton and Dunstable Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

**Scope and subject matter**
The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these 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 below; 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 *Detailed Guidance for External Assurance on Quality Reports*.

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:

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to
- May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from local Healthwatch organisations dated May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012/13 national patient survey;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles 2012/13; and
- The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment.

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 Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Luton and Dunstable Hospital 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 2013, 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 Hospital NHS Foundation Trust for our work or this report save 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 N*HS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- 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.

**Limitations**

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 impact 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 thereof, 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 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 2013:

- 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 above; 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*.

KPMG LLP

KPMG LLP, Statutory Auditor
Chartered Accountants, London
29 May2013

# 9. Glossary of Terms

| | |
|---|---|
| **Anticoagulation** | A substance that prevents/stops blood from clotting |
| **Arrhythmia** | Irregular Heartbeat |
| **Aseptic Technique** | Procedure performed under sterile conditions |
| **Cardiac Arrest** | Where normal circulation of the blood stops due to the heart not pumping effectively. |
| **Chronic Obstructive Pulmonary Disease (COPD)** | A disease of the lungs where the airways become narrowed |
| **Clinical Audit** | A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change |
| **Continence** | Ability to control the bladder and/or bowels |
| **Critical Care** | The provision of intensive (sometimes as an emergency) treatment and management |
| **Elective** | Scheduled in advance (Planned) |
| **Epilepsy** | Recurrent disorder characterised by seizures. |
| **Heart Failure** | The inability of the heart to provide sufficient blood flow. |
| **Hypercalcaemia** | The elevated presence of calcium in the blood, often indicative of the presence of other diseases |
| **HSMR** | Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate. |
| **INOV8** | Inov8 is an Air Disinfection (AD) Unit. The AD Unit supplied by Inov8 is a piece of equipment that is part of the L&D Infection Control Prevention procedures. It is a small unit that offers levels of microbiological air disinfection. |
| | |
| **Laparoscopic** | Key hole surgery |
| **Learning Disability** | A term that includes a range of disorders in which the person has difficulty in learning in a typical manner |
| **Meningococcal** | Infection caused by the meningococcus bacterium |
| **Magnetic Resonance Imaging (MRI)** | A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures |
| **MUST** | Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight. |
| **Myocardial Infarction** | Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged. |
| **Myringotomy** | A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid |
| **Neonatal** | Newborn – includes the first six weeks after birth |
| **Non Invasive Ventilation (NIV)** | The administration of ventilatory support for patients having difficulty in breathing |
| **Orthognathic** | Treatment/surgery to correct conditions of the jaw and face |
| **Parkinson's Disease** | Degenerative disorder of the central nervous system |
| **Patient First** | Patient First is a Luton and Dunstable Hospital Initiative that focuses on team and staff behaviour to improve the patient experience |
| **Perinatal** | Period immediately before and after birth |
| **Pleural** | Relating to the membrane that enfolds the lungs |

| | |
|---|---|
| **Safety Express** | Safety Express is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism |
| **Seizure** | Fit, convulsion |
| **Sepsis** | The presence of micro-organisms or their poisons in the blood stream. |
| **Stroke** | Rapid loss of brain function due to disturbance within the brain's blood supply |
| **Syncope** | Medical term for fainting and transient loss of consciousness |
| **Transfusion** | Describes the process of receiving blood intravenously |
| **Trauma** | Physical injury to the body/body part |
| **UTI** | Urinary Tract Infection |
| **Venous Thromboembolism (VTE)** | A blood clot that forms in the veins |

