University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 1 February 2018

Trust Board paper K

Report Title:	Quality and Outcomes Committee – Committee Chair's Report (formal Minutes will be presented to the next Trust Board meeting)
Author:	Hina Majeed, Corporate and Committee Services Officer

Reporting Committee:	Quality and Outcomes Committee
Chaired by:	Ian Crowe, Non-Executive Director
Lead Executive Director(s):	Andrew Furlong, Medical Director Julie Smith, Chief Nurse
Date of last meeting:	25 January 2018

Summary of key matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 25th January 2018:

- **Care Quality Commission (CQC) Inspections – Update** – paper C updated the Committee on a summary of the feedback received following the CQC's unannounced inspections at the Trust in November and December 2017; on the Trust's actions and improvement work in place following the CQC's recent Notice in relation the prescription and administration of insulin; and on the feedback from the CQC's recent well-led review in January 2018. A copy of the CQC's latest Insight Report was appended to paper C. The Committee Chair requested that a summary of changes from the CQC's latest Insight Report be provided to the Committee on a monthly basis.

- **Cancer Performance Quarterly Update** – paper D provided an overview of the Cancer 62+ day breach findings for quarter 2 of 2017-18 highlighting the individual tumour site data around key themes and actions identified to improve waiting times, where appropriate. It was suggested that it might be better to allocate a theatre for robotic surgery rather than allocating the robot for a particular specialty each week. The Medical Director, Interim Chief Operating Officer and the Cancer Centre Clinical Lead were asked to consider whether the utilisation of the current robot was reaching its capacity and whether a second robot was required. In discussion on improving working practices in relation to tertiary referrals, it was noted that a new Head of the Cancer Alliance had been appointed and she would be meeting with the Trust's Cancer Leads to take this matter forward. The Committee Chair requested a quarterly report on Cancer Outcomes and Harms (i.e. Trust's current position including a comparison with peer Trusts and actions being taken to improve standards) with the first draft of the dashboard being presented to the Committee in March 2018.

- **Mental Health Strategy Update –** the Committee received an update on the mental health work being undertaken across the Trust, on the mental health inspector's feedback following the CQC's unannounced inspections at the Trust in November and December 2017; on the joint CQUIN with Leicestershire Partnership Trust (LPT) for mental health patients attending the Trust's Emergency Department; on the bid for wave 2 transformational funding to expand the provision of liaison mental health services; and on the work in progress to develop a Service Level Agreement (SLA) between UHL and LPT for the provision of Medical and Neuro Psychology services. A further update was requested to be presented to the Committee in March 2018 with an update particularly on whether the Trust was on-track to achieve wave 2 transformation funding and on the SLA as described above.

- **Dermatology Services Action Plan –** the Medical Director provided a comprehensive update on the background of the Dermatology Service and a summary of the never event review and action plan. In discussion on an action in the action plan relating to the non-availability of medical records in dermatology clinics, it was noted that a number of actions had been put in place and a further update on this matter would be provided to the Committee in April 2018. In further discussion on the inherent risk of paper based medical records, it was noted that one of IM&T's strategies for 2018-19 was to implement paperless records in outpatients. A progress report on availability of medical records in clinics was requested to be provided to the Committee in July 2018.

- **Cost Improvement Programme (CIP) Quality and Safety Assessment** – the Committee noted the CIP quality and safety impact assessment update for month 8 of 2017-18. In discussion on a query raised by the Director of Safety and Risk, it was noted that a robust process was in place for monitoring quality and safety impact of CIP schemes, however, it was suggested that further assurance could be provided at a Trust Board Thinking Day on how the Trust was assured that quality and safety was not being compromised.

- **Quality and Outcomes Committee – Annual Work Plan 2018-19** – the Committee received the Annual Work Plan for 2018-19 set out in paper H and some amendments were suggested. The Director of Clinical Quality in particular was asked to update the work plan in light of the amendments suggested.

