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Central Bedfordshire Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

please ask for Jonathon Partridge
direct line 0300 300 4634
date

NOTICE OF MEETING

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Date & Time
Monday, 13 June 2011 10.00 a.m.

Venue at
Room 15, Priory House, Monks Walk, Shefford

Richard Carr
Chief Executive

To: The Chairman and Members of the SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE:

Cllrs Mrs R J Drinkwater (Chairman), N J Sheppard (Vice-Chairman), A L Dodwell, Mrs R B Gammons, Mrs S A Goodchild, Mrs D B Gurney, K Janes, I A MacKilligan and M A Smith

[Named Substitutes:

D Bowater, Dr R Egan, C C Gomm, P Hollick and J Murray]

All other Members of the Council - on request

MEMBERS OF THE PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING

AGENDA

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Minutes**

   To approve as a correct record the Minutes of the meeting of the Social Care, Health and Housing Overview and Scrutiny Committee held on 28 March 2011 and to note actions taken since that meeting.

3. **Members' Interests**

   To receive from Members any declarations and the nature thereof in relation to:-

   (a) personal interests in any agenda item

   (b) personal and prejudicial interests in any agenda item

   (c) any political whip in relation to any agenda item.

4. **Chairman's Announcements and Communications**

   To receive any announcements from the Chairman and any matters of communication.

5. **Petitions**

   To receive petitions from members of the public in accordance with the Public Participation Procedure as set out in Annex 2 of Part A4 of the Constitution.

6. **Questions, Statements or Deputations**

   To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Annex 1 of part A4 of the Constitution.

7. **Call-In**

   To consider any decision of the Executive referred to this Committee for review in accordance with Procedure Rule 10.10 of Part D2.

8. **Requested Items**

   To consider any items referred to the Committee at the request of a Member under Procedure Rule 3.1 of Part D2 of the Constitution.

Reports

Item	Subject		Page Nos.
9	**Social Care, Health and Housing Directorate** To receive an overview of the Social Care, Health and Housing Directorate.	*	Verbal Report
10	**Community Dental Services** To consider proposals for community engagement and stakeholder involvement when discussing plans for community dental services to become a social enterprise.	*	11 - 30
11	**Views of Care and Nursing Home Managers on Hospital Discharge Procedures** To receive a report from the Bedfordshire Local Involvement Network (LINk) relating to patients discharged from hospital into care and nursing homes in Bedfordshire and Luton.	*	31 - 64
12	**Bedfordshire Community Health Services Quality Account** To receive the draft Quality Account for Bedfordshire Community Health Services for 2010.	*	65 - 116
13	**Luton and Dunstable Hospital NHS Foundation Trust Quality Account** To receive the draft Quality Account for Luton and Dunstable Hospital NHS Foundation Trust for 2010.	*	117 - 166
14	**Work Programme 2011 - 12 & Executive Forward Plan** To consider details of the currently draft Committee work programme and the Executive Forward Plan.	*	167 - 186

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Room 15, Priory House, Monks Walk, Shefford on Monday, 28 March 2011

PRESENT

Cllr Miss A Sparrow (Chairman)
Cllr A M Turner (Vice-Chairman)

Cllrs	Mrs J Freeman	Cllrs	J Kane
	Mrs S A Goodchild		P Rawcliffe
	Ms A M W Graham		

Apologies for Absence:	Cllrs	Mr M Coleman P Freeman Mrs R B Gammons	
Substitutes:	Cllr	Mrs D B Gurney (In place of Cllr Mrs R B Gammons)	
Members in Attendance:	Cllrs	Mrs R J Drinkwater Mrs C Hegley J G Jamieson Mr M Coleman	
Officers in Attendance:	Mrs M Clampitt	–	Committee Services Officer
	Mr N Murley	–	Assistant Director Business & Performance
	Mrs J Ogley	–	Director of Social Care, Health and Housing
	Miss C Powell	–	Overview and Scrutiny Officer

SCHH/09/256 **Minutes**

RESOLVED

that the Minutes of the meeting of the Social Care, Health and Housing Overview and Scrutiny Committee held on 24 January 2011 be confirmed and signed by the Chairman as a correct record.

SCHH/09/257 **Members' Interests**

(a) **Personal Interests:-**

There were no declarations made.

(b) **Personal and Prejudicial Interests:-**

There were no declarations made.

(c) **Any Political Whip in relation to items on the agenda:-**

There were no declarations made.

SCHH/09/258 **Chairman's Announcements and Communications**

The Chairman informed the Committee that item 13 – Shared Services – patient flows from Acute hospitals to Central Bedfordshire would be taken as an urgent item and considered at the end of the agenda.

The Chairman informed the Committee that Cheryl Powell, Overview and Scrutiny Officer would no longer be working with the Committee. The Committee thanked Cheryl for all of her work and support and wished her all the best for the future.

SCHH/09/259 **Petitions**

The Chairman announced that no petitions had been received for this meeting.

SCHH/09/260 **Questions, Statements or Deputations**

The Chairman announced that no questions, statements or deputations had been received.

SCHH/09/261 **Call-In**

The Chairman announced that no call-ins had been referred to this Committee.

SCHH/09/262 **Requested Items**

The Chairman confirmed that no requests for agenda items had been received.

SCHH/09/263 **Portfolio Holders' Update**

The Chairman requested an update from each Portfolio Holder in attendance be provided to the Committee.

Cllr Mrs Carole Hegley, Portfolio Holder for Social Care and Health informed the Committee that she had attended a meeting at the House of Commons which discussed the support for self funders. The issue would be considered at a future Social Care, Health & Housing Overview and Scrutiny Committee.

Cllr Mrs Rita Drinkwater, Portfolio Holder for Housing informed the Committee that she had attended ICT training for residents at two of the Council's facilities. The residents had taken a very real interest.

SCHH/09/264 **A Vision for Adult Social Care and Transparency in outcomes: a framework for adult social care**

The Director of Social Care, Health and Housing gave a presentation to the Committee which provided a vision for Adult Social Care: Capable Communities and Active Citizens.

The presentation highlighted the power shift from the state to the citizen which included the rollout of personal budgets to all eligible citizens by 2013. It was noted that Central Bedfordshire Council was currently at over 27%.

The Director explained in detail the seven principles listed below which were the basis for the vision:-

Prevention
Personalisation
Partnership
Purality
Protection
Productivity
People

The presentation was attached to the agenda.

SCHH/09/265 **Budget Management Report for period ended 31st December 2010 for Social Care Health and Housing**

The Committee received and considered a report which set out the financial position to the end of December 2010 and the latest forecast position. The Assistant Director Business & Performance informed the Committee that the overspend had reduced from Quarter 2 and stood at £0.204m.

Members were informed that during the 2010/11 budget setting process there had been no provision for 65+ demographics. This has resulted in pressure in residential and home care due to the increased volumes and the complexity of the care required.

The Committee noted that Central Government had given £70m to the PCTs nationally and that Central Bedfordshire could be receiving up to £0.238m to help with seamless care for patients on discharge from hospitals and to prevent avoidable readmissions. This would involve increasing the Council's reablement service.

In response to a question the Assistant Director for Business and Performance confirmed that an outstanding housing invoice had been received and paid thus using the £0.095m underspend in the Housing Revenue Account.

The Committee considered a proposal that the Executive be asked to have the budget monitoring reports revisited to make them easier to understand and more clearly laid out. It was noted that the Portfolio Holder for Finance, Governance and People was in the process of reviewing the reports formatting issues. It was agreed that the request be sent to the Executive.

RESOLVED

1. **that the forecast outturn of 51.180m and projected £0.204m overspend is noted.**

2. **that further appropriate management actions being taken to bring the projected overspend back into balance are noted.**

RECOMMENDATION TO THE EXECUTIVE

that the budget monitoring report and spreadsheets be reviewed to provide a simplified and more informative layout.

SCHH/09/266 **Quarter Three Performance Monitoring**

The Committee considered the Quarter 2 Performance Monitoring report for the Social Care, Health and Housing Directorate up to and including 31 December 2010. The report had previously been considered by the Executive at the 15 March 2011 meeting.

The Director of Social Care, Health and Housing confirmed that there had been improvements since December. It was noted that the software problems had been resolved and reporting had become more accurate and timely.

Social Care Indicators

NI136 – People supported to live independently (per 100,000 pop)
Members were informed that the people who had only been contacted once per year and who did not receive ongoing support had been removed from this indicator following a review.

NI130 – Clients receiving self directed support
Members were informed that as at the end of February the Year to date figure had been amended to 27.3% against a target of 30%.

NI135 – Carers receiving needs assessment or review and a specific carer's service or advice and information
The published year to date figure was shown as 21.40% against a target of 30%.

D40 – Clients receiving a review
The Director of Social Care, Health and Housing informed the Committee that this figure continued to be low due to the refocusing of staff on assessments over reviews. There was to be a separate review function for care homes. It was noted that whilst this indicator was not a requirement, it would continue to be collected.

Housing Indicators

The Director of Social Care, Health and Housing informed the Committee that all of the housing indicators were performing well, which is good news, given the pressures on the area.

RESOLVED

that the report be noted.

SCHH/09/267 **Work Programme 2010 - 2011 & Executive Forward Plan**

Members considered the Committee's work programme and noted that the following item would be moved within the programme.

Acquiring Community Health Services (formerly Acquiring Acute Services) would be moved to a summer meeting due to the amount of business to be considered at 13 June 2011 meeting.

RESOLVED

that the work programme as amended above be noted.

SCHH/09/268 **Shared Services-patient flows from Acute hospitals to Central Bedfordshire**

The Committee received and considered a report which provided an analysis of the patient flows from acute hospitals into Central Bedfordshire between June and December 2010 and highlights the role of social care in managing these.

The Task Force considered the patient discharge information from five of the surrounding hospitals, Luton & Dunstable (L&D), Bedford, Stoke Mandeville, Lister and Addenbrookes. It was noted that the host council is responsible for patient discharges. The L&D had a different arrangement due to when Luton separated it took its staff out and left the discharge arrangements for other patients to Bedfordshire County Council. When the Unitaries were created it was agreed that Bedford, via a service level agreement, would manage the

discharges at Central Bedfordshire. This arrangement will continue with patient flows being monitored as part of the ongoing work of the Directorate.

It was noted that people could be discharged from hospital not only up until 7.00pm during the week but some hospitals are discharging over the weekend. The Committee expressed concerns about the length of time patients had been left waiting to be discharged and hoped that this could be looked into in future.

It was noted that there were designated posts in both the Lister and the L&D hospitals. Members were informed that arrangements would be strengthened in relation to Milton Keynes, Stoke Mandeville and Addenbrookes hospitals.

RESOLVED

that the Committee:-

(a) **noted the intention that the role of the current manager of the Central Bedfordshire Social Care Hospital Team will include an overview of all discharges from hospitals within Central Bedfordshire;**

(b) **noted that the existing service level agreement with Bedford Borough for Bedford Hospital will be continued and that monitoring patient flow will be undertaken as part of the contract review;**

(c) **noted the intention to make arrangements to designate posts that will be linked with Milton Keynes, Stoke Mandeville and Addenbrookes Hospitals;**

(d) **noted the intention to strengthen closer alignment of Social Care services with health to facilitate expedient and effective discharges from hospital.**

(Note: The meeting commenced at 10.00 a.m. and concluded at 11.50 a.m.)

Chairman……………………………….

Date……………………………….

Report on the outcome of service user engagement on proposals to reduce the number of Community Dental Service (CDS) bases for Central Bedfordshire Social Care, Health and Housing Overview and Scrutiny Committee on 13 June 2011

This paper briefly outlines the outcomes of engagement with service users between March and May 2011 in relation to the number and location of community dental services delivered by NHS Bedfordshire.

RECOMMENDATION(s): The Social Care, Health and Housing OSC Members are asked to note outcomes of the user engagement and comment to NHS Bedfordshire on the proposals as appropriate

1. Introduction

NHS Bedfordshire commissions the Community Dental Service (CDS) for residents in Bedfordshire and Luton. This is a specialist service that was established to provide dental treatment for adults and children with special needs and for other patients who are not able to be treated by 'High Street' NHS dentists.

The service, which was formerly part of Bedfordshire Community Health Services, became a social enterprise in April 2011. NHS Bedfordshire has been working with the service and developing commissioning plans to improve the quality of the service, meet new infection control requirements, improve disabled access and secure better value for money.

The PCT would commission the same range of services and level of activity, but it is proposed that this would be from a reduced number of sites. As shown in the table below.

Current bases	Proposed bases
Bedford Borough	
Dental Access Centre, Bedford	Dental Access Centre, Bedford
London Road Health Centre	London Road Health Centre
Queens Park Health Centre	Queens park Health Centre
Kempston Health Centre	
Central Bedfordshire	
Sandy Health Centre	Sandy Health Centre
Flitwick Health Centre	Flitwick Health Centre
Dunstable Health Centre	Houghton Regis (new health centre)
* Shefford Health Centre	* Shefford Health Centre
Ampthill Health Centre	
Biggleswade Health Centre	
Leighton Buzzard Health Centre	

Luton	
Liverpool Road Health Centre	Liverpool Road Health Centre
Marsh Farm Health Centre	Marsh Farm Health Centre

* The CDS clinic moved to the new Shefford Health Centre in April 2011. A new dental service, including special needs, is currently being tendered.

2. The thinking behind the proposals
NHS Bedfordshire currently spends £7m per 100,000 people on dental services, which is significantly higher than the average across England and is the third highest in the East of England. Service reviews have indicated that there are two specific areas of spend that are particular outliers: hospital based dental services and the Community Dental Service. NHS Bedfordshire has a duty to ensure both quality and value for money from the services it commissions and is rightly looking at how these services can deliver better value. A new minor oral surgery service at Bedford Hospital will improve quality and deliver savings that can be reinvested elsewhere.

NHS Bedfordshire commissioners have been in discussions for some time with the CDS to agree how the service can be made more efficient. The current number of bases is having a significant impact on the efficiency of the service. Some locations are open for a limited number of hours per week and see lower numbers of patients. This increases staffing costs and time spent by specialist dentists travelling between bases. In addition, some of the bases require significant investment to bring them up to new Care Quality Commission (CQC) infection control standards and DDA compliance, where this is possible.

We have agreed with the CDS that a more efficient and viable service would need to operate from fewer sites, but continue to provide the same level of activity and range of services as in 2010/11. The majority of patients would continue to be seen by the same dental staff in other CDS clinics.

3. Service user consultation
The PCT committed that no decisions would be made on the final service configuration without considering the views of those service users at the affected bases. NHS Bedfordshire carried out face-to-face interviews with 40 service users and carers at these bases in December to begin to gain an understanding of their needs, how they use the service and their views on possible changes.

In March, the PCT wrote to 4,838 patients, who currently use the bases that it is being proposed would close, to explain the proposed changes and seek their views. The PCT also wrote to local authority social care departments, community health services, care homes, voluntary organisations and general dental practitioners to seek their views. This report summarises the responses received during consultation.

Letters were sent out between 14 and16 March 2011. We asked for responses to be sent to us by 15 April, although we have continued to include responses received up until 3 may 2011. Analysis of the responses is set out in tables on pages 3-16 below. Percentages are rounded to the nearest whole number.

4. Analysis of responses

4.1 All responses

Table 1: Response rates

Clinic location	Patients consulted	Responses received	% of clinic patients	% of all patient responses
Ampthill	582	61	11	7
Biggleswade	752	231	31	28
Dunstable	1,556	169	11	21
Kempston	642	98	15	12
Leighton Buzzard	1,306	264	20	32
Total	**4,838**	**823**	**-**	**100**

Tables 2, 3 and 4: Profile of respondents

Patient	Carer
54	44

Special care needs	No special care needs	No response
26	65	9

Under 11	11-17	18-44	45-64	65-74	75 or over	No response
23	26	16	18	7	8	2

Table 5: Frequency of attendance at their clinic

Monthly	3 monthly	6 monthly	Yearly	Other	No response
<1	16	61	14	6	2

Table 6: Length of time as a patient

Less than 1 year	1-2 years	More than 2 years
9	17	72

Table 7: How patients travelled to their clinic

Car	Walk	Bus	Taxi	Train	Patient transport	Other
57	34	6	2	<1	<1	1

Table 8: Reasons for choosing CDS clinic

Reason	%
Friendly/helpful staff	81
High standard of care	77
Familiar/comfortable surroundings	70
Close to where I live	70
Well equipped facilities	58
Other family members use the service	48
Lack of NHS alternatives	31
Other	27

Table 9: Alternatives that patients would use if their clinic closed

Nearest CDS clinic	Local 'High Street' dentist	Other	No response
35	38	22	5

Table 10: Is this an acceptable alternative?

Yes	No	No response
24	69	7

Table 11: Is there anything that needs to be improved in your current CDS clinic or service?

Yes	No	No response
14	76	10

4.2 Ampthill Clinic responses

Table 1: Response rate

Patients consulted	Responses received	% of clinic patients
582	61	11

Tables 2, 3 and 4: Profile of respondents

Patient	Carer
46	51

Special care needs	No special care needs	No response
10	82	8

Under 11	11-17	18-44	45-64	65-74	75 or over	No response
21	44	11	15	5	2	2

Majority of patients (65%) are under 18. Only one in 10 patients considered that they had special care needs

Table 5: Frequency of attendance at their clinic

Monthly	3 monthly	6 monthly	Yearly	Other	No response
0	3	56	16	21	4

'Other' included: one-off; when I needed periodontic service; no longer go to this clinic

Table 6: Length of time as a patient

Less than 1 year	1-2 years	More than 2 years	No response
9	17	72	4

Table 7: How patients travelled to their clinic

Car	Walk	Bus	Taxi	Train	Patient transport	Other	No response
79	18	0	0	0	0	0	3

Table 8a: Reasons for choosing this clinic

Reason	%
Close to where I live	64
Friendly/helpful staff	59
High standard of care	54
Familiar/comfortable surroundings	43
Other	43
Well equipped facilities	31
Other family members use the service	28
Lack of NHS alternatives	21

Table 8b: Responses by theme

Themed responses	Number
Referred by other dentist/school	10
Children's services	5
Current service – staff and care	4
Convenience	3
Specialist care	2
Historical	2
Fear of dentist	1

Table 9: Alternatives that patients would use if their clinic closed

Nearest CDS clinic	Local 'High Street' dentist	Other	No response
51	38	8	3

'Other' included: Anyone that has a periodontist service; same dentist we (parents) use.

Table 10a: Is this an acceptable alternative?

Yes	No	No response
59	33	8

Table 10b: Responses by theme of those who said no

Themed responses	Number
Location and transport	6
Current service/quality	4
Preference/convenience	2
Financial	1
Access within the building	1
Need a children's service	1

Table 11a: Is there anything that needs to be improved in your current CDS clinic or service?

Yes	No	No response
26	52	22

Table 11b: Responses by theme of those who said yes

Themed responses	Number
Longer opening hours	4
Parking	3
Larger premises	2
New equipment	2
Modernise / decorate	1
Ensure NHS access	1

Table 12: Is there anything we should take into consideration if we move the service?

Themed responses	Number
Access to other NHS services	5
Location, travel and cost	4
Impact on town	3
Maintain type and quality of service	2
Impact on patient	2
Parking	2
Impact on service / staff	1

4.3 Biggleswade Clinic responses

Table 1: Response rate

Patients consulted	Responses received	% of clinic patients
752	231	31

Tables 2, 3 and 4: Profile of respondents

Patient	Carer
80	18

Special care needs	No special care needs	No response
23	64	3

Under 11	11-17	18-44	45-64	65-74	75 or over	No response
12	13	17	23	13	17	3

Nearly three-quarters of patients were adults (30% were 65 and over). Two-thirds did not consider that they had special care needs.

Table 5: Frequency of attendance at their clinic

Monthly	3 monthly	6 monthly	Yearly	Other	No response
1	11	55	26	5	3

'Other' included: ongoing treatment; when needed; four-monthly.

Table 6: Length of time as a patient

Less than 1 year	1-2 years	More than 2 years	No response
7	23	69	1

Table 7: How patients travelled to their clinic

Car	Walk	Bus	Taxi	Train	Patient transport	Other	No response
51	35	10	3	0	0	1	1

Table 8a: Reasons for choosing this clinic

Reason	%
Friendly/helpful staff	90
Close to where I live	86
High standard of care	86
Familiar/comfortable surroundings	78
Well equipped facilities	71
Other family members use the service	50
Lack of NHS alternatives	46
Other	19

Table 8b: Responses by theme

Themed responses	Number
Disabled access	12
Staff and care	9
Fear of other dentists	8
Convenience	7
Children’s services	1
Specialist care	1
Historical	1
Referred by other dentist / school	1

Table 9: Alternatives that patients would use if their clinic closed

Nearest CDS clinic	Local ‘High Street’ dentist	Other	No response
37	31	24	7

‘Other’ included: cannot afford to go private; has to be on ground floor; I don’t want anything else.

Table 10a: Is this an acceptable alternative?

Yes	No	No response
26	69	4

Table 10b: Responses by theme of those who said no

Themed responses / no	Number
Access within the building	26
Location and transport	20
Preference / convenience	19
Impact on town	14
Current service/quality	12
Financial	7
Need a children’s service	4
Impact on service/staff	3
Parking	1

Table 11: Is there anything that needs to be improved in your current CDS clinic or service?

Yes	No	No response
15	78	7

Table 11b: Responses by theme of those who said yes

Themed responses	Number
Parking	12
Longer opening hours	7
Ensure NHS access	4
Larger premises	3
New equipment	1
Disabled access	1

Table 12: Is there anything we should take into consideration if we move the service?

Themed responses	Number
Location, travel and cost	36
Impact on patient	25
Access to other NHS services	22
Building access	18
Maintain type and quality of service	18
Impact on town	13
Impact on service / staff	11
Parking	2
Provide home visits	1

4.4 Dunstable Clinic responses

Table 1: Response rate

Patients consulted	Responses received	% of clinic patients
1,556	169	11

Tables 2, 3 and 4: Profile of respondents

Patient	Carer
27	71

Special care needs	No special care needs	No response
25	68	7

Under 11	11-17	18-44	45-64	65-74	75 or over	No response
37	40	10	6	3	5	0

Majority of patients (77%) are under 18. One in four considered that they had special care needs.

Table 5: Frequency of attendance at their clinic

Monthly	3 monthly	6 monthly	Yearly	Other	No response
4	25	60	4	7	1

'Other' included: home visit every 6-9 months; rarely; once

Table 6: Length of time as a patient

Less than 1 year	1-2 years	More than 2 years	No response
10	22	66	2

Table 7: How patients travelled to their clinic

Car	Walk	Bus	Taxi	Train	Patient transport	Other	No response
69	18	8	1	0	0	0	4

Table 8a: Reasons for choosing this clinic

Reason	%
Friendly/helpful staff	68
High standard of care	62
Familiar/comfortable surroundings	50
Well equipped facilities	47
Close to where I live	46
Other family members use the service	39
Other	39
Lack of NHS alternatives	15

Table 8b: Responses by theme

Themed responses	Number
Disabled access	12
Need a children's service	12
Referred by other dentist / school	10
Home visits	9
Fear of other dentists	8
Specialist care	7
Historical	2
Convenience	2
Staff and care	2

Table 9: Alternatives that patients would use if their clinic closed

Nearest CDS clinic	Local 'High Street' dentist	Other	No response
42	30	23	5

'Other' included; follow current dentist; would need a recommendation; child specialist dentist

Table 10a: Is this an acceptable alternative?

Yes	No	No response
30	58	12

Table 10b: Responses by theme of those who said no

Themed responses / no	Number
Location and transport	18
Current service/quality	18
Need a children's service	14
Impact on town	14
Impact on service/staff	9
Preference / convenience	8
Access within the building	7
Financial	2
Parking	1

Table 11: Is there anything that needs to be improved in your current CDS clinic or service?

Yes	No	No response
12	76	12

Table 11b: Responses by theme of those who said yes

Themed responses	Number
Disabled access	7
Parking	3
Longer opening hours	2
Larger premises	2
New equipment	1
Ensure NHS access	1

Table 12: Is there anything we should take into consideration if we move the service?

Themed responses	Number
Maintain type and quality of service	39
Location, travel and cost	21
Impact on patient	14
Access to other NHS services	8
Impact on service / staff	8
Impact on town	7
Provide home visits	4
Parking	4
Building access	1

4.6 Leighton Buzzard Clinic responses

Table 1: Response rate

Patients consulted	Responses received	% of clinic patients
1,306	264	20

Tables 2, 3 and 4: Profile of respondents

Patient	Carer
56	44

Special care needs	No special care needs	No response
18	73	9

Under 11	11-17	18-44	45-64	65-74	75 or over	No response
28	30	15	19	5	2	2

Majority of patients (58%) are under 18. Fewer than one in five considered that they had special care needs.

Table 5: Frequency of attendance at their clinic

Monthly	3 monthly	6 monthly	Yearly	Other	No response
3	19	62	12	3	0

'Other' included: every week; as often as needed; and occasionally.

Table 6: Length of time as a patient

Less than 1 year	1-2 years	More than 2 years	No response
10	13	75	2

Table 7: How patients travelled to their clinic

Car	Walk	Bus	Taxi	Train	Patient transport	Other	No response
47	47	2	2	0	0	1	1

Table 8: Reasons for choosing this clinic

Reason	%
Friendly/helpful staff	89
High standard of care	86
Familiar/comfortable surroundings	82
Close to where I live	78
Other family members use the service	67
Well equipped facilities	61
Lack of NHS alternatives	37
Other	23

Table 8b: Responses by theme

Themed responses	Number
Specialist care	8
Staff and care	4
Disabled access	4
Convenience	4
Need a children’s service	2
Fear of other dentists	2
Historical	1
Referred by other dentist / school	1

Table 9: Alternatives that patients would use if their clinic closed

Nearest CDS clinic	Local ‘High Street’ dentist	Other	No response
13	59	22	5

‘Other’ included: follow current dentist; dentist with disabled access; closest alternative.

Table 10: Is this an acceptable alternative?

Yes	No	No response
8	89	3

Table 10b: Responses by theme of those who said no

Themed responses	Number
Location and transport	17
Impact on patient	10
Current service/quality	9
Preference / convenience	7
Parking	7
Access within the building	5
Need a children’s service	5

Table 11: Is there anything that needs to be improved in your current CDS clinic or service?

Yes	No	No response
22	70	7

Table 11b: Responses by theme of those who said yes

Themed responses	Number
Longer opening hours	11
Disabled access	2
Larger premises	2
Parking	1
New equipment	1
Ensure NHS access	1
Modernising / decorating	1

Table 12: Is there anything we should take into consideration if we move the service?

Themed responses	Number
Location, travel and cost	48
Impact on town	41
Impact on patient	33
Maintain type and quality of service	27
Impact on service / staff	12
Access to other NHS services	5
Parking	4
Building access	2

5. Commissioner response
The Community Dental Service is primarily a specialist service that provides very good standards of care. However, the current configuration of the service prevents it from making the best use of resources in order to deliver the necessary value for money. In addition, some of the bases from which it operates do not meet required clinical standards or disability access.

There are currently seven CDS clinics serving Central Bedfordshire: Ampthill Health Centre; Biggleswade Health Centre; Dunstable Health Centre; Flitwick Health Centre; Leighton Buzzard Health Centre; Sandy Health Centre; and Shefford Health Centre. The proposal was to reduce this number by closing Ampthill, Biggleswade, Dunstable and Leighton Buzzard and opening a new CDS clinic in Houghton Regis.

Ampthill
The clinic is situated on a first floor with access via stairs and a lift. Clinic space is limited and investment would be required to bring it up to new decontamination standards. Around one in 10 patients who have used this clinic considered that they had a special care need. Staff shortages have meant that the clinic has not been treating patients since 2010 and patients have been going to Flitwick CDS clinic for treatment.

The main reasons patients gave for choosing the Ampthill clinic were its proximity to where they lived; friendly, helpful staff; high standard of care; and comfortable surroundings. Patients would still be able to access the same high standards of care from CDS staff at the well equipped CDS clinic in Flitwick.

Although closure of the Ampthill clinic would increase travel distances for some patients, the Flitwick clinic is only 1.9 miles from the Ampthill clinic and a high percentage of patients (79%) currently travel by car. A number of patients said they had used Ampthill as it provides a children’s service; this is also provided at the Flitwick clinic. It should also be noted that the CDS provides routine access for patients living in areas of high deprivation and that Ampthill has one of the lowest deprivation scores in Central Bedfordshire, approximately half that of neighbouring Flitwick .

In addition to the CDS clinic in Flitwick, there is an NHS dental practice in Ampthill and three in Flitwick within 1.6 miles for those patients who might choose to visit a High Street NHS dentist. 89% of patients said they would use either the Flitwick CDS clinic or a local NHS dentist.

Biggleswade
There was a high response rate from Biggleswade patients (31%). Just under two-thirds of patients did not consider themselves to have a special care need. The clinic has limited space and would require significant investment to meet new decontamination standards.

The main reasons patients gave for choosing the Biggleswade clinic were friendly, helpful staff; its proximity to where they lived; high standard of care; comfortable surroundings; and well equipped. The alternative CDS clinic in Sandy would provide the same high standards of care, from CDS staff working in a comfortable and well-equipped clinic.

Just over half of patients currently travel to the Biggleswade clinic by car and just over one-third walk. The Sandy clinic is 5.3 miles from the Biggleswade clinic and can be reached by car, train or bus, although the latter two would also require a 10-20 minute

walk. There are two High Street NHS dentists within 0.3 miles of the Biggleswade clinic, one of which has disabled access. There are two further NHS dentists within 3.3 miles in Sandy, one of which has disabled access. Only 12 % of patients visit more frequently than six-monthly. Some patients were concerned about the impact on the town. However, Sandy, unlike Biggleswade, is among the lower 20% of deprivation areas in Central Bedfordshire. Sandy Health Centre also has more potential for future expansion, should this be required.

Dunstable

Dunstable, along with Ampthill, had the lowest response rate to the questionnaire at 11%.One in four of respondents considered that they had a special care need and two-thirds did not. The clinic has limited space and would require investment to bring it up to new decontamination standards. It is situated on the first floor; it does not have disabled access and it would not be possible to install this. Three-quarters of the patients were under 18 and a high number (69%) travelled to the clinic by car.

The main reasons patients gave for choosing the Dunstable clinic were friendly, helpful staff and high standard of care. Fewer than half chose it because it was close to where they live. Some said they chose it because it provided a children's service and a number of patients were referred by other dentists.

The alternative to Dunstable for most patients would be a new CDS clinic in the refurbished health centre in Houghton Regis, which is 2.5 miles from the current CDS clinic. A CDS clinic had been located in Houghton Regis until the health centre closed in October 2007 and patients were then referred to Dunstable. This proposal would be a return to the previous situation, but in modern, newly equipped facilities that would meet all access and decontamination requirements. There is an under-utilised car park located opposite that is currently reserved for health centre staff. The PCT will discuss with the local authority the potential to open this up to health centre patients.

Patients, including children, would continue to receive the same high standards of care from CDS staff. For those patients who do not have special care needs, they would have the option to choose between five NHS High Street dental practices within 0.3 miles in Dunstable. The CDS also has a remit to provide access to dental care in areas of high deprivation and Houghton Regis, unlike Dunstable, is in the lowest 20% of areas in Bedfordshire for deprivation.

Leighton Buzzard

The CDS clinic is located in the health centre and would require investment to bring it up to new decontamination standards. There was a 20% response rate to the questionnaire. Just under three-quarters did not consider that they had a special care need and 18% did. The majority of patients (58%) were under 18. The same percentage walked to the clinic (47%) as travelled by car. There are few designated parking spaces, but there is on-street parking.

The main reasons patients gave for choosing the Leighton Buzzard clinic were friendly, helpful staff; high standard of care; comfortable surroundings; and close to where they live. Although alternative CDS clinics would provide the same high standards of care from CDS staff in well-equipped facilities, the closest alternative in Houghton Regis is 9.7 miles away. The CDS clinic in Leighton Buzzard also provides access in an area of high deprivation. However, for those patients who do not have special care needs, there are currently five NHS dental practices within 0.4 mile of the clinic, three of which have disabled access.

6. Conclusion

The Community Dental Service provides dental treatment for adults and children with special care needs and for other patients who are not able to be treated by 'High Street' NHS dentists, as well as routine access for people in areas of high deprivation.

It is a highly regarded service, but is an expensive service in comparison to similar services in other areas. NHS Bedfordshire has been working very closely with the service to develop proposals that will enable it to meet its remit within the available funding to ensure that the service is viable and sustainable in the long term.

This work has led to proposals to close a number of clinics and provide the same level of activity and range of services from fewer locations. In doing so, we have sought to strike the right balance between assessed health needs, access (particularly for those who are vulnerable and disadvantaged) and service user needs and preferences. The feedback from service users through this consultation has given us a much clearer picture of their experiences, needs and concerns.

As a result, we have concluded that the CDS would continue to provide a high quality, effective and efficient service for its patients in Central Bedfordshire with the number of clinics reduced from seven to five. This would be achieved by closing CDS clinics in Ampthill, Biggleswade and Dunstable and opening a new CDS clinic in Houghton Regis. The proposed closure of Leighton Buzzard would not go ahead.

This is part of an overall package designed to make the service more efficient by reducing running costs and improving productivity. This will deliver efficiency savings of £1 million over two years and enable the CDS to continue to provide specialist and routine access dental care for service users in Bedfordshire and Luton.

