University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper N

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 6 October 2016

COMMITTEE: Quality Assurance Committee

CHAIR: Colonel (Retired) Ian Crowe, Non-Executive Director

DATE OF MEETING: 29 September 2016

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 3 November 2016.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- Aseptic Medications – Update on Chief Pharmacist responsibilities – report appended.

SPECIFIC DECISIONS:

- The Committee supported a proposal by the Chief Pharmacist to allow Pharmacists without prescribing qualifications, to generate the medicine section of the TTO letter – report appended.
- Patient Led Assessment of the Care Environment (PLACE) 2016 Results – report appended.

DISCUSSION AND ASSURANCE:

- **Reducing Readmissions Subgroup Update** – the Trust had been a national outlier for high readmission rates within 30 days with a rate of 8.9% for 2015-16. The 2016-17 Quality Commitment included a target for the reduction in readmissions to below 8.5%. This commitment was now being taken forward through the Reducing Readmissions Steering Group (RRSG) meeting which was being held on a weekly basis. The work programme for the RRSG was based primarily upon a continuation of the Preventing Avoidable Readmissions Project (PARP), which took place between January and April 2016. From continuing refinement of the processes identified in PARP, the Trust had shown a reduction in readmissions, achieving the target of 8.5% in June 2016. The Deputy Medical Director advised that the Reducing Readmissions Steering Group had developed a multidisciplinary approach across the LLR health and social care community to integrate safe discharge processes to reduce readmissions. An update was provided on the work streams being developed to achieve a stretch target of 8.4% and thereby deliver the Quality Commitment for the full year. The Committee supported the resources required to coordinate the implementation of the RRSG work plan.

- **Update on Discharge Workstreams across the Trust including Delayed Discharges** – the Director of Emergency Care acknowledged that discharge processes across the Trust needed to be improved. Therefore, a parallel approach was being taken, whereby the Trust's discharge workstreams was being aligned with LLR workstreams to support the Emergency Care programme externally, whilst supporting ward processes internally. The Senior Site Manager provided a comprehensive update on the various new discharge pathways that were being put in place.

Whilst several of these were relatively new, the support of the clinical team provided confidence that it would improve patient quality and impact on the length of stay. The Trust was managing delayed discharges via the A&E Recovery Board and RAP which identified all the key areas for change and improvement.

- **Radiology Discrepancy Management** – an update on progress being made against identified improvement actions with regard to Radiology Discrepancy Management was provided. A number of environmental factors thought to increase discrepancy rates had been addressed. There was a plan to increase access to workstations dependent on plans for reconfiguration. Improvements in electronic notification of results were reliant on the introduction of Peervue through GE PACS provided through EMRAD as the electronic notification system of choice. The GE PACS provision was expected to become 'live' in mid- September 2016 and there would be a three month period of set-up and preparation before this component of the system would 'go live'. The Medical Director commented that a letter had been received from the CQC requesting if there were any delays owing to the implementation of EMRAD. Despite the Trust having responded to this letter, a further letter from the CQC had been received on 28 September 2016 on the same matter. A conference call had been arranged with the CQC to discuss this matter in detail on 29 September 2016.

- **Homecare Update** – the Chief Pharmacist advised that although there were some risks still associated with Homecare, these had reduced since the previous report to the Committee in February 2016. Homecare remained on the risk register, but the risk score had reduced from 16 to 12. These risks included issues with external homecare companies, risks owing to insufficient capacity in the Pharmacy Homecare team and risks associated with internal processes. Capacity issues within pharmacy had been partly addressed through secondment of a Pharmacist to Homecare and prioritisation of new Homecare schemes based on risk and financial/operational benefit. Where existing schemes had been identified as 'high risk', as a result of external factors, these schemes had been reviewed and switched to alternative provision where feasible. Work was underway with relevant clinical specialities to resolve risks arising from internal processes (e.g. generation of prescriptions and requesting and monitoring of blood results). A business case had been submitted to NHS England and CCGs requesting additional funding for the Homecare team.

- **TTO Accuracy Update and Proposal for Pharmacists to write TTOs** – The Chief Pharmacist also provided an update on TTO accuracy and actions in place to address TTO prescribing errors. She highlighted that TTO accuracy had been re-audited in July 2016 and the error rates were similar to previous audits. The current actions to improve TTO accuracy were targeted predominantly at improving inpatient prescription accuracy, as this had been shown to influence TTO accuracy. There was a need for further actions to improve TTO accuracy and it was recommended that this included greater involvement of Pharmacists in generation of the medicine section of the TTO. A further report was presented which detailed a proposal to enable Pharmacists, who were not prescribers, to write the medication section of the discharge letter (TTO). This proposal would be progressed via a quality improvement project to develop a solution that was multidisciplinary, robust and flexible which could adapt to different services and patient needs. In order to deliver this routinely across UHL would require additional investment in pharmacists' time which would need to be quantified during the project and a business case developed for investment. **In order to allow the project to proceed, it was essential that formal agreement was given for Pharmacists without prescribing qualifications to generate the medicine section of the TTO letter. The Committee supported this proposal.** The CCG Representative noted the need for appropriate documentation be put in place to confirm the accountable officer and also need for appropriate Trust-wide communication regarding this proposal. **The 'Pharmacists writing medication section of TTOs' report presented to QAC on 29 September 2016 is appended to this summary.**

- **Aseptic Medications** – **Update on Chief Pharmacist responsibilities** – the Chief Pharmacist provided a brief background on the recent update to the standards laid out in the Quality Assurance of Aseptic Preparation Services (QAAPS) Guide whereby some additions had been made to the responsibilities of Chief Pharmacists. There was a new requirement to formally document in an organisational policy (such as the injectable medicines policy) that the Chief Pharmacist held ultimate responsibility for the adequate resourcing of the aseptic preparation service to ensure it met QAAPS standards. The Chief Pharmacist was also required to ensure that a policy on aseptic preparation was in place, detailing all products that were prepared aseptically

within the organisation. Both of these requirements would be addressed by an addition to the IV policy (currently under review) and development of an aseptic preparation policy. There were new requirements for Board level approval of the existing capacity plan and delegated product approval. **The Committee recommended the delegated product approval and existing capacity plan to the Trust Board for formal approval.** There were deficits in relation to storage facilities for aseptic consumables that had not been resolved and were currently on the risk register. An update on this subject was requested for the QAC meeting in January 2017. **The Aseptic Medications report presented to QAC on 29 September 2016 is appended to this summary.**

- **Management of Fractured Neck of Femur (#NOF) Patients** – the #NOF Steering Group had met on two occasions and had agreed terms of reference and ensured suitable cross-CMG and Corporate representation for the #NOF Operational Group that would be chaired by Dr A Currie, Clinical Director, MSS CMG. The Operational Group had been tasked to undertake a full review of the action plan developed in June 2016 following the contract performance notice and an updated action plan would be presented at the next Steering Group meeting on 18 October 2016. The outputs of this meeting would form the basis of an update on progress to October 2016 QAC and November 2016 EQB and CQRG meetings. The Medical Director reiterated that theatre capacity and the impact that Spinal Service had on the Services were the main issues that needed to be resolved.

- **Update on External Review of Clinical Quality Assurance Process** – the Medical Director advised that further to discussion at the Audit Committee meeting on 1 September 2016, the scope of the external review of the Trust's quality governance and assurance processes had been reviewed and the terms of reference had been drafted. The review would run over a 6-8 week period and was expected to be completed by mid-November 2016.