**Research – Glossary of terms**

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

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

# Appendix A - Local Clinical Audits

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Paediatric Emergency Re-admissions to Hospital<br><br>N = 40 cases (Re-admissions August -November 2011)<br><br>Links to:<br>CQC: 4, 16<br>NHSLA: 2.6 | Paediatric Medicine | Clinical Audit (Retrospective) | May 2012 | Main aims:<br>• Identify key factors which contributed to an emergency re-admission within 7 days & 30 days post primary discharge<br>• Identify potential actions that may help to reduce the number of emergency re-admissions.<br>Audit identified that the majority of patients (70%) self presented to the hospital. In two-thirds of cases, the re-admission was linked to symptoms treated during the primary admissions. Clinical reviews found that 47% of the re-admissions may have been averted and recommendations include improving the advice and information given to patients/carers as part of discharge process. |
| In-Patient Internal Referrals (Yellow Boards) In Emergency Medicine<br><br>N = 30 (Prospective referrals March 2012)<br><br>Links to:<br><br>Local Policy<br>CQC: 4, 6, 16, 21<br>NHSLA: 1.8, 2.6, 4.9 | Emergency Assessment Unit | Re-audit (Prospective) | May 2012 | Main aims:<br>• Re-measure compliance with Trust policy<br>• Measure areas of improvement since 2009<br>• Identify if there are delays in obtaining review by recipient teams<br>Re-audit has shown high compliance within the same standards. Significant improvement in the recipient documenting the date of their clinical review. Areas for improvement include recording the time of initiating the referral and the time that the recipient completed their review.<br>It is noted that the process for requesting and responding to inter-Consultant referrals will change during 2012-13, as part of the Trust's electronic patient record (EDRMS) project. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Intended In-patient / Day Case Management for Ophthalmology Procedures<br><br>N = 49 cases (of 55 cases either booked or managed on an In-patient basis).<br><br>Links to:<br><br>Dr. Foster RTM Dec10-Nov11<br>CQC: 4, 16, 21<br>NHSLA: 2.6, 4.10 | Ophthalmology | Re-audit (Retrospective) | May 2012 | The procedure group of Cataracts (+/- implant) has continued to flag as an alert within Dr. Foster RTM Day Case reports. Previous audits have identified that the majority of patients are discharged on the day of surgery. Action plans have targeted booking criteria and IPM (PASO system entries.<br>Main aims:<br>• Identify key reasons for booking patients as needing in-patient management<br>• Improve the Trust's Day Case performance within cataract surgeries.<br>Findings have shown that 60% of the cases were booked on the Trust PAS system as intended in-patient management – over half had been recorded as Day Case on the Waiting List form.<br>28% required in-patient stay after being booked as a Day Case. In terms of accuracy of the discharge date/time on the PAS (IPM) system, there was 90% congruency with the date/times recorded within the patient records.<br>The actual in-patient rate for the period Jan-Dec 2011 has been re-calculated as 28 cases of 2659 elective cases (1.1%), which is better than the national rate.<br>Actions are being taken forward by the Ophthalmology MDT to improve the administrative elements of caseload management. |
| Annual Audit of Neonatal & Postnatal Admission Records<br><br>N = 40 records (April 2012)<br><br>Links to:<br><br>CQC: 4, 16, 21<br>NHSLA: 1.8, 2.6<br>CNST: 5.3, 5.9 | Neonatology | Re-audit (Retrospective) | May 2012 | Audit is an integral part of the CNST & NHSLA processes to measure completeness & accuracy of admission records. Current findings were compared with previous audit findings & subdivided into NICU results & Post Natal Ward results.<br>NICU results a marked decline in the recording of NHS number, suboptimal recording of gestational age, birth weight & Vitamin K administration.<br>Documentation of genitalia & baby condition at birth remains high.<br>Post natal results show that improvements are needed in documenting baby genitalia, resuscitation details & staff present at delivery.<br>There has been marked improvement in condition at birth since the previous audit.<br>Actions for improvement will be jointly led by Medical & Nursing staff within Obstetrics & Neonatology. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Assessment & Early Management of Patients Admitted with suspected Alcohol Dependence or Misuse<br><br>N = 16 admissions over 2 month period (Sept-Oct 2011)<br><br>Links to:<br><br>NICE Quality Standard<br>NICE Clinical Guideline 100<br>CQC: 4, 6, 16<br>NHSLA: 2.6, 2.8, 5.6 | Hepatology | Audit (Prospective) | June 2012 | A joint Trust & James Kingham Project audit.<br>Main aims:<br>• To improve the assessment & early management of patients with suspected alcohol dependence / misuse<br>• Measure compliance with NICE Quality Standard.<br>Findings have shown good compliance with taking alcohol history during the admission assessment process, prescribing of vitamin supplements & referral to Hepatology. Actions include: improving adequacy of the detoxification prescriptions & access to regular training sessions for staff on assessment & early management of patients admitted with alcohol issues. There is also scope to further improve opportunistic screening & referral to external specialist alcohol services.<br>A local guideline will be available by autumn 2012. |