This recommendation will be considered by NHS Bedfordshire's Clinical Executive Committee on 6 July for their endorsement, which will go to the Board of NHS Bedfordshire on 27 July for a decision. If approved, implementation will be from September 2011.

NHS Bedfordshire will write to service users informing them of the decision and their options. We will work with the provider to support service users in moving to another CDS clinic. We will also support patients who wish to access a High Street NHS dentist through our Patient Advice and Liaison Service (PALS) and via our dedicated freephone dental helpline.

Information will be placed in the CDS clinics and clinic staff will be fully briefed to ensure correct and consistent information is provided through any patient contacts. NHS Bedfordshire will also write to other stakeholders, such as social care teams, who may have a professional contact with the service or service users.

David Levitt, Deputy Director of Communications and Public Engagement

Tony Medwelll, Head of Primary Care Commissioning

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Meeting: **Social Care Health and Housing Overview & Scrutiny Committee**

Date: **13 June 2011**

Subject: **Bedfordshire Local Involvement Network's (LINk) survey into the views of care and nursing home managers on hospital discharge procedures**

Report of Graham Dinn, Lead for the LINk Social Care Working Group

Summary: The report sets out the findings of a survey undertaken by Bedfordshire LINk to determine how effectively discharge planning is being carried out for patients discharged from hospital into care and nursing homes in Bedfordshire and Luton

RECOMMENDATION:

1. **That the Social Care, Health and Housing Overview and Scrutiny Committee note and comment on the report of Bedfordshire LINk.**

Appendices:
Appendix A – Bedfordshire LINk's survey into the views of care and nursing home managers on hospital discharge procedures (January 2011)

Background Papers: (open to public inspection)
None

Location of papers: Priory House, Chicksands

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BEDFORDSHIRE LOCAL INVOLVEMENT NETWORK (LINk)

BEDFORDSHIRE LINk's SURVEY INTO THE VIEWS OF CARE & NURSING HOME MANAGERS ON HOSPITAL DISCHARGE PROCEDURES

January 2011

ACKNOWLEDGEMENTS:

Derbyshire LINk

Bedfordshire LINk Social Care Working Group Members who formed the research group:

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BEDFORDSHIRE LINk Survey into the views of Care/Nursing Home Managers on Hospital Discharge Procedures – January 2011

Aims and Objectives of Study

The aim of the survey was to determine how effectively discharge planning is being carried out for patients discharged from hospital into care and nursing homes in Bedfordshire and Luton. It is the first part of a study looking at outcomes for patients following discharge from hospital; it is hoped that a second study which may take place between 2011/12 will involve visits to a selection of care and nursing homes to look at the standards of care in line with Care Quality Commission guidelines.

Introduction

Discharge planning and procedures have been on the work programme of the LINk since 2009, as several cases had come to our attention where discharge had not gone well, including cases where the patient has had to be re-admitted to hospital.

During the early stages of our involvement LINk members looked at the discharge policies of both the L&D Hospital and Bedford Hospital, all of which said all the right things and policies and procedures seemed to be in place, including a multi-disciplinary team approach involved in the discharge of patients. But the LINk was aware that sometimes difficulties had arisen and had recorded several cases when this had occurred. We have now devised an incident reporting form in order to record such information **(APPENDIX 2).**

In December 2009, the LINk set up a meeting with the Lead Commissioner responsible for Acute and Urgent Care Commissioning, NHS Bedfordshire to map the whole area of discharge planning; to specifically look at the following areas: what should be happening before admission to hospital, in hospital, at the point of discharge and after discharge.

This meeting only resulted in the commissioner saying she required evidence of the experiences, which we provided, but it did not appear to result in any changes in the system. It did however highlight that some service level agreements with hospitals outside the area, were not always being progressed according to agreements made. Therefore a patient's right to choose a hospital for their surgery/treatment, sometimes resulted in a successful operation being overshadowed by a lack of support once discharged from hospital.

We continued and still continue to log information on inappropriate discharge. Our recent survey of the LINk membership for the *Quality Accounts – Bedfordshire LINk Bulletin No. 27, March 2011* response for both Luton and Dunstable and Bedford Hospitals have highlighted that this remains an issue for the communities we represent.

The issue of discharge procedures came up again at the LINk Social Care Working Group meeting in May 2010, and the survey undertaken by the Derbyshire LINk on inappropriate discharge from hospital into care/nursing homes was discussed. It was agreed that a similar exercise could be undertaken for Bedfordshire. Members of the group worked on adapting the survey questionnaire used by Derbyshire for Bedfordshire.

Methodology

Both the LINk Acute Services and Social Care Working Groups were looking at different aspects of discharge from hospital; the former group looking at the commissioning of services by the primary care trust and the latter at the impact of inappropriate discharge into the community and in particular into care and nursing homes. The above work items dove-tailed and formed the basis of this study.

Also, alongside this, one member of the LINk belonging to both working groups was involved in a piece of work with the *British Orthopaedic Association on discharge entitled "Patient Pathways (Models of Care) for patients who are to undergo planned orthopaedic operations (Feb 2011).* The correct process for discharge for these patients were highlighted in the *May 2010 Bedfordshire LINk newsletter.* This piece of work was in line with the *Department of Health's guidelines on Discharge from hospital pathway, process and practice (2003), DH "Our Health, Our Care, Our Say", better integrated health and social care (January 2006), NHS – DH Achieving Timely 'Simple' discharge from hospital (August 2004)*

The Derbyshire LINk report (May 2010) on the same issue was considered by the Social Care Working Group and it was agreed to use a similar survey to consult the 197 care and nursing home across Bedfordshire and Luton. Although our LINk covers the Central Bedfordshire area, it was agreed that in order to get a more representative sample of homes and because it was evident from accounts from the public and LINk membership that patients were not always able to get into care or nursing homes in their area of residence. The LINk also considered the possibility of holding a small focus group consisting of six home managers, but had to abandon this idea due to contraints on time.

The LINk adapted the questions used by Derbyshire, which required a yes/no response to 16 questions under the key headings of "**At Pre-Discharge Assessment**" and "**At Discharge to the home"**, with a space for written comments.

The survey was a postal survey sent out to care and nursing home managers on 10 January 2011, giving care and nursing homes a two-week period for responses by 31 January 2011. It had been intended to also send this survey out by e-mail and to follow up by telephoning to ascertain if the surveys had reached the care and nursing homes. However, due to constraints on time and resources of the LINk membership and host support team, this was not possible.

To fully understand the full impact and outcomes of the resident's journey from hospital to the care home, we have also commenced communication and liaison with the Local Authority's Compliance Team to understand the way they monitor care and nursing homes, and to ensure the LINk could work with the Council to monitor the homes in the future and independently if required. One of the Council's Compliance Officers undertook training with LINk members on enter and view visiting for members so they could understand our remit as a LINk.

Findings

The full record of findings from the survey are recorded in **APPENDICES 1, 1A, 1B**

There was a 20% response rate to the questionnaire, 40 returned questionnaires out of a possible 197.

Key findings relate to three areas:

- **The practical aspects of discharge relating to aspects of resident's privacy and dignity**
- **Lack of or missing information and possible resident safety issues**
- **Home managers suggesting ways to improve the information/discharge process**

The first two key findings were not dissimilar to that of Derbyshire in terms of two key areas, firstly, in relation to the practical areas of discharge e.g. on the time the resident is discharged and the way in which they are dressed on discharge, and in terms of the information they receive about the resident on discharge to the home. The third key finding is important to our findings, as there are several suggestions made by home managers to improve the discharge process for residents.

It is important to note that although there was generally a more positive response to the **pre-discharge assessment questions**, with 80% of managers saying they were allowed access to resident's notes and that they felt fully involved in the pre-discharge assessment, the responses were more critical to the second list of questions relating to the **discharge process for the patient to the care home**.

In fact if we consider the responses to the initial questions to both sections "*Do you always receive patients discharge information" and "do you consider that the discharge information you receive gives you sufficient information"*, the negative responses of 47.5% and 40% respectively indicates some challenges for managers .

It is important to read the quantitative data in conjunction with the qualitative data. Even where there is a 50% to 80% positive response rate to the question in relation to having access to the patients notes, there were comments indicating that this did not

always happen or managers saying *"On asking" for notes, or "Very rarely am I able to access full notes, daily records and charts", "We have often been given contradictory information".*

It is clear from the comments received in relation to receiving sufficient information, that the managers have suggestions for improving the system and practical ideas as to how information can be presented more effectively. There were seventeen comments suggesting improvements under this question. Some of the suggestions were quite basic, such as wishing to receive guidelines on discharge and not three to four days later, having a copy of the discharge plan, to receive a discharge letter and medication changes, having information in chronological order and to include current next of kin details, NHS Number and name and address, which are not always charted.

47.5 % of home managers indicated that the interaction with the hospital staff and care/nursing home team was done in an appropriate manner. But some of the comments received indicate there is an underlying concern that sometimes hospital staff are under pressure "or occasionally do not have time to answer questions" and can become "defensive and impatient" with the care home staff.

Question 8 – 11 which relates to the well-being and dignity of the residents being discharged all returned a higher negative response with between 47.5% - 57.5 % of homes responding that they felt that residents were discharged too early, sometimes at inappropriate times, e.g. late in the evening or in the early hours of the morning and in unsuitable attire and their continence care not seen to. It would appear from some of the comments that vulnerable residents, such as those with dementia or respiratory problems are sometimes discharged to homes when the patient is not fully ready for release, which has resulted in some residents having to be re-admitted to hospital within a day or two. There was, however, one comment that suggested sometimes residents are kept in hospital too long and would be better in the home surroundings.

45% of home managers indicated that they did not consider that carers of prospective residents were kept fully informed about the choice of home. Several comments indicated this area could be improved, it appears carers/families tend to be directed regarding which home the patient should go to, rather than it being an informed choice.

There was a 50% positive response to the question on prescribed medication from the hospital always being present and correct and errors to medication noted as rare. However, it is evident that sometimes there is a shortfall in the supply of medication or it is sent in the wrong form e.g. tablets instead of liquid form and sometimes nutritional supplements are missing.

Summary and Conclusions

Every day as a LINk we are confronted with and asked to comment on policies and procedures written to ensure that health and social care provision is administered to the highest standard, but as one LINk member put it in the Bedfordshire LINk

response to Quality Accounts for hospitals (March 2011) "*It's often not the failure of protocols, but the failure of management*" to get it right.

The Care Quality Commission circular on *"What standards to expect from the regulation of your NHS Hospital"* is very clear about what patients should expect from treatment in hospital and indicates very clearly the multi-disciplinary approach that is needed from the various health and social care professionals that the patient will come into contact with through the patient journey.

In the paper dealing with a Patient Pathways (Model of Care) planned orthopaedic operations, it clearly mentions that amongst other criteria, discharge should only happen "*according to a treatment plan, expected date of discharge identified on admission or within 24 hrs, and discharge support required identified on admission and active discharge plan in place.* Also*, "the patient should be medically/socially ready to go home – managed discharged to home or place of care*." The paper talks about a multi-disciplinary approach, so generally there is a template for a successful discharge from hospital.

There is evidence in the findings that discharge into such homes does go well, but when it goes wrong it appears to be in the areas of missing resident information, poor recording and sharing of information and in terms of the resident's care, lack of attention to their basic needs such as ensuring they are clean and warm when discharged.

It is very clear from care and nursing home managers who have responded to this survey, they know what a "good" discharge to their home should look like. It is reassuring to note that they are seeing the person at the centre of the discharge. Home managers have given ideas of what would improve the discharge process, and from their comments a seamless hand-over would be if there is a complete discharge plan handed over at the time of discharge, in chronological order with medical history, a note of expected appointments and problems experienced by the patient.

It is also very clear that the home managers are mindful of what is happening within the hospital environment in terms of the pressure on hospital staff having to release hospital beds, discharge at inappropriate times of day, a tendency for patients to move from ward to ward hence gaps in information and sometimes staff having no time to answer questions.

It would be easy to interpret the above failings as the fault of the nurses and staff on duty at the time, and recently nursing care has come into question in the media over the care of the elderly and dementia patients. The *Royal College of Nursing (RCN*) has been critical over the standards of nurse training, which changed with the removal of the State Enrolled Nurse qualification and the advent of Project 2000, which was more academically steered. Certainly there is a question about basic nursing care in this study as patients were discharged without their basic continence and attire needs being met. But is this the fault of the nurse or Ward Sister? Are there pressures being put on these staff from management to meet hospital targets and stop bed-

blocking so that some of the focus on important basic care is lost? Staffing levels and the use of agency nurses/bank nurses may also be an issue.

The LINk has been consistently advised that discharge begins before a patient enters hospital, so it often begins with GP referral or with the care home and social services who have devised a care plan for the resident in conjunction with the person's carers/relatives; a single-assessment that should go with a person throughout his or her journey through the health and social care system. In fact commissioners in the primary care and social care setting also have a very significant input into a patient discharge being successful. With the multi-disciplinary idea still in mind, discharge should include arrangements for all the care and support the patient will need on discharge, otherwise they should not be discharged. The CQC publication referred to earlier clearly states "*You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services*". The example given in the document was of an older person moving from an acute setting to his local community hospital for rehabilitation;" *the community hospital is told before he arrives about what he needs. They make sure that his bed is set up with protective rails and that he continues to get the special diet he needs."*

Our attempts to map the whole area of discharge planning in 2009 ended disappointingly, but looking at the different aspects involved in discharge it is not an easy process if all care providers are not fully engaged and there are targets and funding issues between each provider.

It would appear that there is already some progress with strategic visions and compacts being made by health and social care organisations and trusts in Bedfordshire, including commitments made by *NHS Bedfordshire in their Healthier Bedfordshire strategy 2010-11* and with the whole idea of QIPP, Quality, Innovation, Productivity and Prevention, which is a key focus in Bedfordshire at the moment. The Healthier Bedfordshire strategy's aim is to ensure care closer to home by creating effective support in the community to avoid admittance to hospital. The *QIPP Compact* signed by key partners from the health, social care and mental health trusts and organisations is a step in the right direction and as stated in the document *"The Compact builds on existing partnerships between health and social care organisations. Effective partnership is key to the successful delivery of comprehensive and efficient services*."

So in conclusion, this is an opportunity for these strategies and commitments stated in these important documents to be turned into reality with the person at the "heart" of the process rather than just being a part of the process. It may mean that the whole pathway of discharge needs to be dissected and every process looked at in depth, from reviewing basic nursing care to looking at the role of hospital managers and commissioners of services. Most importantly engaging and interacting with home managers who appear from this basic survey to be very passionate about their residents and do seem to have the patient at the "heart" of the process and recognise that this is the person's home and they should be treated with due respect and dignity.

Recommendations:
It would appear that the whole area of discharge planning should be the subject of a pilot project, led by the Commissioners in both health and social care and assisted by the voluntary sector through an organisation such as LINk/HealthWatch to map out each area of involvement in the process, how it comes together, and gather the experiences of patients through each part of the admission and discharge process; from before admittance to hospital to discharge in order to deliver an efficient and effective service for the population of Bedfordshire. Each organisation should remember that having protocols and procedures is one thing but making them reality is something totally different.

Bedfordshire LINk Social Care Working Group
January 2011

REFERENCES:

British Orthopaedic Association on discharge entitled "Patient Pathways (Models of Care) for patients who are to undergo planned orthopaedic operations (Feb 2011)

Bedfordshire LINk Bulletin No. 27, March 201, Quality Accounts, Hospital Trusts

Bedfordshire LINk newsletter May 2010

The Care Quality Commission circular on *"What standards to expect from the regulation of your NHS Hospital"(2011)*

Department of Health's guidelines on Discharge from hospital pathway, process and practice (2003)

DH "Our Health, Our Care, Our Say", better integrated health and social care (January 2006)

NHS – DH Achieving Timely 'Simple' discharge from hospital (August 2004)

NHS Bedfordshire in their Healthier Bedfordshire strategy 2010-11

The Derbyshire LINk report into Hospital to Care Home Discharges, Inappropriate Discharge, (May 2010)

APPENDIX 1

Bedfordshire LINk Survey on the view of Care/Nursing Home Staff on Hospital Discharge Procedures, January 2011

A total of 40 homes replied, which is 20% of respondents. *

At the Pre-Discharge Assessment	**YES** (%)	**NO** (%)	**UNANSWERED** (%)
1. Do you always receive patients discharge information?	**18** (45%)	**19** (47.5%)	**3** (7.5%)
2. Are the Nursing Assessments for patients always available to you?	**20** (50%)	**16** (40%)	**4** (10%)
3. When making your assessment, were you allowed access to the patient's notes?	**32** (80%)	**3** (7.5%)	**5** (12.5%)
4. When undertaking the pre-discharge assessment, do you consider that you are fully involved in the process?	**19** (47.5%)	**15** (37.5%)	**6** (15%)

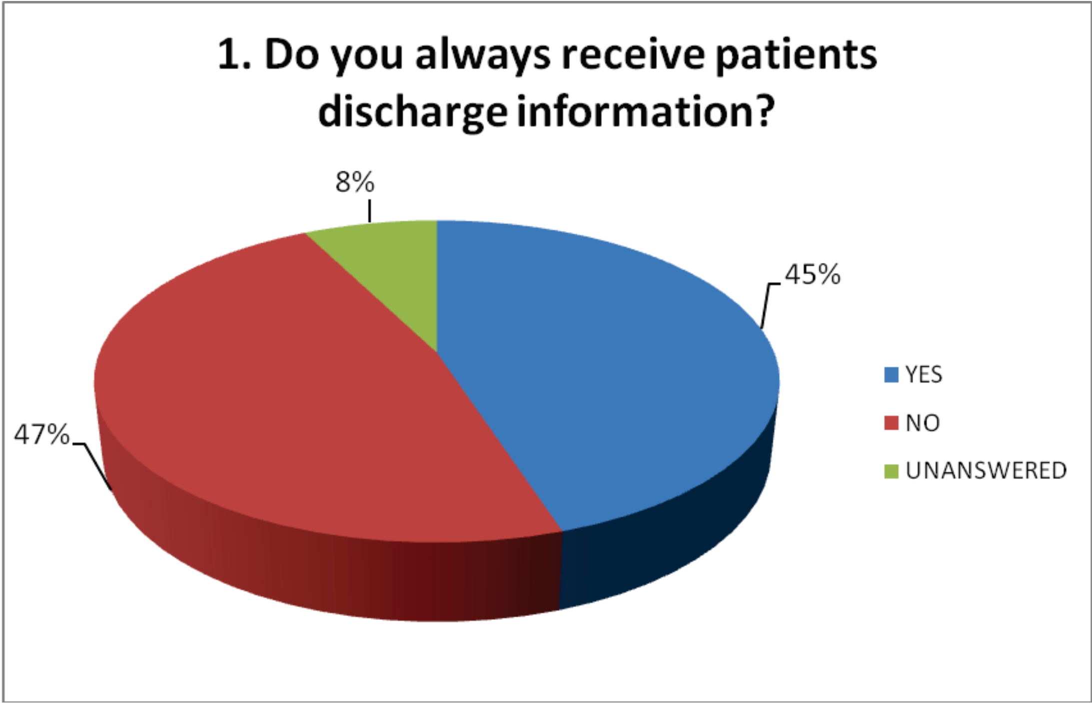
At discharge to the home

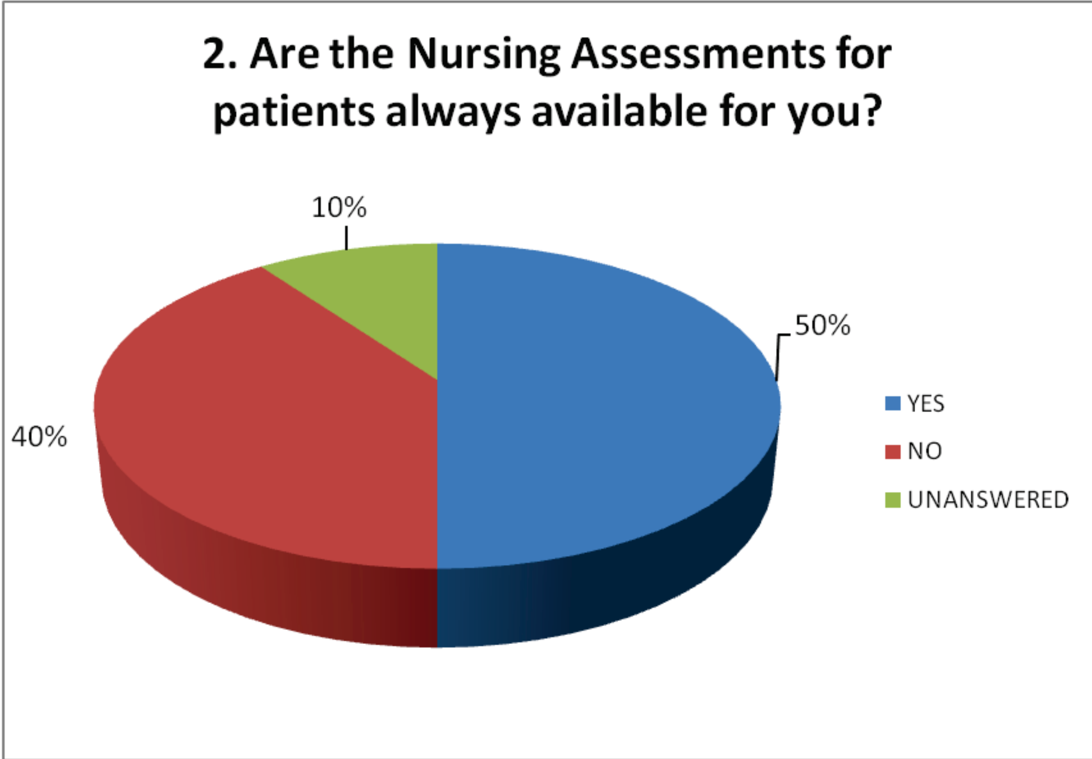
5. Do you consider that the discharge information you receive gives you sufficient information? If not, how do you feel that the information could be presented more effectively?	**16** (40%)	**16** (40%)	**8** (20%)
6. Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?	**34** (85%)	**1** (2.5%)	**5** (12.5%)
7. Is the prescribed medication from the hospital pharmacy always present and correct?	**20** (50%)	**15** (37.5%)	**5** (12.5%)
8. Do you experience any issues with repeat prescriptions from the patient's own GP regarding medicines prescribed by hospital medical staff?	**12** (30%)	**22** (55%)	**6** (15%)

9. Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?	**11** (27.5%)	**23** (57.5%)	**6** (15%)
10. Do you feel that patients are discharged at an appropriate time of day and with appropriate notice?	**14** (35%)	**19** (47.5%)	**7** (17.5%)
11. Are residents always discharged in appropriate attire?	**17** (42.5%)	**19** (47.5%)	**4** (10%)
12. Do you consider that all hospital staff interact with you and your team in an appropriate manner?	**19** (47.5%)	**16** (40%)	**5** (12.5%)
13. Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate home?	**17** (42.5%)	**18** (45%)	**5** (12.5%)
14. Do you consider that telephone discharges are always clear and effective?	**14** (35%)	**18** (45%)	**8** (20%)
15. Do you consider that all the hospital staff support you during discharge process with appropriate information?	**19** (47.5%)	**16** (40%)	**5** (12.5%)
16. Do you consider that you are able to refuse admission of a patient due to an inappropriate discharge?	**26** (65%)	**8** (20%)	**6** (15%)

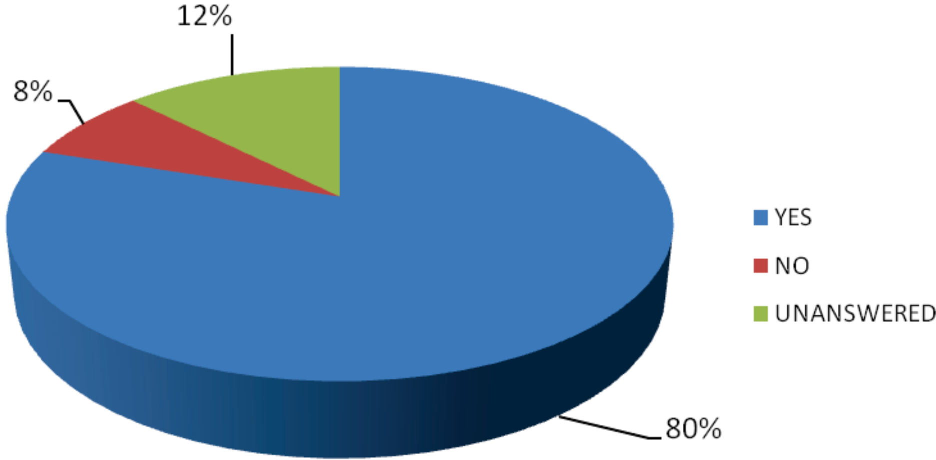
***Percentages quoted in this report are taken purely from the replies received – no account of non-replies is taken.**

APPENDIX 1A – SURVEY PRESENTED IN GRAPHICAL FORMAT

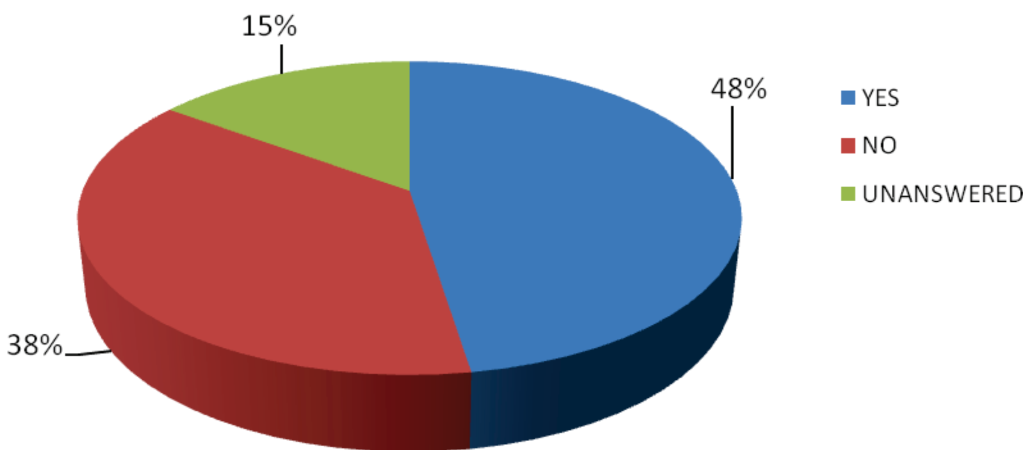




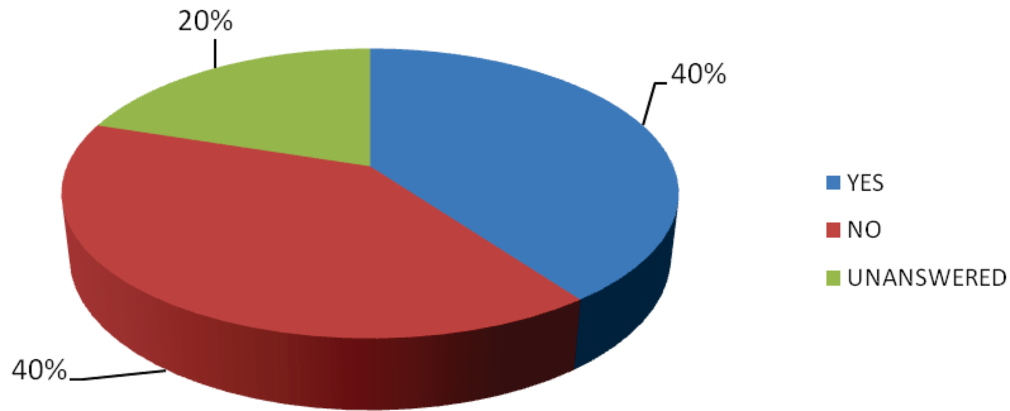
3. When making your assessment, were you allowed access to the patients notes?



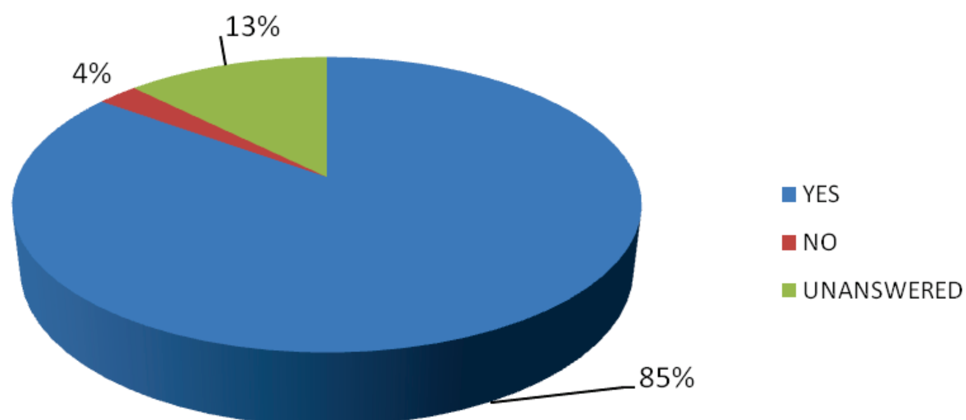
4. When undertaking the pre-discharge assessment, do you consider that you are full involved in the process?

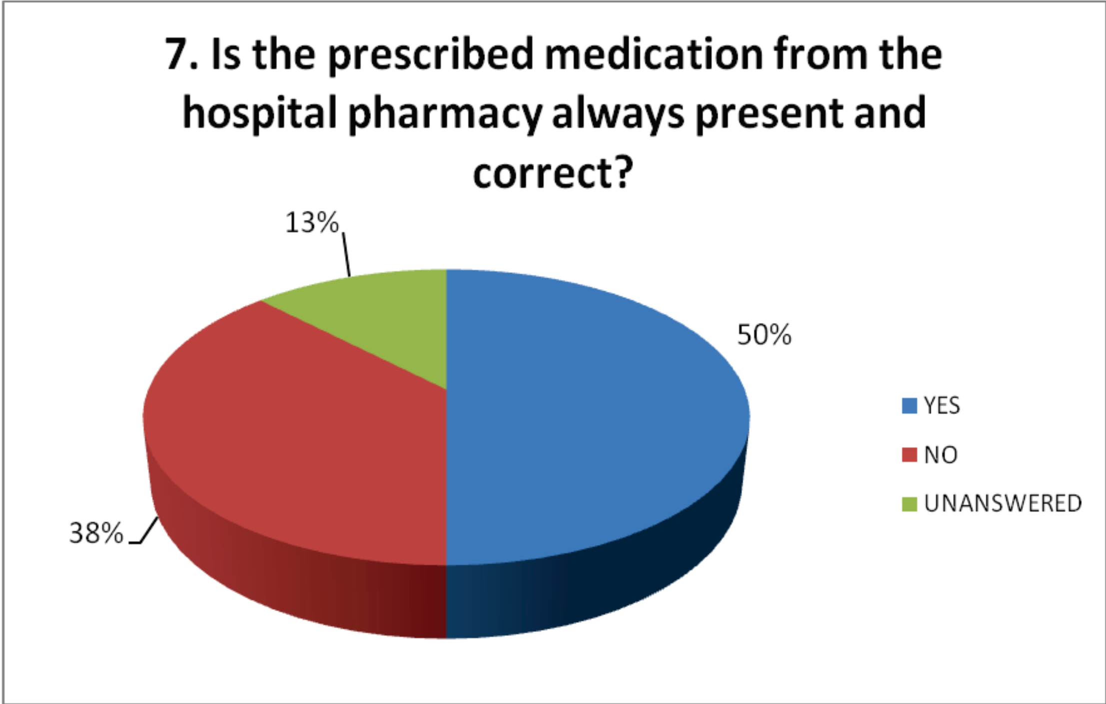


5. Do you consider that the discharge information you receive gives you sufficient information?

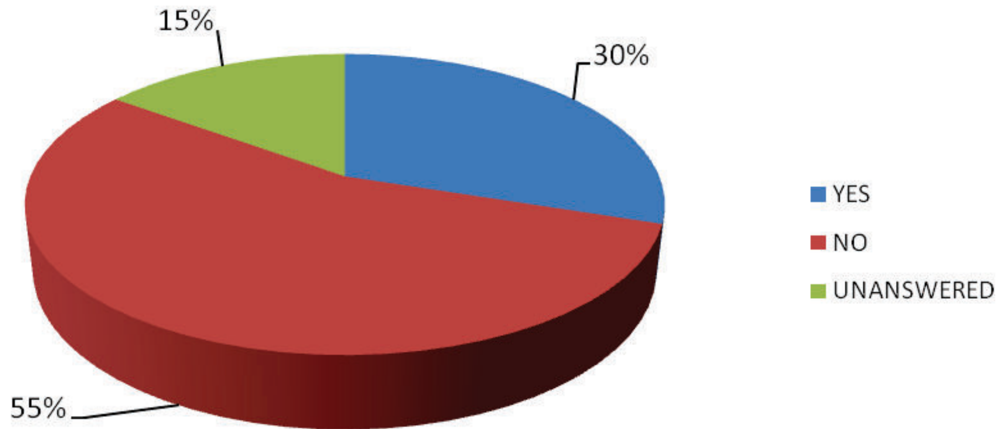


6. Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?