- **Patient Led Assessment of the Care Environment (PLACE) 2016 Results** – it was highlighted that the PLACE audits took place in March 2016, when Interserve were the private provider of soft FM services. Members noted that the results had been disappointing. The Director of Estates and Facilities discussed the results and noted the need to be mindful that the results were a Trust-wide issue. Action plans had been developed and distributed across a number of areas particularly to address cleanliness and maintenance issues. A desktop exercise/ snapshot audit aligned to the PLACE requirements would be undertaken in November 2016 to confirm and inform improvement requirements in advance of next year's PLACE audit. An update on this matter would be provided to QAC in January 2017. A brief discussion took place regarding the PLACE process and criteria and it was noted that a direct comparison to previous year's results could not be made owing to differing criteria each year. Members were advised that the Nutrition Steering Group had been established and metrics had been revised as part of the Nursing Safe Staffing report. **The PLACE 2016 results presented to QAC on 29 September 2016 is appended to this summary.**

- **Environmental Health Officer Inspection** – the Trust had had an Environmental Health Officer (EHO) Inspection, the results of which were disappointing - a rating of 2 for both retail and patient catering at Glenfield and a 3 at the LRI. The main issues raised were in relation to training, environmental cleanliness and estates maintenance. A number of actions had been put in place to resolve the issues identified and these would ensure that the ratings would improve. The Director of Estates and Facilities highlighted that the Trust was now aware of those matters of concern that would require investment and it was crucial that these were dealt with appropriately and investment was available to address these issues as a matter of urgency. The EHO would be re-inspecting on 6 October 2016 to assure that matters had been dealt with and that plans were in place to address environmental reconfiguration and purchase of equipment. A further update on this matter would be provided to the QAC in November 2016.

- **Friends and Family Test (FFT) Scores – July 2016** – the 52.4% coverage in Maternity was impressive. The clinical team in the Emergency Department (ED) were continuing to work towards achieving the nationally expected coverage of 20% in all areas of the department, however, coverage had been low particularly in the Urgent Care Centre and Majors. There was a 5.4% increase in the response rate in Eye Casualty submission levels in July 2016 and EDU had again exceeded the minimal 20% target with a submission level of 24%. The SMS texting trial for outpatients took place during August 2016 and included 119 clinic codes. The early results of the

trial showed excellent response rates from patients. Specific issues identified from the trial were now being addressed and EE (telephone provider) required 6 weeks to establish structures to ensure patients text responses were charged to the Trust. The trial also illustrated that once the service was established it could become expensive and therefore needed to be established with mechanisms to control expenditure. Discussion took place regarding alternative ways of sourcing patient feedback, including the use of digital applications. The peer analysis for the national Inpatient FFT data in June 2016 had ranked UHL in third position for score and fifth position for submission level. The Trust's ED had been ranked third highest in score and twelfth for submission level.

- **CIP Quality and Safety Impact Assessments** – the Medical Director advised that there was a robust process to link quality and safety assurance process in the Trust and identify any CIP schemes that might be adversely affecting outcomes. The CIP programme quality matrix was now in place and was being used within the Quality & Safety Performance meetings led by the Chief Nurse and Medical Director. The Committee were assured by this process.

- **Nursing and Midwifery Safe Staffing Report** – **July 2016** – there continued to be a high number of wards within each of the CMGs that were triggering a level 1 concern predominantly caused by non-achievement of nursing metrics, which was an expected outcome of the changes made to the metrics. There were also an increased number of level 2 concern wards, again mainly caused by nursing metrics and 1 ward was triggering a level 3 concern. The Deputy Chief Nurse provided a brief update on wards particularly triggering a level 2 and level 3 concerns. It was noted that a meeting was to be convened with senior CMG colleagues and the Deputy Chief Nurse to particularly discuss the support that could be offered to wards at the LGH and an update on this matter would be provided to the Executive Performance Board in October 2016.
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- **Month 5 – Quality and Performance Update** – the Committee received a briefing on quality and performance for August 2016. The following points were highlighted in particular:-
  (a) **Mortality** – the latest published SHMI (covering the period January 2015 to December 2015) was 98 – below the Trust's Quality Commitment of 99;
  (b) **Readmission rates** – at 8.3% were within the UHL's threshold of 8.5%, the lowest rate for over 18 months;
  (c) **#NOF** - target not achieved for the second time this year due to the volume and complexity of the spinal surgery activity undertaken in August 2016;
  (d) **Infection Prevention** – performance had been in-line with trajectory;
  (e) **Sepsis –** the new sepsis indicators would be included in future iterations of the Q&P report;
  (c) **Grade 2 pressure ulcers** – there had been a national spike particularly due to the hot weather, and
  (d) **Cancer Standards 62 day treatment –** performance had been disappointing particularly due to cancellations caused by lack of ITU/HDU capacity and emergency pressures.

- **Report on compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update** – weekly updates were being provided to the CQC in respect of Emergency Department (ED) time to assessment (15 minute standard), ED staffing and sepsis care bundle (screening and antibiotics) for patients presenting to the ED. As per the existing conditions on the licence, performance was being monitored on a daily basis against the identification of ED patients with red flag sepsis, using the screening tool and sepsis 6 interventions, with a specific focus on ensuring patients with red flag sepsis received IV antibiotics within one hour. The use of the sepsis screening tool and time to IV antibiotics on Assessment Units (Medical, Surgical, Children's, Oncology, Gynaecology & CDU) and Adult wards was being monitored in a similar way to that being done in ED. Most of this currently relied on paper based audits and was a time-consuming process. The Chief Executive complimented the pace of progress in this area specifically highlighting that it was Trust-wide. Electronic Observations (eOBs), with clinical escalation triggers for both the deteriorating patient and patients with red-flag sepsis, using Nerve Centre would be in place in all clinical areas by October 2016. eOBs was now clinically 'live' on 42 out of 89 wards. Discussions were on-going with NUH NHS Trust in respect of collaborative working to use the different aspects of the Nerve Centre system to generate reports etc. It was noted that the draft report following the CQC inspection in June 2016 was expected in late October/early November 2016.

- **Patient Safety Report** – **August 2016** – the report detailed patient safety data for UHL for August 2016. The number of incidents being reported and the number of prevented patient safety incidents reported (near misses) had increased which reflected a good safety culture. There had been 3 Serious Incidents escalated in August 2016, 2 of which were related to anticoagulation therapy. The CCGs and UHL safety teams had agreed to undertake a joint safety improvement project on improving anticoagulation safety across primary and secondary care. CMG leads had been requested to note the safety theme related to anticoagulation therapy and assure themselves that this was considered consistently within ward rounds, post-operative care and discharge planning. The Director of Safety and Risk also highlighted the following:- incident theme relating to failure to follow policy, the need for safety and governance processes around third party clinical teams and the requirement for a robust escalation process for missing patients.

- **Complaints Performance Report** – **August 2016** – complaints performance for 25 day complaints remained consistent and there had been a significant improvement in performance for 10 day complaints.

- **Duty of Candour (DoC) Update** – the Committee was informed of changes to the UHL Being Open/ Duty of Candour Policy, as follows:-
  (a) DoC letters would be uploaded to Datix rather than adding copy into case notes, and
  (b) that the UHL Being Open/ Duty of Candour Policy to be revised to advise that when moderate or severe harm occurred as a result of a recognised complication, a DoC conversation with the patient and/or relatives should still take place and be documented clearly in the notes, but it was not necessary to follow up with a letter if the patient was consented. It was important that the consent process was robust and the patient was fully aware of the risks of a suggested treatment.

  Members were advised that the GMC visit on 25 October 2016 would have a particular focus on the requirements for Duty of Candour.

- **Safety Improvement at UHL - Presentation** – owing to time constraints, it had not been possible to view this presentation. As the Director of Safety and Risk was not available for the QAC meeting in October 2016, it was agreed that Trust Chairman and Director of Safety and Risk would have a discussion with the Director of Corporate and Legal Affairs regarding whether it would be appropriate to schedule this presentation as a part/end of the next or a future Trust Board Thinking Day session.

- **Freedom to Speak Up (F2SU) Update** – the Director of Safety and Risk advised that a F2SU focus group had taken place at each of the 3 sites and there had been good attendance at these events. An on-line survey had been developed, and gone 'live' to gain further input and opinion. All feedback would be reviewed at the Task and Finish Group meeting on 4 October 2016 with a view to shaping the future of the F2SU guardian appointment and to progress to advert in early October 2016.

- **Any Other Business – Wakerley Lodge** – it was noted that there was still uncertainty in respect of funding for Wakerley Lodge refurbishment. Discussions had been on-going with colleagues in the Diabetes service in respect of funding availability and the outcome of this was awaited. If it was not possible to secure funding, then the scheme would be put on hold until the start of the new financial year (i.e. April 2017).