| Use of Clopidogrel & Modified Release Dipyridamole for Prevention of Occlusive Vascular events<br><br>N = 33 cases (April 2012)<br><br>Links to:<br><br>NICE TA 210<br>CQC: 4, 16<br>NHSLA: 2.6, 2.8 | DME (Stroke) | Audit (Prospective) | June 2012 | Main aims were:<br>• to measure local compliance against 4 audit criterion derived from NICE TA 210 guidance<br>• identify areas for improved practice<br>2 audit criteria did not apply to cases captured within the audit sample. There was 100% compliance achieved within the remaining two criteria.<br>The audit did not identify any areas requiring improvement. However, the results have been disseminated to the Clinical Commissioning Group to consider actions within Primary Care toconsider the prescribing of Clopidogrel/Modified release Dipyridamole for patients currently receiving aspirin only. |
| Management of Hyponatraemia<br><br>N = 66 cases<br><br>Links to:<br><br>CQC: 4, 6, 16, 21<br>NHSLA: 2.6, 5.6 | Gen Medicine | Audit (Retrospective) | June 2012 | Main aims: Improve management & patient outcomes for patients presenting to hospital with hyponatraemia.<br>List of 14 local audit measures identified, some of which included sub-criteria.<br>The findings indicate actions to improve within 17 areas relating to clinical assessment, the ordering appropriate investigations & follow-up post discharge. The recommendations have been taken forward within junior doctor training sessions and ICE clinical biochemistry report alerts. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Day Case Surgery in Orthopaedic Arthroscopy procedures<br><br>N = 40 cases<br><br>Links to:<br>Dr. Foster RTM8 Clinical Benchmark period Dec 2011-Nov 2011<br><br>CQC: 4, 16, 21<br>NHSLA: 1.8, 2.6, 4.10 | Orthopaedics | Re-audit (Retrospective) | June 2012 | The Trust continues to alert within Dr. Foster benchmarks within the Arthroscopy procedure group. Previous audit completed in 2011 identified causal factors and areas to improve performance.<br>Main aims: to improve performance in Arthroscopy Day Case benchmarking and re-explore factors that influenced decisions for in-patient management.<br>Findings demonstrated that the majority of cases were identified as suitable for Day Case surgery at the time they were booked by surgeons. Changes are made to the intended management for many patients following pre-operative assessment to support the bed booking process.<br>The audit also identified that a third of patients subsequently planned for in-patient stay, were actually discharged home on the day of surgery & do not fulfil the national day case management criteria. Administrative errors accounted for 13% of cases where there was disparity between actual length of stay and the date of discharge recorded on the Trust PAS system.<br>Actions identified to improve:<br>- pre-operative assessment records for changes to the original planned management<br>- improvements to ward administrative processes |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Emergency Surgery Pre & Post Commissioning of the Modular Vanguard Unit<br><br>N = 40 cases (20 cases October 2011 & 20 cases January 2012)<br><br>CQC: 4, 16<br>NHSLA: 2.6, 4.10<br>QIPP | Gen. Surgery | Audit (Retrospective) | June 2012 | As part of the Trust's Theatre efficiency work streams, the Trust commissioned a temporary Modular Day Case Surgery Unit in November 2011. This would help to maintain access to dedicated emergency slots within one Theatre within the Central Operating Department.<br>Objective: clinical case reviews for patients requiring emergency surgeries prior to and following the commissioning of the Vanguard Unit:<br>- compare access to emergency Theatre space<br>- identify factors which delayed access to surgery<br>- compare patient outcomes & LoS<br>The audit included a representative sample of emergency cases.<br>Within the constraints of this audit, the conclusion is that the Modular Unit has supported an efficient & effective non-elective surgery service.<br>The audit provided qualitative data which will be used to support quantitative being collected by the Improvement team:<br>- to inform the exit strategy for the Vanguard Unitto inform future arrangements to manage emergency surgery caseload. |