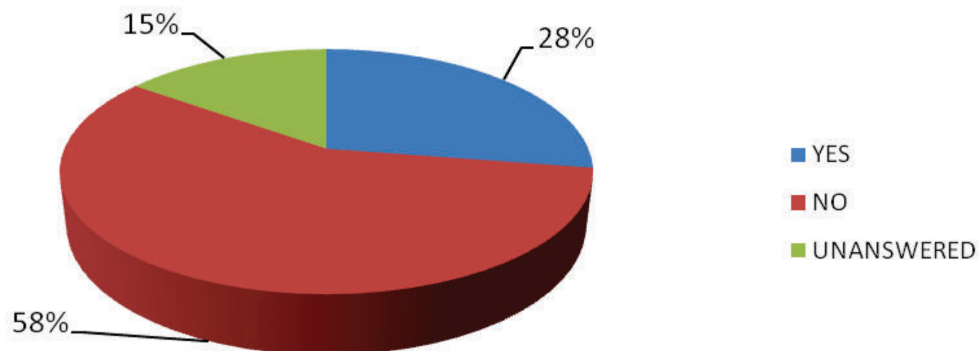


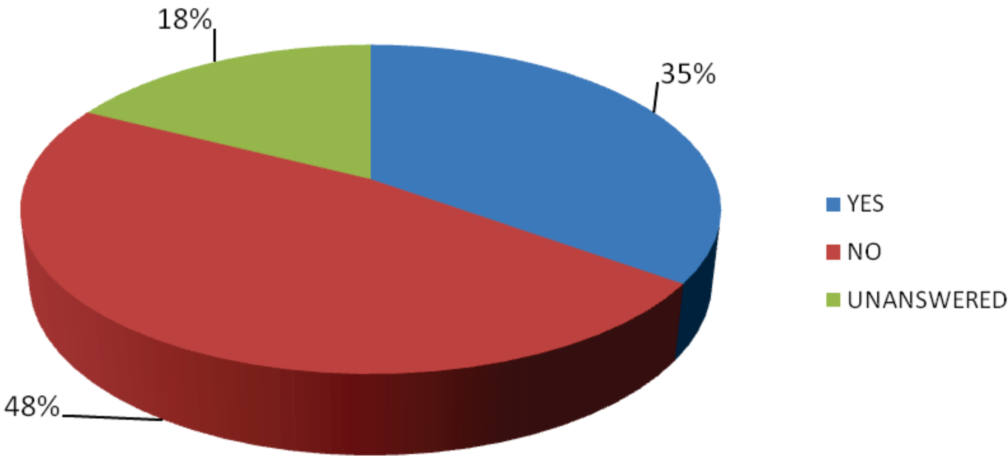

7. Is the prescribed medication from the hospital pharmacy always present and correct?
13%
50%
38%
YES
NO
UNANSWERED

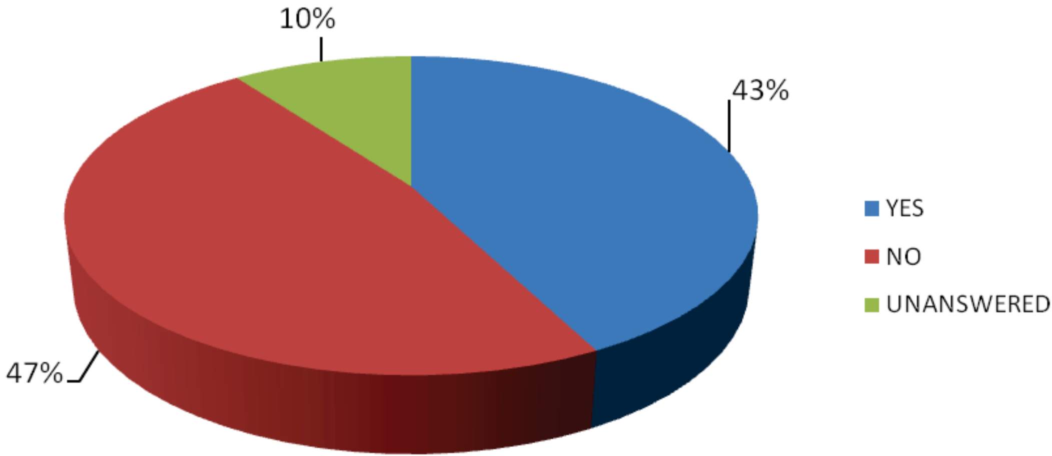
8. Do you experience any issues with repeat prescriptions from the patients own GP regarding medicines prescribed by hospital medical staff?

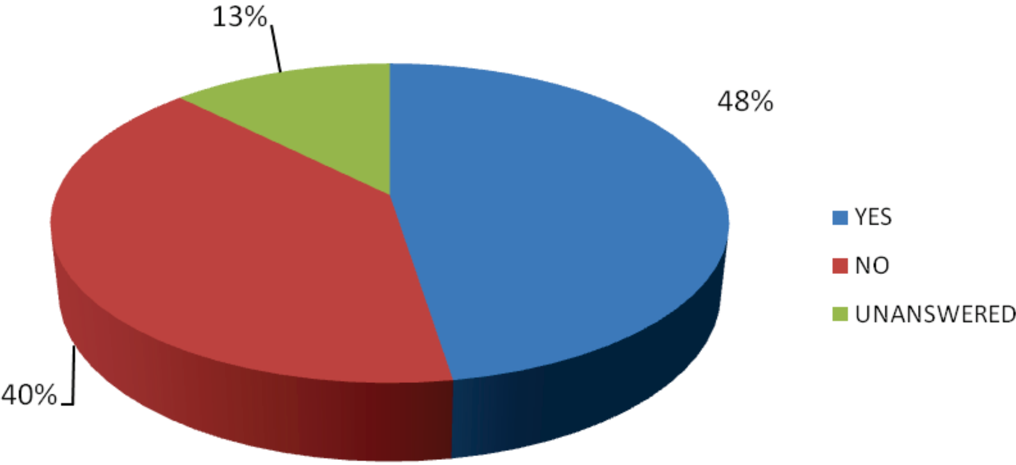


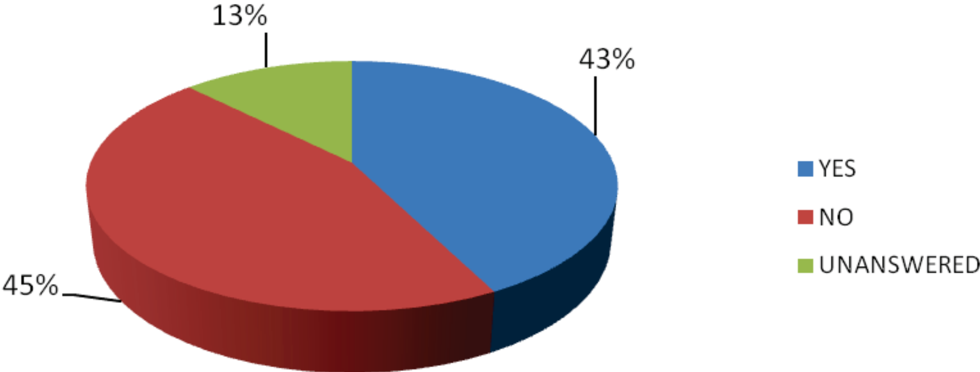
9. Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?

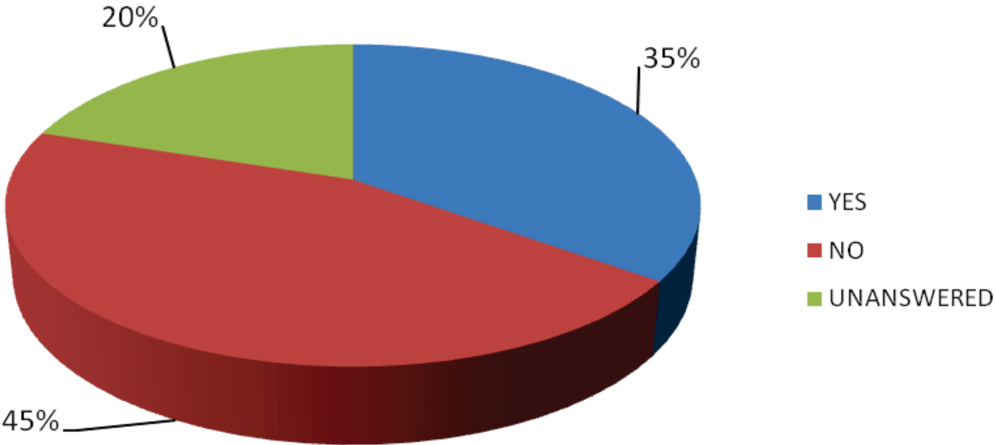


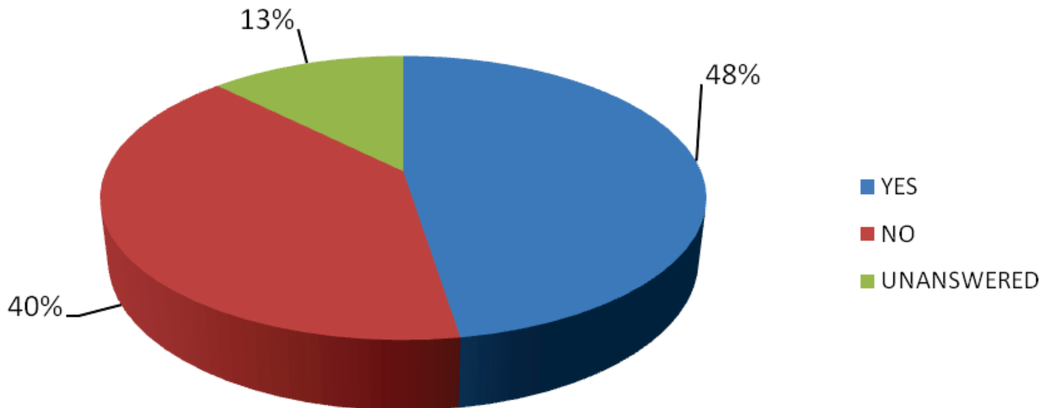

10. Do you feel that patients ar discharged at an appropriate time of day and with appropriate notice?
18%
35%
48%
YES
NO
UNANSWERED

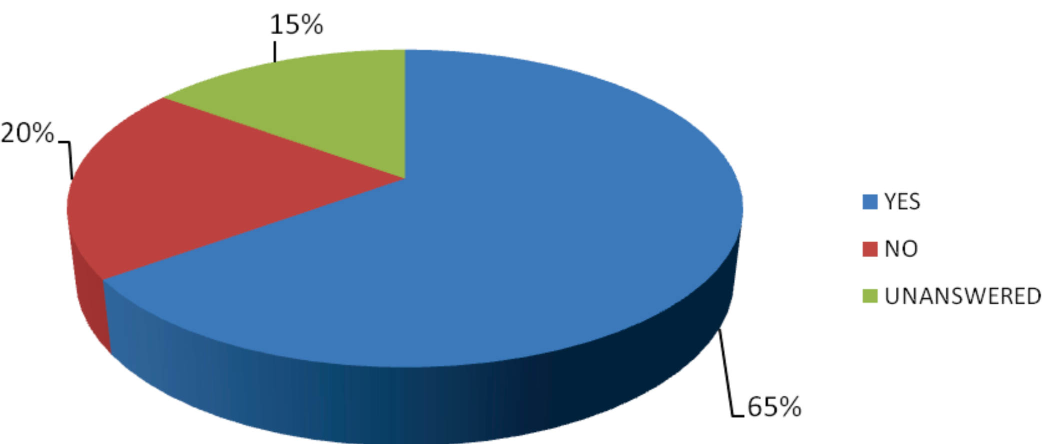

11. Are residents always discharged in appropriate attire?
10%
43%
47%
YES
NO
UNANSWERED


12. Do you consider that all staff interact with you and your team in an appropriate manner?
13%
48%
40%
YES
NO
UNANSWERED


13. Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate?
13%
43%
45%
YES
NO
UNANSWERED


14. Do you consider that telephone disharges are always clear and effective?
20%
35%
45%
YES
NO
UNANSWERED


15. Do you consider that all the hospital staff support you during the discharge process with appropriate information?
13%
48%
40%
YES
NO
UNANSWERED


16. Do you consider that you are able to refuse admission of a patient due to an inapproriate discharge?
15%
20%
65%
YES
NO
UNANSWERED

APPENDIX 1B – INDIVIDUAL REPONSES

Bedfordshire LINk Survey on the view of Care/Nursing Home Staff on Hospital Discharge Procedures, January 2011.

1. **Do you always receive patients discharge information?**

   Respondent 68 – A lot of time no discharge letter is sent, we have to ring up and chase it.

   R87 – On one occasion a lady came back to … and I personally had to go to the hospital and collect paperwork.

   R109 – At times need to contact hospital to fax over and still do not receive.

   R128 – But not always informative, L&D did trial typed ones which were easier to read.

   R138 – Although they can be sketchy with information.

   R139 – Had wrong person sometimes.

   R161 – From A&E, residents frequently return with no paperwork.

2. **Are the nursing Assessments for patients always available to you?**

   R136 – Sometimes notes not on bed.

   R138 – Not always.

   R139 – Yes but not always filled in as moved to different wards.

   R161 – Usually, we often have to ask or use the file/notes.

3. **When making your assessment, were you allowed to access the patient's notes?**

   R20 - I have not asked for this in the past.

   R21 – Only when doctor arrived, did any notes appear on nurse's station.

   R87 – Not all documents but relevant to medication and condition.

R109 – On Asking.

R138 – Very rarely am I able to access full notes, daily records and charts.

R139 – Most of the time.

R161 – We have often been given contradictory information from ward staff. e.g. patient has transferred, patients has not been transferred and has not been out of bed.
R4A – Not always.

4. **When undertaking the pre discharge assessment, do you consider that you are fully involved in the process?**

R87 - We carry out our own assessment before the patient leaves the hospital.

R138 – Mostly

R139 – Most of the time

R156 – Sometimes

R164 – Sometimes

R176 – Always in re to mental health client otherwise it is questionable.

R191 – Staff on the ward will phone.

5. **Do you consider that the discharge information you receive gives sufficient information? If not, how do you feel that the information could be presented more effectively?**

R21 – If the Guidelines on discharge were not 3-4 days later.

R68 – When we get it.

R86 – By always receiving a discharge letter and medication changes, info of pressure area's gained in hospital. Physio follow-ups as we find our residents no longer walk after being in hospital. Bruises, UTI's.

R93 – Copy of discharge plan.

R109 – By hospital phoning.

R111 – For instance, time last medication given is not always available or how many PRN analgesic medication given in last 24 hours.

R113 – We sometimes receive patient's info that is not discharged to us. Wrong info, wrong patient.

R128 – If patient is new to us, a medical history would be useful as we only receive present issues.

R136 – When the nursing discharge is received, yes.

R138 – Would like it to be more detailed. Chronological, also any expected appointments or possible problems.

R139 – Ensuring the medication is on the home discharge to meet CQC regulation as usually only on GP.

R156 – Information coming from Bedford Hospital is usually good.

R168 – We require, 1. Current Next of kin details, 2. NHS No. 3. Name and address. Not always charted.

R176 – Clearer written notes, request management to reassess every time client being discharged.

R179 – The information is not always accurate or complete, we need a history of what has happened and treatment received.

R191 – Printed notes required.

R6A – Although not always up to date.

6. **Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?**

R135 – Especially Psychosocial, Life History

R156 – Particularly as we care for very elderly people, an indication of these things does not necessarily prevent us taking the person but helps us prepare better.

R179 – Also referrals need to be accurate and followed through.

7. **Is the prescribed medication from the hospital Pharmacy always present and correct?**

R83 – Only one medication error in the last two years.

R109 – At times will send medication in tablet form, when they know the individual needs liquid form.

R111 – No, usually sufficient quantity for two weeks but not always, sometimes none sent and we have been asked to contact GP.

R113 – We have problems when we have to give half dosage, as our policy is not to give half medication.

R138 – Although have found items like Thick and Easy or Fortisips Juice not supplied.

R139 – The hospital pharmacy always ring us to check what medication is in the home, sometimes they are inform us they are on the way back.

R161 – We usually ask only for items prescribed whilst in hospital.

R179 – It is often short or with a few items missing.

R5A – Mostly, it is helpful if we have a pharmacist contact the home prior to discharge to discuss medication.

8. **Do you experience any issues with repeat prescriptions from the patients own GP regarding medicines prescribed by hospital medical staff?**

R68 – This is due to the fact that the surgery does not get a copy of the discharge letter.

R87 – On occasion repeat description have been delayed.

R111 – There is sometimes a delay in GP updating their systems but this is rare.

R139 – We fax GP letter to them.

R156 – Sometimes it depends what has been prescribed.

R161 – Occasionally.

9. Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?

R20 – A vulnerable individual with a respiratory problem was discharged to … at 10pm

R55 – Some are discharged when it is obvious that there condition is such that they need an immediate return to hospital.

R68 – A lot of the time it is really late, after 8pm which is not acceptable.

R86 – Sometimes too soon, sometimes very late at night.

R109 – We have Dementia individuals that have been sent back too soon as hospital seem to want them discharged before the weekend.

R111 – Often we are aware that they have been waiting for transport all day, often post 5pm discharge, frequently discharged in skimpy clothing, incontinent.

R113 – We have a cut off time of 6pm

R138 – Mostly, although sometimes would like to see full assessment completed rather than a sketchy brief resume.

R139 – We have experienced some residents they have discharged early and have to be readmitted within a day or two.

R161 – Whilst they may be medically fit for discharge, little thought is often given to how a residential home will then care for them immediately after discharge. I have experienced residents needing re-admission 24 - 48 hours after discharge.

R164 – No always at suppertime, around 5pm.

R5A – I feel that patients are sometimes discharged too early, though not often.

R176 – Some of my very elderly clients have arrived back to my home in early hours of morning

R179 – I often think they have kept in too long and would benefit more from being at home.

10. Do you feel that patients are discharged at an appropriate time of day and with appropriate notice?

R55 – We have particular times when it is appropriate for us to receive discharge from hospital, this is usually agreed.

R68 – As above (A lot of the time it is really late, after 8pm which is not acceptable).

R83 – We had in the past received patients very late in the evening i.e. 11-12 Midnight

R109 – No, have been contacted a few hours before discharge and at night.

R111 – Notice, good (usually agreed with ward) Time of day.

R135 – We are consulted on discharge time.

R136 – Sometimes too late in the day.

R138 – Mostly although have had patients come to home in evening or middle of meal times.

R139 – No arriving back after 5pm, or a new admission coming at this time who has never been here.

R156 – Usually

R161 – If we insist an assessing first, ward staff have tried to insist we take residents back without this.

R164 – Sometimes.

R168 – On occasions due to transport and TTO's we are expected to take after 8pm. I feel this is inappropriate, as no consideration is given to the elderly person.

R176 – Very dependant on Ward/Hospital.

R179 – Often home very late into the evening although we do get notice.

R5A – No, sometimes patients are discharged too late in the day and arrive very disorientated and cold.

11. Are residents always discharged in appropriate attire?

R55 – I have had residents return in just a skimpy night dress and no shoes or blanket.

R69 – We dress and pick them up ourselves.

R109 – Residents have returned back wet, in a nightdress and no blanket.

R111 – See above (Often we are aware that they have been waiting for transport all day, often post 5pm discharge, frequently discharged in skimpy clothing, incontinent.)

R139 – We have had residents in the dark in night clothes and a blanket in the snow.

R161 – Usually.

R5A – Sometimes in night attire, always have blanket though.

12. Do you consider that all hospital staff interact with you and your team in an appropriate manner?

R18 - Most of the time

R20 – They are not flexible with the staff team here visiting the patients, a bit of flexibility to the support staff will benefit the patient.

R87 – On occasion staff have not had the time to answer questions that we feel were needed to give the right care.

R111 – Most of the time, very rarely do we encounter any negative attitude or support.

R128 – Some not all, we are not told if one of our residents passes away, it could be up to 48 hours before we are told.

R139 – Most of the time there are no problems.

R156 – Most are good but we are often made aware of the pressure they feel under, they can be defensive and impatient.

R161 – Usually, I appreciate the pressures hospital staff are under but a bullying approach has been used on occasion and we have been given the wrong information.

R169 – Patronising and ill informed.

R179 – Very rarely have contact unless we call them.

R4A – Mostly.

13. **Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate home?**

R18 - This could be better

R21 – But it is improving

R55 – No, it is a complete mystery to them and they are usually directed to S/Services run homes and are not given a choice.

R139 – Social worker does this.

R156 – Possibly, they don't complain of coming to us but are often rushed and pressurised by the hospital.

R161 – It varies, usually, however families have told me they felt under pressure to find a home.

R179 – Have been told in the past they are given a booklet and told to "go find one".

14. **Do you consider that telephone discharges are always clear and effective?**

R21 – Not experienced one

R87 – For example mobility needs, physio etc.

R128 – Have never had telephone discharge

R139 – When done

R156 – Cannot comment. We have only once accepted a telephone discharge and it did not turn out well.

R179 – Do not accept discharge info over the phone.

15. Do you consider that all hospital staff support you during the discharge process with appropriate information?

R21 – In as much as they are able

R55 – Very little in the way of information comes with the patient.

R83 – We do sometimes have to contact the hospital for further information.

R109 – No, pharmacy most times at hospital always ring home for individual's information for drugs.

R111 – Usually.

R128 – In some cases

R139 – Most of the time

R161 – Usually.

R179 – If you know what to ask!

16. Do you consider that you are able to refuse admission of a patient, due to an inappropriate discharge?

R21 – Not always

R55 – Yes if I consider that the state of the patient is such that the GP will consider their immediate return.

R68 – Especially if it is late – we have a 7pm cut off.

R83 – I don't feel I can turn away a patient on arrival due to inappropriate discharge.

R87 – We are aware we can refuse but the patient remains the priority in all our decision making.

R109 – This is our policy at the home.

R139 – As they are sitting in the car park.

R161 – It usually involves conflict, on one occasion, a resident had been re-admitted and clearly needed nursing care. When I refused readmission I explained to the ward sister why, she then told the family I was wrong and would be reported to (the company). The resident however was assessed as nursing care and went to a nursing home. We often feel the resident's needs are irrelevant and freeing a bed is more important. We have also been lied to by staff to try and get us to accept residents back.

R169 – However hospital staff are rude and start saying "you have to …" Lack of understanding of the type of home, staffing levels etc. Lead to inappropriate discharge hospital staffs ignorance of any other service other than their own leads to the poor quality that they continually practice under.

APPENDIX 2

INCIDENT REPORT	**NO:**
DATE REPORTED	
REPORTEE	
DESCRIPTION OF INCIDENT:	

LOCATIONS INVOLVED:	
DATE OF INCIDENT:	
DETAILS OF PATIENT:	
CATEGORY OF INCIDENT:	
LOGGED BY :	
DATE LOGGED:	

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Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **13 June 2011**

Subject: Bedfordshire Community Health Services Quality Account (2010)

Report of: **NHS Bedfordshire Community Health Services**

Summary: This note provides a brief outline of the Quality Accounts process and the role of the Social Care, Health and Housing Overview and Scrutiny Committee

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Advising Officer: Richard Winter, Chief Operating Officer Bedfordshire Community Health Services

Contact Officer: Jonathon Partridge, Scrutiny Policy Adviser (0300 300 4634)

Public/Exempt: Public

Wards Affected: All

Function of: NHS

RECOMMENDATION:

1. That the Social Care, Health and Housing Overview and Scrutiny Committee comment on the Quality Account submitted by Bedfordshire Community Health Services if so minded.

Background

1. All providers of NHS healthcare services in England are required to publish a quality account that represents the quality of the healthcare services delivered over the previous year. Trusts are required to share their quality accounts with the local LINk and appropriate Overview and Scrutiny committees with responsibility for health matter who are offered the opportunity to comment on the draft document on a voluntary basis. These quality accounts are produced annually and made available to the public.

2. The Department of Heath have produced guidance on Quality Accounts titled "Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)". The DoH guidance states that "Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention."

3. The Department of Health Guidance "Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)" suggests that OSCs might consider the following:-

   - Do the priorities identified by the provider contained in the Quality Account match those of the public?
   - Has the provider omitted any major issues from the Quality Account?
   - Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

4. With regard to the attached quality account the Social Care, Health and Housing Overview and Scrutiny Committee considered the divestment of Bedfordshire Community Health Services (BCHS) (Minute SCHH/09/186 refers) at their meeting on 18 October 2010. The report was noted.

Conclusion and Next Steps

5. The Overview and Scrutiny Committee is asked to consider the Quality Account and provide any comments as they feel appropriate. Comments on the Quality Account are voluntary, the Committee is not obliged to comment if it does not feel it necessary.

6. Any statements agreed by the Committee will be sent to the provider to allow them time to prepare their Quality Account, which will include the statement, for publication.

Appendices:
Appendix A – Bedfordshire Community Health Services Quality Account (2010)

Background Papers: (open to public inspection)
Quality Accounts: a guide for Overview and Scrutiny Committees
(**http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125167.pdf**)

Location of papers: Priory House, Chicksands

Bedfordshire Community Health Services

Bedfordshire Community Health Services

QUALITY ACCOUNT 2010/11

(Version 16 Final DRAFT)

Author Helen Smart, Deputy Chief Operating Officer for Quality & Improvement

Date: March 2011

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Statement from the Chief Operating Officer – Quality at the Heart of the Organisation

Community based services are at the heart of a modern and flexible NHS Bedfordshire Community Health Services (BCHS). BCHS is committed to ensuring that our staff are able to provide the highest quality care to our patients and that the environment in our inpatient facilities in clean, comfortable surroundings. This commitment is enshrined in our strategic vision which is to provide an outstanding local healthcare system and build on our strength as a provider of Community Services. We want our patients/service users to receive the best quality care we can provide and the sort of care that we, or our family, or friends would expect and deserve to experience. Working within our allocated finance is very important, but money is only a means to an end and we want to make sure that every penny is spent effectively on behalf of our patients.

BCHS provides healthcare for a population of over 420,000 covering 1191 square kilometres of Bedfordshire (excluding Luton).

It has approximately 1,100 staff (70% Clinical Services), based at more than 50 locations BCHS provides 30 different community healthcare services, including the following:

- Community Services including Intermediate Care, District Nursing, School Nursing, Wheelchair Service, Podiatry Service, Continence Service, Occupational Therapy, Speech and Language Therapy, Dietetics and Nutrition, Primary Care Counselling, Neuro-rehabilitation, Acquired Brain Injury.
- Community Hospitals: Biggleswade Hospital (28 beds); Archer Unit (20 beds) and ten commissioned nursing home beds.
- Prison Healthcare
- Stop smoking service and other health improvement initiatives, such as Healthy Steps (ended 31 March 2011) to Employment and Active Bedfordshire (ongoing)
- Specialist nursing – Parkinson's disease, Wound Care, Macmillan Nursing
- Specialist Sexual Health

The very nature and core of our business is to prevent ill health and promote good health. This philosophy underpins everything that we do on a daily basis.

Our commitment is to deliver excellence in everything that we do and to ensure that first class patient care and quality lies at the heart of this. This strong focus on quality reflects the priorities of the NHS as a whole, and we welcome the practical steps to support this agenda.

This includes the legislation to introduce quality reporting for all NHS Trusts and the development of the Commissioning for Quality and Innovation scheme, which acts as a positive force to ensure a strong focus on quality from the 'Service to the Board'. BCHS is overseen by a Committee which fulfils the role of a 'management board' for the organisations and is referred to hereafter as 'the Board'.

In 2010 the organisation registered without conditions with the Care Quality Commission (CQC), which regulates the quality of health and adult social care.

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BCHS has worked hard over the past year to bring these initiatives, along with the requirements of the NHS Constitution, together into a coherent, over-arching strategy which will drive improvements in the quality of clinical care and the patient experience in all our services. Actions range from developing a quality and improvement monitoring framework for all clinical services to a new patient experience strategy which enjoyed a very successful launch day. The development of the monitoring framework will be crucial in the monitoring of key clinical indicators, and improvements to the services and inpatient environment. Set out in this report are our priorities for improving patient safety, effectiveness and experience in 2011/12. The aim is that the organisation will move the quality account forward by ensuring every service and every member of staff is focused on quality outcomes from service level to the Board. There will be a clear commitment to increase the Board level emphasis on safety and quality by reporting quality measures.

Both the Board and the Commissioners take a keen interest in this work, and I can personally assure you that the contents of this document meet our rigorous data quality standards. Finally BCHS welcomes the continuation of partnership working to endorse the ethos of this quality account.

BCHS has benchmarked itself with Monitor's Quality Governance Framework (see table in appendix 1**)**. The framework captures the combination of structures and processes at and below board level that drive organisational-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best-practice
- identifying and managing risks to quality of care

Since my appointment to BCHS in September 2010 there has been an increased focus on quality and safety through a review and redesign of governance structures and processes. New mechanisms have been developed to engage the whole organisation in the delivery of necessary standards across a wide range of indicators. The culture of the organisation has been transformed from an organisation in financial 'turnaround' into a very viable business with a 'can do' attitude. We have held a number of communication sessions with staff, patients and our other customers such as the Local Authorities, GPs and PBCs Chief Operating Officers and Chairs. We have listened to what you have told us and introduced changes including new and innovative ways of working.

I can confirm on behalf of the organisation's Board that to the best of my knowledge and belief the information contained in this Quality Account is accurate and represents our performance in 2010/11 and our priorities for continuously improving quality in 2011/12.

We look forward to building on achievements to date and driving forward with targets for the coming year.

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Our quality account will be published on our website and a copy can be translated into different languages on request.

If you would like to comment on any aspect of the BCHS Quality Account please email me at Richard.Winter@bedfordshire.nhs.uk

Richard Winter

Chief Operating Officer

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1. Priorities for improvement

Our 2011-2012 priorities

Performance management in the NHS has begun to shift from focusing on inputs (such as the numbers of doctors or nurses employed), through measuring process (such as waiting times), to capturing the outputs – or outcomes – that matter to patients. By focusing on the latter,

- providers will be able to benchmark their performance and introduce improvements in quality
- commissioners will be able to make decisions based on quality as well as cost
- patients will be supported in exercising choice on issues that really matter to them.

BCHS will focus on specific quality priorities rather than general aspirations, thereby enabling us to accurately assess the success of our priorities. BCHS have chosen 9 priorities, identified on page 10, for improvement for the coming year. BCHS has concentrated on areas where improvement to the organisations performance is a high priority. Throughout the year we will report our progress against these initiatives directly to the Board on a quarterly basis, and also report externally through our monthly meetings with our Lead Commissioners at NHS Bedfordshire.

Early in our discussions with staff and users it became apparent there was a concern that if an improvement priority was not included in the Trust's Quality Accounts, then this area or issue would not be prioritised. This is not the case; Quality Accounts are at the centre of an over-arching quality strategy, and are just one important vehicle for driving quality improvements.

Directorates and clinical teams will continue, throughout the year, to innovate and develop local and organisational-wide quality improvements, for example by responding proactively to user feedback. An early action is to enhance our patient's experience in all clinical areas.

Our aim at BCHS is to be the best we can be and reduce variation. The new 'Clinical Service Performance and Improvement Framework is a tool to support improvement and progress in the first instance but it is also a mechanism to identify potential risk for the organisation as a whole and subsequently take appropriate actions to mitigate that risk. It will also:

- ensure that minimum service standards are delivered against agreed national, regional and local targets and standards
- enable clear feedback to be given, together with support and sufficient time to remedy any deficiencies in areas where performance is considered below acceptable standards
- drive up overall performance including identifying areas where BCHS needs to invest in extra support to improve performance

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- identify high performing services and encourage the sharing of good practice
- allow for escalation where there is a clear and consistent failure to perform to acceptable standards or remedy deficiencies

The 'framework' will be an evolving document as the new NHS Operating Framework 2011/12 and subsequent challenges come into fruition.

The list of our 9 priorities was developed:

- by listening to staff via our Senior Managers Forums
- through engagement with our commissioners, PBC Chairs and PBCs,
- by analysis of local and national evidence, audit and policy
- through meetings and feedback from patients and with members of LINk.

Where appropriate we also aligned priorities with our 2010/11 Commissioning for Quality and Innovation Programme (CQUIN).

We have developed plans to achieve each of the quality improvements included in the CQUIN scheme agreed with our commissioners. After consulting with our patients and community about areas they would like to see improved, and with our staff, our priorities for 2011/12 are listed in the table below. Progress against each of these priorities will be monitored, measured and reported regularly to our committee. Together they cover each of the safety, experience and outcome domains of quality and innovative practice.

The views of PBCs and community groups have been essential in shaping these Quality Accounts, and in particular have helped BCHS to identify further areas for improvement in relation to the care of older people that had not previously been considered.

Our Quality Account will enable us to

- Demonstrate accountability to the public for the quality of our services
- Review services and determine improvement priorities
- Supply information on the quality of services to patients
- Involve patients, the public and other stakeholders in shaping services and respond to their feedback

Our priorities for improvement in 2011-12 are detailed below with an indication of why each priority was chosen and how we will measure progress and success. The timescales for the delivery of the priorities below is within the financial year of 2011/12, completion by 31st March 2012. All of the identified priorities have performance baselines with clear measurable improvements?

