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.

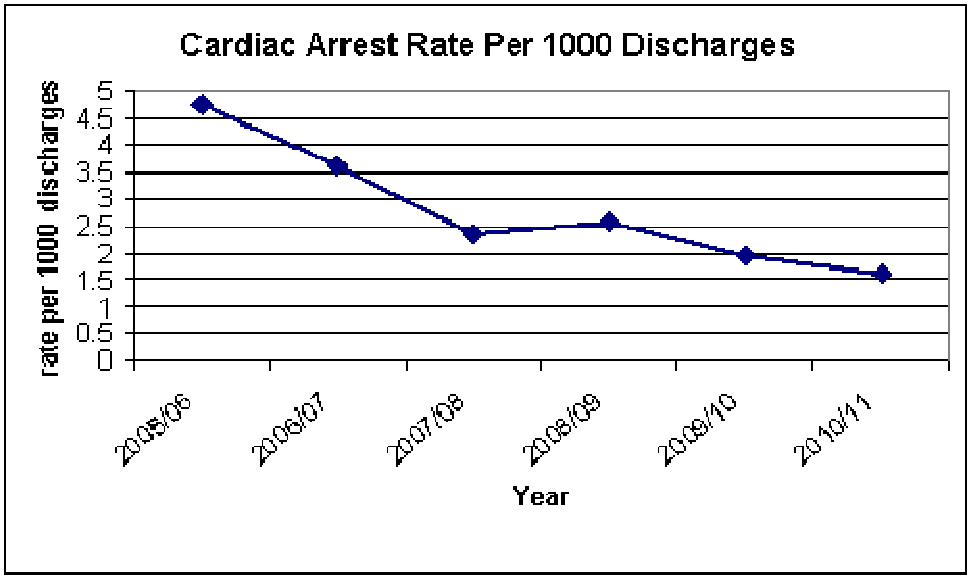
Performance Indicator	Source of data	2008/9	2009/ 10	2010* or 2010/11	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases	Trust Performance & Efficiency and Patient Safety Reports (DH criteria)	6	3	1	N/A	Excellent performance with reduction since last year
Hospital 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

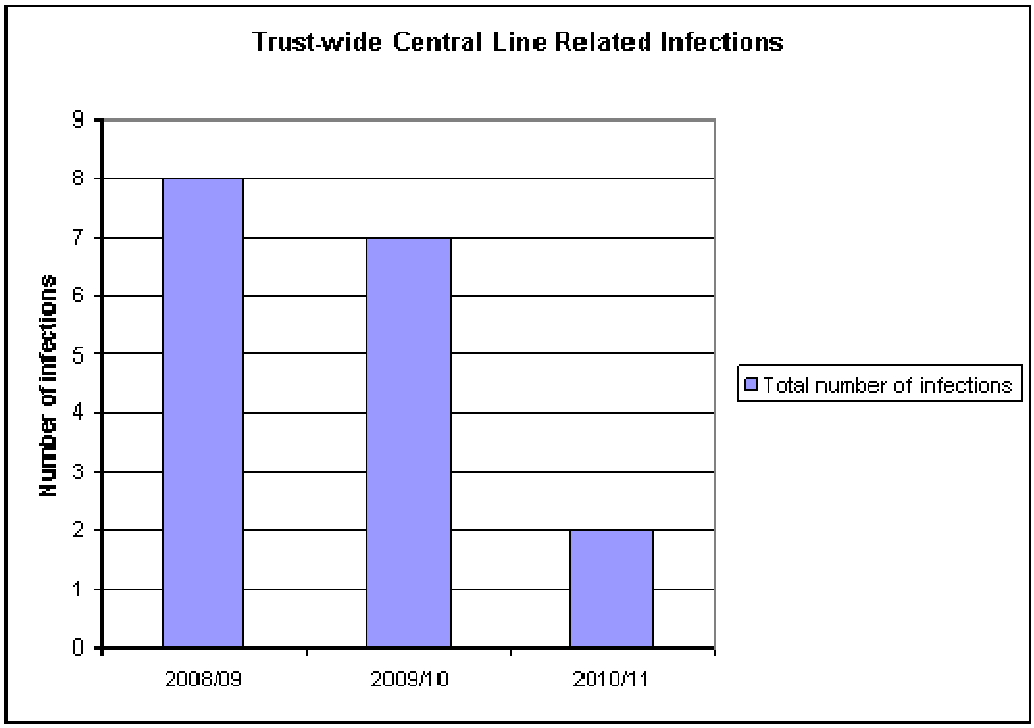
* denotes calendar year 2010 result drawn 21/4/11
** range 21-28% average of 12 months = 24.7%
*** X no > 30 days, x no < 30 days
**** % for a defined population excluding day cases and neonates etc 0.44 % for pressure ulcer incidence in relation to all hospital spells
1. note the question changed giving 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