DATE OF NEXT COMMITTEE MEETING: 27 October 2016

Colonel (Retired) Ian Crowe – Non-Executive Director and QAC Chair
30 September 2016

Aseptic dispensing-update on Chief Pharmacist responsibilities

Author: Claire Ellwood, Chief Pharmacist Sponsor: Andrew Furlong, Medical Director Date: 29th September 2016

Executive Summary

Context

The aseptic dispensing suite within Windsor pharmacy is responsible for dispensing of chemotherapy and other aseptically prepared products. All activities within the unit must follow the standards laid out in the Quality Assurance of Aseptic Preparation Services (QAAPS) Guide. As a result of an update to the guide in July 2016 there have been some additions to the responsibilities of Chief Pharmacists. This paper summarises the new requirements and required actions and highlights key areas were board level approval is required.

Questions

Does the service currently meet all new requirements?

Conclusion

New requirements in terms of policies are not yet in place but it is anticipated these will be fully met within three months. There are new requirements for board level approval of the existing capacity plan and for delegated product approval. These approvals are not yet in place. There are deficits in relation to storage facilities for aseptic consumables that have not been resolved and are currently on the risk register.

Input Sought

QAC are asked to note the contents of the report and recommend to Trust Board to approve delegated product approval and the existing capacity plan

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Not applicable]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken:

4. Results of any Equality Impact Assessment, relating to this matter:

5. Scheduled date for the next paper on this topic: [TBC]

6. Executive Summaries should not exceed 1 page. [Yes]

7. Papers should not exceed 7 pages. [Yes]

SUBJECT: Aseptic dispensing-update on Chief Pharmacist responsibilities

1. Introduction

The aseptic dispensing suite within Windsor Pharmacy is responsible for production of aseptically prepared medicines, principally but not exclusively chemotherapy. The unit does not hold an MHRA licence, but instead operates under a Section 10 exemption to the Medicines Act, which allows aseptic preparation to be carried out under the responsibility of a pharmacist. All activities within the unit must follow the standards laid out in the Quality Assurance of Aseptic Preparation Services (QAAPS) Guide. The guide outlines specific responsibilities of the Chief Pharmacist, who has overall responsibility for aseptic preparation and ensuring QAAPS standards are met.

2. Changes to Chief Pharmacist responsibilities

The 5th edition of the QAAPS guide was published at the end of July 2016. There have been some additions and clarifications to the responsibilities of the Chief Pharmacist, in particular:

2.1. Changes required to policies

There is a new requirement to formally document in an organisational policy (such as the injectable medicines policy) that the Chief Pharmacist holds ultimate responsibility for the adequate resourcing of the aseptic preparation service to ensure it meet QAAPS standards. The Chief Pharmacist is also required to ensure that a policy on aseptic preparation is in place, detailing all products that are prepared aseptically within the organisation.

Both of these requirements will be addressed by an addition to the IV policy (currently under review) and development of an aseptic preparation policy. Both should be complete within three months.

2.2. Formal requirement for approval for delegated responsibilities

There is a new requirement to ensure that where an aseptic preparation policy allows delegated product approval in line with Nationally Recognised Framework requirements (ASAWG 2014), this has specific, formal organisation board-level agreement.

We do not currently use delegated product approval but are currently training pharmacy technicians to do this in line with ASAWG 2014 standards. Once trained, technicians will be permitted to perform the final check of aseptically prepared products which is currently performed only by pharmacists. Technicians will be trained to nationally approved standards. We are therefore requesting QAC to recommend to Trust Board that delegated product approval is approved.

2.3. Response to external audits

The Chief Pharmacist is required to ensure that any faults or deficiencies identified through external audits of aseptic preparation are promptly rectified.

The aseptic suite is externally audited annually. There is a deficit identified in the last 2 external audits in relation to an unacceptable environment for storage of consumables for aseptic preparation. We have partially mitigated this through a review of storage in Windsor pharmacy. This cannot be rectified until the re-development of pharmacy stores is completed, which was originally scheduled for 16/17 but has been deferred due to constraints on capital funding. This remains on the trust risk register. Note despite this deficiency the suite was given an overall risk rating of low in both audits. A summary of the report is included in appendix 1.

2.4. Formal ratification of capacity plan

The Chief Pharmacist is required to ensure the capacity plan for the unit is approved by senior hospital management external to pharmacy, for example at board level, to enable it to be effective at managing pharmacy workload in the context of the organisations injectable medicines policy.

There is a capacity plan in place and this is actively monitored by pharmacy; this has not been reviewed at board level and we are currently above capacity for pharmacists. The plan is included in Appendix 2 for information. Although not reviewed at board level, this plan was submitted as part of the evidence for our last external audit in April 2016 and was approved by the external auditor with a requirement that we address pharmacist capacity. There is a plan in place to address this and recruitment has been successful. We anticipate the capacity issue with pharmacists to be fully resolved within the next 8 weeks. We are therefore requesting QAC to recommend to the Trust Board that the capacity plan is formally approved

All other requirements are either unchanged from previous additions, or are fully met.

QAC are asked to:

- Note the revised requirements and actions proposed to ensure compliance, including the current risk in relation to storage.
- Recommend to the Trust Board that delegated product approval is supported
- Recommend to the Trust Board that the aseptic unit capacity plan is approved.

INSPECTION OF UNLICENSED ASEPTIC PREPARATION
SUMMARY OF RESULTS

Region: East Midlands **Hospital Trust:** University Hospitals of Leicester NHS Trust **Hospital Site:** LRI

In accordance with EL(97)52 the aseptic unit at the site named below was audited against the Quality Assurance of Aseptic Preparation Services Standards (NHS QA Committee 2006). The findings are summarised below.

Date of Audit	; 15/04/2016
Date of Previous Audit	; 03/12/2014
Date of Proposed Re-audit :	July 2017

Overall Risk Assessment to Patient Safety: High / Significant / **Low**

Deficiencies	Action
Critical	Critical deficiencies that require immediate action (within 24 hours)
Major	Major deficiencies that require action within three months
Other / Minor	Other / Minor deficiencies that need to be addressed within twelve months
Satisfactory	Complies with standards

Category	Audit Result	**Summary of Comments / Action Required** (see full report for details)
Minimising Risk with Injectable Medicines	Other / Minor	Risk Assessment for preparation of eye drops should be reviewed and signed by Chief Pharmacist.
Prescription Verification	Satisfactory	
Management	Other / Minor	Pharmacist capacity issues need to be addressed.
Formulation, Stability & Shelf-Life	Satisfactory	
Facilities	Other / Minor	Periodic microbiological bioburden testing of water used for staff handwashing should be undertaken. There should be a TA in place with Envair.
Pharmaceutical Quality Systems	Other / Minor	Staff need to be retrained in how to make corrections or amendments on worksheets. Records of errors and near misses should be reviewed to detect development of trends.
Personnel, Training & Competency Assessment	Satisfactory	
Aseptic Processing	Satisfactory	Use of a sporicidal agent should be considered, pending introduction as a requirement.
Monitoring	Major	Active air samples, sessional plates and finger dabs all frequently above limits, this should be investigated and CAPAs raised.
Cleaning & Sanitisation	Satisfactory	
Starting Materials, Components & Consumables	Major	Outer storage area wholly inadequate for storage of any sterile components or finished licensed products. This situation has not been resolved for the last 2 audits. Urgent escalation is required.
Product Approval	Satisfactory	
Storage & Distribution	Other / Minor	Stock control checks need to be instigated with urgency. Remapping of fridges on a 3yearly basis should be considered.
Internal & External Audit	Satisfactory	

Overall Comments:

The overall impression of the aseptic preparation unit, is that it presents a LOW risk. However I am very concerned about the pharmacy storage facilities, especially those outside of the building. I understand that refurbishment is planned; this needs to be addressed with some urgency, as I believe present storage conditions could put patients at risk. Bulk IV fluids stored in these areas could have vermin (rats and mice) crawling over them, with subsequent bacterial, pathogenic micro-organisms and biological contamination being left behind.
I urge the senior management of this hospital to take immediate action.

Auditor: Bernie Sanders **Affiliation: EM Regional QA** **Signature:**  **Date: 12/5/16**

Appendix 2 UHL PHARMACY SERVICES

LEICESTER ROYAL INFIRMARY ASEPTIC UNIT CAPACITY PLAN

The Pharmacy Aseptic service to UHL is currently provided from the aseptic suite located within the main pharmacy department, Windsor building, Leicester Royal Infirmary. The service mainly provided is the preparation of chemotherapy for adult and paediatric cancer services.