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Domain (related Initiatives) & identified lead	Our quality priorities	Why we chose this?	What is the baseline and what will success look like
Patient Safety *(Aligned to)* *- Safety Express and CQUIN* *- Lead DCOO for Adults & Older Adults*	1. Reduce the number of patients who come to harm following a fall.	Across the UK patient falls are the single most common event reported to the National Patient Safety Agency. Whilst acknowledging that all falls cannot be prevented, the Chief Nurse for England recently placed reducing harm from falls as being one of the top health priorities for nurses in England.	Baseline will be taken for inpatient units. This is still in development. The main part of our CQUIN for 2011/12 for this will be a 2 year CQUIN of assessing patients in community as at risk and then identifying baseline. Baseline for Archer/ Biggs for Moderate to severe was 5. Other areas currently being developed. Reduction in the number of falls that result in harm by 50%.
As Above	2. Reduce the number of catheter infections	Urinary tract infections (UTI's) make up a large proportion of healthcare – associated infections (HCAIs) in the UK and four out of every five can be traced to indwelling catheters. The Chief Nurse of England placed reducing occurrence of UTIs as a priority to help save precious healthcare resources and improve the quality of patients' lives	Baseline currently being developed at present – this is an area looking to do PDSA cycle as per Safety Express to audit an area and then begin the work Reduction in the number of catheter infections by 50%
As Above	3. Reduction of community acquired pressure ulcers	The Chief Nurse for England recently placed reducing pressure ulcers as another top health	Baseline to be agreed will possibly use 9 months of data from Aug 10 – Mar 11 Reduction in the number of

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		priority for nurses. Pressure ulcers reduce quality of life for patients and create significant difficulties for patients, their carers and families. Even a grade one pressure ulcer is very painful. New pressure ulcers affect an unknown proportion of people in the community, as reliable data is not available, but it is estimated that up to 30% of patients may suffer and 20% of patients in nursing and residential homes may be affected. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the elderly, obese, malnourished and those with certain underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection and a two to four fold increase of risk of death in older people.	avoidable community acquired pressure ulcers by 30%
As Above	4. Implementation of venous thromboembolism (VTE) assessment in inpatient areas	VTE is a significant case of mortality, long term disability and chronic ill health, it was estimated in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS	Implementation of VTE assessment in the community hospitals and appropriate administration of prophylaxis. This indicator will be a two year indicator and measurement of achievement and outcome will be assessed in year 2, i.e. 2012/13.

		leadership Team.	
Clinical *Effectiveness* *Lead DCOO for Adults & Older Adults & Head of Pharmacy*	6. Patients to receive Intra Venous antibiotics at home where appropriate.	To facilitate early discharge from hospital when patients would only be there for IV administration, in line with care Closer to Home agenda.	Baseline: small service at present Success: Implement and Increase the % of patients referred for IV antibiotics administration
Patient Experience *Lead DCOO for Improvement & Quality*	7. Improving our patient experience in the five key areas highlighted by the Department of Health in all service areas: • Were you as involved as you wanted to be in decisions about your care? • Did you find someone to talk to about worries and fears? • Were you told about medication side effects to watch out for? • Were you told who to contact if you were worried about your condition? • Were you treated with respect, dignity and courtesy? We will also be using real time data to capture patient experience/outcomes Implementation of	To deliver year on year improvements in patient experience. To be able to address issues as they arise and not have a long time lag for responding-improved timeliness of response Timely response and reducing hospital admissions To build on feedback from patient experience focus day	To increase patient satisfaction and demonstrate improvement through survey results and benchmarking Community hospitals inpatients get medication information from a pharmacist. Improvement in patient experience/survey Completed Implementation of QIPP initiatives Strategy delivered

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	initiatives such as Mobile working and Telehealth Delivery of patient strategy by working closely with LINk and encouraging patient led groups Patient experience BCHS will work with LA linked groups (the Learning Disability Partnership Board as well as Carers' networks) to get additional feedback on the patient and carer experience.		
Customer Experience / Reputation	8. Improving our reputation with key stakeholders such as GPs, LAs and PBCs	From our GP survey results we were keen to improve our reputation as a high quality service provider	Improvement on last year's survey
Innovation *(Aligned to)* *- Safety Express and CQUIN* *- High Impact Actions for Nursing and Midwifery* *- Lead DCOO for Adults & Older Adults*	9. Implementation of Intelligent Fluid Management Bundle across community teams (Community nursing, Rapid Intervention) to reduce the number of patients admitted to hospital with poor hydration.	Every year, too many patients sustain injuries as a result of poor hydration which have resulted in falls, pressure ulcers and increase risk of developing infection or deep vein thrombosis. Effective and consistent fluid management is recognised nationally as being an area of weak practice (NPSA, NRLS)	Implementation of Intelligent Fluid Management Bundle across community teams (Community nursing, Rapid Intervention). This indicator will be a two year indicator and measurement of achievement and outcome will be assessed in year 2, i.e. 2012/13.

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2. A List of BCHS Indicators to Measure our Performance

Data Quality

Good quality information, including notably the quality of ethnicity and other equality data, underpins the effective delivery of patient care and is essential for improvements in care quality.

Information Governance

BCHS keeps person-identifiable information confidential and secure. The Information Governance Toolkit provides a national standard assessment of information security and confidentiality.

BCHS has been working hard to achieve the requirements of the 'toolkit' in relation to ensuring all staff are trained in this important area and after a 'slow' start is now achieving an acceptable level of performance. BCHS will continue to make progress in this area.

Indicator Reporting and Management

Performance against target is reported to the PCT via Balanced Business Scorecards. Internally performance is reported and managed through comprehensive service, locality and team level KPIs and dashboards. From March 2011 this process will be addressed more formally with greater depth and accountability via a Performance Management Framework. This Framework is covered more fully later in this document.

The areas below are an outline of performance attained by BCHS in 2010/11.

Pledge 2

Description	Target	Performance
East of England SHA Pledge 2 (Referral to Treatment within 18 Weeks) NHS Bedfordshire NHS Luton Please note that we aim for a 100% target in relation to the NHS Constitution and the EoE SHA pledge 2 (Referral to treatment within 18 weeks) but the actual target requirement is 95%	 100% 100%	 99.3% 98.8%

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Immunisation

Description	Target	Performance
Immunisation rate for human papilloma virus (HPV) vaccine for girls aged around 12-13 years Dose 1 Dose 2 Dose 3	 83% 83% 83%	 91.1% 89.5% 83.9%

Obesity in children

Description	Target	Performance
Percentage of children in reception year with height and weight recorded	89%	93%
Percentage of children in Year 6 with height and weight recorded	88%	90.7%

Breastfeeding

Description	Target	Performance
Proportion of women breastfeeding at 6-8 weeks	52.1%	43.3%
Percentage of children with a breastfeeding status	95%	90.8%

Note: We recognise the benefit of breast feeding for the long term health of mother and babies and working towards achieving UniCEF baby friendly status. Our breast feeding coordinator has been working closely with local authority Children's Centres, and the maternity units at Bedford Hospital and the Luton & Dunstable Hospital to standardise training for staff to support breast feeding mothers. We have trained peer support workers and this year saw the highly successful launch of Baby Brasserie across Bedfordshire. The Brasserie offer a relaxed environment for mothers to meet and gain support. They also provide support for pregnant women to find out about breastfeeding.

Infection Control

Description	Target	Performance
MRSA Screening	100%	100%
Hand hygiene audits	96%	98%
	Limit	**Performance**
MRSA Bacteraemia	0	1
C. Difficile	5	2

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Note: The MRSA screening, MRSA Bacteraemia and C.Difficile performance relates to community hospital inpatients. Further infection control audits such as hand hygiene relate to all clinical services.

Tissue Viability

Description	Target	Performance
All patients at high risk of developing a pressure ulcer will be assessed within 4 hours of admission 2011/12	100%	100%

Smoking Quitters

Description	Target	Performance
Number of BCHS referrals resulting in 4 week quitters	29	36

Note: Although BCHS reported the number of quitters in the NHS Bedfordshire Balanced Business Scorecard no target had been set by the PCT. At the SHA review in September it was agreed that we would set an internal target against which to report to the SHA. The BCHS Committee agreed a target of 30 based on performance last year (29) and the first six months of the current year. There had been 55 recorded quitters up to the end of December 2010, these figures include the prison. The end of February the figure is 36.

3. Review of Last Year's Performance

Our priorities for 2010/11 were largely driven by two issues.

We said we wanted to improve our services, ensuring they deliver high quality, effective healthcare and excellent value for money. This was particularly important in the context of the current economic climate.

We were preparing to transfer from NHS Bedfordshire to another NHS Trust which has since been confirmed as South Essex Partnership Trust (SEPT). We were and still are striving to ensure that the transition is smooth with no loss of continuity of care for patients and no reduction in quality of service. In the face of such change a strong focus will be maintained on patient care and safety throughout the organisation and through our governance arrangements.

Other priorities last year were specified as they are national or locally determined expectations. Our priorities for last year were:-

Priority 1 Maintain and improve patient care and patient safety
Priority 2 Develop our services, our quality and our productivity
Priority 3 Improving the experience of patients using our services
Priority 4 Maintain a high priority on control of cross infection
Priority 5 Deliver a waiting times guarantee

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4. How did we do in the delivery of these?

Priority 1 Maintain and improve patient care and patient safety

BCHS is committed to continuous improvement. We will continue to promote incident reporting and ensure that clinical teams have time to review the learning from incidents. It is recognised that a high level of incident reporting, combined with a low level of harm arising from the incidents is a characteristic of a safety conscious culture.

Why is incident reporting important?

Resources targeted more effectively: reported incidents provide evidence to better target resources. They identify areas for change and improvement in both patient care and patient safety.

Increased responsiveness: timely reporting can help increase responsiveness, particularly when undertaking investigations. It also enables staff to be open with patients and their carers at an earlier stage.

Pre-empting complaints: organisations can prepare proactively for potential complaints and litigation cases. More detailed information on a patient safety incident given to patients and their carers at an early stage may lead to fewer complaints and litigation claims, saving time and resources.

Reducing costs: financial benefits arise from reduced severity of incidents, e.g. reduced costs of treatment, reduced length of stay.

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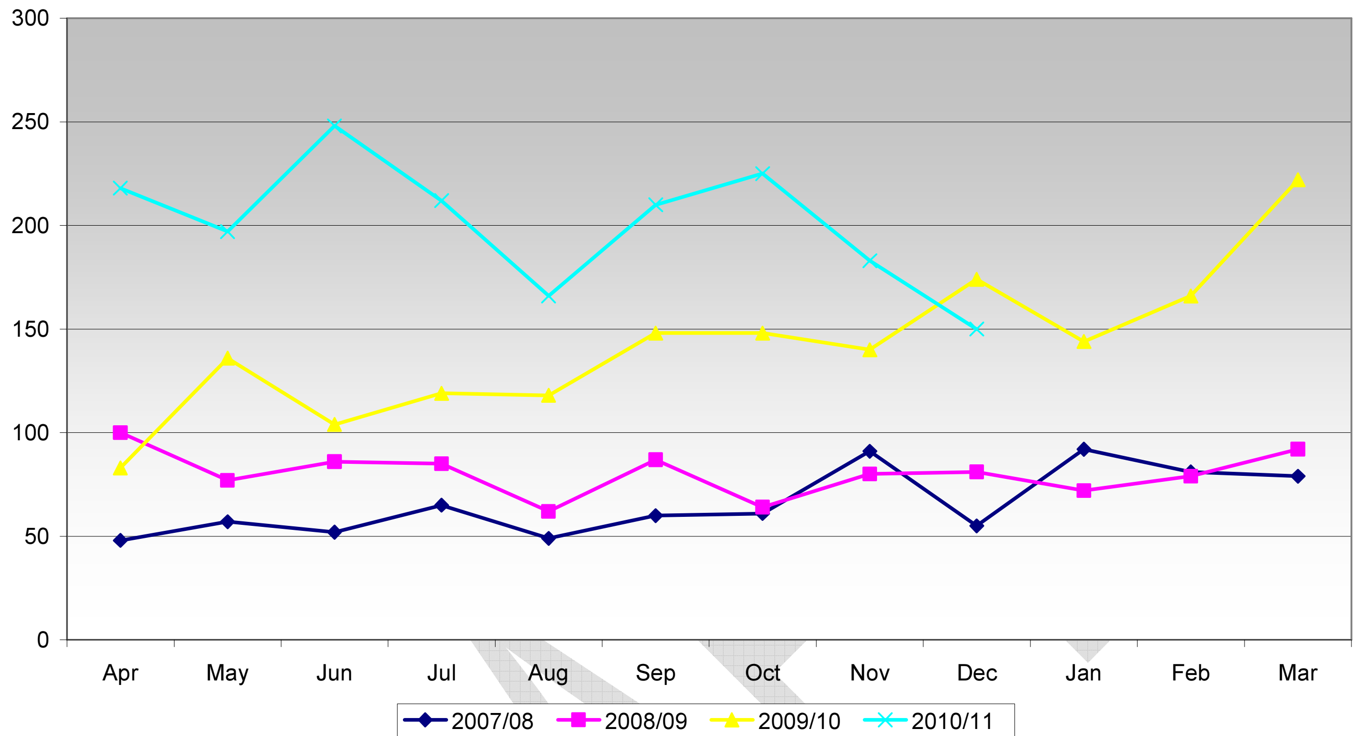
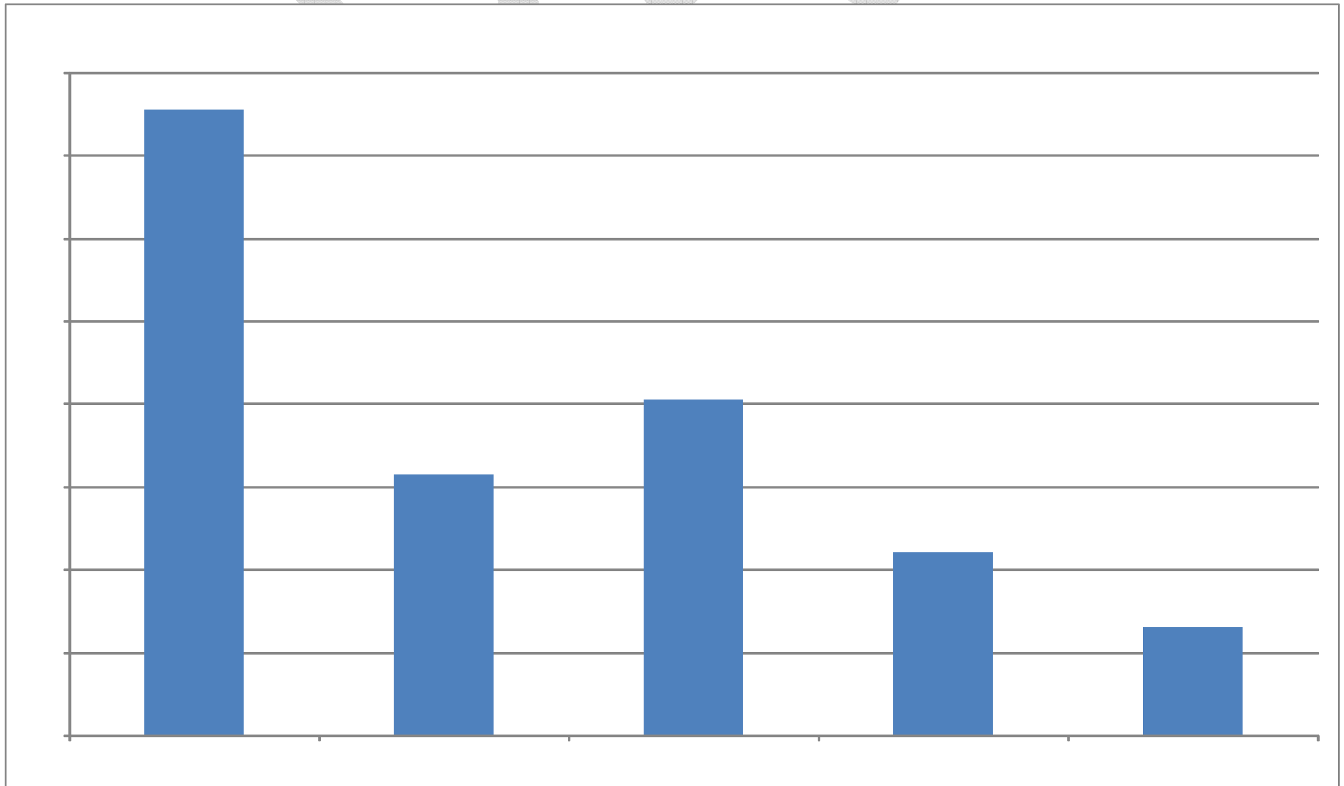
Figure 1 below shows the rise in incident reporting over the last year, evidencing increased vigilance by our staff.

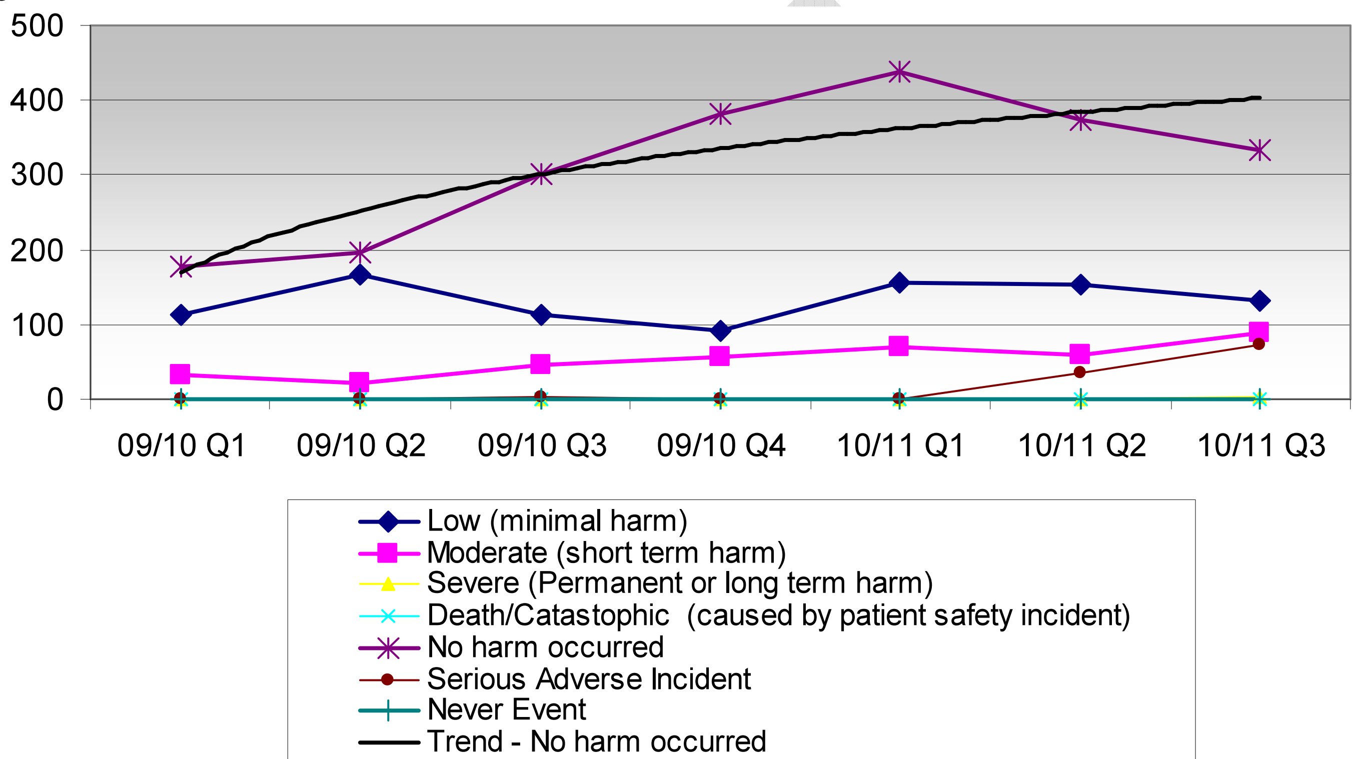




The highest number is clinical incidents which is mainly all the pressure ulcers. There is a countywide action plan in pace to reduce the number of pressure ulcers.

- The main theme with the health and Safety incidents reported are slips, trips and falls from patients. There is also a Falls steering group which is part of the Safety Express and CQUIN agenda and has a work plans in place..

Figure 2 below demonstrates that the rise is in "no harm" incidents.



5. Lessons learnt

Lessons learnt from reporting category 3 and 4 pressure ulcers

To work across Bedfordshire health economy in understanding the present position and to agree work to be taken forward ensuring:-

- Timely assessments of skin, nutrition and hydration
- Appropriate equipment in place
- Appropriate and timely referrals to specialist support
- Appropriate interventions and evaluation
- Agreed reporting of pressure ulcers
- Education and training of staff, patients and cares
- Shared leaning from incidents and Root cause analyses

Lessons learnt from a medication error- Patient at HMP Bedford was given medication which was incorrectly labelled and dispensed by the in-house pharmacy staff.

"In-possession" policy has been ratified and training implemented. Securities have been negotiated with HMP Bedford. Medicine boxes have been installed on a rolling programme.

The Pharmacy now ensures that all dispensed medication includes clear labels of drug, dosage, batch and expiry date to ensure nursing staff are able to check dispensed medication against blister pack.

The bagging of medication has ceased. Drug trolleys have been put in place and nursing staff administer medication to patients from stock drugs within the trolley.

Lessons learnt -Loss of patient identifiable information from diary/note book.

A Standard Operating Procedure for safer transportation of patient identifiable information linked to information governance has been developed for Adults services and is being developed for Children's services

Information Governance training is now mandatory.

We said - We will sustain the improvement in incident reporting. Our goal is to be amongst the best community providers for reporting rates and low levels of harm and we will monitor our performance through the National Patient Safety Agency (NPSA) reports. See below:

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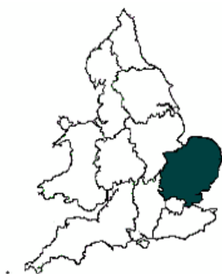


Organisation Patient Safety Incident Report

1 October 2009 to 31 March 2010

Bedfordshire PCT

Organisation type: **Primary care organisation with inpatient provision**

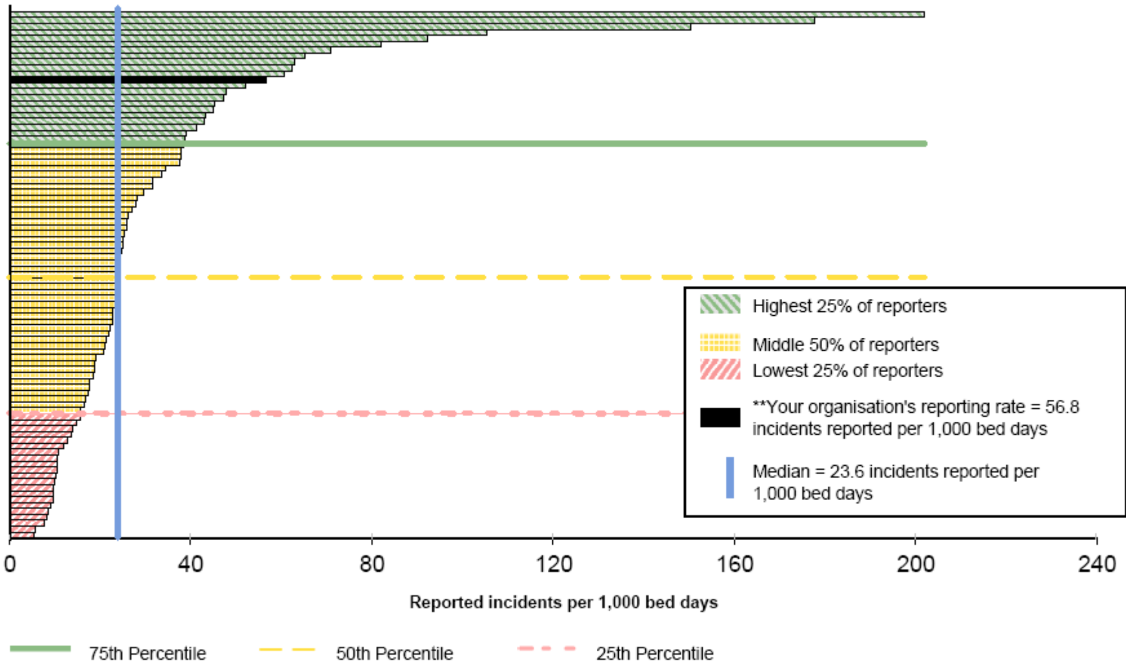
Location: **East of England SHA**

.

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 October 2009 and 31 March 2010. 622 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 90 primary care organisations with inpatient provision.

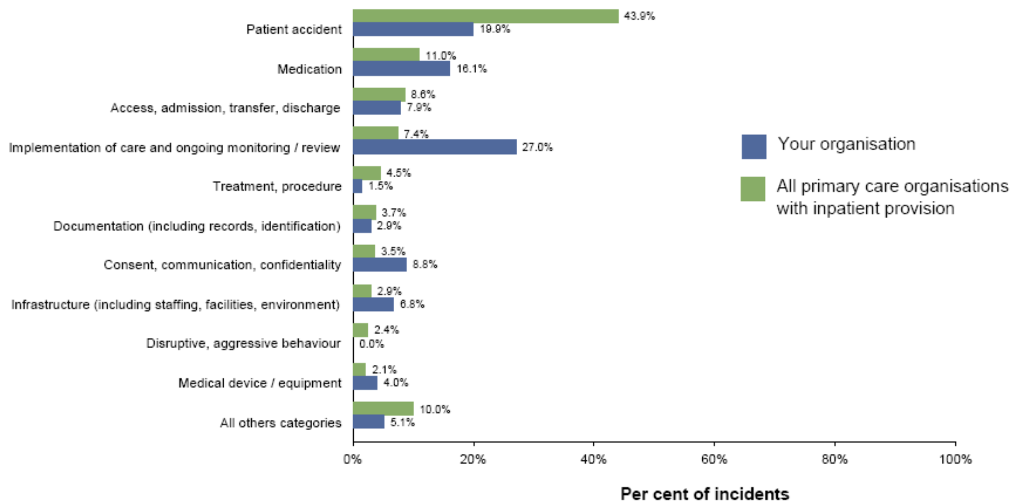


Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

We did- Improve incident reporting and are in the top quartile as demonstrated above. Ensured action plans were delivered and lessons learnt to prevent incidents of a similar nature. Introduced a log in system for the monitoring of delivery of action plans. Encompassed ‘risk’ monitoring in service balance scorecards.

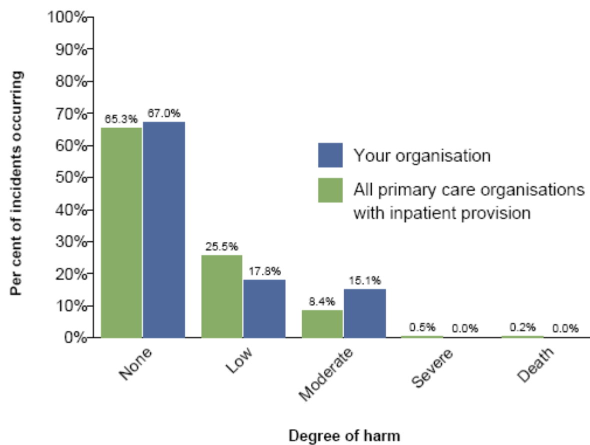
What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for primary care organisations with inpatient provision



Degree of harm

Your figures:	None	Low	Moderate	Severe	Death
	417	111	94	0	0

Do you understand harm?

Nationally, 68 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

We did – Priority 2 Develop our services, our quality and our productivity

We said – We would deliver patient-centred services in conjunction with our partner agencies such as social care by:-

- Improve efficiency
- Increase performance and improve productivity
- Deliver Quality, Innovation, Productivity and Prevention (QIPP) improvements

We did - Improve efficiency through various initiatives but we recognise there is still work to be done in this area and more progress to be made through initiatives such as the Productive Community Services, (PCS). Our Quality, Innovation, Productivity and Prevention plan has been developed to ensure we improve quality but also provide the most cost effective services that are as efficient as possible and deliver the required health outcomes for our patients.

We have demonstrably increased activity and data input quality by running reports to highlight deficiencies. We have also appointed post-implementation SystmOne trainers to help drive data quality.

These, together with QIPP and performance management driven improvements, continue to bring significant productivity increases. They are evidenced by a continual improvement in our position relative to other community providers in the benchmarking opportunities in which we participate. These are mainly co-ordinated by NHS Benchmarking, of which we are active members.

Priority 3 Improve the experience of our patients using our services

We said - we would use the framework below to maintain and improve our responsiveness to patients and carers.

	Information	**Feedback**	**Influence**
Individual	Increase the range of patient information leaflets available, and involve service users in the design and “road testing” of new leaflets	Use Viewpoint to capture patient feedback. Use feedback from complaints and compliments to improve quality	Explore opportunities for condition-specific expert patient programmes
Collective	Engage with LINk to inform plans, and review feedback from patients. Develop relationship with media to showcase our work	Conduct regular patient surveys through a rolling programme of surveys.	Use our Patient Experience Group to oversee activities, including the design of surveys and leaflets, and other key measures of the patient experience. Invite patients to take part in evaluation of services.

We did -. BCHS has developed a patient experience strategy from the feedback and work sessions outlined from the highly successful interactive ‘patient focus/experience event held in November 2010. A number of methods are in use to collect feedback including patient satisfaction questionnaires, comment cards and use of PALs (Patient Advice and Liaison service). These are reviewed and fed back to teams through different meetings and forums

to ensure we use the information to help us implement changes and ensure the patient is at the centre of all we do. We will continue to identify further ways to assist with capturing the voice of the patient throughout our services.

Priority 4 Maintain a high priority on control of cross infection

We said - We will sustain the focus we have placed on the control of cross infection, including MRSA and C. Difficile, and will monitor and report our results through key performance indicators.

KPIs for control of cross infection 2010/11

Description	Target	Performance
MRSA Screening	100%	100%
MRSA Bacteraemia	0	1
C. Difficile	NA	
Hand hygiene audits	99%	Awaiting validation

We did- Key performance indicators as agreed with commissioning are being reported monthly for all clinical teams. As a minimum, all clinical teams undertake hand hygiene audits and uniform compliance audits as a minimum. These results are fed back to team meetings and infection control committee. Our inpatient areas undertake MRSA screening on admission and the above table shows we have achieved 100% compliance to this.

There has been one case of MRSA Bacteraemia for which a full root cause analysis was undertaken jointly with Bedford Hospital to identify areas of learning to take forward. The root cause analysis of this case identified that this was an unavoidable case, but learning around discharge information and earlier access to results for our inpatient areas are being taken forward.

There have been two cases of Clostridium Difficile – one in Archer unit and one in Knolls (Nursing home with contracted community beds). Both cases have been fully investigated through root cause analyses to understand the causes and to ensure learning is taken forward. The case on Archer Unit, identified that the main cause was due to inappropriate prescription of broad spectrum antibiotics. The primary exposure to C.Difficile could not be identified as the patient was admitted from L&D following a lengthy admission. The infection appeared to have been triggered by the prescription of three successive courses of broad spectrum antibiotics and has been addressed with the patient's GP by NHS Bedfordshire. There were also concerns raised in timely isolation and treatment once diagnosed and staff training has been undertaken to raise diagnostic awareness and highlight the infection prevention and control requirements for C. Difficile. The pharmacy arrangements for the unit have been reviewed to secure a stock supply of drugs on the ward to avoid delays in commencing treatment and a dedicated unit pharmacist has been employed to help prevent future occurrences of inappropriate prescribing. The second case at the Knolls was another patient admitted from L&D hospital, again following a long admission. The patient had two

lengthy courses of antibiotic treatment while in L&D but these were prescribed under the guidance of the microbiologist and were unavoidable in the light of the patient's condition. Root cause analysis indicated that exposure is likely to have occurred in L&D. It is not clear if the patient developed diarrhoea as a result of C.difficile or a viral infection. Symptoms lasted only 2 days and no treatment was required.

Further to this work, we have maintained our increased audit activity with collection of KPIs, cleaning audits and spot checks across the different locations.

Other work within infection control has included:-

- A new link practitioner programme
- A capital estates works programme undertaken to improve facilities in inpatient areas and clinics.
- Detailed assurance framework
- Infection control annual report
- Development of Dental services to meet essential requirement within the new directive on standards of decontamination (HTM 01-05). A programme of estates work is in progress at present to support this.

Priority 5 Deliver a waiting time guarantee

We said - We will endeavour to offer our patients the shortest possible waiting time for care, adhering to the East of England Pledge 2 target that all patients will commence treatment within 18 weeks of referral.

We did – Achieved 18 week targets for all services, including wheelchair services. We also delivered the NHS Constitution.

Clinical Audit

We said we would develop an annual clinical audit programme to actively encourage clinical staff to undertake audits that would improve the quality and safety of care delivered by their services. The annual programme was monitored on a quarterly basis using a RAG (Red, Amber, and Green) system and was fed back through the quarterly quality schedule reports and the local governance groups.

We did strengthen our Clinical Audit Policy to include a robust monitoring system that include managers adding outstanding action plans to their local risk registers in order to enable systematic monitoring.