- **Safety and Quality of Emergency Care** – the Committee received the Emergency Department Quality Scorecard for the period ending 31st December 2017 and noted performance against the indicators set out therein. Quality concerns remained around performance against the 4-hour emergency care target, trolley waits, re-attendance rates and ambulance handover times. The Medical Director advised that a review of re-attendance rates would be undertaken in future, when resources improved.

- **Patient Safety Report –** the Director of Safety and Risk reported that two serious incidents including one never event had been escalated in December 2017. She highlighted the following issues in particular: - importance of all staff following national and local checking processes, the need to improve the quality of clinical documentation and the importance of local leadership for safety. There had been an increase in the number of complaints related to cancelled operations which was owing to emergency activity. A brief update on the revisions to the Never Events policy and framework was provided.

- **Nursing and Midwifery Quality and Safe Staffing Report - November 2017** – the Committee noted those wards which had triggered a 'level 2 concern' and 'level 1 concern' in the judgement of the Chief Nurse and Corporate Nursing Team, as set out in paper K. No wards had triggered a 'level 3 concern' in November 2017. Registered Nurse vacancies had increased in month and were reported at 543 WTE.

- **Retained Guidewire Never Event** – paper L was noted for information.

- **Never Event Action Plan Update** – the Committee was advised that a Never Event Safety Summit had been set up following a number of never events within the Trust. The Summit had resulted in developing a Never Event Action Plan which was outlined in paper M. A key component of the action plan was the implementation of the new Safer Surgery Policy, supported by a Stop the Line Campaign. The action plan would be monitored as part of the Quality Commitment for 2018-19.

- **Imaging Investigation Rejection Working Group** – the Committee received a report on actions taken under the auspices of this Working Group to prevent further occurrences of the rejection of requests for imaging, leading to patient harm. The Working Group had dealt with all the actions within its remit and some actions had been transferred to relevant Committees and increased service engagement had been planned with CCGs. The Committee Chair requested that a list of the non-completed actions and the Committees that would be taking those forward be provided to the Quality and Outcomes Committee, for information.

- **Facilities Update** – paper O updated the Committee on the Estates and Facilities performance data for the provision of key services across UHL. The previously reported plateaued performance standards had continued and remained short of overall targets across services apart from Patient Catering. Financial pressures continued to challenge the maintenance of standards and the pace of service development required to progress improvement. Responding to a query, the Director of Estates and Facilities undertook to present an updated report on the theatre refurbishment programme to the Committee in February 2018.

- **Acting on Results Quarterly Update** – paper P updated the Committee on progress against the 2017-18 Quality Commitment to implement revised processes to improve diagnostic results management. The Deputy Medical Director advised that although the Acting on Results programme had made progress in some supporting areas, the main element of developing ICE and using the Mobile Version 7 had been significantly delayed owing to IT issues relating to product configuration. Therefore, a full rollout of Mobile ICE would not be delivered by March 2018 as previously envisaged. Therefore, for the remainder of 2017-18, focus would now shift to encouraging the changes required to enable Clinicians to file the results on ICE. This would require a detailed communication and engagement plan. CONSERUS (messaging of unexpected findings in radiology) was now operational and being piloted in Respiratory Medicine. Acting on Results had been included in the first draft of the 2018-19 Quality Commitment to enable this work to continue to fruition. In response to a request to support inclusion of this work into next year's Quality Commitment, the Medical Director noted that one of the IT priorities for 2018-19 was to support the Quality Commitment work streams. The Chief Executive took an action to liaise with the Chief Information Officer in respect of (a) the need for dedicated IT resource to take forward the upgrade to ICE 7 and building an interface between ICE and Patient Centre, (b) on-going resource to resolve issues when the upgraded system was in place, (c) resources required to assist Clinicians to file the results on ICE (which was being done on a temporary basis until the Mobile ICE solution was fixed), and (d) ownership of various IT systems used within the Trust.