This capacity plan takes into account facilities, staffing and complexity of the items being manufactured. Its aim is to provide guidance as to safe and effective manufacturing limits and trigger points for review of workload, staffing or facilities.

Peaks and troughs in activity are to be expected due to the nature of the work being undertaken, however sustained breaching of the agreed capacity levels may be indicative of potential problems in maintaining quality and should be investigated.

Variable time per item in Clean Room (Cleanroom Operator) (V)

The time taken to manipulate a single aseptically dispensed item will vary according to the number of stages and complexity of the stages to achieve the end product. e.g.

- Simple – Draw up of small volume methotrexate for a pre-filled syringe
- Complex – Reconstitution, draw up and addition of multiple components for an infusion e.g. Ifosfamide and Mesna infusion.

In order to place a value on these complexity issues timings have been undertaken for a range of products and a rating assigned.

Time assigned for aseptic manipulation (minutes)	Rating (Workload Units)
0 to 5	1
6 to 10	2
11 to 15	3
16 to 20	4
21 to 25	5
26 to 30	6

Fixed time per item in Preparation Room

In addition to the time taken for physical manipulation of the required product there will also be a time factor attached due to the set-up and checking requirements. These timings have been standardised and are assigned to either an Operator or Pharmacist. These timings (P) or (F) will remain constant irrespective of the complexity rating to compound the product.

Process	*Pharmacist Time per item 1(P)*	*Prep room Operator time per item (F)*	**Total Time per item (mins)**
Professional Check(Clinical Validation) by clinical team	(1)		(1)
Preparation of worksheet & labels		2	2
Checking worksheets & labels		1	1
Setting up of ingredients		3	3
Checking setting up of ingredients		2	2
Transfer decontamination (spraying in)		1	1
Labelling & checking		1	1
Final Check & packing	3		3
Final Release	1		1
Total	**4**	**10**	**15**

Therefore production time required for 1 item rated as 1 workload unit

Prep room Operator **(F) = 10 Mins**

Clean room Operator **(V) = 5 Mins**

Pharmacist **(P) = 4 Mins**

Fixed Sessional time

In addition to the time requirements per item produced there are also fixed timings associated with the beginning and end of each production session for quality assurance and monitoring requirements to be undertaken:

Process	**Operator Time (mins) (F)**	*Pharmacist (P)*
Change into clean room clothing	10	
Initial clean of workstation	3	
Setting sessional plates	1	
Finger dabs	2	
Final clean of workstation	3	
Change out of clean room clothing	6	
Total per session	**25**	**0**

On average there will be 4 sessions per day resulting in 100mins of fixed sessional Operator time per day = 8.3 hours per week = 0.2 wte

Dispensing of pre-filled Dose Banded Chemotherapy

50% of current demand for chemotherapy is met by pre-made dose banded products supplied by commercial companies.

The dispensing and checking of these products is all done by Aseptic unit operators and carries a workload value of 1 unit (5 minutes) per item dispensed, equivalent to aseptic dispensing of a simple manipulation item (5mins, 1 workload unit)

Also, based on the timings for professional checking and release of aseptically prepared items each dose banded product would produce a requirement of 2 minutes of pharmacist time.

General Running of Unit

In addition to the timings directly associated with the compounding or dispensing process there are additional time pressures linked to maintenance and Quality Assurance (QA) of the unit and equipment including environmental monitoring, processing of cleanroom garments, data collection and filing. These are summarised below and make up an additional requirement

Process	**Time (mins)**	*Pharmacist (P)*	*Operator (T)*	*Weekly Total*	*Monthly Total*
Daily Tasks	532		532	2660	10640
Weekly Tasks	724		724	724	2896
Monthly Tasks	465		465		465
Total				**3384**	**14001min = 1.5wte**

Staff hours establishment

Pharmacist	**wte**	*Production time available (P) (wte)*
Pharmacist band 8b	0.6	0.1
Pharmacist band 6/7/8a	1.1	1.1
Total	**1.7**	**1.2**

Operators	**wte**	*Production time available (T) (wte)*
Team leader band 6	1	0.5
Technician band 5	2.5	2.0
Technician band 4	2	1.6
Assistant band 3	4.5	3.6
Level 3 Apprentice	2	1.4
Total	**12**	**9.1**

NB. Less 20% for annual leave, sick leave, breaks etc & less than 100% efficiency, less 50% for band 6 for management time and 30% for apprentices for college days & QCF time.

Staffing Capacity:

Pharmacist Time (P):

With 1.2wte available for production duties this would indicate that a maximum of 675 workload units per week can be maintained.
(1.2wte x 37.5hrs x 60mins) / 4mins
= 35,100 workload units per year

Operator Time (F & V):

Production time available = 9.1wte

Fixed time requirements = Fixed Sessional time = 0.2wte
= General running of unit = 1.5 wte

Remaining time = 9.1 – 1.7 = 7.4 wte

7.4 wte operators available for production (prep room & clean room) would indicate a maximum of 1110 workload units per week can be maintained.
(7.4wte x 37.5hrs x 60mins) / 15mins
= 57,720 workload units per year

Facilities and Equipment

Clean Room Availability

Equipment = 2 x CDC F negative pressure Isolators for chemotherapy
Daily sessions = 8 x 120mins for chemotherapy = 960mins per day = 4800mins per week

Fixed sessional time for chemotherapy = 8 x 25mins = 200mins per day = 1000mins per week

Clean room availability = 120 - 25mins = 95mins per session = 760mins per day = 3800mins per week = 1.7wte

Dose Banded items

Dose banded items have a workload value of 1 (5 mins)

Prep room Operator time to dispense **(F) = 3 mins**
Pharmacist time to check **(P) = 2 mins**

Additional time is required to release these items from bond following the unlicensed medicines procedure. This task is normally carried out by a pharmacy technician (or

pharmacist) from the aseptic unit who has undertaken the necessary competency assessment.

Technician time to release each item from bond **(F) = 2 mins**

Staff hours actual as at Feb 2016

Pharmacist	wte	*Production time available (P) (wte)*
Pharmacist band 8b	0.6	0.1
Pharmacist band 6/7/8a	1.1	1.1
Total	**1.7**	**1.2**

Operators	wte	*Production time available (T) (wte)*
Team leader band 6	1	0.5
Technician band 5	2	1.6
Technician band 4	1.5	1.2
Assistant band 3	3.5	2.8
Level 3 Apprentice	2	1.4
Total	**10**	**7.5**

NB. Less 20% for annual leave, sick leave, breaks etc & less than 100% efficiency, less 50% for band 6 for management time and 30% for apprentices for college days & QCF time.

Operator Capacity Actual

Operator Time (F & V):

Production time available = 7.5wte

Fixed time requirements = Fixed Sessional time = 0.2wte
= General running of unit = 1.5 wte

Remaining time = 7.5 – 1.7 = 5.8 wte

5.8 wte operators available for production (prep room & clean room) would indicate a maximum of 870 workload units per week can be maintained.
(5.8wte x 37.5hrs x 60mins) / 15mins
= 45,240 workload units per year

Dose Banded Item Capacity

Staff Required for Dose Banded Items Oct-Dec 2015 (Q3)

Staff Grade	Items	Required wte	Available wte	Capacity
Pharmacist	3,764	0.26	0.26	100%
Operator	3,764	0.39	0.39	100%
Release from bond	3,764	0.26	0.26	100%

Compounding Capacity (workload units – dose banded items)

Staff Establishment vs Workload Oct-Dec 2015 (Q3)

Staff Grade	Available wte	Workload Units	Required wte	Capacity
Pharmacist	1.2-0.26 = 0.94	7,504	1.03	110%
Operator	7.4-0.65 = 6.75	7,504	3.9	58%

Staff Actual vs Workload Oct-Dec 2015 (Q3)

Staff Grade	Available wte	Workload Units	Required wte	Capacity
Pharmacist	1.2-0.26 = 0.94	7,504	1.03	110%
Operator	5.8-0.65 = 5.15	7,504	3.9	76%

Current Capacity Status

Approximately 50% of current demand (items) for chemotherapy is met by pre-made dose banded products supplied by commercial companies.

The unlicensed medicines process, dispensing, checking and releasing of these products is all done by Aseptic unit operators and pharmacists and carries a workload value of 1 per item dispensed.