CQUIN Audits

The 2010/11 annual audit programme included the following CQUIN audits:

- Pressure ulcer risk assessment audit
- End of life care plan audit

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Audit	Service	Indicator	QUIN target (Qtr 4)	Achievement
Pressure Ulcer Risk Assessment Audit	BCHS Inpatient units	All patients to have had a pressure ulcer risk assessment within 4 hours of admission	100%	100%
	Community Nursing	All patients to have a pressure ulcer risk assessment on initial visit	100%	100%
End of life pathway	Macmillan Service	Patients on end of life pathway to have and advanced care plan in place	100%	100%

National Audits
In Qtr 2, BCHS were involved in the national audit for falls and bone health which was organised by the royal college of physicians. The audit was broken down into the following two parts:

- Clinical audit - Luton and Dunstable hospital carried this out on behalf of BCHS as this involved Bedfordshire and Luton patients having been admitted to the L & D
- Organisational audit – carried out by the BCHS community OT team

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Local Audits
In addition to organisational audits identified through the CQUIN and Quality schedule requirements staff were encouraged to carry out local audits.

The following table shows just some of the audits undertake in 2010/11 and the changes identified as a result of the audits

Audit	Service	Actions implemented as a result of the audit
Discharge Summary Audit	BCHS Inpatient units	• Discharge summary documentation has been reviewed in light of results specifically around infection information.
Internal community Nurse / Community staff Nurse referral process	0-19 team	• Referral form redesigned to reflect the audit findings. • Guidelines produced and cascaded to the 0-19 teams.
Prescription pad audit	Dental	• Procedure established for the destruction of prescriptions that had not been completed and then not issued. • Recording prescriptions that are taken on domiciliary visits • Procedure established for destroying prescriptions within clinics and clinical procedures updated.

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6. Background to priorities and who has been involved and engaged with to determine the content and priorities contained in the BCHS Quality Account

In 2010/11 BCHS made good progress against the goal of improving quality across the organisation. The organisation has moved from one of financial turnaround to one that is focused on the business of providing services that are high quality, safe, cost effective and innovative, as well as ensuring the patient experience and health outcomes are met. The Strategic Health Authority, NHS East of England, has removed BCHS from 'an organisation of concern' to one of progress and success.

The patient safety focus and ongoing development of clinical indicators will continue and is monitored at Board level to ensure continued improvement in the range of indicators available for service review. In the planning and assurance process this year BCHS has identified some key areas for improvement for 2011/12. These will build on the work done this year and ensure that services for patients are significantly improved next year. The organisation is committed to continue the work which improves the physical environment for patients and the work on embedding quality indicators at service level. BCHS will continue to work with commissioners at NHSB to embed a meaningful CQUIN framework according to national and local priorities.

The priorities for 2011/12 have been chosen to improve safety, clinical effectiveness and patient experience. They have been identified during the year as a result of engagement with staff, clinicians, senior management team and the Board. All the areas for improvement identified will be monitored by the services concerned and a Board level to ensure continual improvement. The organisation has engaged with patients and the local population to identify key areas for concern which have informed the priorities identified in this account but realises the need to increase and improve patient involvement over the next year and has developed plans to do this.

BCHS is pursuing many initiatives, which involve feedback from our patients and our wider stakeholders. A number of these areas are outlined below, showing how they have shaped the priorities for the quality account. BCHS also wants to build on and improve the organisations reputation as well as striving to be a provider of excellence.

- **Safety Express**

This programme was launched on the 6 January 2011 by East of England for a period of 9 months. This is part of a national NHS programme to work in partnership with existing programmes (in particular Energising for Excellence, High Impact Actions, Patient Safety First, the productive series and the National VTE implementation group). BCHS has been chosen as a host organisation for this initiative and is working closely with Luton & Dunstable Hospital (also nominated as host organisation) to ensure the work is taken

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forward across the whole health and social care economy. BCHS is holding monthly steering groups with good attendance from acute, community and LINks services. The aim of the national programme is for a shared aim of reducing harm from pressure ulcers, falls, catheter acquired urinary tract infections and blood clots (venous thromboembolism VTE). The following is a snapshot of the work plan chosen which aligns to the chosen BCHS priorities.

- The county wide pressure ulcer group are continuing to work on reporting of serious incidents, learning from RCAs, transfer of information and patient leaflets. The group focussing on training and support for nursing and residential homes through bidding for QIPP money following findings from the first 20 Root cause analyses undertaken.
- Re-instating the county wide falls group to oversee work streams and partnership working with other stakeholders including Local Authorities and EEAST.
- Implementation of post fall protocol as per NPSA Rapid Response Report – Essential Care after an inpatient fall (13th January 2011)
- Bedford Hospital to lead on VTE work stream and for implementation of VTE assessment in community hospitals.
- Agree data set collection across the county and undertake Safety Thermometer as requested by EoE SHA.

- **Chief Operating Officer Safety Walkabouts**

BCHS continues to develop a culture in which staff openly talk about incidents, errors or harm to patients. The programme of visits to clinical areas by the Chief Operating Officer and members of his senior team give frontline staff the opportunity to share their experience of patient and staff safety in BCHS. We are confident that these conversations will promote our safety culture, incident reporting, and Committee to service level understanding of the important issues and priorities.

- **Safety Strategy Programme**

Our strategy for improving patient safety is set out in our Risk Management Strategy. We are ambitious that all our staff understands their opportunities to identify hazards, and have the confidence and skills to exploit them. We appreciate that patients and their families and carers are valuable partners in this endeavour, and seek to involve them, through their complaints, concerns, and comments and through patient feedback surveys.

We are in the process of drafting a *Patient Safety Strategy*

We have paid particular attention this year to establishing effective leadership for safety, and reducing harm from medicines

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We have paid particular attention this year to establishing effective leadership for safety, and to reduce harm from medicines.

- **Board Patient Safety Conversations**

BCHS Committee receives information on a wide range of quality indicators, many described in the Account. The Board Assurance Framework has recently been refreshed by an independent expert and each service area has a risk register where individual risks are scored and escalated to corporate risk register when appropriate. These are reviewed at various meetings and committees. We are confident that these conversations will promote our safety culture, incident reporting and Board to ward/floor understanding of the important issues and priorities. Continuous quality improvement is our first priority and our Board is committed to ensuring this is happening. A recent report by the King's Fund, '***Putting Quality First in the Boardroom'*** indicated that 'clinical quality occupies a fragile position in many NHS Boardrooms and often receives far less attention to that of finances, mergers etc. BCHS will ensure that they are successful by delivering further focus on clinical quality by the introduction of a clinical quality strategy. This will provide a framework for all other systems and processes around quality improvement, introducing quality metrics and increasing the frequency of service walkabouts. BCHS has also included quality outcomes in the organisations balance scorecard.

- **Introduction of Risk Panel**

In January 2011 the BCHS Serious Incident process was reviewed to make the process more robust and to introduce a Risk Panel was introduced to scrutinize the draft reports so that they can be signed off by the COO before being submitted to NHSB. This has resulted in no reports being returned from NHS Bedfordshire requesting more detail etc to date. The panel also critically reviews the report with the incident investigator who is the author of the report. This is within a supportive environment and can lead to report changes or further investigation.

- **Development of service improvement and develop of 'dashboard' for clinical services**

Commencing March 2011 BCHS is implementing an innovative service review and improvement framework. This is a comprehensive scorecard encompassing the quality, CQC, CQUIN, Pledge 2, patient feedback, KPIs, process, financials, workforce information and many other areas in its capture and presentation. This RAG rated with direction of travel document is used at structured periodic reviews of services at which the services themselves will be rated and the period until their next comprehensive review determined. The reviews will be driven and managed by the Performance Delivery and Improvement Team and attended by Clinical Leads and Heads of Services.

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- **CQUIN**

A proportion of BCHS's 2010/11 income was conditional on achieving quality improvement and innovation goals agreed with commissioners. The agreed areas are outlined below with a commentary of achievement:

	CQUIN Indicator	Achievement
1a	All patients at high risk of developing a pressure ulcer will be assessed and preventative measures taken within 4 hours of admission.	Full achievement to quarter 3 with 90% of patients receiving assessment and preventative measures taken.
1b	Improve care and promote fast recovery for patients who have a pressure wound.	Achieved to Quarter 3. Pressure ulcer report received, risks identified, lessons learnt and actions to be taken identified and implementation begun.
1c	Implementation of practice changes identified from lessons learnt following investigation in 1b.	Achieved to Quarter 3. Pressure ulcer report submitted with action plan from county wide pressure group established by BCHS and lessons learnt.
2a	Improvement of net promoter score	Patient experience questionnaires for qtr 3 showed a 27.29% improvement from the indicator's baseline, currently on target to achieve 100% of the indicator value.
2b	Improved patient rating of overall care	This indicators baseline is based on qtr1 and qtr 2 data, giving a baseline of 80%, BCHS has achieved this as far as Quarter 3.
2c	Improvements in areas which have attracted negative patient feedback	Achieved to quarter 3 where BCHS have shown areas of improvement. Examples include:- - implementation of different water jugs, - patient information leaflets.
3a	Undertake the You're Welcome self assessment in 2 services, identify themes for improvement. Action plan to be agreed with commissioner	This is ongoing at present as Local Authorities have been unable to support local assessors to undertake the assessment. BCHS is planning to undertake this assessment during March if no local assessors are available.
4a	Improve the care of the dying patient	Achieved to Quarter 3. The data provided shows that 70% of patients are dying in their place of choice. The data is taken from SystmOne for the MacMillan Service and KPI

		reports for Community Nurse Services.
4b	Partnership working to enable patients to die in the place of their choice, following a care plan with appropriate involvement from other organisations	Achieved to Quarter 3. From the data provided 100% of patients on an end of life care plan have an advanced care plan in place and their place of death choice was met
5a	Safe and effective discharge for health related transfer of care	Partially achieved to Quarter 3. BCHS has provided evidence of patients who were cared for in the community and early discharge from the acute trusts but further work is in progress, working with the Acute Trusts to agree data collection.
5b	Improved patient and carer experience of discharge process and outcome	Achieved to quarter 3. From the patient surveys returned 93.3% of patients positively responded to their experience of the discharge process, this is around 16% improvement from the baseline.

- **Quality framework: Service Level to Committee**

Patient Safety is only one domain of quality. BCHS recognise that the improvements for patients are achieved through integrating our efforts to improve safety, clinical effectiveness, outcomes and patient experience and engagement.

Bedfordshire Community Health Services is committed to providing safe community healthcare services to the local population. We recognise that to provide high quality and safe healthcare services we must:

- Develop all members of the workforce to be the best they can be;
- Provide regular and frequent training;
- Improve management capability to deliver on our vision of quality, safety and value;
- Implement a robust performance and appraisal system;
- Demonstrate a clear accountability framework that provides regular board assurance that our data is timely, meaningful and actionable so that key risks are being managed and mitigated proactively.
- Promote, through our revised Risk Management Strategy promotes a safety culture that is transparent, accountable, owned within the services and overseen by the Risk Team. The whole process aims to provide safe healthcare services through embedding a proactive risk management culture within BCHS and promoting sharing of lessons learned with other healthcare organisations. For example, it enables staff to report incidents promptly. This supports the integrated risk management process that tracks, analyses and enables effective management of patient safety, complaints and claims

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Key deliverables include:

Adherence to policies and procedures for **safeguarding children and vulnerable adults**. BCHS has a dedicated safeguarding lead who works closely with the Local Safeguarding Children Board. A similar structure and process is also in place for Safeguarding Vulnerable Adults. There are several levels of 'safeguarding training' dependant on roles and responsibilities. BCHS training compliance for Safeguarding Children & Adults can be seen in the table below for 2010/11:-

Safeguarding Children Level 1&2 One off training	Safeguarding Children Level 3 Annual	*Vulnerable Adults* Bi Annual
100%	70%	96%

Training update has improved over the last 12 months through improved reporting but there is still progress to be made. Each service will have a performance review and mandatory training update is monitored through the service balance scorecard. This is a new development which was implemented the 1st of March 2011.

- **Workforce**

In 2009, our workforce told us that 82% of staff felt satisfied with the quality of work they were able to deliver. 92% of staff felt their role made a difference to patients and 84% of staff felt valued by work colleagues. 93% of staff felt they had clear team objectives and 79% of staff felt they could discuss how to improve their team. Only 38% of staff felt that managers were committed to maintaining work life balance. 87% of staff recognised they had had relevant learning opportunities with 71% of staff having had an appraisal.

85% of staff had had relevant health and safety training with 81% of staff having had control of infection training. 33% of staff had experienced work related stress and 11% of staff had received a work related injury. 31% had witnessed potential harmful errors and 94% of staff reported that they or a colleague had reported these. Job satisfaction overall was reported as 3.38 out of 5 and the intention to leave the organisation was reported as 2.89 out of 5. Only 19% of staff reported that communications with senior management was good. Staff recommending BCHS as a good place to work or receive treatment was scored at 3.19. Staff who are motivated was scored at 3.84 out of 5.

As a result of these returns, our focus for 2010/11 has been on aligning staff to organisational goals; continuing to ensure clear team objectives; to increase reporting of incidents and near misses; to ensure clear feedback to staff by managers, to improve the

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number of appraisals; increase job satisfaction while reducing the extra hours worked and reducing work pressure felt by staff.

This work was undertaken through introducing a team coaching model of development, focussing on increasing personal and team performance, introducing regular team bulletin, continuing to focus on mandatory training and improving understanding of risk management and incident reporting. There has also been an emphasis on how individuals and teams can improve performance and affect patient outcomes and experience.

- **Continually Learning**

BCHS is committed to research and innovation as drivers for improving quality of care (including outcomes) and patient experience. A full clinical annual audit programme is in place and 27 clinical audits were registered in 2010/11. Two of these were national audits. This programme is still in process, with 22 audits completed and 5 audits in progress. The outcomes of the audits are disseminated across the relevant teams and discussed at clinical governance groups to ensure wider learning is taken forward.

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7. A Listening Organisation

What did staff and patients say about Bedfordshire Community Health Services?

Patient surveys

BCHS does not solely rely on the national patient survey. We are keen to improve on the national survey year on year by have embarked on own 'surveys'. BCHS collates patient experience stories on a regular basis and examples of these can be viewed at;

http://www.youtube.com/watch?v=R6KB_dcd_bg

Staff Survey

The 2010 survey has identified a number of improvements for our staff and some areas for increasing focus. Our workforce told us that there had been a reduction in the number of staff who felt satisfied with the quality of work they were able to deliver to 73%, however, 92% of staff continued to feel their role made a difference to patients and 82% of staff felt valued by work colleagues. Effective team working was scored at 3.82 which is above average for PCTs. Commitment to maintaining work life balance was scored at 3.43 which is below average. 81% of staff recognised they had had relevant learning opportunities with 58% of staff having had an appraisal. This is reduced from last year and will be an area of focus for 2011/12.

82% of staff had had relevant health and safety training. 29% of staff had experienced work related stress which was a reduction from last year and 12% of staff had received a work related injury. 28% had witnesses' potential harmful errors and 100% of staff reported that they or a colleague had reported these. The percentage of staff working extra hours has decreased to 61% and the percentage of staff experiencing work related stress has decreased from 38% to 29%. Job satisfaction overall was reported as an improved 3.49 out of 5 and the intention to leave the organisation was reported as a decreased 2.72 out of 5. 28% of staff reported that communications with senior management was good which represents an improvement from last year. Staff recommending BCHS as a good place to work or receive treatment was scored at an improved 3.4 Staff who are motivated was scored at 3.81 out of 5, similar to last year. Staff have also reported an increase in the amount of support they receive from managers from 3.52 to 3.65 and an increase in the amount they can contribute to improvements at work from 59% to 63%

As a result of these, our focus for 2011/12 will continue to focus on aligning staff to organisational goals; continuing to ensure clear team objectives; to ensure clear feedback to staff by managers, to improve the number of appraisals and improving work life balance. There is a clear correlation between staff satisfaction and improved patient care. BCHS has

made improvements over the year which will continue in to 2011/12 focussing performance on the quality outcomes for patients.

Transformational Leadership Programme

BCHS were successful in obtaining Leadership Seed Funding to undertake a transformation project. Originally this work was to be carried out in partnership with Luton Community Services but after the awarding of preferred providers it has been decided to complete the development programmes independently. However, we have ensured that Luton has been able to access the learning from this project.

Our programme has focussed primarily on team and organisational coaching. This has also enabled us to identify and deliver specific skills training as identified via the coaching.

What's changed?

Initially we were aware that the organisational reputation was poor and was having an impact on performance, through self-perpetuating stories, affecting people's belief about what they could and could not do. This has been a focus throughout the coaching and the Senior Management Team worked to change the organisation's story so that perception more closely matched reality. The organisation is now clearer about its strengths and also has specific information about what is not working and strategies to manage this. The style has moved from being directional to a more coaching style throughout the organisation, with more questioning and more shared responsibility and accountability.

There have been quantifiable changes in performance, including:

•Increase in activity through more accurate recording and productivity gains

•All services meeting 18 week targets

•Sickness/ absence rates reduced

•Turnover reduced

•Staff survey results showed an increase in staff satisfaction with better than average effective team working and an increase in staff feeling supported by their line manager.

Although these results cannot be directly correlated to the coaching alone, we know that there has been an impact from changes in behaviour and changes in the stories that are told and the language that is used. There is a greater willingness and ability to manage and discuss performance. As a result we are more aware of what needs to change, what change and what to do to make the change.

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Complaints

Our committee receives monthly reports on complaints and the reasons for them. This enables the committee to possibly benchmark with other organisation across the region. Complaints, concerns and compliments are an important source of information in our efforts to improve services, and these results are fed back to the various clinical governance meetings for services where they are discussed in detail and lessons learnt and shared across the organisation to ensure good patient outcomes.

	2010-2011
Total number of complaints	79
Response within deadline as agreed with complainant.	91%*
Referrals to the Ombudsman by referral date	0
Referrals to the Ombudsman by complaint date	0

*Based on 65 complaints as 2 complaints were withdrawn by the complainant before timescales were set and 2 did not proceed as the complainant was not the client and could not provide authority to make a complaint on behalf of the client. 10 complaints remain open with agreed timescales after the end of 2010/11.

The 2010/11 response within deadlines as agreed with the complainant is recorded at 91% this was as a result of annual leave of investigating officers, complaint signatories, changes in senior management and long term sick leave of the Complaints and Quality Co-ordinator who managers the complaint function.

Top 3 complaint categories are as follows:

	2009-2010	**2010-2011**
Main Issues		
Service provision	23	15
Attitude	13	15
Communication	9	22

The senior management team is monitoring service areas in relation to the above and identifying any correlation or higher numbers in particular service areas or with individuals.

Other categories include;

- Medication, Prison Healthcare, Equipment Choice

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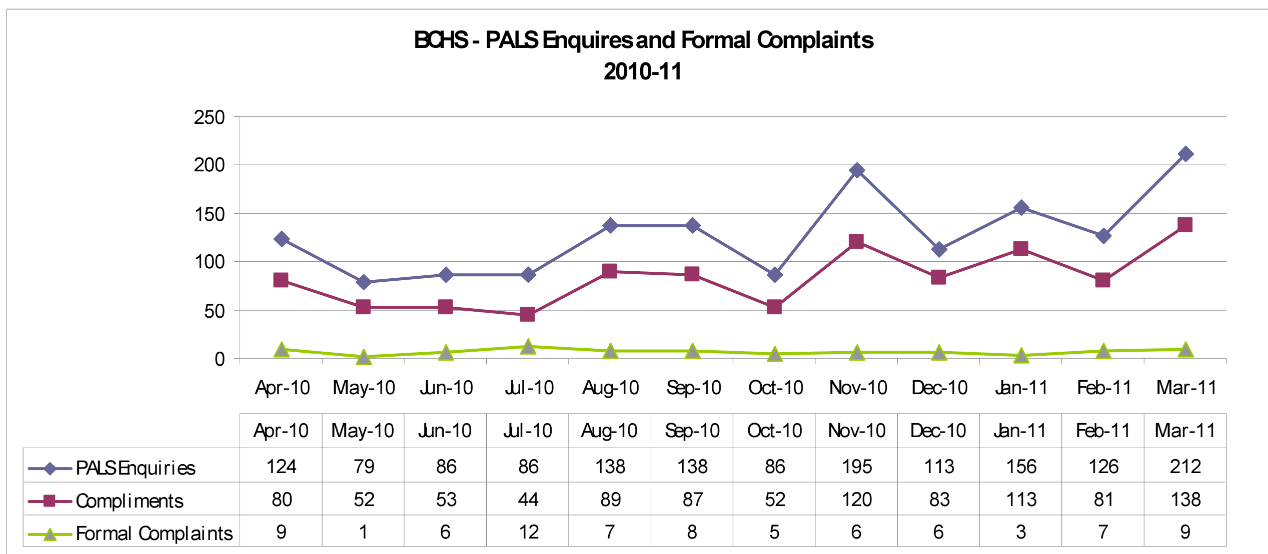

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
PALS Enquiries	124	79	86	86	138	138	86	195	113	156	126	212
Compliments	80	52	53	44	89	87	52	120	83	113	81	138
Formal Complaints	9	1	6	12	7	8	5	6	6	3	7	9

Patient Advice and Liaison Service (PALS) enquiries.

BCHS received 1539 PALS enquiries during 2010/11. This was a 96% increase on the previous year when there were only 782 enquiries. PALS enquires can be broken down in to four categories:

- Advice and Information
- Compliments
- Feedback
- Issues for Resolution. These are usually verbal complaints which Service Managers resolve with within a 24 hour period and therefore avoiding escalation to the formal complaints procedures.

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Compliments

Of the 1539 PALS enquiries 64% were compliments to BCHS services.

Examples of compliments received

"My Father (77) was taken ill three weekends ago. He had a high temperature, aches and chills and difficulty standing. My mother (74) and I (disabled) were finding it difficult to manage him. I called out an out of hours Doctor who diagnosed a virus/bladder infection (he wasn't sure which).

Your "Rapid Intervention Squad" was called in. They phoned within the hour and arrived at our house shortly after. Over the next 3 days they came to us twice a day. They monitored his condition, helped him wash and dress, arranged for antibiotics and a commode.

If they had not been involved I think my Father would have been taken into Hospital, which he would have hated.

We have had problems with this sort of acute illness before and found the Health Service lacking. This time however your services were excellent. Please pass our appreciation on to your staff. It is much better to be nursed in your own home and also an acute Hospital bed is not taken up.

Thank you for your help, but I hope we don't need it again."

Received for Rapid Intervention Services

A Dunstable woman who has had five major operations in the past couple of years claims she would not have survived without the support of Macmillan Nurses.

"The Macmillan team are there for you all the time. They made me see there's light at the end of the tunnel and that I wasn't alone."

Macmillan Team

Bedford is very popular this year your reputations are getting around it seems.

Received for Podiatry from Steve Avil senior lecturer at Northampton University who is responsible for their podiatry undergraduate placement programme regarding 1st year placements

"My daughter's speech therapist is fantastic. She has changed my daughter in five months to a lovely confident, well spoken girl. She has really helped our family and I can not praise her highly enough"

Received for Speech and Language Therapy

"The service was offered to me via the OT Department and I have found the services to be invaluable and crucial. As an MS sufferer the nurse has given me medical information and

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support in a professional manner over the past few months to make my suffering more bearable"

Received for Neurological Rehabilitation

Compliments

Compliments Received	Figures for 2009-2010	Figures for 2010-2011
Administration (community/PCT bases)	1	5
Acquired Brain Injury	4	8
Children's Services	5	9
Community nursing (District Nurses)	49	134
Continence Service	6	7
Dental Services	70	2
Dermatology Service	0	223
Facilities (PCT premises)	0	0
PCT owned GP surgery	1	7
Heart Failure Nurses	5	0
Health visiting/school nursing	49	6
Improving Access to Physiological Therapies	0	20
Information	0	0
Intermediate Care	77	0
Leg Ulcer clinic	7	129
MacMillan Nursing	24	0
Community Matrons	4	98
Neurological Rehabilitation	1	6
Occupational Therapy - Paediatrics	0	11
Occupational Therapy - Adults	4	2
Parkinson's Nurses	15	14
Phlebotomy	0	3
Podiatry	12	45
Prison Health Care	0	0
Rapid Intervention Team	24	24
Rehabilitation and Enablement	21	2
Shared Care	0	1
Speech and Language Service	35	57
TB Nurses	6	126
Wheelchair Services	0	27
Totals:	420	1122

- **Local patient experience**

BCHS hosted a very successful 'patient experience' day in November 2011 The purpose of the day was to 'listen' to listen to what patients said about services, what they would like to see in relation to service provision, what we could do better and what was presently going well.

An action plan was developed from the day and from which a patient experience strategy has been developed.

This will be taken to the Patient and Carer Experience Group which is currently being created.

- **Equality and Diversity**

The equality and diversity elements are reflected in our commitment to embed the principles of the NHS Constitution and when benchmarked demonstrates our compliance with Human Rights legislation.

Training is provided for all staff on Equality, Diversity and Human Rights which include patient and public involvement. Additional training is available on how to undertake and complete comprehensive Equality Impact Risk Assessments as well as consider mitigating actions. The impact assessments have resulted in minor changes being made but to date there have been no negative impacts identified. We increased our emphasis on dignity and respect. In 2009/10 we developed Standard Operating Procedures across all services to cover all aspects of care, including the environment so that patients experience a consistent and common approach across all services. Key policies such as Confidentiality, Consent and Respect & Dignity are currently being reviewed in order to capture the essence of promoting equality, respect for human dignity and confidentiality of service users and staff.

- **Key Findings from Patient Feedback of Inpatient Units**

Within our two community hospitals and two nursing homes where we have 12 rehabilitation beds, patient satisfaction questionnaires are completed on discharge. Overall these responses have been extremely positive with the majority reporting excellent or very good responses. These finding are reported back to relevant teams to identify areas and trends to take forward and to ensure wider stakeholder feedback. Areas identified have included:-

- Information to patients about medication side effects
- Patients receiving information prior to discharge from acute trusts
- Clear explanation for care and treatment.
- Involving patients in decisions around their care and treatment.

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Actions to take forward from these have included:-

- New patient safety cards implemented within the inpatient areas
- Production of patient information leaflets and passports which are shared with the Acute Trusts for distribution prior to transfer
- New pharmacist appointed who will work closely with units in regards to medicines reconciliation and support staff and patients.

- **General Practitioner Survey**

When the new Chief Operating Officer commenced his role at the beginning of September 2010 anecdotal feedback from GP colleagues indicated some dissatisfaction. A questionnaire was devised to provide a 'snap shot' of how services were perceived and to get a sense of any issues. It also provided a further opportunity to engage with our stakeholders and improve on our reputation and improve or change services through any feedback received. The feedback included; a lack of understanding as to the services BCHS provided, in some instances a lack of 'team connection between district nurses, health visitors and the GP practice and a lack of continuity with staff especially in the 0-19 teams. BCHS staff are currently being asked the same questions to 'triangulate' the responses. We know there is a clear correlation between staff satisfaction and improved patient care. BCHS has made improvements over the year which will continue in to 2011/12 focussing performance on the quality outcomes for patients.

As a result of feedback from this survey an action plan has been formulated to make these improvements and a service directory has been developed which should prove invaluable to stakeholders. Other actions include: each GP practice has an identified lead for communication purposes and continuity, the development of a patient and carer experience group, introduction of focus groups for service users, carers and GPs etc

The Chief Operating Officer is also meeting with all Practice Based Commissioning (PBC) chairs to invite further feedback but also inform of new initiatives etc.

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- **PEAT**

Independently assesses Patient Environment Action Team (PEAT) assessments have been undertaken within both the community hospitals. The PEAT team assess the environment from the patient's perspective, focussing on environment, food and privacy and dignity.

Site	***Environment***	***Food***	***Privacy & Dignity***
Archer Unit	Acceptable	Good	Excellent
Biggleswade	Good	Excellent	Excellent

Biggleswade Hospital has shown a marked improvement within their PEAT scores with achieving excellent in two areas. The environment score has improved from last year, mainly due to the large capital programme that has been undertaken and was in progress at the time of the PEAT assessments for 2009/10. Since the inspection this year, the outside of the hospital has been decorated which it is hoped will further enhance the scoring in this area.

- There was capital work planned for Archer this year but we are waiting a Commissioner intent/decision in relation to this being taken forward.

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8. Statements on the BCHS Quality Account received from Key Stakeholders

BCHS would like to thank all stakeholders who have taken the time to feedback and write statements, theirs views and support is very much welcomed. Changes have been made as a result of feedback received. BCHS will ensure progress on delivering the Quality account is shared with our partners.

- **NHS Bedfordshire**
- **LINk**

BEDFORDSHIRE LINk RESPONSE to the Bedfordshire Community Health Services - QUALITY ACCOUNT

Overall the contents of the BCHS Quality Account document is welcomed by the LINk as it indicates a real drive by the service to improve on past performance and to raise the quality of care, patient safety and outcomes for patients. The document is set out in a very clear, readable format and it contains comments from the patients and relatives where good care/outcomes have been achieved.
Whereas some of the priorities set in the document can be measured in quantitative terms, statistics and graphs, other, particularly parts of numbers 2 and 3, require different more qualitative methods.

1. **Development of Services**: Development implies change and innovation so it is good to note the emphasis on staff training and coaching e.g. relating to vulnerable children and adults, in health and safety training and by staff appraisals. Further suggestions for future priority developments are mentioned below.

2. **Improving the Experiences of Patients**: As it says on page 17 “You can’t learn.......... and improve if you don’t know what the problems are”.

There are statements about:

a) carrying out regular patient surveys through a rolling programme
b) identifying further ways to assist with capturing the voice of the patient and
c) using PALS*(see below) to get patient feedback. The crucial point seems to be to identify and **REGULARLY USE** effective methods of getting the authentic, frank views of service-users which should include the voices of carers, parents, and workers in voluntary organisations.

In relation to page 16.5 Lessons Learnt: - The episodes reported indicate Lessons Identified. The specific Lessons may not be described as “Learnt” until such time as clear evidence on future performance has been demonstrated.
3. **PALS**: The provision of an independent, adequately staffed, sufficiently available and approachable service to advice patients, their carers and relations and to liaise between them and health-service personnel is of enormous help when it is there.

Bedfordshire LINk is supported by Voluntary Action Luton, tel: 01582 733418 e-mail: beds-links@valuton.org.uk

Sadly, only a small percentage of families know about the service but when introduced to one of the number of different PAL services which Bedfordshire patients have to use some of them are found to be less than satisfactory. A patient who is not able, willing, brave or well enough to persist with an issue or complaint – even contacting PALS staff can be very difficult – s/he will soon give up. As it is „the patient" who must carry the matter forward, not the relative or carer, the issues are often dropped, thus precluding useful learning by the medical personnel.

4) Preventive Work: There is little reference to support and prevention of ill-health in those caring for patients at home.

5) Children's Special Services : The standards of services for children, particularly those with special needs, as illustrated in the GP Survey, is un-acceptable and needs to be prioritised for urgent priority as it too is preventive".

6) Also, with regard to the two care/nursing homes to which patients who would have been housed at Steppingly Hospital accounting for a further twelve beds do not appear to be listed in the accounts.

As a LINk we have also welcomed the involvement of lay members in the QIPP task groups, Safety Express meetings, Wheelchair Services meetings with LINk where we have raised areas of concern. We would like to stress the importance of early notification of meetings and circulation of paperwork, so that the meetings are attended by all the key stakeholders required to implement action/change.
We welcomed the BCHS GP survey, which we hope will improve interaction and communication between BCHS and the GPs and community nursing teams.
There is, however, a concern about the number of changes to this organisation over the past few years. Indeed, there is another change in the pipeline when BCHS is absorbed into the SEPT organisation. These changes have affected staff morale and it is hoped that the recent excellent progress made both clinically and administratively will be sustainable under the new culture. It is to be hoped that the various teams will continue this progress and not be disrupted.
There is clearly some work to be done on in terms of communication and attitude; the figures in the account indicating a rise in complaints in relation to these areas. Although very fundamental issues, communication and attitude are very important issues in the patient journey. It is good to see that this is being taken on board by the management team.
Bedfordshire LINk 11 May 2011

Changes made to the as a result of the Bedfordshire LINk statement

BCHS is currently working on a Patient & Carer Strategy, which is in now in draft and circulated for comment. BCHS will then be subsequently being forming a Patient & Carer Committee which will involve members of the GP Consortia.

Communication has been sent to all GP practices inviting members of the Bedfordshire population to become members.

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In relation to the comment "The episodes reported indicate Lessons Identified. The specific Lessons may not be described as "Learnt" until such time as clear evidence on future performance has been demonstrated"
BCHS monitor all action plans and can assure evidence is available to demonstrate lessons learnt.

Preventive Work: The very core of BCHS business is to prevent ill-health and promote good health this statement has been included in the Chief Operating Officer's statement.

Children's Special Services: There is lots of work being or has been undertaken to improve the reputation and understanding of all BCHS services. The Chief Operating Officer is keen to ensure our reputation is the best it can be with all customers and are their organisation of choice. The Children's Services are scrutinised along with every other BCHS service through a serious of robust services reviews and audits to provide the assurances required both from an internal and external perspective. The survey carried out was with GPs and an action plan is in place to make improvements

"Also, with regard to the two care/nursing homes to which patients who would have been housed at Steppingly Hospital accounting for a further twelve beds do not appear to be listed in the accounts".- These have been included in the text.