| Early Recognition & Early Management of Ovarian Cancer<br><br>N = 28 cases (Jan – December 2010)<br><br>Links to:<br>NICE CGs 27 & 122 & Quality Standard (2012)<br>CQC: 4, 6, 16<br>NHSLA: 2.6, 2.8, 5.7 | O&G | Audit (Retrospective) | July 2012 | Baseline audit to measure compliance with 14 NICE audit criterion.<br>Findings indicated that 50% of the standards were either fully met or achieved high levels of compliance. Four standards achieved compliance < 75%.<br><br>One of the recommendations is currently not practiced locally (use of Risk Malignancy Index – RMI-1) and it is recommended that the MDT considers including this within case reviews to plan clinical management. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Generic Skills & Knowledge for Assistant Therapy Roles: Phase 1<br><br>N = 13 respondents (return rate of 81%)<br><br>Links to:<br>CQC: 12, 14<br>NHSLA: 2.6, 3.5<br>QIPP | Therapies | Staff Survey | July 2012 | Assistant roles were introduced within Occupational Therapy & Physiotherapy during 2011, as part of the Department's efficiency programme.<br>Phase 1 (Staff Survey) was undertaken during May 2012, to receive feedback from staff employed as a Generic Therapy Assistant. The purpose of the survey was to receive feedback on the training programme & completion of the competency sign off process. The results will inform future training and supervision for staff employed into these roles.<br>Feedback indicates that attendance to the initial training programme needs to be more carefully monitored. The Generic Skills Checklist which is used by qualified staff to assess completion of all Competencies will be re-launched. In addition, some Assistants identified delays in completing and having their competencies signed off. The Dept will introduce firmer deadlines for these to be completed.<br>Phase 2 is planned during autumn 2013. |
| End of Life Care (Trust-wide) – Part A<br><br>N = 58 respondents (return rate of 81%)<br><br>Links to:<br>CQC: 1,4,16<br>NHSLA: 2.6, 3.5 | Trust wide | Staff Survey | July 2012 | The DH strategy for End of Life Care recognises the multiple challenges when caring for patients approaching end of life.<br>PART 1 of the audit included a survey of non-consultant medical staff and registered nurses to obtain feedback to support the training & educational needs of staff involved in end of life care.<br>The survey findings have identified the need to improve training in:<br>-consent & MCA<br>-communicating bad news<br>-launch of the E Learning programme for EoL Care<br>Phase 2 will involve clinical case reviews (planned winter 2012/13) |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Prevention of Early-Onset Group B Streptococcal Disease in the Newborn<br><br>N = 20 cases (April – June 2011)<br><br>Links to:<br><br>CQC: 4, 8, 16<br>NHSLA: 2.1, 2.6, 5.6 | NICU | Audit (Retrospective) | July 2012 | Baseline audit to measure compliance with local clinical guidance, including maternal screening practices, the application of intrapartum antibiotic prophylaxis, and the early management of neonates identified as at increased risk of developing early-onset GBS infection.<br><br>Findings indicated that 13 standards were fully met. Two standards demonstrated moderate compliance and 15 standards achieved compliance <74%.<br><br>Actions to improve discharge documentation, including information given to parents, community midwives & GPs. Also actions to replace the current triplicate discharge letter with a typed discharge letter. |
| Re-audit of Venous Thromboprophylaxis in Medicine<br><br>N = 30 cases (April 2012)<br><br>Links to:<br><br>NICE Quality Standard<br>NICE Clinical Guideline 92<br>CQUIN Goal 2011/2012<br>CQC: 4, 9, 16, 21<br>NHSLA: 2.6, 2.8, 5.9 | Gen Medicine | Audit (Retrospective) | July 2012 | Re-measure compliance with the standards identified in NICE Clinical Guideline 92 for the assessment and prevention of venous thromboembolism.<br><br>Nine audit criteria identified. Findings indicated 2 standards were fully met. One standard demonstrated high compliance; 2 standards measured moderate compliance and 4 measures achieved compliance <74%.<br><br>The audit suggests that risk of bleeding is predominantly assessed within 24 hours of admission, with few having risk of bleeding assessed as part of admission clerking.<br><br>The re-audit shows a fall in compliance with regards to the appropriate prescribing/with-holding of pharmacological thrombo-prophylaxis and is an area for targeted interventions.<br><br>The current audit indicates compliance in the provision of patient information and advice about VTE & VTE prophylaxis has declined further since the baseline audit and is another area for targeted interventions |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Audit of Chronic Heart Failure<br><br>N = 38 cases (20 In-patients & 18 Outpatient new referrals)<br><br>Links to:<br>NICE Quality Standard for HF<br>Nice cg 108<br><br>CQC: 4,6,9,16,21<br>NHSLA: 2.6, 2.8, 5.7, 5.10 | Cardiology | Audit (Retrospective for In-patient cases & Prospective for new HF referrals to OPD) | July 2012 | The main objective was to measure local compliance with national standards for the diagnosis & management of chronic heart failure (HF).