The unit is operating at approximately 75 to 110% capacity with current staffing levels. Therefore there is little or no capacity for increasing workload without additional pharmacist support (an extra 0.4wte pharmacist post would bring pharmacist capacity to approximately 75% based on current workload). At peaks of activity additional pharmacist support is required to manage the workload currently. Operator vacancies have now been recruited to. There is sufficient operator staff resource available to maintain the current service within 80% capacity required by MHRA to retain sufficient headroom for variable peaks in activity and occasional staff shortages.

Hours of Service: 0900-1730 Hours Monday to Friday

(Outside of these hours an On-Call Aseptically trained member of staff is available to undertake aseptic preparation when treatment is considered clinically urgent)

Standards for Service Provision to Wards and Clinics

Chemotherapy Day Case Suite: The Day Case Suite operates a 2 stop treatment system and therefore the majority of prescriptions should be received by the Aseptic Unit by 4pm the day prior to treatment. Completed treatments are transported back to the day case suite by pharmacy personnel on the evening prior to the treatment day. Treatments that cannot be made in advance due to e.g. short expiry dates are scheduled for production on the day and the clinic contacted when ready for collection. There is a two hour turnaround time agreed for 1 stop chemotherapy, however peaks of activity on some days of the week mean that turnaround times are extended beyond two hours at these times. This has been raised as an issue with the Cancer Services chemotherapy group.

Oncology/Haematology Wards

Inpatient chemotherapy is treated as per 1 stop treatment. There is a two hour turnaround time agreed for inpatient chemotherapy unless treatment is scheduled to commence at a later time and the ward contacted when ready for collection prior to this. However peaks of activity on some days of the week mean that turnaround times are extended beyond two hours at these times. This has been raised as an issue with the Cancer Services chemotherapy group.

Haematology Day Case

Osborne Day Care operate a 1 stop treatment system. There is a two hour turnaround time agreed for 1 stop chemotherapy, and the clinic contacted when ready for collection, however peaks of activity on some days of the week mean that turnaround times are extended beyond two hours at these times. This has been raised as an issue with the Cancer Services chemotherapy group.

HOPE Clinical Trial Unit

The HOPE unit operate a 2 stop treatment system as far as possible within the constraints of trial protocols. The majority of prescriptions should be received by the Aseptic Unit by 4pm the day prior to treatment. Treatments that cannot be made in advance due to e.g. short expiry dates or protocol restrictions are scheduled for production on the day and the clinic contacted when ready for collection. There is a two hour turnaround time agreed for 1 stop chemotherapy, however peaks of activity on some days of the week mean that turnaround times are extended beyond two hours at these times. This has been raised as an issue with the Cancer Services chemotherapy group.

Paediatric Chemotherapy: Prescriptions for chemotherapy should be received by 4pm on the day prior to treatment. Chemotherapy is released to the ward following receipt of a treatment confirmation list for that day. Treatments that cannot be made in advance due to e.g. short expiry dates are scheduled for production on the day and the ward contacted when ready for collection. There is a two hour turnaround time agreed for 1 stop chemotherapy.

Updated by David Lovett (Principal Pharmacist for Aseptic Services) 26.02.16
Approved by Claire Ellwood (Chief Pharmacist) 18.03.16

Pharmacists writing medication section of TTOs

Author: Claire Ellwood, Chief Pharmacist and Kristy Link, Deputy Chief Pharmacist – Clinical Services
Sponsor: Andrew Furlong, Medical Director Date: 29th September 2016

Executive Summary

Context

The purpose of this paper is to provide a proposal to enable pharmacists, who are not prescribers, to write the medication section of the discharge letter (TTO). This report summaries the need to implement this change, the national and local best practice and a proposed plan for measuring improvements.

Questions

1. Is there a need to improve the quality of the medication section of TTOs?
2. Can pharmacists writing the medication section of the TTO improve the accuracy and efficiency of our TTOs and discharge process?
3. What are the plans to progress this proposal?

Conclusion

1. UHL TTO prescribing is consistently inaccurate with 52-70% of TTOs containing an error. Accuracy rates have improved slightly but significant improvements have yet to be seen in the medication section of TTOs written by doctors.
2. Pharmacists writing the medication section of the TTO supports achieving the Trust 2016/17 quality commitments and working towards the Carter recommendations for hospital pharmacy
   2.1. Nationally studies have shown that pharmacists make fewer errors (0.3-3%) when writing medications on TTOs
   2.2. UHL TTO accuracy audit showed a link between TTO error rate and timely discharge
   2.3. Other hospitals have successfully implemented models where pharmacists, who are not independent prescribers, safely and effectively write the medication section of the TTO in line with, training, competency assessments and governance arrangements
3. This proposal will be progressed via a quality improvement project to develop a solution that is multidisciplinary, robust and a flexible model which can adapt to different services and patient needs
   3.1. Improvements with the TTO process are greater than pharmacy and ownership needs to extend to all CMGs. There is a need for engagement from clinicians and key stakeholders in progressing this and making it a success.

Input Sought

QAC are asked to note the actions, approve the proposal to enable pharmacists (who are not prescribers) to write the medication section of the TTO and support the recommended next steps.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Not applicable]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken:

4. Results of any Equality Impact Assessment, relating to this matter:

5. Scheduled date for the next paper on this topic: [TBC]

6. Executive Summaries should not exceed 1 page. [Yes]

7. Papers should not exceed 7 pages. [Yes]

SUBJECT: Proposal to enable Pharmacists to write the medication section of discharge letters (TTO)

1. Introduction

The issue of TTO turnaround times and delays at discharge is a long standing issue for many Trusts in the UK. In a number of cases, the patient experience implies perceived inefficiencies by the pharmacy department but on investigation shows inefficiencies in the whole discharge pathway.

The purpose of this paper is to provide a proposal to enable pharmacists, who are not prescribers, to write the medication section of the TTO for patients on their ward following attendance at the board/ward round. It is envisaged that the doctor will retain the responsibility of writing the clinical letter.

It is recognised that this proposal will not be suitable for all areas of the hospital, patients or pharmacy staff to be involved in. It is envisaged that during the process of the project key target areas will be identified which may benefit from this model and also highlight areas which may benefit from improvements from alternative TTO models e.g. pharmacist prescribers.

It is proposed this will be trialled via a quality improvement approach by adopting a model based on national best practice learnt from the success of colleagues working at Kings and Sherwood Forest.

The service is not proposed to be a floating TTO pharmacist discharge team to write medication lists for patients that are unknown to them or when a doctor is not available to write a TTO. This approach has previously been trialled and it was found that due to lack of knowledge of the patients and no close working relationships with the medical team efficiencies were not achieved.

2. Background

UHL TTO prescribing errors were audited in January 16 across all CMGs. This showed 52% of TTOs in UHL had an error, with an average of 2.5 errors per TTO. Previous TTO accuracy reports have highlighted errors in 70% of medical TTOs (June 2014). Error rates on TTOs from other Trusts range from 40-70%. Accuracy has been increasing slightly but a significant improvement has yet to be seen in the quality of TTO letters written by doctors.

`The recently published Carter report (2016) placed an emphasis on pharmacists becoming increasingly involved in patient's clinical care and activities which can directly affect outcomes especially as part of a team and through innovative services. The report highlights opportunities to increase service efficiency by removing, reducing or replacing steps which effect efficiency of services and utilising resources (staff) more effectively to meet service need. Increasing the amount of pharmacist clinical activity and the number of active pharmacist independent prescribers was highlighted as key target areas for success.

A key focus of the Carter report (2016) highlights the need to target the delays in discharge and transfers of care. The UHL TTO accuracy audit showed that there is a link between TTO error rates and timely discharge, with an average time for a pharmacist to professionally check a TTO without errors 7 minutes compared to 25 minutes for a TTO with errors (June 2014 data).

A study completed at Countess of Chester Hospital (Green et al 2015) showed that on average only 13% of the total TTO journey time was spent with pharmacy. This highlighted that to influence timeliness of TTOs the greatest opportunities for reducing delays and improving patient experience (51% of total time) could be achieved through targeting the time between the patient being informed and the last item being entered on the TTO.