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- **Overview & Scrutiny Committee**

Bedford Borough Council's Adult Social Care and Health Prd Committee

5 April 2011

MINUTE EXTRACT: COMMENT FOR QUALITY ACCOUNT 2011/12

"81. BEDFORDSHIRE COMMUNITY HEALTH SERVICES – QUALITY ACCOUNT 2011/2012

The Committee welcomed Richard Winter, Chief Operating Officer, and Helen Smart, Deputy Chief Operating Officer, Improvement, Bedfordshire Community Health Services who attended to present the draft 2011/2012 Quality Account for Bedfordshire Community Health Services and invited Members to comment on the draft and provide a statement for inclusion in the final published version.

Richard was pleased to be able to report that, in respect of the Bedfordshire Community Health Services' performance indicators, for the first time, all eighteen weeks targets had been met. This year's Quality Account priorities were:-

Patient Safety

- Reduction in the number of falls that result in harm by 50%
- Reduction in the number of catheter infections by 50%
- Reduction in the number of acquired pressure ulcers by 30%

Clinical Effectiveness

- Patients to receive Intravenous antibiotics at home where appropriate

Patient Experience

- Improving our patient experience in the five key areas highlighted
- Improve on last year's survey

With regard to breast feeding, it was noted that close work was being undertaken with local authority children's centres and the maternity units at Bedford and Luton and Dunstable Hospitals to standardise training to support breast feeding mothers. Richard reported that, this year, baby brasseries were launched across Bedfordshire to provide a relaxed atmosphere for mothers to meet and gain support. It was recognised that performance remained below the target but Members noted that it was steadily improving and were assured that every effort was being made to achieve the target set of 52.1% of women still breast feeding at 6 – 8 weeks. It was pointed out, however, that where mothers fed their babies by a mix of breast and bottle methods, those cases were not treated as breast fed occasions and were, therefore, not counted towards the target.

Reference was made to the need to reduce the number of pressure ulcers which reduced the quality of life for patients themselves and create significant difficulties for them and their carers and families. This was a 'whole system' priority for all health providers including Bedford Hospital. It was reported that the presence of pressure ulcers was associated with an increased risk of secondary infection and a two to four fold increase in the risk of death in older people. Members recognised the importance of addressing this and noted that the Chief Nurse for England had recently accorded this as a high priority for nurses.

In endorsing the priorities for improvement, the Committee felt that every effort should be made to prevent and where necessary treat pressure ulcers to avoid the discomfort and risk of subsequent secondary infection.

The Chair, on behalf of the Committee, thanked Richard and Helen
for their attendance and presentation and for the opportunity for the Committee to comment on the draft Quality Account.

RESOLVED:

1. That the Committee supports the priorities set out in the Bedfordshire Community Health Services draft Quality Account.

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2. That the Committee recommends that Bedfordshire Community Health Services work with Bedford partnership Board to improve services for carers."

Changes made to the as a result of the Bedford Borough OSC statement

BCHS has strengthened the carer elements in their Quality Account and the Deputy Chief Operating Officer will be attending the Bedford Partnership Board to work with the Local Authority on improving services to carers.

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9. Glossary

BCHS	Bedfordshire Community Health Services
C. Difficile	Clostridium Difficile
COO	Chief Operating Officer
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Programme
DCOO	Deputy Chief Operating Officer
EEAST	East of England Ambulance Service Trust
EoE	East of England
GP	General Practitioner
HCAIs	Health Care Associated Infections
HMP	Her Majesty's Prison
HPV	Human Papilloma Virus
IV	Intra Venous
KPI	Key Performance Indicator
LAs	Local Authorities
L&D	Luton & Dunstable
LINk	Local Involvement Network
MRSA	Meticillin-resistant Staphylococcus Aureus
NHSB	NHS Bedfordshire
NHSLA	National Health Service Litigation Authority
NPSA	National Patient Safety Agency
PALS	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PCS	Productive Community Service
PCT	Primary Care Trust
PDSA	Plan Do Study Act
PEAT	Patient Environment Action Team
QIPP	Quality, Innovation, Performance and Productivity
RAG	Red Amber Green
RCA	Root Cause Analysis
SEPT	South Essex Partnership Trust
SHA	Strategic Health Authority
UTIs	Urinary tract infections
VTE	Venous Thromboembolism

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10. References

- *Quality Accounts toolkit 2010/11*
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122540.pdf

- *Quality Accounts – Survey of providers*
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122542.pdf

- *Quality Accounts – Survey of PCTs/SHAs/LINks/OSCs*
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122544.pdf

- *NCAs for inclusion in Quality Accounts 2011*
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_121087.pdf

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Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **13 June 2011**

Subject: Luton and Dunstable Hospital NHS Foundation Trust Quality Account (2010)

Report of: **Luton and Dunstable Hospital NHS Foundation Trust**

Summary: This provides provides the Members of the Social Care, Health and Housing OSC with an opportunity to comment on the Quality Account for the Luton and Dunstable Hospital NHS Foundation Trust for 2010.

Advising Officer: Elaine Hide, Director of Quality Luton and Dunstable Hospital NHS FT

Contact Officer: Jonathon Partridge, Scrutiny Policy Adviser (0300 300 4634)

Public/Exempt: Public

Wards Affected: All

Function of: NHS

RECOMMENDATION:

1. That the Social Care, Health and Housing Overview and Scrutiny Committee comment on the Quality Account submitted by Luton and Dunstable Hospital NHS Foundation Trust if so minded.

Background

1. All providers of NHS healthcare services in England are required to publish a quality account that represents the quality of the healthcare services delivered over the previous year. Trusts are required to share their quality accounts with the local LINk and appropriate Overview and Scrutiny committees with responsibility for health matter who are offered the opportunity to comment on the draft document on a voluntary basis. These quality accounts are produced annually and made available to the public.

2. The Department of Heath have produced guidance on Quality Accounts titled "Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)". The DoH guidance states that "Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention."

3. The Department of Health Guidance "Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)" suggests that OSCs might consider the following:-

   - Do the priorities identified by the provider contained in the Quality Account match those of the public?
   - Has the provider omitted any major issues from the Quality Account?
   - Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

Conclusion and Next Steps

5. The Overview and Scrutiny Committee is asked to consider the Quality Account and provide any comments as they feel appropriate. Comments on the Quality Account are voluntary, the Committee is not obliged to comment if it does not feel it necessary.

6. Any statements agreed by the Committee will be sent to the provider to allow them time to prepare their Quality Account, which will include the statement, for publication.

Appendices:
Appendix – Luton and Dunstable Hospital NH Foundation Trust Quality Account (2010)

Background Papers: (open to public inspection)
Quality Accounts: a guide for Overview and Scrutiny Committees
(**http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125167.pdf**)

Location of papers: Priory House, Chicksands

Luton & Dunstable Hospital NHS Foundation Trust

QUALITY ACCOUNT/REPORT

Quality Account 2010/11

Part 1

A statement on Quality from the Chief Executive

The Trust Board of Directors is committed to providing safe, effective and high quality care for all our patients.

Everything we do as a Trust is geared towards meeting the challenges of delivering the best possible outcomes for our patients. Our commitment to the NHS agenda to drive up both quality and efficiency is reflected in our corporate objectives for 2011/12:

1. Improve Clinical Outcome and Patient Safety
2. Improve Patient Experience
3. Progress Strategic Developments
4. Deliver Excellence in Teaching
5. Ensure Financial and Environmental Sustainability
6. Work with Partners to Improve Clinical Pathways
7. Develop and Motivate staff
8. Maintain compliance with Terms of Authorisation

I would like to record my thanks to our stakeholders for their ongoing contribution to the development of our Quality Report, in particular our staff and Governors who have worked hard to ensure that we are capturing and addressing the issues that matter to patients and the public.

The Trust continues to focus on raising the quality of the care that it provides to patients and to ensure that it remains at the forefront of national patient safety agenda.

- We achieved NHS Litigation Authority Risk Management Standards Level 2 for the Trust in March 2011. This is a significant achievement and demonstrates the Trust commitment to staff and patient safety across the site.
- The Trust significantly outperformed national targets for the reduction of both MRSA bacteraemia and *Clostridium difficile* in 2010/11.
- We commenced a major project to redesign the provision of Emergency Medicine at the Trust. Working with experts in the field we have developed a new emergency pathway and invested significant resources in providing a new Emergency Department (A&E) with dedicated facilities for children. The new

facility has been designed in conjunction with colleagues in other parts of the local health service and is on target for full launch in summer 2011.

- Following changes to the registration process to obtain Care Quality Commission (CQC) registration the Trust was registered with two conditions in April 2010. However, following swift remedial action the two conditions were lifted in June 2010 and the Trust maintained registration without conditions for the remainder of 2010/11.

Whilst we are proud of our achievements we recognise the need to continually improve our performance as we strive to provide even greater service quality. The Board of Directors and Council of Governors have set a series of priorities for 2011/12 which are outlined in this Quality Report.

The Board of Directors will continue to work in partnership with staff, patients and other stakeholders to improve clinical outcomes for all who use our services.

Pauline Philip
Chief Executive

Priorities for improvement in 2011/12

Following consultation with key stakeholders the Trust Board of Directors has agreed the following priorities for quality improvement in 2011/12

Priority 1 Patient Safety
To improve overall safe care for patients

Why is this a priority?

Making care safer for patients remains one of our top priorities. We have continued to make progress in a number of discreet areas, for example in the reduction of hospital acquired pressure ulcers, but want to consider the patient pathway from beginning to end in order to make this as safe as possible for patients.

It is important that as part of this priority Trust staff continue the harm reduction work already started as well as beginning new initiatives. For example; during the last year we have worked to improve risk assessment for patients who might develop a deep vein thrombosis because of a hospital stay, this work will be continued in order to consistently achieve the highest levels of compliance for patients. The Trust will also build on work completed in 2010/11 in the emergency pathway to enhance patient safety through early senior clinical review and management.

Consultation with stakeholders has made it clear that the safe discharge from hospital is a priority for patients and their families. This includes early planning for discharge, communication with the patient and family to involve people in decisions and to share information, not staying any longer than needed and timeliness of discharge on the day.

What actions will we be taking to improve our performance?

The following actions are planned to improve our performance

- Improved pre assessment before a planned admission to identify adults 'at risk' because of their capacity to protect themselves and early identification of emergency patients who may also be at risk
- Combining risk assessments to make sure that they are completed and that actions are initiated to reduce harm
- Continuing work to embed venous thrombo-embolism (VTE) risk assessment and prophylaxis on admission and at intervals during the patients stay
- Planning discharge in such a way as to meet the needs of the individual patient, involving the patient and family and using newly developed checklists to ensure that all aspects of care are covered
- Reviewing and improving the quality of information contained in the electronic discharge letter sent to General Practitioners and copied to the patient
- Implementing processes to reduce delays before and on the day of discharge
- Spreading team effectiveness (human factors) work to emergency care and admission areas
- Continuing work to further reduce harm e.g. falls, hospital acquired pressure ulcers, catheter associated urinary tract infection and VTE by continuing as a host for the National Safety Express initiative
- Implementing electronic observations to secure further reductions in mortality and earlier identification and management of the deteriorating patient

- Continuing to reduce all hospital acquired infections with an emphasis in the coming year on understanding E.Coli bacteraemia, its prevention and management
- Continuing work to recognise sepsis and to use recognised prescriptions for care to ensure the best outcome for patients
- Further development of the ward clinical quality dashboard including actions to increase the visibility of the dashboard to patients and visitors

Goals have been set within the CQUIN scheme for 2011/12 in relation to

(i) patient discharge from hospital with measurement based on patient and health care professional feedback
(ii) risk assessment for VTE for all patients, including maternity

How will improvement be monitored and measured?

Improvement will be monitored and measured through the use of a selection of indicators taken at frequent intervals to track progress and assess achievement.

Many of these measures are already in place for example the rate of hospital acquired pressure ulcers, the rate of falls, the percentage of patients with a risk assessment for VTE on admission and the percentage with appropriate prophylaxis and the number of incidents reported in relation to care at different points in the patient pathway. The National Safety Express initiative uses a measure of the percentage of patients who are free from the four harms of hospital acquired pressure ulcer, fall, VTE, and catheter acquired urinary tract infection and we have adopted that measure.

Measures of safe discharge will include patient reported outcomes of discharge from hospital as well as readmission rates. Each case of readmission within 30 days will be examined to determine why this has occurred and if the original discharge was safe. These reviews will also be used to guide improvement work. Feedback from other health care professionals who receive patients for care, particularly their views on the quality of transfer information, will also be used to judge success.

How will progress be reported?

Progress will be reported through the Clinical Outcome, Safety and Quality Committee and therefore ultimately to the Board of Directors, Governors, Local LINks and other patient representative groups will also be kept informed of progress. Regular Quality Monitoring meetings with our commissioners will include agenda items on the progress of quality improvement initiatives including CQUIN goals.

Priority 2 Patient Experience
To implement the Trust's Patient First Initiative

Why is this is a priority?

In a census of patients, public and other stakeholders sent to 15,000 people locally in September 2010 we asked which aspects of care are most important to a patient at the hospital. The results showed that the following were the top four aspects of care:

- Caring, friendly, sympathetic staff was the most important feature of care (mentioned as priority by 61%)

- Cleanliness (51%),
- Efficient and effective communications (44%)
- High quality care and treatment (43%).

When asked, 35% of patients felt that we had very friendly, sympathetic and caring staff but 16% felt that this was an aspect of care delivery where we did not do well. In addition, 15% felt we performed very well in communicating with patients but 21% of respondents felt that communication was poor. These aspects of care are also the frequently mentioned in complaints and compliments.

Stakeholder groups consulted while developing the Quality Account describe the negative impact on patients and carers when caring and compassionate behaviours are not displayed, information not given or attitude poor. Stakeholders are also keen that visitors are welcomed. Members of these groups identify that work to ensure that each patient feels that they are the only patient of concern at the time should be one of our top priorities. This priority is closely related to keeping patients safe and achieving the best outcomes for patients.

The national in-patient survey shows that we are only average where we would want patients to feel able to describe the L&D as a place where their experience of care is excellent and do so because of the approach staff take; the way care is organised and the outcome for them as the patient. Given that it is clear what is most important to patients we recognise that we need to work to develop the culture of the organisation to one that puts the patient first in everything that we do.

What actions are we planning to improve our performance?

A fresh approach has been introduced to improving patient experience with the launch of the ‘Patient First’ initiative. Feedback from the census, received in October 2010 has helped us to understand what we do well, where we need to improve and what changes we need to make to become the Hospital of Choice.

A steering group has been formed and the initiative is being managed through line management and divisional processes. An initial 20 pathfinder wards and departments have been established to test the ideas, values and approaches to improving patient experience. The key aspects of the approach are:

- A clear model of patient experience to recognise all of the opportunities to achieve ‘customer’ expectations.
- An innovative Staff Award and Recognition Scheme (STARS) designed to foster ownership of patient experience at personal and departmental level and based on the opinions and expectations of our patients and other key stakeholders.
- Six rapid improvement events in the pathfinder areas focussing on: values, behaviours, standards, patient feedback, benchmarking, performance, appraisal and other HR aspects.

This approach launched at the beginning of April will motivate staff and provide a toolkit to help plan objectives and appraisals.

Additionally the Trust signed up to the MENCAP ‘Getting it Right’ Charter and has worked with partners including representatives of patients and families to create a task and focus group. The group have an action plan to implement each of the parts of the Charter over the next 9 months.

We have started work to improve the care of patients with dementia through increased training, the use of 'all about me' information for each patient completed with the family so that staff can improve anticipation of patient need.

An external review of nursing practice has been planned for May 2011 to provide independent assessment of the quality of nursing care and to inform the Trust of further actions that can be taken to enhance care delivery.

How will improvement be monitored and measured?

We will use the percentage of patients who, in patient surveys, rate the care they receive as excellent as *one* of our measures. We anticipate that as we improve patient experience this score will rise**.** Other results, particularly those in relation to 'information giving' and 'confidence in staff' from surveys of patients while they are in hospital and after they leave, will also be used. Some responses from national surveys are used to make up a composite score in relation to our responsiveness to patient need and this will be used to measure progress in our agreed CQUIN scheme for the coming year. Monitoring the numbers, nature and severity of complaints will also help us to track progress.

Other measures will include the number of teams and departments completing the Patient First programme and achieving awards and recognition.

Measures of staff support including appraisals will also be used here, for example percentage of appraisals completed. Well supported staff deliver a better patient experience.

The Learning Disability Task and Finish group have created a dashboard to monitor and report progress against their action plan.

How will progress be reported?

Progress will be reported through the Clinical Outcome, Safety and Quality Committee and therefore ultimately to the Board of Directors. Governors, Local LINks and other patient representative groups will also be kept informed of progress. Regular Quality Monitoring meetings with our commissioners will include agenda items on the progress of quality improvement initiatives including CQUIN goals.

Priority 3 Clinical Effectiveness
To improve clinical outcome

Why is this a priority?

The Trust is committed to driving up clinical outcomes in a number of areas and has plans to help staff to do this. The outcome of care, through making a good recovery, getting better and getting the right result from an operation or procedure are most important in healthcare.

One particular example is in relation to nutritional care. The Luton and Dunstable Hospital has, in the past, excelled in delivering excellent nutritional care and we would wish to return to that position. We have identified that we can improve the care given to patients; in the assessment of patients to identify those who may be at risk of malnutrition; in relation to the food and fluids that patients need and also in the

help they may need to take food and fluids. Good nutritional care can help to combat hospital acquired pressure ulcers; contribute to avoiding falls; enable shorter stay in hospital and better healing and recovery.

Reducing hospital mortality continues as a priority. We have examples of excellent Hospital Standardised Mortality Ratios (HSMR) in relation to some patient groups, for example those with myocardial infarction (heart attack). However our total HSMR, which had been lower than peers in recent years, has moved closer to the national average. Through service improvement, for example in relation to stroke care, we can make a positive impact on reducing mortality.

Through case note review we have seen a reduction over time in the more severe harms but still see evidence of harm occurring to patients in relation to medicines, procedures or unnecessary delay. Reducing harm remains a priority.

What actions are we planning to improve our performance?

One action the Trust is taking in order to improve clinical outcome is to become a University College of London (UCL) Partner. This will enable a shared ethos to create better care through partnership working for the benefit of patients. Our population base shares many demographic features and healthcare needs and the UCL Partners can offer easier access to clinical trials infrastructure, educational platforms and collective influence for our patients.

Becoming a UCL partner will enable greater access to and participation in networks of care; access to opinion leaders and clinical advocates; and further opportunity to participate in research and education.

UCL Partners work together to develop and provide solutions focussing on areas such as patients' needs and preferences; taking a system-wide view to deliver innovation across a defined population – with an emphasis on health outcomes as well as cross-boundary healthcare, spanning primary, secondary and tertiary care, and connecting different phases of academic research.

Becoming a UCL partner will assist with our ambition to further develop our clinical pathways. Each Division has identified pathways they would wish to develop for example the Women's and Children's Division are already working on pathways for children with epilepsy and for head injury.

In relation to improving nutritional care we have planned a number of actions which include:

- Implementation of a prescription for care called 'the intelligent fluid management bundle'
- Regular rounds by nurses checking with patients to help them to achieve targets in relation to fluid intake
- Further development of staff and volunteer training and of the numbers of volunteer assistants at mealtimes

Obesity in children is a growing problem and consequently we will take actions to ensure that height and weight is recorded for each child admitted to calculate body mass index (BMI). We will also introduce a validated tool to further assess nutritional status in children and to guide onward referral to an appropriate professional. Nutrition in children and in the elderly are both included in the agreed CQUIN scheme for 2011/12.

Work will continue to improve patient pathways to ensure outcomes are optimised for all patients. For example the national Sentinel clinical audit for stroke 2010, published in February 2011, demonstrates continued positive improvement in acute stroke care at the L&D, demonstrating good overall performance against NICE quality standards and other key performance indicators. The service is keen to continue the success in improving stroke treatment achieved over the course of the last year, to enable improved stroke prevention in 2011. This will be achieved by introducing 7 day Transient Ischaemic Attack (TIA) clinics, improved access to Carotid Doppler scanning and working with primary care colleagues to improve awareness of pre-stroke symptoms and the necessity to refer patients directly to TIA clinics immediately for maximum patient benefit and prevention of progression to stroke.

How will improvement be monitored and measured?

Measurement will be taken of the percentage of patients (children and elderly) having a nutritional risk assessment recorded with appropriate actions taken. The outcomes for patients in relation to nutrition will also be measured.

HSMR will be tracked to monitor improvement and regular case note review will continue.

The number of pathways reviewed and improved will be tracked together with related outcome measures for the pathway including measures of mortality and morbidity.

How will progress be reported?

Progress will be reported through the Clinical Outcome, Safety and Quality Committee and therefore ultimately to the Board of Directors. Governors, local LINKs and other patient representative groups will also be kept informed of progress. Regular Quality Monitoring meetings with our commissioners will include agenda items on the progress of quality improvement initiatives including CQUIN goals.

Statements related to the quality of services provided

Review of services

During 2010/11 the Luton and Dunstable Hospital NHS Foundation Trust provided and/or sub-contracted 34 clinical services. The Luton and Dunstable Hospital NHS Foundation Trust has reviewed all of the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable Hospital NHS Foundation Trust for 2010/11.

Participation in clinical audits and national confidential enquiries

During 20010/11, 28 national clinical audits and five national confidential enquiries covered NHS services that Luton and Dunstable Hospital NHS Foundation Trust provides.

During that period the Luton and Dunstable Hospital participated in 76% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Luton and Dunstable Hospital NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

National Clinical Audits			
Audit	**Organiser**	**Audit Cohort Submitted**	**% return**
Dementia - Organisational Audit - Clinical Audit	Royal College of Psychiatrists	N = 40	100%
National Audit of Familial Hypercholesterolemia - Organisational Audit - Clinical Audit (no eligible cases identified)	Royal College of Physicians	Organisational data	NA
Falls & Bone Health (Round 3) - Organisational Audit - Fragility Fractures - Fractured Neck of Femur	Royal College of Physicians	N = 60	100%
National Sentinel Stroke Audit Round 7 - Organisational Audit - Clinical Audit - SINAP	Royal College of Physicians	N = 80	100%
College of Emergency Medicine 2010-11 (3 National Audits) - Vital Signs - Renal Colic - Feverishness In Children -	College of Emergency Medicine	N = 50 x 3	100%
Inflammatory Bowel Disease (Round 3) - Organisational Audit - Clinical Audit	Royal College of Physicians	N = 40 Consecutive admissions	Organisational data completed Clinical Audit &

National Clinical Audits			
Audit	**Organiser**	**Audit Cohort Submitted**	**% return**
- GP & Patient Questionnaires			Questionnaires continue to August 2011
Use of Platelets (Re-audit) - Clinical Audit	NHS Blood & Transplant	Eligible Transfusions N = 7	NA
Use of O Negative Blood Use	NHS Blood & Transplant	Eligible cases June 2010 N = 13	NA
NHS Diabetes In-patient (Adult) Audit 2010 - Clinical Audit - Patient Questionnaires	NHS Diabetes	All eligible cases identified on audit day. N = 84	NA Questionnaire response rate 43% (national rate 39%)
National Pain Audit (Phase 1) Organisational /Service Survey	Dr. Foster	Organisational Questionnaire	NA
Emergency Use of Oxygen: Oct-Nov 2010	British Thoracic Society	Prospective	NA
National Audit of Seizure (Adults) - Institutional Audit 2011 - Clinical Audit 2011	University of Liverpool	30 Cases from 1st October 2010	Project continues
Epilepsy 12 (Paediatric) 2010-2012 - Early Adopter Site (January 2011) - National Audit May 2011 - Organisational Audit - Clinical Audit - Patient Experience	Royal College of Paediatrics & Child Health	All eligible cases identified from EEG service	Project continues
National Audit of Heavy Menstrual Bleeding Year 2 Patient Questionnaires	Royal College of Obstetricians & Gynaecologists	Prospective	Project continues
Myocardial Infarction National Audit Database Annual MINAP Validation Audit - Case reviews -	CCAD CCAD	All cases N = 20	Ongoing 100%
National Heart Failure Data base	CCAD	All cases	Ongoing
National Cardiac Arrest Audit: In-patients (>28 days old) having cardiac arrest & receive chest compression/defibrillation	ICNARC	All cases	Ongoing

National Clinical Audits			
Audit	**Organiser**	**Audit Cohort Submitted**	**% return**
Hip Fracture Data base:	British Geriatric Society/British Orthopaedic Society	All patients admitted with fractured neck of femur	Ongoing
Hip and Knee joint replacements	National Joint Registry	All cases	Ongoing
Neonatal Intensive Care & Special Care (NNAP)	Standardised Electronic Neonatal Database (SEND)	All cases	Ongoing
Adult Critical Care (ICNARC)	Intensive care National Audit & Research Centre	All cases	Ongoing
Potential Donor Audit	NHS Blood & Transplant	Intensive Care Patients	Ongoing
Stillbirths & Neonatal Deaths (Formerly CEMACH)	Centre for Maternal & Child Enquiries (CMACE)	All cases	Ongoing
Cancer (Three national audit database) - Head & neck - Colorectal - Lung Cancer	DAHNO NBOCAP NLCA	Newly diagnosed cancers	Ongoing

Eligible National Audits - Non Participation

The Luton & Dunstable Hospital NHS Foundation Trust did not submit data during 2010/11 to nine national audits:

- Paediatric Pneumonia (British Thoracic Society)
- Paediatric Asthma (British Thoracic Society) – we were not formally invited to register for 2010/11 but have registered for 2011/12
- Paediatric Diabetes (RCPH) - we were not formally invited to register for 2010/11 but have registered for 2011/12
- Adult Non Invasive Ventilation (British Thoracic Society)
- Parkinson's Disease 2009 (National Parkinson's Audit)
- COPD (British Thoracic Society European Audit)
- Adult Asthma (British Thoracic Society)
- Bronchiectasis (British Thoracic Society)
- Severe Trauma (Trauma Audit & Research Network) – covered within internal audit

National Confidential Enquiries

	Topic/Area	Database/Organiser	Audit Period Data collected 2010/11	% return*	Participated Yes/No
1	Surgery in Children	NCEPOD	April – Sept 10	100%	Yes
2	Peri-operative care	NCEPOD	2010	(5/6) 83%	Yes
3	Cardiac Arrests	NCEPOD	Spreadsheet completed November 10	100%	Yes
4	Bariatric Study	NCEPOD	Data request	100%	Yes
5	Maternal, Still births and Neo-natal deaths	CEMACH	April 2010 – March 2011	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

The reports of 7 national clinical audits were reviewed by the Trust in 2010/11 and the action the Luton and Dunstable Hospital intends to take to improve the quality of healthcare provided:

Continence Round 3: 2009-2010 (ended March 2010)

Local results have demonstrated good practices relating to:

- Reviewing continence history as part of hospital admission assessment process
- Use of screening tools for bladder and bowel symptoms
- Practice of rectal examinations

Areas for development:

- Development of an integrated continence service
- Integration of the written protocol for continence assessment

Achievements:

- A Continence Nurse Specialist has been appointed to the Trust (August 2010).

Dementia Round 1: 2010

Local results have demonstrated good practices relating to:

- Organisational arrangements for multidisciplinary assessment of dementia, recognition of signs/symptoms and nutritional assessment
- Liaison with Psychiatry service.
- Provision of information to patients/carers on discharge from hospital

Areas for development:

- Introduction of a standardised tool to assess functioning
- Use of a dementia nursing management plan
- Access to a cross organisational liaison nurse specialist

National Anticoagulation Computer System Audit: July 2010

Data is submitted twice during the year and extrapolated from computer system entries. The findings have shown that the Trust's performance is broadly in line with national findings. The key learning from the report is to increase the application of computer derived instructions within the clinical decision making process.

Myocardial Infarction National Audit Project (MINAP): Results 2010

Maintenance of data quality is crucial to MINAP and data are used locally and nationally to indicate the care of patients following heart attack. A validation audit is undertaken annually to examine the consistency of data entry from each participating site. Results were published in May 2010 (for 2009 cases).
The validation included 20 randomly selected records for patient discharged from hospitals with a coded diagnosis of Troponin positive Acute Coronary Syndrome. The results have shown that the median national score was 90 with a range nationally of 60-100. The L&D's overall score was high at 95.3%.
The Trust also demonstrated an excellent data completion rate (our missing data rate was zero). The results are used by the Trust's Cardiac Care Project Group to support areas for further action and to provide benchmarking of best practice. One area the Group have highlighted to improve during 2010-11, relates to confirmation of GP codes.

All Parliamentary Thrombosis Group Round 4: 2010

Data were returned by 92% of all NHS Acute Trusts.

The report highlighted the need for national guidelines to be developed for Day Case procedures and for specific groups of patients considered at low risk of developing Venous Thromboembolism (VTE).

National Recommendations:

- VTE prevention indicators included within the NHS Outcomes Framework
- Continue with national CQUIN goals

National Audit of Familial Hypercholesterolemia (FH): 2010

The Trust submitted organisational data (no local cases were identified within the clinical data review period).

Several areas highlighted within the national results apply to local service arrangements:

- Review of commissioning arrangements for FH services.
- Improved coordination between hospital based services and improved links with primary care services.
- Development of a comprehensive cascade testing service including: follow-up of index patients, IT systems, pedigree assessment and FH dedicated patient data bases.

National Sentinel Stroke Audit Round 7: 2010

Round 7 of the National Sentinel Stroke Audit included patients admitted to hospital with a coded diagnosis of stroke during the period 1st April – 30th June 2010. Each site was eligible to submit a maximum of 60 cases. The Luton & Dunstable Hospital submitted data for 60 patients. Over 11,000 patients were included within the audit across Trusts treating acute stroke patients within England, Wales and Northern Ireland. The audit reviewed care across the patient journey. The Trust has been able to benchmark its services against the national figures. Key learning points show that 95% of patients were admitted to hospital within 24 hours of stroke (94% nationally), with just over half within 3 hours (56% nationally). Local results show that 72% of stroke patients were initially admitted to an acute/combined stroke ward (36%

nationally). All patients received a brain scan, thee quarters being performed within 24 hours of stroke (70% nationally). The results have identified 10 national priorities for improvement, which the Trust will continue to incorporate within its ongoing service improvement plan. From 2010, it is proposed to revise arrangements for collecting national Stroke data by using a national prospective minimum dataset.

Local Clinical Audits

The reports of 46 local clinical audits were reviewed by the Trust in 2010/11 and the action the Luton and Dunstable Hospital intends to take is detailed in Appendix 1 to improve the quality of healthcare provided.

Other National Clinical Audits

The Luton & Dunstable Hospital NHS Foundation Trust also participated in 13 national audit topics not included in the eligible list and 9 national datasets, as detailed in Appendix 2

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Luton and Dunstable Hospital NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 1,228. This research can be broken down into 131 research studies (92 Portfolio and 39 Non-Portfolio).

Participation in clinical research demonstrates the Luton and Dunstable NHS Foundation Trust'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 L&D NHS Foundation Trust is proud to be one of the highest recruiting hospitals within the local West Anglia Comprehensive Local Research Network.

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

A proportion of Luton and Dunstable Hospital income in 2010/11 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. Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at

http://www.institute.nhs.uk/commissioning/pct_portal/cquin_schemes_in_east_of_england/

Care Quality Commission Registration

The Luton and Dunstable NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration is Registration Without Conditions.

The Luton and Dunstable Hospital NHS Foundation Trust had two conditions on registration in April 2010. These were as follows.

1. The registered provider must review its contractual and monitoring arrangements with nurse agencies and ensure that it only accepts nurses to carry out any regulated activity from nurse agencies that are registered with the CQC or, where the main contractor has subcontracted the matter, that the sub contracted agency has been appropriately registered with the CQC by 30 April 2010.

2. The registered provider must ensure that a review is carried out of the trust's infection control governance arrangements, to ensure that systems and processes are in place to protect people who use services. Evidence to demonstrate that any identified concern has been addressed must be available to the CQC by 30 June 2010.

Compliance reviews took place on 30 April 2010 and 01 July 2010 and the service was found to be compliant with these conditions

The CQC took enforcement action against the Luton and Dunstable NHS Foundation Trust during the reporting period April 1st 2010 and 31st March 2011 issuing two warning notices on 22nd March 2011. One warning notice was in relation to regulation 11 (1) (a) & (b) Safeguarding Service Users from Abuse and the other in relation to Regulation 24 (1) (a) & (b) (i) Co-operating with Other Providers. The Trust also received a report following a responsive review visit 24th February 2011. The Trust was found to be non-compliant in relation to two further outcomes. These were Outcome 14 Supporting Workers and Outcome 20 Notifications. The Trust has responded to these warning notices and to the responsive review detailing action taken to achieve compliance and has provided an improvement plan for further actions to be taken in relation to the delivery of care in these areas.