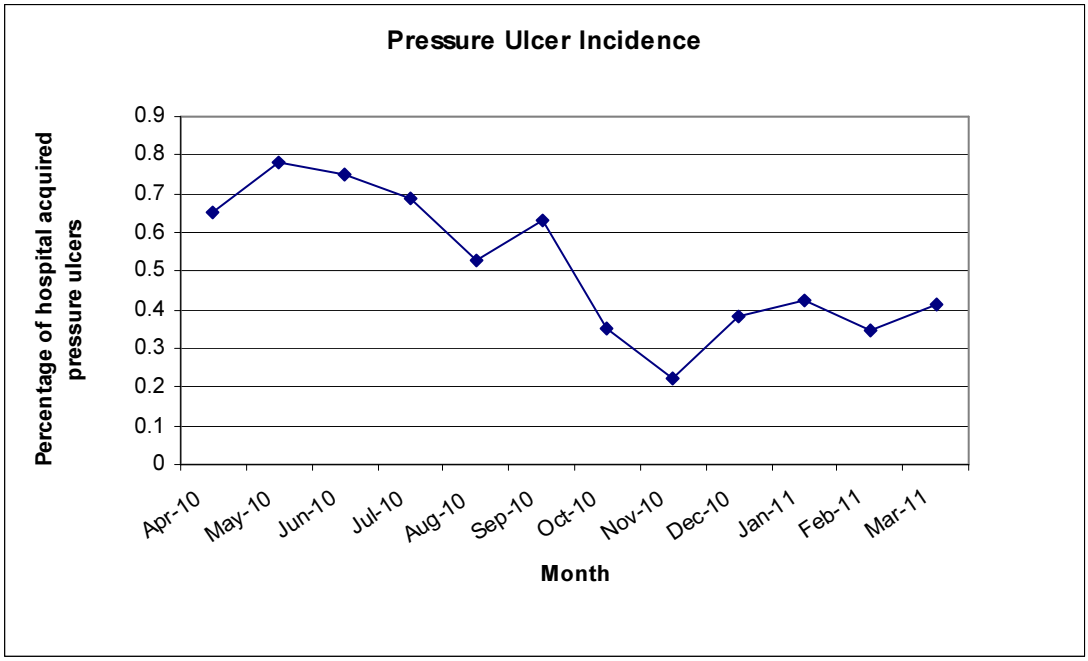
dependency levels of care and length of stay therefore this system is to be implemented in 2011.



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

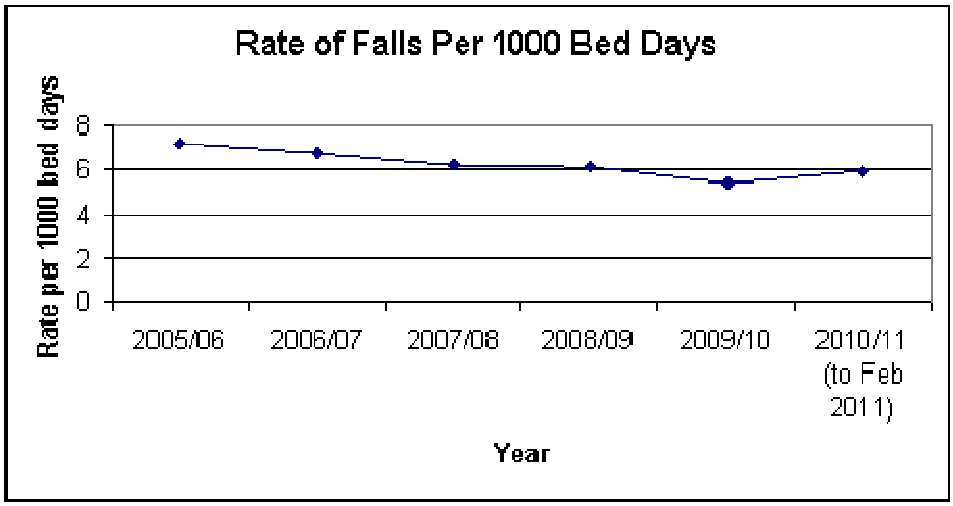


Reporting and coding of pressure ulcers has been improved to capture information on all pressure ulcers. Staff conduct root cause analysis of any pressure ulcer that occurs in order to understand further ways to reduce hospital acquired ulcers. We have seen a reduction in the incidence of hospital acquired 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

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