3. Review of the national data to support this change

- **Kings Hospital:**

Kings were an early adopter of pharmacists who are not independent prescribers writing the medications to support the discharge process. Over several years they have progressed from a small pilot to a position where within the hospital the pharmacists write approximately 80% of all the medications on discharge prescriptions.

This is a highly valued, high profile clinical pharmacy service which is seen as extremely beneficial for the department, patients and the Trust. The pharmacist works as an integral part of the multi-disciplinary team making clinical decisions which improve the safety and quality of the patients discharge. The doctors retain the responsibility for writing the clinical letter and final checking the finished TTO.

The critical success factors for the Kings model were that:
- Each clinical ward pharmacist is responsible for working with their ward team to help to prepare the discharge medication lists for their patients on their wards under their care.
- This work was commonly done as part of the ward round.
- The pharmacists do not write the discharge letter, this remains the clinician's responsibility
- The work has been embedded into practice over a number of years and is now time neutral

- **Sherwood Forest Hospital:**

A similar pilot was completed at Sherwood Forest Hospital which showed that of the TTOs analysed only 3% contained an error. This is consistent with other national studies showing pharmacist prescribing errors to be significantly less than doctors. Studies in the North East have reported a 0.3% error rate for pharmacist inpatient prescribing, which compares with 9% for medical prescribing (EQUIP, 2009).

The hospital has a comprehensive governance framework, revalidation package and education and training plan which provides assurance of competency for the pharmacists involved in delivery of the extended role

However, the Sherwood Forest data appeared to have no impact on the discharge time of the sub-group. This is thought to be because the doctor was still delayed in writing their section due to other time commitments. This highlights the need for there to be a multi-disciplinary change to the TTO approach for benefits to be seen to discharge time.

Medical staff were asked for feedback on their perceptions of the pilot, these are shown below:

Benefits to themselves	Benefits to their patients
• Helps TTO turnaround time • Reduces TTO errors • Assists with medicines reconciliation • Quicker TTO letters • Less pressure on junior doctors who have other jobs they can be doing	• Ensures medicines aren't missed • Highlights drug interactions • Reduces errors • Earlier and quicker discharges • Pharmacists are more knowledgeable about medicines than doctors so it make sense

4. What are the potential benefits and limitations within UHL?

Benefits:

This proposal supports the Trust 2016/17 quality commitment by aiming to:

- Decrease medication errors on TTOs (supported by evidence) and therefore aims to reduce the risk of avoidable readmission related to medications

- Improve the quality of information provided to patients and primary care on TTOs related to medications stopped, started or modified during admissions therefore keeping patients and carers informed and involved in their care and treatment
- Reduce medication related errors on TTOs across the interface that have the potential to result in moderate or severe harm

Opportunities for increases in efficiencies related to timely discharge, which in turn may benefit length of stay for UHL and assist with pressures across the wider hospital and emergency department

There is potential for increased staff morale by implementing this project as pharmacists and doctors will be completing more role specific clinical work which is increasing the quality of care for patients and improving the patient experience through efficient discharges.

The Carter Report (2016) highlights an urgent need for pharmacists to provide increasingly clinically focused activities and greater utilisation of pharmacist prescribers. UHL is currently working on increasing the number of independent prescribers within the pharmacy teams but this is subject to accessing funding and course availability. Until such point that all pharmacists are qualified as prescribers this presents a viable opportunity to work within governance frameworks to enable pharmacists who are not prescribers to write the medicine section of the TTO letter with appropriate training and competency packages implementing successful models similar to other hospitals.

Limitations:
To progress to this alternative model the pharmacy team would need additional funding to deliver this routinely across UHL because:

- Compared to the Kings model pharmacists within UHL do not routinely participate on the ward round or board round
- The pilot completed at Sherwood Forest showed that on average pharmacists spent an extra hour a day per ward to support this enhanced work. (It is important to note that this time may be greater at UHL as patients are likely to be more complex and TTO numbers higher)

There was limited success during the pilot at Sherwood Forest within the surgical ward due to variable discharge planning, multiple teams, fast unpredictable turnover of patients and poor medicines reconciliation. This data suggests that selection of wards for the early pilots will be essential to demonstrate success

5. Summary of the proposal

Following a number of successful initiatives in other hospitals the pharmacy team, working collaborating with other healthcare professionals within UHL, would like to progress a project to allow non-prescribing pharmacists to write the medication section of the TTO letter.

We believe that this has the potential to help to facilitate and deliver:

- more timely discharge of patients from UHL
- improved quality of care for UHL, patients and across the interface
- increased utilisation of skill mix within the multi-disciplinary team to suit expertise
- the release of junior doctor time to complete other tasks
- a reduction in medication errors on TTOs
- the Carter recommendations to increase pharmacist clinical activity

It will be essential to develop a solution that is multidisciplinary with the pharmacist being an integral part of the team, attending the ward/board round on a daily basis. To deliver this routinely across UHL will

require additional investment in pharmacist's time which would need to be quantified during the project and a business case developed for investment.

It is acknowledged that one model may not be suitable for all areas, patients or pharmacists skills and during the project other opportunities to support improved TTO efficiency will be factored in where possible

6. Next steps

It is proposed that this project will be completed utilising a quality improvement change model with clear aims, objectives and measures.

Key criteria for implementation and measurement of success:

- Key stakeholders, staff and patient partners will be engaged
- A robust governance structure will be in place to support this new process
- Comprehensive education and training packages will be developed
- The pharmacist must be embedded as part of the ward multi-disciplinary team
- The new process must impact on both accuracy and timeliness of TTO prescribing.
- Doctors must be engaged to ensure the full TTO (medications and letter) is completed earlier to achieve the full benefits to UHL of adopting this revised model of working

Support is required from the Trust and relevant CMGs, nurses and clinicians in all areas to identify and implement actions for improvement with the project.

In order to allow the project to proceed, it is essential that formal agreement is given for pharmacists without prescribing qualifications to generate the medicine section of the TTO letter.

7. Recommendations

Executive Quality Board are asked to:

- note the contents of the report
- approve pharmacy to progress the quality improvement project to allow pharmacists, who are not independent prescribers, to write the medication section of TTOs within UHL within an agreed framework
- advise on whether an update is required for further assurance

Patient Led Assessment of the Care Environment (PLACE) 2016 Results

Author: Liz Tebbutt Sponsor: Darryn Kerr Date: 29 September, 2016

Executive Summary

Context

To inform the Quality Assurance Committee of the published results of the PLACE assessment programme for 2016.

Questions

- What actions can be taken to improve standards and the organisation's performance in relation to other Trusts?
- Are sufficient resources available to continue to invest in services and to undertake environment refurbishment programmes?

Conclusion

- Action plans already developed and distributed to wards and departments and Estates & Facilities management to address cleanliness and maintenance issues.
- It is proposed to undertake a snapshot audit aligned to the PLACE requirements during November to confirm and inform improvement requirements in advance of next year's assessment.
- Improved meal service could be achieved by ensuring Protected Mealtimes is implemented across the organisation and housekeeping/nursing colleagues are available to prepare patients and assist during meal service.

Positive

- Design Guide for Dementia Friendly Spaces has been developed EFMC/Gelder & Kitchen based on guidance from Stirling University who lead in this field.
- Organisational Food and Drink Strategy now developed.
- Improved Nutritional Audit results
- Improved scores were achieved where refurbishment had been carried out i.e. Balmoral reception

Input Sought

The QAC is asked to note the content of the report and support suggested actions to improve standards.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[~~Yes /No /~~Not applicable]
Consistently meeting national access standards	~~[Yes /No /~~Not applicable]
Integrated care in partnership with others	~~[Yes /No /~~Not applicable]
Enhanced delivery in research, innovation & ed'	~~[Yes /No~~ /Not applicable]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[Yes /~~No /Not applicable~~]
Enabled by excellent IM&T	[~~Yes /No~~ /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes /No /Not applicable]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: Patient Assessors made up 50% of assessment team.

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: [Next QAC meeting]

6. Executive Summaries should not exceed 1 page. [My paper does / ~~does not comply~~]

7. Papers should not exceed 7 pages. [My paper ~~does~~ / does not comply]

Purpose

The purpose of this report is to:

Provide feedback and the formal results of the Patient Led Assessment of the Care Environment (PLACE) assessment programme which took place during March 2016 when service delivery and quality was the responsibility of our private sector provider.