<br><br>A total of 13 individual audit criteria were identified (within 10 categories).<br>Findings have shown high compliance (>90%) for 5 criteria. There was moderate compliance (76% - 89%) for 1 standard. One of the standards measured local uptake to a cardiac rehabilitation programme – 9% were referred & 6% accepted.<br><br>Generally, compliance with the audit standards was higher within the out-patient referral group.<br><br>The findings will be integrated within the local & network discussions on the possible introduction of BNP assessment for in-patients as well as improving referral for specialist review for admitted patients. |
| Audit of the Use of Rituximab in Rheumatoid Arthritis following failure of TNF Inhibitor<br><br>N = 18 cases receiving Rituximab treatment<br><br>Links to:<br>NICE CG 79 & NICE TA 195<br><br>CQC: 9, 16<br>NHSLA: 2.8, 5.10 | Rheumatology | Audit (Retrospective) | August 2012 | The overall objective was to measure local compliance with NICE TA 195.<br><br>7 audit criteria were identified based up NICE recommendations.<br>The audit sample included 2 patients treated as exceptional requests to use Rituximab monotherapy. One further case had Rituximab monotherapy after side effects to Methotrexate.<br><br>Overall, the audit demonstrated high levels of compliance with national recommendations of the use of Rituximab therapy in this group of patients. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Audit of the Management of Infective Endocarditis<br><br>N = 8 of 10 coded admissions 2011<br><br>Links to:<br>ESC Guidelines & NICE CG 64<br><br>CQC: 4, 9, 16<br>NHSLA: 2.8, 5.7, 5.10 | Joint Cardiology & Microbiology | Audit (Retrospective) | August 2012 | The background to the audit followed a perceived increase in the number of admissions coded as I.E during 2011.<br>The main aim was to improve the management of I.E in patients presenting at higher risk.<br><br>A preliminary review of the coding data identified that 4 patients had multiple admissions which included follow-up antibiotic treatments (i.e not a primary presentation).<br>Case reviews for 8 cases showed one coding error, and this case was excluded from the audit sample.<br>Three patients were transferred to a tertiary service as part of their ongoing management.<br>The audit recommends early involvement of the cardiology & microbiology teams to support the diagnostic / investigations process. |
| Re-audit of Outcomes Following Division of Ankyloglossia for Breastfeeding<br><br>N = 50 cases (April 2011 – April 2012)<br><br>Links to:<br>NICE Interventional Procedure 149 | Oral & Maxillofacial Surgery | Audit (Retrospective) | August 2012 | Baseline audit conducted in 2009 with overall positive outcomes to the tongue-tie divisions performed during this audit period.<br>Re-audit to measure intra-procedural outcomes/ complications; measure local outcomes; identify areas requiring further actions.<br>NICE recommends that division of tongue-tie for breastfeeding should only be performed by registered health professionals who are properly trained. Locally, tongue tie division is undertaken by Consultants, therefore compliant with the NICE recommendation.<br><br>Current evidence suggests that there are no major safety concerns surrounding this procedure and limited evidence suggests that this procedure can improve breastfeeding. NICE quote success rates of 95% for improved breastfeeding 48 hours after tongue-tie division, and Griffiths (2004) reported success rates of 80% for improved feeding at 24 hours. Locally, the Early Assessment Check is usually carried out a few days post procedure but can be carried out up to a month post procedure in some cases. This repeat survey found that 85% of the mother's reported that feeding was better at the Early Assessment Check. This is comparable to the success rate reported by Griffiths (2004).<br><br>Actions to continue to pursue training for Int Board Certified Lactation Consultant to perform frenotomy and to identify ways to dividing tongue-ties when Consultant is absent . |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Sedation in Children and Young People<br><br>Sedation for Diagnostic and Therapeutic Procedures in Children and Young People<br><br>N = 40 cases (July 2011 – March 2012)<br><br>Links to:<br><br>NICE Clinical Guideline 112<br>CQC: 4, 16<br>NHSLA: 2.1, 2.6, 2.8, 5.2 | Paediatrics | Audit (Retrospective) | August 2012 | The overall objective was to measure local compliance with NICE CG 112.<br><br>19 audit criteria were identified based upon NICE recommendations.<br><br>Findings indicated 5 standards were fully met. Eight standards demonstrated high compliance; 7 standards demonstrated moderate compliance and 9 standards achieved compliance <74%.<br><br>Several actions identified requiring targeted teaching and training for staff involved in the assessment and delivery of sedation in children and young people. |