- **#Neck of Femur (NOF) Update** – paper Q updated the Committee on performance against the agreed standards for operating on patients with fractured neck of femurs within 36 hours of presentation and the challenges that still remained. An action plan was appended to paper Q.

Matters requiring Trust Board consideration and/or approval:

The Committee agreed that the Committee Chair should report to the Trust Board that the Imaging Investigation Rejection Working Group had completed its work and all actions had either been dealt with or had been transferred to existing workstreams.

The Committee Chair was requested to highlight the 62 Day Cancer Breach Thematic Findings and 104 Day Cancer Patient Harm Reviews as appended to this summary.

Matters referred to other Committees:

None

Date of next meeting:	22 February 2018

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Executive Quality Board / Quality Outcomes Committee**

DATE: **9 January 2018 / 25 January 2018**

REPORT FROM: **Sarah Morley – Deputy Head of Performance – Cancer**

SUBJECT: **Q2 62 Day Breach Review Analysis**

Introduction

The purpose of this report is to highlight the following:

- Number of 62+ day breaches by month
- Thematic review of contributory factors impacting on delays
- Avoidable non clinical delay reasons

The national threshold for the 62 day target reflects an understanding that some pathways are clinically complex or affected by patient choice factors and are therefore not deliverable within the timeframe. For such patients – a pathway in excess of 62 days (breach map) is recorded on Infoflex. The review of prolonged pathways aims to elicit those themes and situations where inefficiencies or inadequacies in the process have occurred.

Where themes identified are deemed to be within the gift of the Trust to resolve, these are added to the Cancer Action Recovery Plan (RAP) which is challenged internally as well as with NHSI and City CCG to ensure a robust approach to performance improvement.

Quarter 2 01/07/2017 – 30/09/2017

The graph below outlines the number of cancer patients treated (between day 63 and 103) by month by tumour site in Q2 2017-2018.

Of the 158 breaches, 31 were Tertiary referrals.

In comparison with Q1 and in reflection of the activity towards reducing the 62 Day Backlogs, an additional 26 patients were removed from the backlog in Q2 compared to Q1.

Performance comparisons for 62 Day shows a deterioration in 7 out of 11 tumour groups.

Contributory Factors

Primary Delay reasons taken from Open Exeter categorisation for breach delays:-

Reason	July 2017	August 2017	September 2017
Outpatient Capacity	2	0	0
Administrative Delays	1	1	0
Elective Capacity	1	1	2
Complex Diagnostic Pathway	13	19	24
Treatment delayed for medical reasons	3	0	4
Diagnosis delayed for medical reasons	0	1	1
Patient Choice/Patient initiated delay	3	3	1
Health Care Provider Initiated delay to diagnostic test and/or treatment planning	3	11	11
Other	0	0	13

A more detailed review of delay reasons can be found in the following thematic review by Tumour site.

Themes by Tumour Site

The following table details the Top 3 primary delay reasons for each tumour site for Quarter 2, identifying the average number of delays identified through breach map review analysis conducted with representation from each tumour site.

		TOP 3 Delay Primary Delay Reasons **based on total number of days delay across 3 months*					
		1	Av	2	Av	3	Av
Urology		Late Tertiaries	78	Surgical Capacity	36	Patient Choice	19
H&N		Complex Patients	19	Inpatient Diagnostics	16	Outpatients	5
Lung		Late Tertiaries	65	Oncology	14	Inter-Specialty Referrals	32
Haem		Interspecialty Referrals	30	Clinical Decision Delays	30	Patient Choice	13
Gynae		Interspecialty Referrals	32	Patient Choice	20	Oncology	9
HPB		Late Tertiaries	54	Complex	21	Oncology	6

LOGI		Complex Patients	32	Patient Choice	18	Oncology	12
Sarcoma		*N/A - only 1 breach for Quarter 2*					
UPGI		Complex Patients	30	Oncology	20	Inter-Specialty Referrals	15
Breast		Patient Unfit	34	Patient Choice	23	Oncology	21
Skin		*N/A - only 1 breach for Quarter 2*					

Avoidable Non Clinical Factors

The delay reasons highlighted in the above table are considered to be avoidable non clinical factors within the gift of the Trust to take improvement action against.