PLACE Process and criteria

The PLACE process is reviewed annually with updates and amendments made to the criteria and questions. For 2016 there are additional assessment questions and a new dedicated section for Disability.

The 2016 assessments were carried out with a minimum 50% representation of Patient Assessors as required and the results submitted to the Health & Social Care Information Centre (HSCIC) within the required timescale.

The Patient Assessors have contributed fully to the assessments and have ensured that their views were made known to staff at all levels both during the assessments and by way of their comments all of which have been submitted to the HSCIC as part of the process.

Whilst the process could be considered as subjective with potential for significant variation within assessment teams and organisations, the results are reported nationally and constitute part of the Carter efficiency and quality metrics as well as being utilised by NHSI as a measure of quality and performance.

There are 5 criteria against which our hospitals are assessed as follows:

Cleanliness – This includes all ward, outpatient, communal and public areas. Criteria assessed are broadly based on the National Specification for Cleanliness standards which include nursing responsibilities for patient equipment and domestic services for the environment.

Food – The score is calculated by three separate domains: a) ward score – includes the service of the meal, availability of staff to assist patients, adherence to protected mealtimes b) organisational score – includes policies and procedures, nutritional screening audit results, menu cycles, 24hr availability and c) patient assessors score which includes sampling of meals after patient meal service and their observation of the meal service delivery.

Privacy, Dignity and Wellbeing – The criteria for this is wide ranging and includes – single sex accommodation, privacy curtains, bed space size, separate treatment rooms on wards, patient access to television and radio, access to social spaces, appropriate signage, availability of differing height/type of seating etc.

Condition, Appearance and Maintenance – These questions include the décor, flooring, furnishings and furniture in all areas visited. Car parking facilities and payment mechanism, overnight accommodation for relatives or carers, safety, temperature of areas etc are also assessed.

Dementia – The criteria for this element is based on the guidance from the King's Fund and Stirling University. This includes flooring, décor, signage, colours, bathroom and toilet fixtures and fittings etc.

Disability – New for 2016, the scoring for this has previously been within other elements. This includes wheelchair availability, access routes, disabled toilet facilities, signage, hand rails, hearing loops, space within waiting areas.

Scoring

With the exception of Food and Hydration, where there is a weighting applied based on importance of the element, questions are often multiple choice e.g. if there are six options the highest score which can be achieved will be 2 and the lowest 0.4, 0.

The results collated are not just about outcomes i.e. is the food of a high quality but is also very much about inputs i.e. do we provide the recommended number of drinks per day etc. It is a whole process assessment and not just about E&F services and the environment.

1. Summary of Results

The results achieved by the three acute hospitals for UHL can be seen at Appendix 1.

The results for 2016 are very disappointing.

This year's scores shows that the Cleanliness results for all three hospitals have deteriorated compared to 2015 results. Condition and Appearance criteria were lower at LGH and GH than last year's assessment with an improved score at the LRI. Food and Hydration improved at GH and LRI but significantly reduced at LGH. Privacy and Dignity elements were reduced across all three sites and Dementia improved at GH but decreased at LGH and LRI. Disability, new for 2016, achieved a credible 80.62%, above national average but only 62.86% achieved at LGH and 63.57% at GH giving the Trust an average score of 67.51% which is well below the national average of 78.74%.

Appendix 2(a) and (b) compares UHL results to those of our peer group. The highest ranking is 14/18 for Privacy and Dignity, 18/18 for Cleanliness, Food and Hydration and Condition, Maintenance and Appearance with Dementia ranked 15/18 and Disability 16/18.

In terms of the Trust's overall position compared to all of those organisations (287) taking part in the process, Cleanliness is 284th, Food and hydration 281st, Privacy, dignity and wellbeing 264th, Condition, maintenance and appearance 287th, Dementia friendly 254th and Disability 268th.

Reference to post transition improvements, recent CQC visit findings and what we have and intend to do to improve are included in section 8.

2. Glenfield Hospital

Cleanliness

The result achieved was in excess of 95% however the national average has this year increased to 98%. The cleanliness standards throughout the wards and departments, including patient equipment, observed on the days of the assessments were generally very good and 95% is in line with the National Specification for Cleanliness in high risk areas.

Condition, maintenance and appearance
The main issues raised were related to some décor being tired and scuffed and damaged paintwork.

Food and Hydration
The food score comprises three elements: food quality, ward service, and organisational questions and the average score for Glenfield was an improvement from 75.89% in 2015 to 81.96% this year. Concerns were noted about the time staff had to deliver meal service and once meals were ready, the time it took to serve it to patients.

Privacy, dignity and wellbeing
There was a decrease with a score of 73.48% achieved against the criteria. As with last year the Trust does not have much social space available to patients. Access to Computers/Wi fi is not available everywhere throughout the Trust. Television access in many areas is communal and not individual which impacts on the score.

Dementia-Friendly Environment
Previously this section was assessed but not scored. The hospital achieved a score 72.89%. It was noted there were issues with flooring, signage and décor that were not compliant with current guidance.

Patient Assessors' Summary
"Though the hospital was built 30 yrs ago the building is generally in good condition and well maintained. The cleaning was varied but in some areas moveable objects were cleaned around rather than moved".

3. Leicester General Hospital

Cleanliness
Eight of the ten wards assessed scored above 90%. Two of the outpatient areas assessed scored below 90%. There were many cleaning issues noted by the assessors with many elements failing in communal areas, receptions, corridors and public toilets.

Condition, maintenance and appearance
The results for condition maintenance and appearance were particularly poor this year with scores ranging from 50% and only two out of eighteen areas achieving above 90%. Floors particularly in communal areas are damaged and tired and are in need of replacement. The external fabric of the building requires some considerable maintenance as noted in previous assessments**.**

It is noted that there has, since March, been a marked improvement in the condition of these areas by way of repairs and redecoration carried out during May and June 2016.

Food and Hydration
There was a significant decrease in score this year achieving 78.41% for the food section, this is very disappointing. Not all areas ensured patients were readied for the meal service, over-bed tables not cleared etc. which impacts on the overall results.

Privacy, dignity and wellbeing
As in the other sites there are few social spaces available to patients and there is no patient access to computers within the hospital. Televisions in most areas are in communal areas only.

Dementia-Friendly Environment
LGH achieved a score of 62.43% as with the other sites there were issues with Flooring, Signage and Décor not being compliant.

Patient Assessors' Summary
"Not as good as last year. This is a hospital of extremes".

4. Leicester Royal Infirmary

Cleanliness
On the days of the assessments, only four of the ten wards and that three of the ten outpatient departments that were assessed achieved above 90% and the emergency department scoring 70%. The main cleaning issues noted that required attention related to floors, hand wash basins and ceiling vents. The main issues identified in communal areas including receptions, corridors, stairs and lift areas were the floors, debris and dust, with nearly all wheelchairs requiring cleaning.

Condition, maintenance and appearance
In many of the wards the assessors noted décor as being tired, damaged and in need of redecoration and some flooring replacement needed. There were many outstanding repairs and maintenance works to be addressed. Whilst work to redecorate and replace flooring had taken place in some wards and areas further investment is required to improve the environment. It is disappointing that whilst noting improvements made to the environment in many areas the assessors focus tended to be on the appearance i.e. cleanliness / tidiness.

Food and Hydration
Whilst improved in some areas, the food service in only two of the five wards observed had readied patients for the meal service. There still appeared to be a lack of staff engagement with patients and the 'Protected Mealtimes' was not apparent in any areas visited. Quality of food was scored as generally good or very good with occasional acceptable.

Privacy, dignity and wellbeing
In several of the waiting areas the seating tended to be of the same type. There should be a range of seating provide to meet patient's needs including different heights and chairs to accommodate bariatric patients should be available. Lack of social spaces, communal televisions were an issue as previously noted within assessments.

Dementia-Friendly Environment
The score for Dementia is reduced this year to 57.22%. It is difficult to compare with 2015 as each year different wards and departments receive a visit.

Patient Assessors' Summary
The assessors were generally dismayed at the standards of cleanliness they perceived this year. Also in some areas new assessors commented that they were concerned as to whether the required quality of care could be delivered in the poor environments.