| Re-Audit of Post Traumatic Eye Observations (Literature & Local Protocol)<br><br>N = 39 patients having surgery between January 2012 to July 2012<br><br>Links to:<br><br>CQC Standards: 4, 16<br>NHSLA Standards: 2.1, 2.6 | Oral & Maxillofacial Surgery | Patient Survey | December 2012 | A baseline survey looking specifically at patient experience within the Oral and Maxillofacial surgery department was required to identify areas for improving patient experience.<br><br>Main aims of the survey:<br>• To identify levels of patient satisfaction within the Oral and Maxillofacial Surgery department<br>• To identify specific areas for improving patient experience<br><br>The survey identified delays with patients seen in clinic; lack of information regarding how to contact the department if necessary; % of staff introducing themselves suboptimal.<br><br>Actions to minimise any delays for patients seen in clinic; Informing patients if delays are encountered; staff to introduce themselves to patients prior to treatment/consultation; & developing information leaflet for patients including contact details of the department. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Venous Thromboembolism – Re-Audit of NICE CG 92 General Surgery<br><br>N = 132 cases (May 2012 – July 2012)<br><br>Links to:<br><br>NICE Quality Standard<br>NICE Clinical Guideline 92<br>CQUIN Goal 2011/2012<br>CQC: 4, 9, 16, 21<br>NHSLA: 2.6, 2.8, 5.9 | General Surgery | Audit (Retrospective) | January 2013 | Re-measure compliance with the standards identified in NICE Clinical Guideline 92 for the assessment and prevention of venous thromboembolism.<br><br>Six audit criteria identified. Findings indicated 1 standard was fully met. Four standards demonstrated high compliance; and 1 measure achieved compliance <74%.<br><br>There has been a general improvement/high compliance demonstrated against the audit standards<br><br>Actions to continue regular spot checks of VTE risk assessment completion across all General Surgical wards. Further actions to continue to use ExtraMed ensuring it is updated daily . |
| Group Hand Therapy Evaluation<br><br>N = 28 (June – December 2012)<br><br>Links to:<br><br>CQC: 1, 4, 13, 16<br>NHSLA: 2.6 | Therapies | Evaluation (Patient Survey) | January 2013 | Measure the impact of group therapy sessions on the management of patients.<br>Survey identified:<br><br>• All patients (100%) found the day/time of group satisfactory<br>• 96% of patients felt group had right number of patients<br>• 93% of patients felt that there were adequate resources to assist with the treatment<br>• All patients considered the activities a useful part of treatment<br>• All patients felt they had progressed since starting the group sessions<br><br>Actions to increase resources in terms of equipment available . |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Management of Babies Born following Maternal Prolonged Rupture of Membranes<br><br>N = 42 (May – December 2011)<br><br>Links to:<br><br>Local Clinical Guidance<br>CQC: 4, 8, 16<br>NHSLA: 2.1, 2.6, 5.6 | NICU | Audit (Retrospective) | January 2013 | Baseline audit to measure compliance with local clinical guidance, including the application of antibiotic prophylaxis, and the management of babies following maternal prolonged rupture of membranes.<br><br>Findings indicated 20 standards were fully met. Two standards demonstrated moderate compliance and 16 standards achieved compliance <74%.<br><br>Actions to improve discharge documentation, including information given to parents, community midwives & GPs. Also actions to replace the current triplicate discharge letter with a typed discharge letter. |
| Pain Management in Hospital Inpatients 2012<br><br>Annual Survey and Audit of Medical Records<br><br>N =<br><br>Inpatient Survey = 111<br><br>Records Audit = 30<br><br>Links to:<br><br>CQC: 1, 4, 9, 16<br>NHSLA: 2.1, 2.6, 5.10 | Anaesthetics | Survey & Audit | January 2013 | Annual survey to measure the efficacy of the action plans formulated within previous surveys; & to inform the ongoing development of pain management care for all in-patients at the Trust.<br><br>Additionally, the medical records audit was required to measure current documentation of pain scores and pain management.<br><br>Audit identified 86% of patients surveyed reported that they experienced pain during their pain with 41% experiencing unbearable pain.<br><br>Actions to improve:<br>• On the spot ward checks<br>• Work with poorly achieving wards<br>• Participate in Enhanced Recovery Programme<br>• Delivery of on-line pain education programmes<br>• Continually monitor standards<br>• Develop pain assessment system for cognitively impaired patients / patients unable to communicate |