The Luton and Dunstable NHS Foundation Trust has participated in special reviews or investigations by the CQC relating to the following area during 2010/11: 'Support for families with disabled children'

Statements on relevance of data quality and action to improve data quality

The Luton and Dunstable Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Continuing our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Using the data warehouse established February 2011 to provide timely alerts and to increase the visibility of any data and data quality problems
- Installing a new data capture system in A&E. These actions will ensure that improvements can be achieved more quickly with greater ownership by the departments involved

Luton and Dunstable Hospital NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 98.7% for admitted patient care; 99.4% for out patient care and 2.1% 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 not subject to a Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

The Luton and Dunstable Hospital was subject to the Payment by Results clinical coding audit during 2009/10 and at that time the error rates reported for diagnosis and treatment coding (clinical coding) were 3.33% (national average at that time was 8.1%). This indicated good performance against the recommendations from 2008/09 review.

Information Governance toolkit attainment levels

The Luton and Dunstable Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2010/11 was 71% and was graded green (IGT Grading Scheme)

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

A Review of Quality Performance

Progress 2010/11

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness clinical indicators that patients, families, governors and staff have told us they would like to hear about.

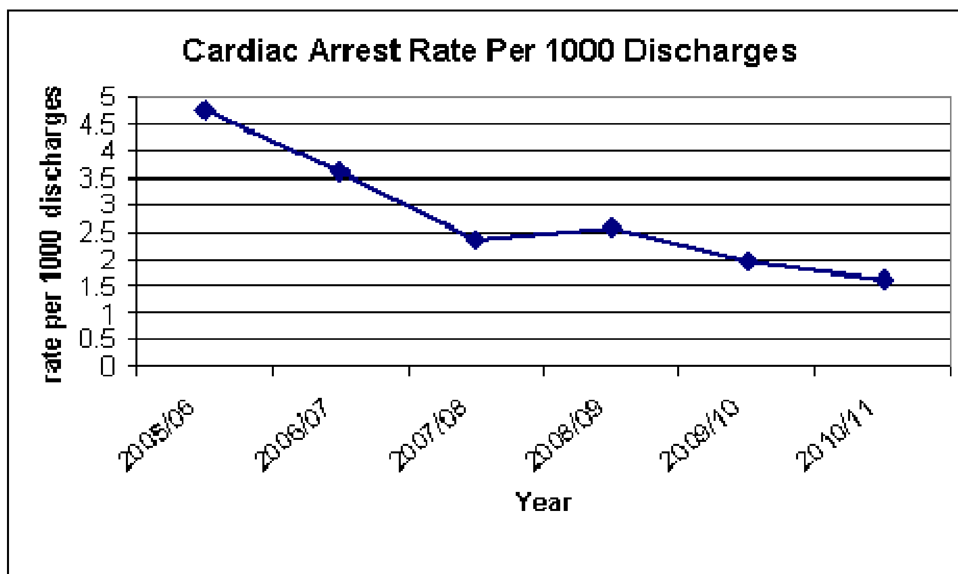
Performance Indicator	Source of data	2008/9	2009/10	2010* or 2010/11	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases	Trust Performance & Efficiency and Patient Safety Reports (DH criteria)	6	3	1	N/A	Excellent performance with reduction since last year
Hospital Standardised Mortality Ratio*	Dr Foster / Trust Patient Safety Report	94.6*	88.8*	97.4*	100	This has been lower (better) in the past but is now tending towards average
Number of hospital acquired C.Difficile cases	Trust Performance & Efficiency and Patient Safety Reports	66	53	36	N/A	Good performance with reduction since last year
Incidence of Hospital Acquired Grade 3 or 4 pressure ulcers	Trust Patient Safety Report	0.55%	0.65%	0.52%	N/A	Evidence of reduction in hospital acquired pressure ulcers
Number of Central line infections (Adults)	Trust Patient Safety Report	8	7***	2	N/A	Improved performance again this year
Cardiac arrest rate per 1000 discharges	Trust Patient Safety Report	2.57	2.17	1.63	N/A	A further reduction compared to last year
Average LOS	Trust Performance and Efficiency Report	4.1 days	4 days	3.9 days	N/A	Gradual reduction year on year
Rate of falls per 1000 bed days	Trust Patient Safety Report	6.1	5.46	6	N/A	This has reduced in previous years but we have seen a slight upward trend.
% of stroke patients spending 90% of their inpatient stay on the stroke unit	Performance and Efficiency Report	47.2%	62%	81.3%[2]		Improving each year
Rate of fractured neck of femur to theatre in 24hrs	Dr Foster	87%*	80%*	69%*	N/A	A lower percentage than last year – some

Performance Indicator	Source of data	2008/9	2009/ 10	2010* or 2010/11	National Average	What does this mean?
						patients are not suitable for surgery within the first 24 hours and every case over 24 hours is investigsyrf
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack)	Dr Foster (drawn 16/04/10)	94.3*	88.6*	58.7*	100	An excellent result – a lower number reflects less deaths than expected
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke)	Dr Foster (drawn 16/04/10)	86.3*	89.1*	93.7*	100	Within normal limits
Readmission rates*: Knee Replacements Trauma & Orthopaedics	Dr Foster	8.0%	7.7%	5.3%	6.1%	Improving year on year and better than the national average
% Caesarean Section rates	Obstetric dashboard	24.5%	24.9%	24.7%**	Trust goal <25%	This is proving difficult to reduce
% patients who would recommend the Trust to a friend (maternity only)	Patient Experience Tracker	96%	99%	85%[1]	N/A	A lower score. Some changes in the way this has been measured.
Average Patient satisfaction score (from PET)	Trust Patient Experience Report	86%	89%	88%	N/A	This result is staying about the same
Complaints rate per 1000 discharges (in patients)	Complaints database and Dr Foster number of spells for the year	2.8*	3.2*	3.2*	N/A	This result is staying about the same
% patients disturbed at night by staff	CQC Patient Survey	17%	26%	22%	21%	A slight reduction compared to last year

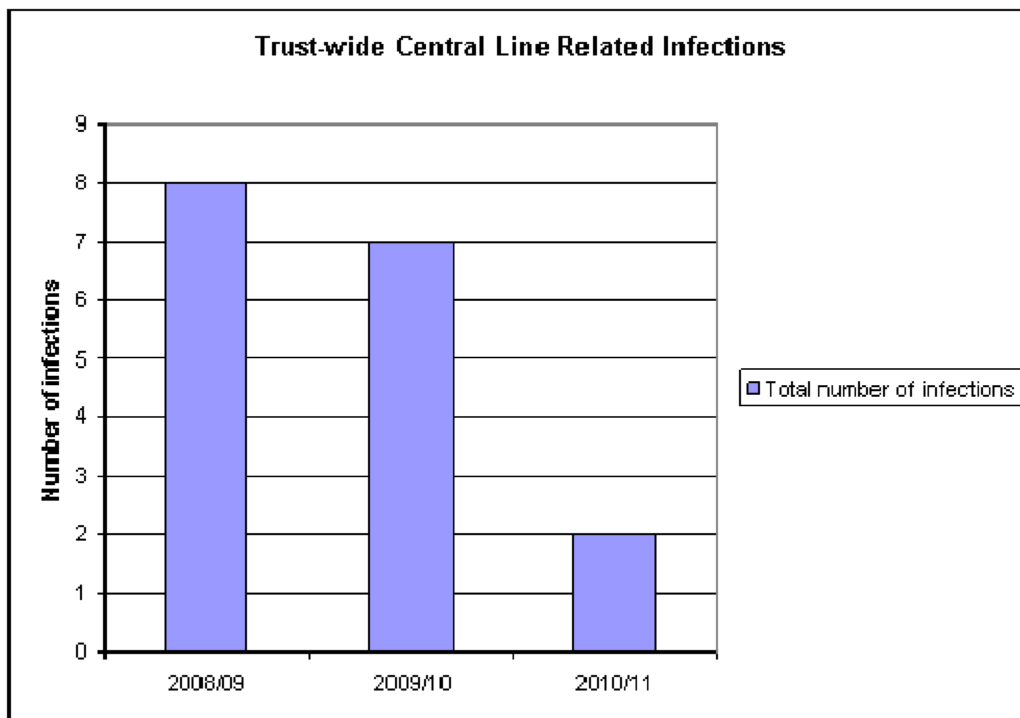
* denotes calendar year 2010 result drawn 21/4/11
** range 21-28% average of 12 months = 24.7%
*** X no > 30 days, x no < 30 days
**** % for a defined population excluding day cases and neonates etc 0.44 % for pressure ulcer incidence in relation to all hospital spells
1. note the question changed giving more response options, only response of very likely used here
2. 81.3% is data from Trust systems, drawn 21st April 2011. Heart and Stroke Network validate quarterly data. Oct to Dec 2010 validated but Jan to March not yet validated – this figure may change

The Trust has performed well in reducing the rate of cardiac arrests through work to increase the reliability of patient observation recording and staff response to abnormal observations. A pilot of recording and displaying patient observations electronically demonstrated reduction in mortality, the need to transfer to higher

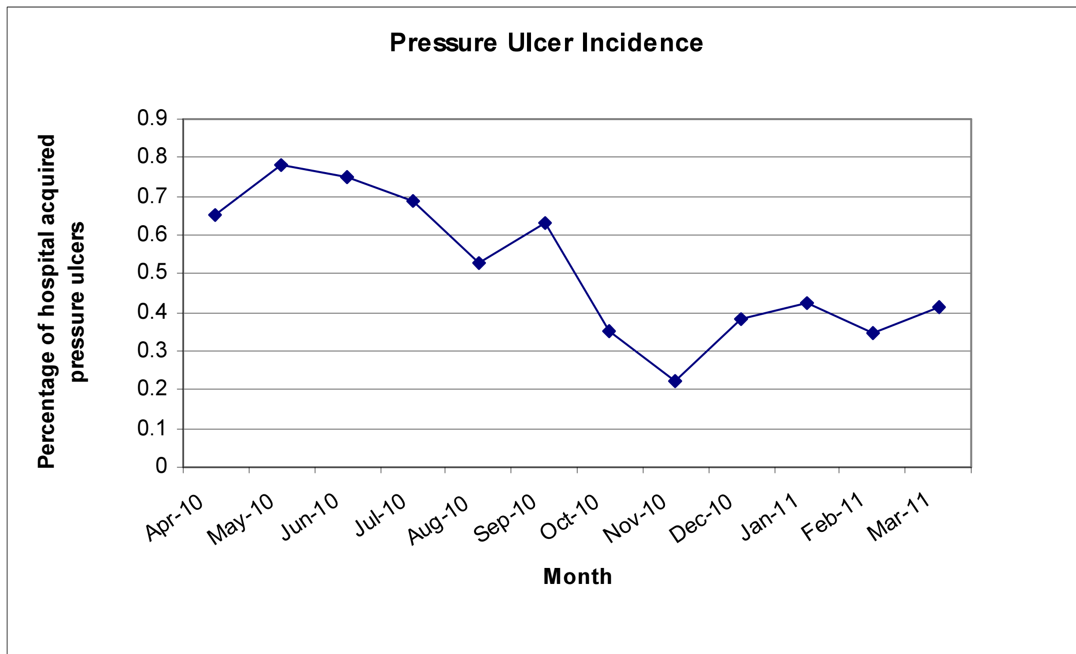
dependency levels of care and length of stay therefore this system is to be implemented in 2011.



The Trust also continues to reduce hospital acquired infections maintaining a reduction in the number of MRSA, C.Difficile and central line infections.

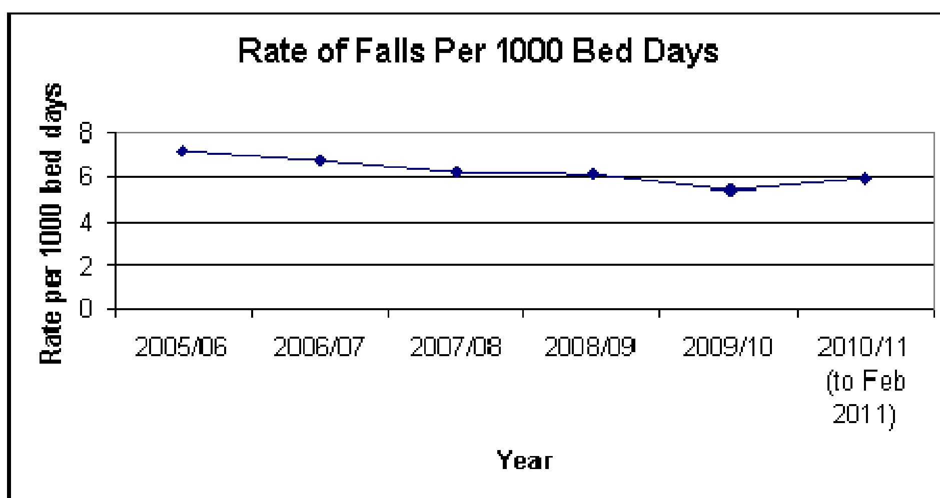


Reporting and coding of pressure ulcers has been improved to capture information on all pressure ulcers. Staff conduct root cause analysis of any pressure ulcer that occurs in order to understand further ways to reduce hospital acquired ulcers. We have seen a reduction in the incidence of hospital acquired pressure ulcers from 0.8% to 0.6% by March 2010 with a further reduction to 0.52% by March 2011 as well as a reduction in the number of the more severe grade 3 and grade 4 pressure ulcers.



All of the above contribute to a reduction in hospital mortality. The Trust continues to strive to reduce mortality but is seeing a slight upward trend in mortality as measured by the basket of 56 diagnosis used by Dr Fosters.

The Trust has made good progress in reducing falls over the past 3 years however we are seeing a slight increase in the number of falls related to patients with dementia or other cognitive impairment. We are therefore concentrating our effort on this patient group and on reducing injury from falls in any patient.



Our maternity services have completed excellent work in promoting normal delivery wherever possible and have been commended for this work with a case study appearing in the Institute for Innovation and Improvement High Impact Action Guide for Trusts. The Trust has also tried to reduce the rate of caesarean section over the past year but without significant change in the percentage of deliveries by this method. This may in part be related to delivery in higher risk pregnancy linked to our Level 3 Neonatal Intensive Care Unit. Increased consultant presence in delivery suite is in place and should faciilitate a reduction next year. The service was commended

in the Dr Foster Good Hospital Guide for a low rate of third degree tears following normal and instrumental delivery.

Last year patients and others requested that we add some indicators during the year. We have collected information about how well we perform in relation to Venous Thrombo-Embolism (VTE) risk assessment and prophylaxis during the year. We were aiming for greater than 90% compliance with risk assessment by the end of the year and we achieved this. Through work on our systems to complete and record risk assessment for every patient we have demonstrated that greater than 90% of patients are receiving the risk assessment. This enables the correct actions to be taken to help prevent VTE from occurring.

Examples of CQUIN achievements 2010/11

The Trust achieved 80% of the CQUIN goals set for 2010/11. CQUIN goals are designed to provide challenging targets to incentivise improvement.

The numbers of patients booked for planned surgery who were asked about smoking habits and referred to smoking cessation services increased each quarter until the goal of greater than 60% being asked was achieved. We continue to build on this work in partnership with PCT colleagues.

We have assessed the child friendliness of our services and set plans in place for improvement in our Paediatric Assessment Unit and Genito-Urinary Medicine.

Other achievements included increasing consultant presence on delivery suite in maternity and measuring body mass index (BMI) for all pregnant women in the first half of pregnancy.

The Trust also worked to reduce the time to pain assessment and treatment in A&E with some success.

Up to 25% of our patients have diabetes and some need to be referred to the diabetes nurse specialist while they are an in-patient. During the year Trust staff learnt about an assessment tool (ThinkGlucose) that can be used to make sure that the right patients get early referral to the team. Regular measurement of how quickly the patient's blood sugar level is returned to normal is one marker of success. This tool is now regularly used to good effect as the patients who need early specialist referral receive this.

Other quality improvement achievements

The Luton and Dunstable Hospital NHS Foundation Trust is one of 4 hospitals taking part in a two year project to improve patient safety and patient experience through enhanced teamwork (human factors). This human factors work started in maternity and has shown significant improvements, especially in the delivery suite. Teams regularly practice briefing and debriefing and are increasingly involving women and their partners in these. More effective teamwork is known to enhance the outcome and contribute to reducing the chance of crisis situations occurring or to manage them well if they do occur.

Staff have demonstrated their ability to be innovative in order to improve the delivery of patient care. One example is the provision of ice cream machines on the ward where head and neck cancer patients are cared for.

Staff have also demonstrated their ability to use the knowledge they have about the best ways to make improvements to care. One example is the effective way in which

staff of the Neo-natal Intensive Care Unit (NICU) implemented a series of steps, collectively called a 'care bundle' in order to make the use of intravenous Gentamycin safer. The way in which this change was made by staff was commended by the Neo-Natal Network.

Sepsis work to embed the use of the prescribed care for sepsis is beginning to show results with some evidence of reduction in mortality and length of stay for patients with pneumonia.

Paediatric pathways continue to be reviewed and developed with partners from other local organisations to ensure that patients get the right care in the right place. During the past year pathways have been completed for bronchiolitis and asthma and diabetes ketoacidosis to add to those for childhood fever and gastro-enteritis. Pathways for epilepsy, head injury and chest infection are currently being developed.

Stroke services have continued to develop over the course of the past year and L&D was the first Trust in Beds and Herts to commence 24/7 emergency stroke thrombolysis treatment in February 2010. After a successful 6 month pilot, the service has been established on a permanent basis and L&D is now a regional thrombolysis centre, taking patients for out of hours thrombolysis management from Bedford and East &North Herts hospitals. Over the course of the last year, some 50 patients have benefited from thrombolysis treatment, reducing mortality and morbidity and reducing length of stay.

Stroke services have been further enhanced with the very recent introduction of telemedicine, enabling patients to be examined by stroke consultants on call from outside the Trust to facilitate expert timely clinical decision making and intervention to benefit patients throughout the region via the telemedicine network of physicians. The Stroke Network has also supported the Trust in funding a one year pilot to demonstrate the benefit of extending therapies provision to patients 7 days a week, including weekends.

Emergency Care

Attending Emergency Department (A&E) or being sent by your General Practitioner to the hospital for an urgent or emergency specialist opinion can be a frightening experience. During the year we started to make changes to emergency care areas to improve both the experience of emergency care and its effectiveness and efficiency.

The first change has been to co-locate the Emergency Assessment and Observation beds with the Emergency Department. This means that patients do not have to be moved very far if they need to be cared for in this environment and the medical and nursing team can work more closely together to create and follow the care plan for the patient. These changes will help to limit the number of bed moves for patients. Further changes are now in progress and include the development of a paediatric Emergency Department.

Patient Experience

Our stated priority last year was to improve the percentage of patients who would in patient surveys rate their care as excellent. For the 2010 national in-patient survey 35% of patients rated their care as excellent which is an improvement on 31% the previous year. The same percentage as last year rated care as very good (41%) and the same percentage as last year rated care as good (18%). Fewer patients rated care as 'fair'; 5% rather than 8% and less rated care as poor; 2% rather than 3%.

Our composite score for patient experience which comes from the results of answers to five particular questions in the national in-patient survey improved from 62.4 to 65.3 when 2010 was compared to 2009. When we have used Patient Experience Trackers to ask in-patients how satisfied they are with care we find 84-90% respond as yes with an average of 88%.

Over the past year the Trust has concentrated most on improving areas identified in last year's patient surveys as needing improvement. The Trust scored poorly in comparison to others for responses to questions that related to staff attitudes to patients. For example some patients reported that staff talked over them as if they were not there. We have seen improvement in those scores this year through actions taken to manage staff and the way that they perform.

The Trust also scored less well than other Trusts for responses about the cleanliness of care areas, bathrooms and toilets. We have replaced a number of our toilets over the last year and refurbished bathrooms particularly in maternity and regularly monitor the cleanliness of care areas, toilets and bathrooms. We have also instigated more frequent checks of toilets in public areas and in wards and departments.

The Maximiser now scores 49 elements of the National Standards of Cleaning which is in line with CQC inspection audits. National standards require 75% minimum for a low risk area, 85% for a significant risk area e.g. labs, out patient department and high risk 95% e.g. general wards. Very high risk functional areas e.g. ITU and theatres, immuno-compromised, are required to achieve 98%. We achieve all of these standards.

Results were received in 2010 of the National Maternity survey completed by women who delivered in February 2010. This was prior to the opening of the Midwifery Led Birthing Unit and during the implementation of the maternity services action plan. Maternity scores improved compared to the previous year. The Trust increased information about scanning to address the lower score in relation to women feeling that the reason for the dating and 20 week scans were explained to them.

In November 2010 the Trust started to send out a monthly postal survey to a sample of patients a week after leaving hospital. Results for the 3 months November to January averaged 42% of patients who rated their care, rated it as excellent. Overall there was a high confidence level in ward staff, patients being treated with dignity and respect all or most of the time and involvement in care and in discharge planning.

The scores we have received this year from in-patients and from other groups indicate that patient experiences have improved but the scores also indicate that we are only average and that we still need to achieve a cultural change to make a significant difference to patient experience. During the latter part of 2010/11 we have launched our Patient First Initiative to help us to achieve this.

Results of the national in-patient survey 2010

Question	Score 2008 out of 10	Score 2009 out of 10	Score 2010 out of ten	Trust year on year comparison	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	7.3	7.1	7.3	Better	The same
Waiting lists and planned admission, answered by those referred to hospital	5.7	6.5	6.7	Better	The same
Waiting to get to a bed on a ward	7.4	7.1	7.3	Better	The same
The hospital and ward	7.6	7.7	8	Better	The same
Doctors	8.1	8.1	8.4	Better	The same
Nurses	8.1	7.9	8.3	Better	The same
Care and treatment	7.1	7.1	7.3	Better	The same
Operations and procedures, answered by patients who had an operation or procedure	7.9	8.2	8.1	About the same	The same
Leaving hospital	6.3	6.5	6.8	Better	The same
Overall views and experiences	6.4	6.2	6.5	Better	The same

Our local Luton LINks group published a report in December describing the results of their face to face surveys with patients between April and December 2010. Most patients, generally around (17-18 of 20 each time), expressed satisfaction and gave positive comments about care. When dissatisfaction was reported it tended to be in relation to information given to patients especially while waiting to go home and about the different types of staff and comments about the cleanliness of toilets and bathrooms.

The Trust continues to learn from complaints, incidents and compliments.

Number of complaints per month:

2010/11	Total
April 2010	44
May 2010	36
June 2010	49
July 2010	41
August 2010	26
September 2010	40
October 2010	40
November 2010	33
December 2010	37
January 2011	37
February 2011	36
March 2011	38

Complaints are received about variety of topics including staff communication with patients and family, the environment, processes and delivery of care or treatment and in relation to administration or waiting.

The breakdown of the subjects of complaint is as follows.

Subjects of Complaint	**Number**
Administration	35
Appointments	49
Attitude	108
Communication	106
Confidentiality	2
Discharge Arrangements	33
Facilities (including cleanliness, food, car parking)	36
Lost Property	8
Medical Care	198
Nursing care	112
Staffing Levels	1
Waiting List	11
Waiting Time	25

The number of subjects is greater than the number of complaints as some complaints include more than a one issue. Trust staff act wherever possible on comments made in complaints to improve the situation for patients.

National targets and regulatory requirements (2010/11)

Note colour achieved boxes green in final version

		2009/10	2010/11	Target 10/11
Target 1: Clostridium Difficile	To achieve contracted level of no more than 66 cases per annum (hospital acquired)	53	36	44
Target 2: MRSA	To achieve contracted level of no more than 14 cases per annum	7	1	4
Target 3: Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	TBC	96%
Target 4: Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	93.2%	TBC	85%
Target 5: Patient Waiting Times	18 week maximum wait by 2008 (from point of referral to treatment)	92%	94%	90%
Target 6: Patient Waiting Times	Maximum waiting times of 18 weeks for Non-Admitted patients from point of referral to treatment	96%	98%	95%
Target 7: Accident & Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	97.4%	98.2%	98%
Target 8: Thrombolysis	People suffering heart attack to receive thrombolysis within 60 minutes of call	100%	100%	68%
Target 9: Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	97.7%	TBC	93%
Target 10: Cancer	Maximum waiting time of 31 days from diagnosis to treatment for first treatment	100%	TBC	98%
Target 11: MRSA Screening	Screening all elective inpatients for MRSA	85%	TBC	100%

Review of quality performance - how the Trust identifies local improvement priorities

Trust Governors, the hospital patient representative and local LINks groups (Luton and Bedfordshire) have been involved again this year in determining the priorities for inclusion in these accounts.

The list of clinical indicators which were developed and added to last year, were used as the foundation for discussion. 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. Possible priorities have also been discussed with staff in management executive and general managers meetings. In addition a web-based survey on http://www.ldh.nhs.uk was used to offer members, all staff and other members of the public opportunity to comment on which clinical indicators they would most like to see reported and to tell us which quality improvements should take priority. We have been in discussion with local Overview and Scrutiny Committees while constructing this Quality Account.

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 has been a high level of agreement among the various groups of people that have contributed to determining priorities.

Any statements provided from your commissioning PCT, LINks or OSCs (in regulations) including any explanation of any changes you made to the final version of your QA after receiving those statements

Glossary

Glossary of Terms
Clinical Audit

Term	Definition
Anticoagulation	A substance that prevent/stops blood from clotting
Arthroscopy	A procedure that uses a piece of equipment to examine/treat the interior of a body joint e.g. knee, shoulder, through a small incision.
Avascular necrosis	A disease where cells in the bone die due to interruption or loss of the blood supply.
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
Colonoscopy	Internal examination of the larger bowel & end part of the small bowel using a flexible tube and camera.
Compression Hosiery	Socks/stockings used to apply pressure to help the veins carry blood back to the heart.
Dementia	A state of serious mental deterioration.
Depression	A mental state where there is low mood & loss of interest/pleasure in normal daily activities.
Epidural	Type of anaesthetic using an injection of drugs into the spinal canal.
Epilepsy	Recurrent disorder characterised by seizures.
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercholesterolemia	The presence of high cholesterol in the blood.
Hypothermia	Abnormally low body temperature.
Laparoscopic	Key hole surgery
Medications Adherence	Taking medications as prescribed.
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked & heart muscle is damaged.
Neonatal	Newborn – includes the first six weeks after birth.
Percutaneous	A medical procedure where access to body organs/body tissue is performed via a needle puncture.
Platelets	Small round / oval discs in the blood that help in the formation of blood clots.
Pressure Ulcer	Bed sore.
Prophylaxis	Prevention or protective treatment.

Renal	Relating to the kidneys.
Seizure	Fit, convulsion.
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
Septoplasty	Surgical procedure to straighten the nose.
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply,
Surgical Site Infection	An infection occurring at the site of a surgical incision.
Transient Ischaemic Attack (TIA)	Mini - stroke
Ultrasound	Use of high energy sound to produce pictures (scans) of body organs/tissues.

Research – Glossary of terms

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

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

Quality Accounts 2010-11: APPENDIX 1

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

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
Non rigid Stabilisation (Dynesis) of the Lumbar Spine (NICE Interventional Guidance 183)	Orthopaedics (Spinal)	Baseline Audit	April 2010	Local outcomes in line with international data. Recommendation: Development of self –assessment questionnaire based upon Oswestry Index & Prolo Score system.
Trust wide Surgical Site Infection (NICE Guideline 74 & Local Policy)	Microbiology & Anaesthetics	Baseline Audit	April 2010	Improve uptake of local policy for prophylactic antibiotics Improve completion of documentation
Head Injury (In-patient Management – Adults) (NICE Guideline 56)	Orthopaedics	Baseline Audit	April 2010	Improve frequency of neuro-observations Patient information leaflets: Head Injury, alcohol & substance misuse Referral pathway to Head Injury clinic post discharge
Urinary Tract Infection in Children (NICE Guideline 54)	General Paediatrics	Re-audit	May 2010	Re-audit demonstrated improvements. 7 /15 standards achieved > 90% compliance. Ongoing actions: - Documentation of full medical histories - Infants < 3miths to be treated with parenteral antibiotics.
Epidural Analgesia in Colorectal Surgery (L&D Guidelines for Epidural Management)	General Surgery	Baseline Audit	June 2010	The use of Epidural Analgesia to be consistently recorded on the IPM Theatre module. Re-launch local guidelines (to be updated) for post operative observations .
Use of Drotrecogin Alfa for the Management of Severe Sepsis (NICE TA 84 & European Medicines Evaluation Agency Standards)	Anaesthetics & Microbiology	2nd Re-audit	June 2010	Re-audit has shown full compliance with all 3 standards for the use of Drot. Alfa. Internal dept. audits at 6/12 intervals.

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
Antenatal Screening (NICE Guideline 62)	O&G	Re-audit	June 2010	Re-audit took into account previous action plan: Amendments made to Maternity documentation. New deputy screening coordinators introduced Sept 2009 Recommendations: Explore early booking visits to help improve access to Nuchal Screen service Introduction of monthly alert lists to named Consultant Haematologist for 'at risk' couples.
Percutaneous Disc Compression (NICE Interventional Guidance 173 & International literature)	Orthopaedics	Baseline Audit	July 2010	Local outcomes demonstrated 3 or 4 Audit standards achieved >90% compliance Recommendations: Development of self –assessment questionnaire based upon Oswestry Index & Prolo Score system. To introduce patient self assessment functional questionnaire (pre & post op)
Skin incision for Basal Cell Carcinoma (British Association of Dermatology Guidelines & International publications)	Dermatology	Baseline Audit	July 2010	Local outcomes demonstrated > 90% compliance in both auditable standards. Recommendations: Adopt new local standards for histological surgical margins Dissemination across local skin cancer forums
Clinician Survey for Improving Medications Adherence (NICE Guideline 76)	Medicine	Baseline Survey	July 2010	The survey demonstrated awareness of the guideline principles. Recommendations: Training of junior doctors & pharmacists on applying NICE interventions Update appointment letters advice to patients Develop display posters within clinical areas advising patients to raise medication concerns with

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				clinician at consultation.
Inadvertent peri-operative hypothermia (NICE Guideline 65)	Anaesthetics (Trust wide)	Baseline Audit	August 2010	Areas for improvement across the range of audit standards. Recommend: Patient information to raise awareness of risks of peri-operative hypothermia Explore options to introduce pt. warming devices Improve temperature observation prior to anaesthetic induction & immediately post operatively (Theatre Recovery)
Patient/Carer Survey of Medicines Adherence (NICE CG 76)	Paediatrics	Baseline Survey	August 2010	Parent / carer feedback. Actions plan ties in with General Medicine recommendations
Privacy & Dignity (Essence of Care & Local Guidelines)	Trust wide	Re-audit	August 2010	The re-audit demonstrated several areas of improvement. Actions which are to continue: MDT training programme for P&D Designated ward/clinic areas for confidential discussions with patients/carers Application of SMURF principles across all clinical areas.
Assessment of VTE Risk in Obstetrics (NICE Guideline 92)	O&G	Baseline Audit	August 2010	Baseline assessments across 13 standards; Action plan: Improve assessment & documentation of BMI in Obstetric cases Develop local clinical protocol based on national guidance Introduction of admissions proforma to include VTE risk assessment pathway
Electro-fetal Monitoring & Intrapartum	O&G	Baseline	August	Baseline assessments across 29 auditable

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
Care (NICE Guideline 55, CNST & Local Policy)		Audit	2010	standards, showed that 26 scored >90% compliance rate. Recommendations: Promote use of CTG Interpretation Sticker Indications for Fetal Blood sampling within Drills & Skills training programme.
Pressure Ulcer Policy (NICE CG 29 & Local Policy)	Trust wide	Re-audit	October 2010	Re-audit showed Trust wide prevalence rate of 14.9%. Hospital acquired 6.4% Ongoing actions: Waterlow assessment within 6 hrs of admission Improve schedule of re-assessments RCA for all grade 3 & 4 Hosp. Acquired Pressure Ulcers Increase Patient Information re: risk factors
Initial Assessment of Emergency Asthma (BTS & GINA Guidelines)	Resp. Medicine	Baseline Audit	October 2010	Compliance of >90% for 4 out of 6 auditable standards. Recommendation: Promote assessment criteria within emergency care Integrate asthma assessment within Junior doctor training programme
Learning Disability Audit (Six Lives Report): 3 Cross organisational Surveys	Trust wide	Baseline Audit	October 2010	Audit findings presented at Grand Round to help raise awareness of Six Lives report. Recommendations: Promote role of the LD Nurse Improve access to LD Training events Improve regular feedback from pts/carers at discharge & attendance to clinics Investigate 'Flagging system' on IPM system
Carotid Endarterectomy (Publication data 1998 & European	DME Stroke	Baseline Audit	October 2009	Baseline assessment shows areas for improvement across 3 audit standards:

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
Carotid Surgery Trial 2003)				Recommendations: Update referral pathway for carotid imaging for symptomatic patients Establish MDT meeting to improve 'pick up' rates.
Long length of Hospital Stay- Abdominal Pain (Dr. Foster RTM benchmark data)	General Surgery	Re-audit	October 2010	Dr. Foster RTM report continued to trigger long LOS. Re-audit shows improvements in waiting time for in-patient CT & USS imaging Majority of cases required LoS > 2days due to clinical need 100% correlation between electronic discharge date & documented discharge date in paper record.
Graduated Compression Hosiery (Links to NICE Guideline 92)	Orthotics	Baseline Surveys	Oct 2010	Patient feedback. Baseline assessment of referrals to Orthotics for cor hosiery. Recommendations: Introduce single orthotic referral form for Compression hosiery Re-design patient information leaflet Patient to have copy of Orthotics discharge Letter to GPs/Pharmacist
Surgical tooth extractions: Local Day case rate (Links to Dr. Foster RTM)	MFS	Re-audit	Nov. 2010	Dr. Foster RTM report continued to trigger alerts within the overall tooth extraction Day Case rate. Audit focused on local Referrals only, where majority of cases expected to be performed as day cases. Findings showed an actual in-patient rate of 2% for local cases (in line with national rate). Recommendations: Improve timeliness of pre-operative