5. Waste Management

Although waste bins have been replaced in some areas and labels have been provided, it was apparent, from this year's assessment that there is still a long way to go. There is evidence of inappropriate disposal of waste into the wrong waste streams. Within our sites we do not have sufficient domestic waste bins of an acceptable condition and this is a key area to be addressed. With the purchase of the necessary domestic bins the Trust could realise significant savings by reducing clinical waste disposal costs.

6. Food and Hydration

The Trust does now have a Food Strategy document and our nutritional audit assessment tools achieved a much improved score of 95% from 71% in 2015. The lack of separate dining areas, meal courses not delivered separately, no hot breakfast choices, patients not always being made ready for meal service and non-implementation of Protected Mealtimes are a few of the areas which impact on the food and hydration results. The actual food quality was generally scored as good or very good.

7. General

Since the inception of PLACE in 2013 (which was a replacement of the previous PEAT assessments) the paperwork has been reviewed on an annual basis and has expanded considerably. It is extremely difficult to compare results due to both the reviews and additions/deletions but it should also be noted that the same areas are not visited each year. Issues noted in 2015 on one ward may have been dealt with but the assessors normally do not score that ward the following year, this is particularly the case at the LRI.

It is also important to note that, whilst an extremely disappointing set of results, there are many issues that cannot achieve the highest scores without significant investment e.g. Food – higher scores are achieved if there is a dining room available, if you have a cooked breakfast, if chilled water is available at all times to patients, if each course of the meal is served separately. These are just a few examples. For privacy, dignity and wellbeing, again if every patient has access to their own television, social spaces, patient wifi access etc – all of these impact on the score achieved.

8. Action Planning

Estates and Facilities have developed and distributed individual action plans for each ward and department visited on the days of the assessments. These have been distributed to both nursing colleagues and Estates and Facilities management to action the issues raised and to endeavour to undertake general environmental improvements.

It is noted that these assessments were carried out prior to the transfer of Estates and Facilities services back in-house to the Trust. Historically, we were in dispute with our PSP around the quality of services particularly the standards of cleanliness. Whilst still in the early days post transition and acknowledging that we have stated that it will take us some time to implement change across all of our services, we can't wait to improve some of these critical areas. Our strategy in this area centres around the 3T's. Providing our staff with Technology (the right tools to do the job), Training (the knowledge to do the job properly) and Time (enough time to do the job to the standards that they and we want to achieve). There have been significant improvements by way of deep cleaning and increased resources within domestic services and standards have improved.

Whilst the CQC visit in June did raise some issues in this respect they were mainly related to common and outpatient areas and not areas that we class under the NSC as very high and

high risk areas such as wards. It is these areas that we have being prioritising as we establish new cleaning resources and regimes.

Whilst many of the issues noted in respect of cleaning from domestic services have been addressed there is also a need for further significant investment to improve the general condition of our hospitals if we are to improve the environment and hence improve the Trust's standing within these assessments going forward.

The PLACE process is an extremely onerous one and becomes larger and takes longer each year. However, rather than waiting till next March we intend to carry out a snapshot audit aligned to the PLACE requirements during November to confirm and inform improvement requirements in advance of next year's assessment. The PLACE paperwork will be used to complete this piece of work to ensure that all aspects of PLACE are covered in terms of wards/OPD etc. This will give the Trust an idea of where we may still have issues that can potentially be resolved prior to the full assessment process in March 2017.

9. Support required

The EQB are asked to note the findings in this report related to the publication of the national PLACE results 2016 and support the actions to improve.

UNIVERSITY HOSPITALS OF LEICESTER

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT RESULTS 2015

SITE AND AVERAGES	CLEANLINESS			FOOD & HYDRATION			PRIVACY, DIGNITY AND WELLBEING			CONDITION, MAINTENANCE AND APPEARANCE			DEMENTIA		DISABILITY
	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2015	2016	2016
TRUST AVERAGE SCORE	**98.36%** ↑	**93.74%** ↓	**90.37%** ↓	**83.27%** ↓	**77.01%** ↓	**78.41%** ↑	**83.58%** ↑	**83.65%** ↑	**75.84%** ↓	**88.62%** ↑	**78.90%** ↓	**80.23%** ↑	**67.10%**	**62.72%** ↓	**67.51%**
NATIONAL AVERAGE	**97.25%** ↑	**97.59%** ↑	**98.06%** ↑	**88.79%** ↓	**88.49%** ↓	**88.07%** ↓	**87.73%** ↓	**86.03%** ↓	**84.16%** ↓	**91.97%** ↑	**91.11%** ↓	**93.37%** ↑	**74.51%**	**75.28%** ↑	**80.62%**
GLENFIELD HOSPITAL	**99.81%** ↑	**97.12%** ↓	**95.89%** ↓	**88.87%** ↑	**75.89%** ↓	**81.96%** ↑	**82.00%** ↓	**88.29%** ↑	**83.45%** ↓	**96.61%** ↑	**87.70%** ↓	**87.42%** ↓	**72.89%**	**75.37%** ↑	**80.62%**
LEICESTER GENERAL HOSPITAL	**98.83%** ↑	**91.81%** ↓	**91.5%** ↓	**74.80%** ↓	**87.19%** ↑	**78.41%** ↓	**82.29%** ↑	**82.10%** ↓	**73.30%** ↓	**88.92%** ↑	**77.62%** ↓	**73.79%** ↓	**72.47%**	**62.43%** ↓	**62.86%**
LEICESTER ROYAL INFIRMARY	**97.44%** ↑	**92.96%** ↓	**87.46%** ↓	**86.15%** ↑	**73.38%** ↓	**76.64%** ↑	**86.49%** ↑	**82.16%** ↓	**73.48%** ↓	**80.35%** ↑	**75.33%** ↓	**79.66%** ↑	**62.22%**	**57.22%** ↓	**63.57%**

UHL PLACE Results 2016 - % Comparisons to Peer Group and National Averages

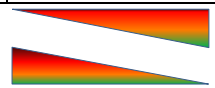
Site	Cleanliness	Food	Privacy, Dignity & Wellbeing	Condition, Maintenance & Appearance	Dementia	Disability (new 2016)
Barts Health	99.72%	84.20%	75.73%	96.02%	64.39%	68.83%
East Kent	98.96%	88.86%	81.42%	95.99%	83.84%	87.84%
Heart Of England	98.67%	92.93%	77.57%	91.51%	60.56%	66.24%
Hull & East Yorks'	97.40%	90.39%	79.31%	88.39%	64.66%	71.03%
Imperial College	98.73%	87.10%	71.77%	91.02%	62.62%	64.82%
King's College	98.54%	97.36%	75.46%	93.47%	78.10%	76.30%
Norfolk & Norwich	99.39%	84.80%	90.23%	92.94%	82.55%	78.91%
Pennine Acute	98.44%	88.96%	84.42%	91.23%	66.00%	72.44%
United Lincoln'	93.34%	82.51%	80.40%	85.72%	61.59%	68.56%
University College London	99.56%	85.98%	86.96%	97.19%	76.90%	85.75%
University Hospital North Midlands	99.52%	88.65%	86.99%	96.81%	80.11%	85.47%
Nottingham	94.83%	85.85%	81.38%	93.40%	72.80%	78.76%
Leeds Teaching	99.67%	94.14%	83.96%	96.91%	72.03%	77.79%
Sheffield Teaching	99.52%	88.27%	86.76%	92.70%	69.04%	73.68%
Central Manchester	97.79%	83.94%	84.42%	96.70%	84.68%	86.19%
Newcastle Teaching	99.91%	88.21%	94.70%	97.07%	58.55%	69.08%
Oxford University	97.29%	82.84%	86.90%	91.83%	77.10%	77.89%
University Hospitals of Leicester	**90.37%**	**78.07%**	**75.84%**	**80.23%**	**62.72%**	**67.51%**
Peer Average	98.31%	87.94%	82.85%	93.46%	71.50%	75.86%
National Average	98.06%	88.24%	84.16%	93.37%	75.28%	78.84%
Ranking 1= Best -18 = Worst	**18**	**18**	**14**	**18**	**15**	**16**

RED = greater than 2% below average

AMBER = within 2% of average

RAG rating agains peer average

RAG rating against national average



UHL PLACE Results 2016 - % Comparisons to Peer Group and National Averages