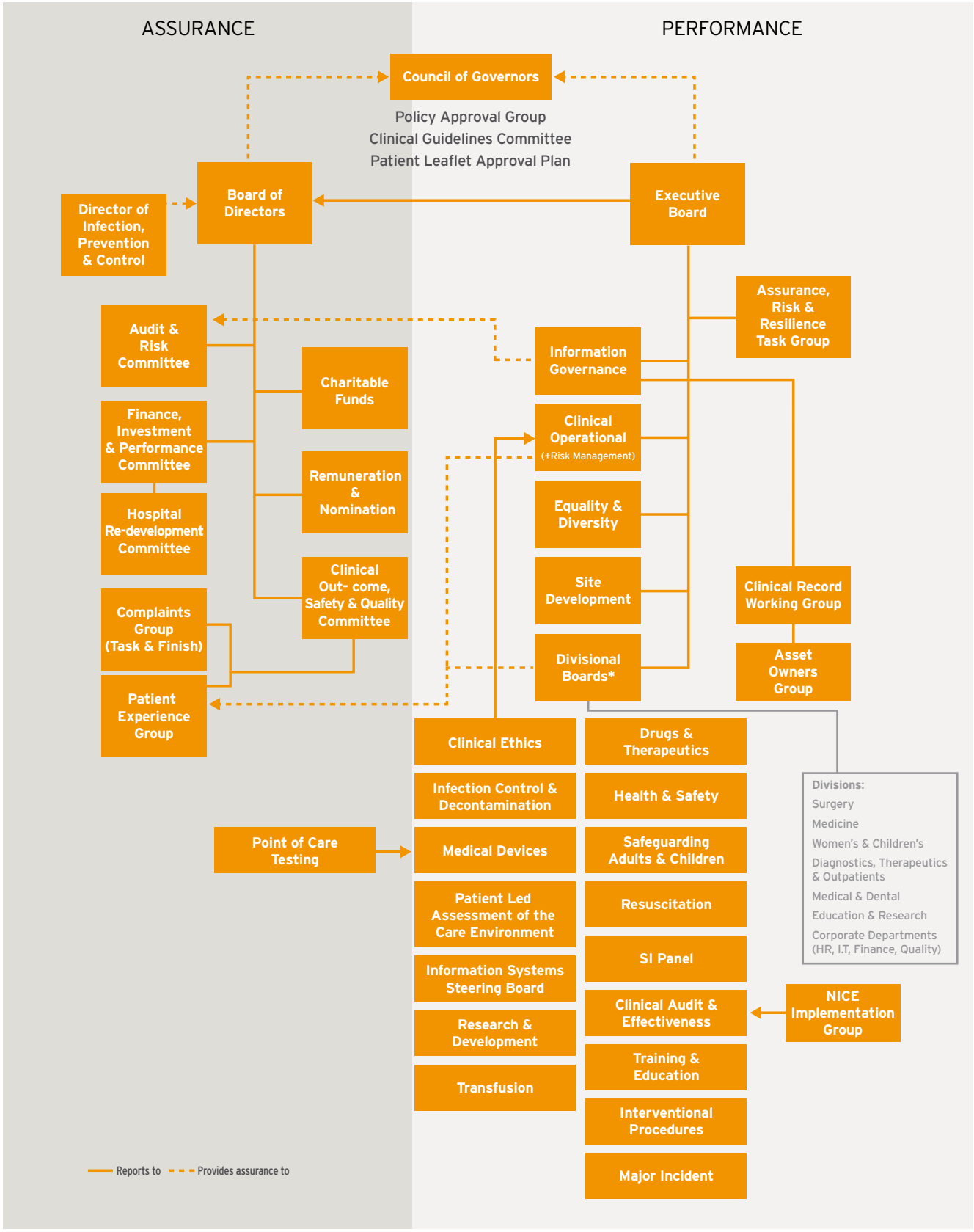
| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Consent (Local & DoH Guidance) | Trust | Patient Survey (July 2012)<br><br>Staff Survey (August 2012) | February 2013 | Patient Survey (55 respondents – 85%)<br>High levels of compliance in having the procedures fully explained & procedural risks.<br>Having essential information to support patient's decisions 98%<br><br>Staff Survey (45 respondents – 42% )<br>Included range of clinical groups across Trust specialty groups.<br><br>Recommendations<br>Further improve training opportunities across the Trust – E learning. Review local consent policy (Action complete – policies updated and there is a marked increase in training in relation to safeguarding and Mental Capacity Act) |
| Trust wide Health Records Audit<br><br>(NHSLA, RCP & Local Standards)<br><br>N = 110 records across all sub-specialty groups | Trust | Audit (Retrospective) | February 2013 | A Trust wide audit is conducted on an annual basis on behalf of the Clinical Records Working Group. Results are compiled for individual Divisions & for the Trust as a whole. The audit supplements internal audits undertaken by each specialty as part of the internal governance and educational programmes.<br>The results are:<br>-presented at a Grand round session (January 2013)<br>-inform the improvement work streams coordinated by the Clinical Records Working Group<br>-Divisional reports inform areas for action within each sub-specialty area<br>Current trust wide audit results show levels of compliance across 107 standards:<br>Fully met (33%)<br>High compliance (35%)<br>Moderate compliance (17%)<br>Low compliance (15%)<br><br>The Trust will be implementing its EPR strategy during 2013 and future audits will need to be re-designed to take into account new practices and procedures. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Referral of Patients Presenting with Haematuria<br><br>N = 38 (April – May 2012)<br><br>Links to:<br><br>CQC: 16<br>NHSLA: 2.6 | Urology | Audit (Retrospective) | March 2013 | Baseline audit to review management of patients referred with haematuria, including patients referred via 2 week urgent pathway and non-urgent pathway<br><br>Key findings demonstrated:<br>• The average time from referral to date patient first seen was 11 days for urgent cases and 39.5 days for non-urgent referrals.