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				Assessment. Reduce discrepancies between waiting list Management (intended day cases) vs. IPM records (booked as in-pts.)
Flexi-kids Physiotherapy Programme Surveys	Therapies	Service Evaluation	Nov. 2010	Baseline parental survey. Clinical Assessment audit. Findings have been integrated into the ongoing development of the service. One action will be to trial a revised fexikids Appointment programme.
Acutely Ill Patients (NICE Guideline 50)	Trust wide (Anaesthetics)	Re-audit	Nov. 2010	Total of 10 auditable standards across 3 sections. Re-audit has demonstrated several areas of improved compliance. Ongoing actions & recommendations: Revision of transfer documentation (ITU to General wards) Critical Care Network formulating a generic Discharge summary fro use ITU & HDU Cases. Outreach team to help roll out Track and Trigger System across the Trust.
Trust wide Completeness of the Surgical Admissions Proforma	Trust (Anaesthetics)	Re-audit	Nov. 2010	Comparative review of how well teams fully Complete the admissions proforma. Results has demonstrated similar levels of Compliance trust wide. The proforma Continues to provide essential clinical information within one document. Recommendations: Education & training programme to improve awareness of the tool. The proforma is due

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				for updating and will be re-launched.
Venous Thromboembolism – Medical (NICE Guideline 92)	Medicine	Baseline Audit	Nov. 2010	Baseline audit of 5 auditable standards. Need to improve admission assessment. >90% of eligible patients received Pharmacological prophylaxis. Findings presented at Grand Round to raise Awareness. Action plan: Development of local VTE assessment tool Ward spot checks VTE to be integrated within the development of an electronic prescribing chart.
Management of Gonorrhoea (BASHH Guidelines)	GU Medicine	Re-audit	Nov. 2010	Re-measure compliance across eight audit Standards. Re-audit has demonstrated that 100% (full) compliance over 5 standards (vs. 4 standards baseline audit) Principal recommendation: Ensure all patients receive written information & advice leaflet.
Cataract Day Case Surgery (Links to Dr. Foster RTM Report) March 2009-Sept 2010	Ophthalmology	Re-audit	Dec. 2010	Dr. Foster RTM report (2009-10) continued to trigger alerts within the procedure Day Case rate. Review of case entered onto Waiting list during April 2010. Audit has demonstrated improvements in Correlation of discharge dates (IPM vs. Medical notes) The actual in-patient rate of 1% (in line with National rate. Continued actions: Clinicians to clearly state intended

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				Management at waiting list booking. Recent Dr. Foster reports have shown Improved local day case rate.
Trust wide Health Records Audit (NHSLA, CQC, RCP & Local Policy)	Trust wide	Re-audit	Dec. 2010	Comparative audit by directorate & Subspecialty groups. Includes paper & electronic records. Supplements internal audit process. Findings formally presented at Grand Round annually. Actions are integrated into divisional & sub-specialty governance plans.
Baby Records & Admission Form (Local Documentation Protocols)	Neonatal & Maternity	Audit	January 2011	To measure the completeness & accuracy of documentation within NICU & Post natal Ward areas. Findings identified areas of good practice in both locations. Areas requiring targeted interventions will be taken forward through local Junior Doctor induction and ongoing programme of mini spot checks.
Emergency Admissions to Hospital: Patients with confirmed diagnosis of Lung Cancer. (NICE Cancer Service Guidance; Suppo & Palliative Care. NICE Guideline 24 Cancer Reform Strategy 2007-2009)	Respiratory Medicine (Admissions to All teams)	Audit	January 2011	To measure primary causes for emergency presentation & admission to hospital; involvement of Community services pre-presentation, in-patient review by the Respiratory team, avoidable vs. non avoidable admissions. Action plan : Improve pathways within the Community re: symptom management and referral to hospital team. Re-launch internal referral pathway

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				to the Respiratory Physicians for inpatient review.
Supporting Medications Adherence in the Elderly (NICE Guideline 76) International publications	DME	Survey	January 2011	The survey demonstrated awareness of the guideline principles. Recommendations within DME link with medical action plan.
Induction of Labour: (NICE CG70, Local Policy & CNST)	O&G	Baseline Audit	January 2011	16 NICE Auditable Standards: 56% achieved high compliance (90-100%). 31% achieved 70-89% compliance. Both local standards fully met (100%). Awareness of actions will continue to be cascaded as part of Obstetric Study days & Delivery Suite Forums.
Use of Ultrasound for Insertion of Central Venous Catheters (NICE TA 49)	Anaesthetics & Vascular Access Team	Re-audit	January 2011	To re-measure compliance across three principal audit standards. Results show that two standards were fully met. Improvements shown in the % of elective cases and fewer procedure related complications. The project leads will continue to work with Training & Education Dept to improve uptake to onsite training sessions.
Communication Audit a) Patient Survey b) Observational audit	Trust wide	Re-audit	January 2011	To re-measure patient experience relating to Communication in hospital following completion of 2007 action plan. Results show improvements relating to ability to raise with staff & then acted upon, feeling well informed about procedures.
Venous Thromboembolism – General Surgery House of Commons Health Committee 2005	Gen. Surgery	Baseline Audit	January 2011	5 core auditable standards identified. 165 cases Oct-Nov 2010. 90-100% compliance: 2 standards 80-89% compliance: 2 standards

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
(NICE Guideline 92)				Action plans includes actions to improve Compliance relating to early mobilisation (where appropriate) & continue programme Of ward spot checks re: use of risk assessment tool.
Hospital Length of Stay Septoplasty Procedures (Links to Dr. Foster RTM)	ENT	Baseline Audit	February 201	Dr. Foster RTM reports continue to trigger alerts within the day case rate: procedure group of submucous resection. Septoplasty is one of four procedures falling within this category & is predominantly booked as an in-patient procedure locally. The audit identified that the intended Management recorded on the waiting list & Health record entries was not always replicated on the Trust IPM system (source of Waiting list Management data). 72% actually incurred an in-patient stay (vs. national expected rate of 52%) & included a small number of cases undertaken on an evening theatre list. Action plan to improve waiting list booking Protocols.
Day Case Arthroscopy (Dr. Foster RTM)	Orthopaedic Surgery	Baseline Audit	February 201	Dr. Foster RTM reports continue to trigger alerts within the local procedure Day Case rate. Retrospective review of caseload over a 3 month period to help identify factors which impact intended management & actual length of stay. 18% of cases had evening surgeries.

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				21% booked as day case actually stayed overnight. Recommendations include review of arthroscopy booking protocols & waiting list management.
Respiratory Physiotherapy Twilight Service	Therapies	Evaluation	February 201	A trial service ran from Feb-May 2010. The evaluation assesses the impact of the Service to the routine on-call physiotherapy Service, the number of patients who Accessed the service during the trial period, Identify future service provision. Actions: 1. Review Physiotherapy 'core' operational Business case for permanent Twilight service.
Diagnosis & Management of Stroke & TIA (NICE CG 68/Quality Standard)	DME	Baseline Audit	February 201	To measure local compliance against NICE auditable standards (sub-divided into 7 main categories). Recommendations include target actions to be led across the Trust by the MDT Stroke Team: Promote use of FAST Screening tool & Stroke Pathway & improve Early access to brain imaging.
Prophylaxis against Infective Endocarditis (NICE CG 64)	Microbiology & Cardiology	Clinician Survey	February 201	Historically, the use of antibiotics as a preventative measure to prevent infective endocarditis has been based on empirical evidence. NICE recommend that the use of prophylaxis needs to be weighed against possible adverse effects of antimicrobials. The aim of the survey was to assess clinician's awareness of the guidance principles. The results identified the need to develop integrate NICE recommendations

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				into a local clinical protocol.
Documentation & Electronic Data Quality for Patients admitted for ENT procedures	ENT	Re-audit	February 201	To re-measure outcomes following implementation of the 2009 action plan. Findings show improvements in the correlation of electronic data & hard copy health record entries across several key areas. Ongoing actions to ensure that Waiting list forms are maintained within Patient records.
Trust wide Hygiene Audit (Essence of Care)	Trust wide	Re-audit	March 2011	The project is divided into 3 survey areas: - Patient survey (assisted) - Patient survey (self completed) - Observer / reviewer survey Several areas of improvement following the 2009 action plan. Targeted improvements identified include: - helping patients with their hair washing - Increase provision of water Thermometers across Trust ward Areas.
Laparoscopic Sub-total hysterectomy (Links to NICE IP 239)	O&G	Baseline Audit	March 2011	The procedure was introduced within the Trust during late 2007, following an application to the new procedure committee. The audit measures local procedure Outcomes, and findings are in line with the studies reviewed by NICE. The clinical team will continue to audit LSH cases.
Diabetes in Pregnancy (NICE CG 63)	O&G	Baseline audit	March2011	The audit is divided into two sub-groups • patients with pre-existing diabetes • gestational diabetes.

Title/Topic	Directorate/ Specialty	Project Type	Completed	Intended action to improve the quality of healthcare provided
				To measure local compliance against NICE standards for each category. The findings will inform the ongoing development of the gestational Diabetes service, including life style advice interventions. The Trust is working with the PCT to assess setting up a local support Group. Joint hospital & primary care teaching programme is in place for women with pre-existing diabetes, advice on pre-conception care & reducing risk of unplanned pregnancy.
Inter-consultant in-patient referrals to ENT Teams. (Local Policy)	ENT	Baseline audit	March 2011	The audit reviewed completeness and accuracy of inter-consultant referral documentation & compliance with the Trust's policy. General compliance was high. Recommendations include the referrer to Include specific clinical questions to be Addressed by the recipient team & clarity on the urgency of the review.

Appendix 2
Other National Clinical Audits & National Datasets

Audit	Organised by:	Data period	Cases identified
K20 Inpatient Project: - Haematology - Lower GI	Mount Vernon Cancer Network	May – July 2010	Haematology: 57 Lower GI: 60
K20 Survivorship Audit (Picker): Trust participated Prostate Cancer - Retrospective Case reviews - National Patient Questionnaire: Test Community projects postal questionnaire	National Cancer Action Team	June – July 2010	Local Case reviews 100 (100%) Overall national response rate: 62% (all cancers)
K 20 National Patient Experience Audit - All adults with primary diagnosis of cancer 1st Jan – 31st March 2010	DH/Quality Health	Jan – March 2010	461 Patient questionnaires: 68% Trust response rate
British Association of Surgical Oncologists (BASO): Screen detected Breast cancers	BASO	April – Nov. 2010	All screen detected cancers 1.4.09-31.03.10
Depression detection & long term sickness Absence (NICE PHG 2009)	Royal College of Psychiatrists	Eligible Consultations Jan – Aug 2010 N = 40	NA
National Colonoscopy Audit	British Society of Gastroenterology	All cases Undergoing Colonoscopy	Project continues
Thrombosis VTE Annual Organisational Survey	All Parliamentary Thrombosis Group	CQUIN Questionnaire	NA
Pain Management Clinics: failed back pain surgery - Organisational Survey	University of York	Organisational Questionnaire	NA
Avascular necrosis/Bisphosphonate related jaw necrosis. - Clinical Audit	Faculty of General Dental Practice	Prospective case selection	Project continues
Public Health Guidance: Implementing guidance in the workplace (NICE PHG 5,8,13,10 & CG43) - Organisational Audit	Royal College of Physicians HEALTH & Work Development Unit	Organisational Questionnaire	NA
Quality Evaluation Tool - self evaluation tool; staffing; service structure; user experience; training needs	Royal College of Speech & Language Therapists	Organisational evaluation	NA
National Anticoagulation Computer System:	DAWN Benchmarking	All system entries	NA
National Audit of Wisdom Tooth Extraction: Process (NICE TA 1)	British Association of Oral Maxillofacial Surgeons	10 cases per team (x5)	100%

National database / Registries	Organisation	Data submissions
Rare Disorders of Pregnancy	UK Obstetric Surveillance System UKOSS)	Ongoing
Cancer National database / Registries	**Organisation**	**Data submissions**
Cancer National Databases: - Urology - Upper GI	BAUS AUGIS	Ongoing
Cancer Registry (East of Endland): - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	Eastern Cancer Registry & information Centre (ECRIC)	Ongoing. All cases discussed at Cancer MDT meetings. Submissions within 15 working days from the month of MDTs
Open Exeter: a) Month of First Treatment b) Month of Subsequent Treatment - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Referrals via NHS Screening Services: - Breast - Gynaecology - Colorectal	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Two week Wait Referrals: - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Routine & Urgent Referrals: - Breast	NHS Connecting for Health	Monthly: Within 25 working days of the month

		end.
Open Exeter: Rare Cancer Referrals treated within 31 days of receipt of referral: - Haematology - Children's Cancers - Testicular	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Routine referrals which are upgraded by clinician & treated within one month: - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	NHS Connecting for Health	Ongoing

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Meeting:	**Social Care Health and Housing Overview & Scrutiny Committee**
Date:	**07 June 2011**
Subject:	**Draft Work Programme 2011–2012 & Executive Forward Plan**
Report of:	**Richard Carr, Chief Executive**
Summary:	The report provides Members with details of the currently drafted Committee work programme and the latest Executive Forward Plan.

Contact Officer:	Jonathon Partridge, Scrutiny Policy Adviser (0300 300 4634)
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

The work programme of the Social Care Health and Housing Overview & Scrutiny Committee will contribute indirectly to all 5 Council priorities.

Financial:

n/a

Legal:

n/a

Risk Management:

n/a

Staffing (including Trades Unions):

n/a

Equalities/Human Rights:

n/a

Community Safety:

n/a

Sustainability:

n/a

RECOMMENDATION(S):

1. that the Social Care Health and Housing Overview & Scrutiny Committee

(a) considers and approves the draft work programme attached, subject to any further amendments it may wish to make;

(b) considers the Executive Forward Plan; and

(c) considers whether it wishes to add any further items to the work programme and/or establish any Task Forces to assist it in reviewing specific items.

Work Programme

1. Attached at **Appendix A** is the currently draft work programme for the Committee. The Committee is requested to consider the draft programme and amend or add to it as necessary. This will allow officers to plan accordingly but will not preclude further items being added during the course of the year if Members so wish and capacity exists.

2. Also attached at **Appendix B** is the latest version of the Executive's Forward Plan (1 June 2011 to 31 May 2012) so that Overview & Scrutiny Members are fully aware of the key issues Executive Members will be taking decisions upon in the coming months. Those items relating specifically to this Committee's terms of reference are shaded in grey.

Task Forces

3. In addition to consideration of the work programme, Members will also need to consider how each item will be reviewed i.e. by the Committee itself (over one or a number of Committee meetings) or by establishing a Member Task Force to review an item in greater depth and report back its findings.

Conclusion

4. Members are requested to consider and agree the attached work programme, subject to any further amendments/additions they may wish to make and highlight those items within it where they may wish to establish a Task Force to assist the Committee in its work.

Appendices:
Appendix A – Draft Social Care Health and Housing Overview & Scrutiny Committee Work Programme
Appendix B – The Executive Forward Plan for the period 1 June 2011 to 31 May 2012

Background Papers: (open to public inspection)
None.

Location of papers: Priory House, Chicksands

Appendix A

Draft Work Programme for Social Care, Health and Housing Overview & Scrutiny Committee 2011 - 2012

Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
1.	1 August 2011	Quality, Innovation Productivity and Prevention (QIPP)	To present to the Committee with an update from 22 November on the programme for QIPP.	NHS organisations at regional and local level have QIPP plans in place to address the quality and productivity challenge. Supporting these are twelve national work streams designed to help NHS staff successfully deliver these changes. Five work streams relate to commissioning of care and five relate to the running and staffing of NHS organisations. Two focus on primary care commissioning and contracting, and digital technology.
2.	1 August 2011	Directorate approach to the Corporate Web Strategy	The Committee will receive a presentation on the Council's Web Strategy in relation to customers accessing Adult Social Care Services via the Council's Website.	The Committee to consider and discuss what the Directorate can do to ensure customers are aware of and use the web to contact the Directorate. This is an opportunity for established and potential service users to contact and communicate with the Council, particularly the most vulnerable in the region.

NOT PROTECTED
Note: an item on the Committee's work programme will be received at each meeting.

Last Update: 08 June 2011

Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
3.	1 August 2011	Adult Social Care: Customer Feedback – Complaints, Compliments Annual Report 2010/11	To provide members of the Committee with a report relating to the number of cases received; complaint outcomes (upheld/not upheld); learning and improvements resulting from complaints; and cases referred to the Local Government Ombudsman.	The purpose of this report is to fulfill the duty to produce an annual report of the complaints procedure for Adult Social Care for 2010/11.
4.	1 August 2011	Tenant local offers and annual report	The Committee will receive a report regarding the local offers with tenants and the annual report that is produced by tenants.	
5.	1 August 2011	HealthWatch Transition Plan	The Committee will consider a report regarding the transition of the Bedfordshire Local Involvement Network (LINk) to a Healthwatch organisation	
6.	1 August 2011	Q4 Performance Monitoring Report	To receive the performance position for the Social Care Health and Housing Directorate.	The Committee will receive a statement of the position Directorate's performance for Q4 Executive: 12 July 2011
7.	1 August 2011	Q4 Budget Monitoring Report	To receive the budget position for the Social Care Health and Housing Directorate.	The Committee will receive a statement of the position Directorate's budget for Q4 Executive: TBC
8.	12 September 2011	TBC	TBC	Potential Member site visits.

NOT PROTECTED

Note: an item on the Committee's work programme will be received at each meeting.

Last Update: 08 June 2011

Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
9.	24 October 2011	Annual report of Bedford and Central Bedfordshire Adult Safeguarding Board	To receive the annual report of Bedford and Central Bedfordshire Adult Safeguarding Board.	The board is an independent body and the consideration of this report is considered good practice. Executive: 23 August 2011
10.	24 October 2011	Health reform implications	To receive a report outlining the major implications of recent health reforms on Central Bedfordshire	
11.	24 October 2011	Q1 Budget Monitoring Report	To receive the quarter 1 budget position for the Social Care Health and Housing Directorate	Executive: 4 October 2011
12.	12 December 2011	Strategic Tenancy Policy	The Government proposes a new Affordable Rent, for Housing Association new-build accommodation and re-lets of existing accommodation, which will be at up to 80% of market rents. The Council is required to produce a Strategic Tenancy Policy, which will also set out a position on flexible tenancies.	The Council's Strategic Tenancy Policy will have implications for the affordability of accommodation in Central Bedfordshire and, depending on the Council's position, could adversely impact on the delivery of new affordable housing, and could result in major sites becoming stalled. In addition, the Policy will set out the Council's position on flexible tenancies and how they should be used. The date for this item is provisional and subject to confirmation closer to the meeting date.

NOT PROTECTED
Note: an item on the Committee's work programme will be received at each meeting.

Last Update: 08 June 2011

Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
13.	12 December 2011	Transition of Bedfordshire Community Health Services to the South Essex Partnership University NHS Foundation Trust (SEPT)	To receive a report outlining progress in relation to the transition of Bedfordshire Community Health Services to SEPT.	
14.	23 January 2012	Q2 Budget Monitoring Report	To receive the quarter 2 budget position for the Social Care Health and Housing Directorate	Executive: 10 January 2012
15.	5 March 2012	TBC		
16.	12 April 2012	Q3 Budget Monitoring Report	To receive the quarter 3 budget position for the Social Care Health and Housing Directorate	Executive: 27 March 2012

Work Programme Items TO BE SCHEDULED			
Ref	**Report Title**	**Report description**	**Comment**
17.	Asset management of sheltered housing consultation plan and approach	TBC	There will be a series of 4 items that will be added to the work programme of the OSC in order to feed into Executive discussions. These meetings will focus on providing an opportunity for residents to attend to raise their views.
18.	Self-financing	TBC	TBC
19.	Sheltered Housing Review	TBC	A consultation in relation to the sheltered housing review is due to complete in December 2011. This will be added to the work programme following the completion of the consultation.

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Appendix **B**

Central Bedfordshire Council
Forward Plan of Key Decisions
1 June 2011 to 31 May 2012

1) During the period from **1 June 2011 to 31 May 2012,** Central Bedfordshire Council plans to make key decisions on the issues set out below. "Key decisions" relate to those decisions of the Executive which are likely:

   - to result in the incurring of expenditure which is, or the making of savings which are, significant (namely £200,000 or above per annum) having regard to the budget for the service or function to which the decision relates; or

   - to be significant in terms of their effects on communities living or working in an area comprising one or more wards in the area of Central Bedfordshire.

2) The Forward Plan is a general guide to the key decisions to be determined by the Executive and will be updated on a monthly basis. Key decisions will be taken by the Executive as a whole. The Members of the Executive are:

Executive Member

To be appointed at the Council's AGM on 19 May 2011

3) Those items identified for decision more than one month in advance may change in forthcoming Plans. Each new Plan supersedes the previous Plan. Any person who wishes to make representations to the Executive about the matter in respect of which the decision is to be made should do so to the officer whose telephone number and e-mail address are shown in the Forward Plan. Any correspondence should be sent to the contact officer at the relevant address as shown below. General questions about the Plan such as specific dates, should be addressed to the Head of Democratic Services, Priory House, Monks Walk, Chicksands, Shefford SG17 5TQ.

4) The agendas for meetings of the Executive will be published as follows:

Meeting Date	Publication of Agenda
15 March 2011	03 March 2011
05 April 2011	24 March 2011
31 May 2011	19 May 2011
12 July 2011	30 June 2011
23 August 2011	11 August 2011
4 October 2011	22 September 2011
15 November 2011	3 November 2011
6 December 2011	24 November 2011
10 January 2012	22 December 2011
14 February 2012	2 February 2012
27 March 2012	15 March 2012
15 May 2012	3 May 2012

Central Bedfordshire Council

Forward Plan of Key Decisions for the period 1 June 2011 to 31 May 2012

Key Decisions

Date of Publication: 13.05.11

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
1.	Local Economic Plan -	To approve the Central Bedfordshire Local Economic Plan.	12 July 2011		Draft final Local Economic Plan	Executive Member for Sustainable Communities – Strategic Planning & Economic Development Comments by 11/06/11 to Contact Officer: James Cushing, Head of Economic Policy Email james.cushing@centralbedfordshire.gov.uk Tel: 0300 300 4984
2.	Biggleswade Town Centre Strategy and Masterplan -	To consider and formally adopt the Biggleswade town centre strategy and masterplan as a supplementary planning document.	12 July 2011	Non statutory consultation – July 2009 comprising public exhibition Non statutory consultation – 3 July to 27 August 2010, 4 public exhibitions in addition to web and print consultation methods Formal statutory consultation – Early November 2010 for a period of four to six weeks	Biggleswade town centre strategy and masterplan	Executive Member for Sustainable Communities – Strategic Planning & Economic Development Comments by 11/06/11 to Contact Officer: Liz Wade, Assistant Director Economic Growth and Regeneration Email: liz.wade@centralbedfordshire.gov.uk Tel: 0300 300 6288

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
3.	Award of Contract: 24/7 Community Alarm and Emergency out of hours telephone call handling service -	To award the contract.	12 July 2011		Tender report	Executive Member for Social Care, Health & Housing Comments by 11/06/11 to Contact Officer: Basil Quinn, Housing Asset Manager Performance Email: basil.quinn@centralbedordshire.gov.uk Tel: 0300 300 5118
4.	Post 16 Transport Policy -	To approve the draft policy to be implemented from September 2012.	12 July 2011	Consultation to run between 9 May 2011 and 24 June 2011. Workshops to be held with schools, colleges, neighbouring authorities and Youth Parliament.	Report Consultation forms and feedback Draft policy Equality Impact Assessment	Executive Member for Children's Services Comments by 11/06/11 to Contact Officer: Sylvia Gibson, Interim Assistant Director, Learning and Strategic Commissioning or Ben Pearson, Head of Joint Strategic Commissioning Email: sylvia.gibson@centralbedfordshire.gov.uk Tel: 0300 300 5522 or ben.pearson@centralbedfordshire.gov.uk Tel: 0300 300 5679

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
5.	Business Case for Integrated Children's System Improvement -	To consider the business case for the procurement of a replacement Integrated Children's System and improvement of related processes and workflows.	12 July 2011		Report	Executive Member for Corporate Resources Comments by 11/06/11 to Contact Officer: Clive Jones, Assistant Director Customer and Systems Email: clive.jones@centralbedfordshire.gov.uk Tel: 0300 300 4168
6.	Consultation on Central Bedfordshire's draft Approach to Parking Management -	To consider the consultation on Central Bedfordshire's draft Approach to Parking Management.	12 July 2011	Members and Town and Parish Councils Exhibitions at Priory and Watling House Tuesday 6 June 2011	Draft Approach to Parking Management	Executive Member for Sustainable Communities Services Comments by 11/06/11 to Contact Officer: Basil Jackson, Assistant Director Highways & Transport Email: basil.jackson@centralbedfordshire.gov.uk Tel: 0300 300 6171
7.	Budget Management - Provisional Outturn 2010/11 -	To provide information on the budget outturn as at 31 March 2011.	12 July 2011		Report	Executive Member for Corporate Resources Comments by 11/06/11 to Contact Officer: John Unsworth, Interim Assistant Director of Finance Email: john.unsworth@centralbedfordshire.gov.uk Tel: 0300 300 6147

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
8.	Community Engagement Strategy -	To endorse the refresh of the Community Engagement Strategy.	23 August 2011		Report	Leader of the Council Comments by 22/07/11 to Contact Officer: Ian Porter, Assistant Director Policy, Partnerships & Performance Email: ian.porter@centralbedfordshire.gov.uk Tel: 0300 300 6529
9.	Transforming learning and our relationship with schools - Review of school places in Leighton & Linslade -	To consider the responses to the consultation on the preferred option(s) and to authorise the publication of statutory notices.	4 October 2011		Education Vision, Children and Young People's Plan, Learning Transformation Dunstable and Houghton Regis Review Protocol	Executive Member for Children's Services Comments by 03/09/11 to Contact Officer: Sylvia Gibson, Interim Assistant Director, Learning and Strategic Commissioning Email: sylvia.gibson@centralbedfordshire.gov.uk Tel: 0300 300 5598
10.	Budget Management Report - Quarter 1 -	To consider the quarter 1 budget management report.	4 October 2011		Report	Executive Member for Corporate Resources Comments by 03/09/11 to Contact Officer: John Unsworth, Interim Assistant Director of Finance Email: john.unsworth@centralbedfordshire.gov.uk Tel: 0300 300 6147

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
11.	Transforming learning and our relationship with schools - Review of school places in Leighton & Linslade -	To approve the statutory proposals and financial commitment to implement the chosen option.	15 November 2011		Education Vision, Children and Young People's Plan, Learning Transformation Dunstable and Houghton Regis Review Protocol	Executive Member for Children's Services Comments by 15/10/11to Contact Officer: Sylvia Gibson, Interim Assistant Director, Learning and Strategic Commissioning Email: sylvia.gibson@centralbedfordshire.gov.uk Tel: 0300 300 5598
12.	Central Bedfordshire Approach to all Age Skills -	To approve Central Bedfordshire's approach to All Age Skills in order to: A: establish the priorities and actions requirement to ensure the skills challenges facing Central Bedfordshire can be met; and B: demonstrate the Council's commitment to demonstrate leadership in driving the skills agenda forward.	15 November 2011	Workshops and focus groups will be held throughout May/June with partners, stakeholders and individuals. From July – September the Council will be running a formal consultation for a minimum of 13 weeks.	Local Economic Assessment	Executive Member for Sustainable Communities – Strategic Planning and Economic Development Comments by 14/10/11 to Contact Officer: Kate McFarlane, Head of Community Regeneration & Adult Skills Email: kate.mcfarlane@centralbedfordshire.gov.uk Tel: 0300 300 5858

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
13.	Budget Management Report - Quarter 2 -	To consider the quarter 2 budget management report.	6 December 2011		Report	Executive Member for Corporate Resources Comments by 05/11/11 John Unsworth, Interim Assistant Director of Finance Email: john.unsworth@centralbedfordshire.gov.uk Tel: 0300 300 6147
14.	Review of Central Bedfordshire Council Library Service -	Approval is sought to: A: agree the Central Bedfordshire vision for the Libraries Service; and B: agree a sustainable model of future Library Service provision.	6 December 2011	Throughout May/June a series of focus groups and workshops with service users and partners and stakeholders. From July – September/October a formal consultation for a minimum of 13 weeks on the vision and potential service delivery models.	Emerging vision, core service offer and aspiration Libraries Service Review Report Outcomes from consultation process Equality Impact Assessment	Executive Member for Sustainable Communities Services Comments by 05/11/11 Kate McFarlane, Head of Community Regeneration & Adult Skills Email: kate.mcfarlane@centralbedfordshire.gov.uk Tel: 0300 300 5858

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
15.	Gypsy & Traveller DPD -	To recommend to Council the adoption of the Gypsy & Traveller DPD.	10 January 2012	Statutory LDF consultation process and Examination by Planning Inspector.	Gypsy & Traveller DPD (DLF North)	Executive Member for Sustainable Communities – Strategic Planning and Economic Development Comments by 09/12/11 to Contact Officer: Richard Fox, Head of Development Plan Email: richard.fox@centralbedfordshire.gov.uk Tel: 0300 300 4105
16.	Award of the Housing Responsive Maintenance and Void Repairs Contract -	To award the housing responsive maintenance and void repairs contract.	10 January 2012		Report	Executive Member for Social Care, Health & Housing Comments by 09/12/11 to Contact Officer: Basil Quinn, Housing Asset Manager Performance Email: basil.quinn@centralbedfordshire.gov.uk Tel: 0300 300 5118
17.	Community Safety Partnership Priorities and the Community Safety Partnership Plan for 2012-2013 -	To adopt the Community Safety Partnership Priorities and the Community Safety Partnership Plan for 2012-2013.	27 March 2012	Strategic Assessment & Partnership Plan will be considered at the Community Safety Partnership Executive meeting in November/December, Overview and Scrutiny Committee and the Local Strategic Partnership.	Strategic Assessment Priorities & Community Safety Partnership Plan 2012-2013	Executive Member for Sustainable Communities Services Comments by 26/02/12 to Contact Officer: Jeanette Keyte, Community Safety Manager Email: jeanette.keyte@centralbedfordshire.gov.uk Tel: 0300 300 5232

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
18.	Food Law Enforcement Service Plan 2012-2013, Age Restricted Sales Plan 2012-2013 and the Health and Safety (as a Regulator) Service Plan 2012-2013 -	To approve the Food Law Enforcement Service Plan 2012-2013, Age Restricted Sales Plan 2012-2013 and the Health and Safety (as a Regulator) Service Plan 2012-2013.	27 March 2012		Central Bedfordshire Enforcement Policy; FSA Framework Agreement on Local Authority Food Law Enforcement; Food Law Code of Practice (England); HSE Section 18 Standard on Enforcement	Executive Member for Sustainable Communities Services Comments by 26/02/12 to Contact Officer: Susan Childerhouse, Head of Public Protection (North) Email: susan.childerhouse@centralbedfordshire.gov.uk Tel: 0300 300 4394
19.	Budget Management Report - Quarter 3 -	To consider the quarter 3 budget management report.	27 March 2012		Report	Executive Member for Corporate Resources Comments by 26/02/11 to Contact Officer: John Unsworth, Interim Assistant Director of Finance Email: john.unsworth@centralbedfordshire.gov.uk Tel: 0300 300 6147

Ref No.	Issue for Key Decision by the Executive	Intended Decision	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Portfolio Holder and Contact officer (method of comment and closing date)
NON KEY DECISIONS						
20.	Quarter 4 Performance Report -	To highlight key Quarter 4 performance for Central Bedfordshire Council.	12 July 2011		None.	Executive Member for Corporate Resources Comments by 11/06/11 to Contact Officer: Ian Porter, Assistant Director Policy, Partnerships & Performance Email: ian.porter@centralbedfordshire.gov.uk Tel: 0300 300 6529

Postal address for Contact Officers: Central Bedfordshire Council, Priory House, Monks Walk, Chicksands, Shefford SG17 5TQ

Central Bedfordshire Council
Forward Plan of Decisions on Key Issues

For the Municipal Year 2011/12 the Forward Plan will be published on the fifteenth day of each month or, where the fifteenth day is not a working day, the working day immediately proceeding the fifteenth day, or in February 2012 when the plan will be published on the fourteenth day:

Date of Publication	Period of Plan
15.04.11	1 May 2011 – 30 April 2012
13.05.11	1 June 2011 – 31 May 2012
15.06.11	1 July 2011 – 30 June 2012
15.07.11	1 August 2011 – 31 July 2012
15.08.11	1 September 2011 – 31 August 2012
15.09.11	1 October 2011 – 30 September 2012
14.10.11	1 November 2011 – 31 October 2012
15.11.11	1 December 2011 – 30 November 2012
15.12.11	1 January 2012 – 31 December 2012
13.01.12	1 February 2012 – 31 January 2013
14.02.12	1 March 2012 – 28 February 2013
15.03.12	1 April 2012 – 31 March 2013