In Quarter 2, Oncology outpatient wait times are a common theme across the majority of tumour sites. Any potential risk to patients has been assessed by the CHUGGS CMG and submitted to the risk register. RAP Action IS-8 reflects the latest position on recruitment and interim plans.

Appropriate actions (excluding Oncology) are identified in the table below, which are reflected in line with the Cancer Action Recovery Plan (RAP):-

Tumour Site	Avoidable Non Clinical Factors	Actions
Urology	• Capacity delays to robotic surgery • Pathway delays where patients require Urological and Oncological consultation prior to treatment decision making • Late Tertiaries, ranging from Day 43 to Day 128 • Patient related delays where engagement/non-compliance is evident	RAP Action U-1 RAP Action U-11 RAP Action U-14 & IS-4 RAP Action U-15
Head & Neck	• Lack of compliance with Next Steps in ENT resulting in unnecessary outpatient delays • Diagnostic Capacity and management of.	RAP Action HN-7 See also completed RAP Actions HN-9 & 1
Lung	• Late Tertiaries	RAP Action L-1 & IS-4
Haematology	Inter-specialty referrals are often received in Haem greater than Day 62 due to prior complex pathways. Improved Next Steps performance across all other tumour sites would have the potential to improve referral handover to Haematology as well as delivery on capacity RAP actions for key tumour sites, eg Head & Neck	RAP Action IS-7 Next Steps monthly auditing along with changes to Infoflex – RAP Action IS-10 will support performance improvement across Tumour sites. Next Steps is audited and reported on separately on a b-monthly basis

Gynaecology	• Inter-specialty referrals	RAP Action IS-7
HPB	• Late Tertiaries	RAP Action IS-4
Upper GI	• Inter-specialty referrals	RAP Action IS-7

Recommendations:

The Executive Quality Board / Quality Outcomes Committee is requested to note the content of this report, the Cancer Action Recovery Plan and the following recommendations:

- CMG Leads are requested to ensure that attendance at the breach map review meetings with the Cancer Centre are mandatory remaining a priority

- CMG Leads are requested to remain focussed on ensuring that where appropriate, thematic learning from completion of the breach map reviews is fed back to the clinical teams to prevent future recurrence and ongoing education

- CMG Leads are request to ensure operational management resources to support effective pathway management for all patients on a Cancer pathway remains a top priority within their services

Cancer Performance Q2 -104 Day Harm Review Findings

Author: Dan Barnes, Clinical Lead Cancer Centre & Jane Pickard, Macmillan Lead Cancer Nurse
Sponsor: Andrew Furlong, Medical Director

Executive Summary

Context

This report will provide an overview of the Cancer 104+ day performance for Quarter 2 in line with the National Cancer Waiting Times Backstop Policy 2015.

The report illustrates the Trust overall current position and individual tumour site data where applicable. Avoidable non-clinical factors have been identified and where relevant, actions are linked to the Cancer Recovery Action Plan (RAP).

Questions

1. How many patients have waited 104+ days from referral to their first definitive treatment
2. Was there any potential harm caused to the patients as a result of the wait?
3. Why did these patients wait?
4. What actions are being taken to reduce the waiting times?

Conclusion

1. In Q2 a total of 35 patients waited over 104 days from referral to first definitive treatment.
2. No patient harm was identified as a result and therefore no root cause analysis required.
3. Key themes have been identified including, late tertiary referrals, capacity for prostate robotic surgery, appointment delays for high risk anaesthetic assessment / cardiology and Next Steps compliance.
4. Actions have been identified in the body of the report.

Input Sought

The Executive Quality Board is requested to note the content of this report and support the continued monitoring process of 104+ day harm review process by the Cancer Centre.