<br>•<br>• With the exception of 1 case where the date of referral was unknown,all cases referred via the 2 week urgent pathway were seen within 2 weeks.<br>• The average time from referral to flexible cystoscopy for urgent cases was 16 days and 68 days for non-urgent referrals.<br>• The average time from referral to ultrasound scan was 25 days forurgent cases and 43 days for non urgent referrals.<br>• The average time from referral to CT Urogram / IVU for urgent cases was 23 days and 55 days for non urgent referrals.<br><br>Since reviewing data for this audit all visible haematuria patients have undergone a CT urogram as first line upper tract imaging for 2WW and 'routine' patients. This will continue to avoid unnecessary delays in diagnosis and treatment.<br>All non visible haematuria patients will continue to have USS KUB for upper tract imaging<br><br>A letter will be sent to all GPs to remind them that ALL visible haematuria patients and patients with non visible haematuria over the age of 50 years<br>should be referred via the 2WW pathway. |

| Title/Topic | Directorate/ Specialty | Project Type | Completed | Aims, Key Findings, Actions |
|---|---|---|---|---|
| Chest Pain of Recent Onset<br><br>Audit Against NICE Clinical Guideline 95<br><br>N = 30 (August – December 2012)<br><br>Links to:<br><br>NICE Clinical Guideline 95<br>CQC: 4, 16<br>NHSLA: 2.1, 2.6, 2.8 | Medicine | Audit (Retrospective) | March 2013 | Baseline audit to improve the management of patients presenting with chest pain of recent onset. Specifically to measure local compliance with NICE recommendations (Clinical Guideline 95)<br><br>Twelve audit measures were identified. Findings indicated that 3 standards were fully met. Five standards demonstrated high compliance, one standard demonstrated moderate compliance, and 3 standards achieved compliance <74%.<br><br>Actions to improve areas of poor compliance in line with NICE recommendations. |

# 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
Note: A number of task and finish groups report to formal committees and are not represented on this diagram.

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