Quality Accounts Data Sets – Luton and Dunstable University Hospital NHS Foundation Trust

Quality Accounts Data Set – Luton & Dunstable (2015/16)		
Priority	**Target areas**	**What we achieved and RAG Rating**
Priority 1: Clinical Outcomes	Implement earlier recognition of Acute kidney injury (AKI) illness severity and earlier senior clinical involvement	More than 90% of our junior doctors have completed the AKI eLearning training module, increasing the likelihood that patients with AKI will get the treatment necessary to maximise their recovery. An AKI discharge template has been developed and the discharge letter is started when a patient develops stage 2 or 3 AKI. The template prompts the doctor writing the discharge letter to complete the necessary information regarding medication changes and recommended blood tests for monitoring renal function. In Quarter 4, compliance at the time of reporting has been excellent with more than 90% of AKI patient discharged with full information.
	Implement a new model of integrated care for older people	The Cluster alignment has been completed in Luton and the MDTs are in the process of being standardised. The Cluster 1 Pilot was able to demonstrate that a new model of care that will provide continuity of care for patients and allow more collaborative work with Primary Care is possible. There were a number of qualitative benefits for patients and GPs identified through the pilot. This was especially the case with patients living in Care Homes and immobile patients in their own home. GPs benefited from the easy access to a specialist opinion and the pilot was also able to identify changes that need to be put in place within the current medical model to enable the full roll out of integrated care. A programme has been launched to introduce a Needs Based Care approach which will be the vehicle used to introduce integrated care to all medical specialties.
	Implement processes for screening patients for sepsis and ensuring that intravenous antibiotics are initiated within 1 hour of presentation for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock	Audit has shown that compliance with sepsis screening is now above 90% and 71% of patients presenting with severe sepsis or septic shock now receive antibiotics within one hour.
Priority 2: Patient safety	Ensure that we have the appropriate level of clinical expertise available to deliver consistent inpatient care irrespective of the day of the week	7 day working is embedded in a number of services within the Trust and working patterns and rotas are already designed with this in mind. Significant progress has been made in imaging and work is planned for delivering the on-going consultant review standard. The Trust has participated in the national 7 Day Services progress survey in April 2016 with results expected to be made available by the end of May 2016.
	Ongoing development of Safety Thermometer, improving performance year on year	• We consistently achieved 98% harm free care. • We continued to reduce the overall incidence of category two and three hospital acquired avoidable pressure ulcers. This was achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. • We have maintained a falls rate of 4.32 per 1,000 bed days which is below the national average with continued challenges from an ageing and more frail population with complex health needs.

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Priority	**Target areas**	**What we achieved and RAG Rating**
		• We have achieved the 95% or greater target compliance of all VTE assessments.
	Improve the management of the deteriorating patient	• The delivery of the improvement programme to safely and effectively manage the deteriorating patient has made notable improvements right across the deteriorating patient pathway. There has been a reduction of 42% in the inpatient cardiac arrest rate. Further work needs to be undertaken over the next year to ensure that the Trust devises strategies to sustain this improvement.
	Reduce Avoidable Harm by ensuring patient's current medicines are correctly identified, communicated and prescribed at admission	• More than 85% of patients identified, using the risk prioritisation tool as at high risk of medication related adverse events, received a pharmacy- led medicines reconciliation at some point within their inpatient stay.
Priority 3: Patient Experience	Implement patient focussed booking systems including self check-in and partial booking of outpatient clinics	• We have seen substantial reductions in DNA rates achieved, with follow up DNA rates from April 2015 to the present across those specialties that have gone live with partial booking showing an overall reduction of 1.6%. The target is to achieve an overall Trust follow up DNA rate reduction of 2% in 2016/17 with full implementation of partial booking.
	Improve the experience and care of patients at the end of life and the experience for their families.	• **Strengthened resource and communication** Investment in the Palliative Care Team has been strengthened to include a team leader who will focus on clinical leadership supported by two band 7 Clinical Nurse Specialists. • **Improved the recognition of End of Life** The Palliative Care team and the Resuscitation team have worked with Consultants to improve the way we use our 'Personal Resuscitation Plans' (PRPs) more effectively. **Improved care planning** Collaborative working with the Emergency Department (ED) has enabled the introduction of the End of Life Care pathway for the department. ED are also monitoring palliative patients who have been inappropriately referred to ED and following investigation have shared the lessons that can be learned to prevent patients from dying in the ED.
	Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with dementia and delirium	• The Trust was compliant with over 95% of screening taking place each quarter; 90% compliance with onwards referrals and recommendations for patients with cognitive dysfunction in line with local pathways. • A robust training plan has been implemented and all 4000 staff were given a dementia awareness booklet in February 2016. Feedback is being collected and is generally positive. • Feedback is on-going and evidence of the impact of training will be evaluated using patient and carer feedback, complaints, compliments and incidents. Staff comments and feedback on the impact training is being gathered. • Feedback has been received from the carers survey which refers to aspects of care in hospital and the wider health economy. This information is being used to inform local commissioners of any areas of improvement recommended by the carers of people with dementia. Each organisation has evaluated its findings and discussed themes to report.

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Quality Accounts Data Set – Luton & Dunstable (2016/17)		
Priority	**Target areas**	**How it will be measured**
Priority 1: Clinical Outcomes	**Improve the management of patients with acute kidney injury (AKI)**	• Continued and improved use of AKI Alerting system • Implementation of the standards for recognition and treatment of AKI. • Monitor compliance with AKI standards • Provision of a plan of care to monitor patients identified with AKI whilst in hospital after discharge • Establish a baseline for accuracy of fluid charts.
	Improve the management of patients with severe sepsis	• Compliance with appropriate sepsis screening (audit) for emergencies and ward –based patients. • Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward – based patients.
	Improve our approach to mortality surveillance, identifying and reducing avoidable deaths	• Improving HSMR • On-going review by the Mortality Board
	Reduce our antibiotic consumption	• A baseline of antibiotic consumption (audit) • Implementation of a process for antibiotic reviews within 72hrs.
Priority 2: Patient safety	**Ongoing development of Safety Thermometer, improving performance year on year**	• Further reduce incidence of grade 2 pressure ulcers. • Maintain the current position in providing 98% or above in new harm free care (95% in 2013/14, 97% in 2014/15 98% in 2015/16)) • Maintain the current prevalence of patients who experience a fall and incur harm • Aim that no more that 16% of all inpatients will have a urinary catheter • Maintain 95% (minimum) patients to have had a VTE risk assessment and those that are identified as at risk of developing a thrombosis are provided with appropriate prophylaxis
	Improve the management of the deteriorating patient	• Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline. • To continue to sustain improvements all along the deteriorating patient pathway ensuring: 1. Timely and appropriate observations 2. Timely escalation of concerns to medical staff 3. Timely medical response times, 4. Improvement in timely and appropriate decision making by medical staff.
	Further development of stroke services	• Improved compliance with the Sentinel Stroke Audit (SSNAP)
Priority 3: Patient Experience	**Improve the experience and care of patients at the end of life and the experience for their families**	• Improved performance in the national 'Care of the Dying' audit • Improved performance in the further local audits of the EOL Individualised Care Plan • A reduction in incidents and complaints through the End of Life Steering Group • Continued improved feedback from patients and carers
	Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium	• Reduction in the number of falls for a patient with Dementia • Maintain and increase the number of staff with appropriate knowledge and skills training • Reduced number of emergency re-admissions within 30 days • Maintain good feedback on overall quality and experience from carer/ patient survey
	Completing the Roll Out of Partial Booking across the Trust	• Reduce the volume of missed appointments to 8%.