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	Not applicable
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	Not applicable
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register — Not applicable

b. Board Assurance Framework — Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken: None

4. Results of any **Equality Impact Assessment**, relating to this matter: None

5. Scheduled date for the **next paper** on this topic: Quarterly

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**Executive Quality Board**
DATE:	**22nd December 2017**
REPORT FROM:	**Dan Barnes - Clinical Lead Cancer Centre** **Jane Pickard - Macmillan Lead Cancer Nurse**
SUBJECT:	**Quarterly Cancer Performance -104 Day Harm Review Findings**

Introduction

In October 2015 the National Cancer Waiting Times Taskforce requested all NHS England Trusts introduce a 'Backstop' policy for prolonged pathways. Specifically the policy should promote a clear, transparent review of pathways which exceed 104 days, to determine whether clinical harm has been caused to the patient by the delay. This is aligned with the reporting capabilities of the Open Exeter data collection system.

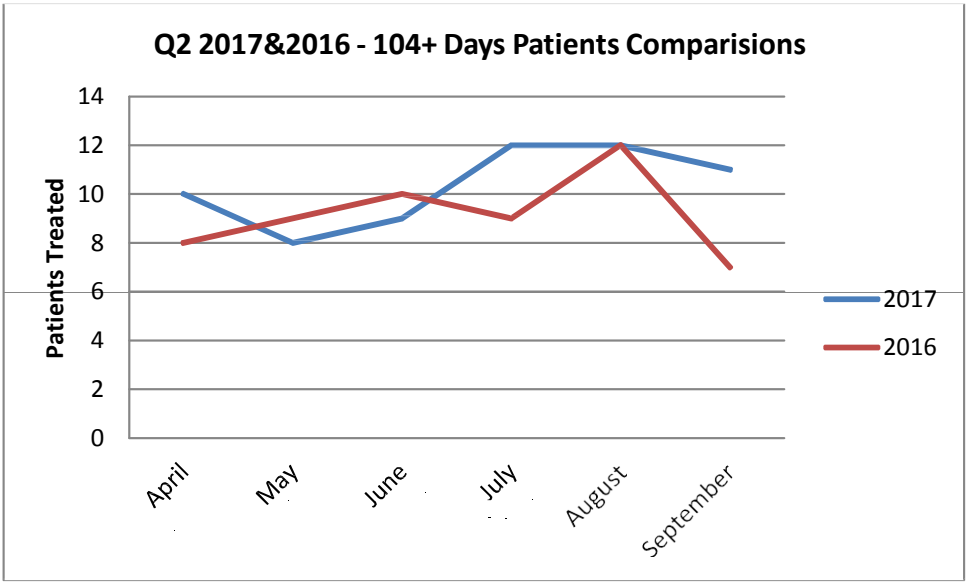
The purpose of this report is to highlight the following:

- Number of 104+ day breaches by month
- Number of 104+ day breaches which has resulted in harm to the patient
- Root Cause Analysis findings for those where harm has been identified
- Thematic review of contributory factors impacting on delays

The national threshold for the 62 day target reflects an understanding that some pathways are clinically complex or affected by patient choice factors and are therefore not deliverable within the timeframe. For such patients – a pathway in excess of 62 days (breach map) is recorded on Infoflex. The review of prolonged pathways aims to elicit those themes and situations where inefficiencies or inadequacies in the process have occurred.

Quarter 2 01/07/2017 – 30/09/2017

The following graph outlines the number of cancer patients breaching for 104 + days from April 2017 – September 2017 in comparison with 2016.



Breaches by Tumour Site:

Tumour Site	No of Patients 104+Days	July 2017	August 2017	September 2017
Head & Neck	1	1	0	0
Lung	4	2	1	1
Urology	15	3	7	5
Gynaecology	6	1	2	3
Breast	1	1	0	0
HpB	1	0	0	1
Lower GI	6	4	1	1
Maxillofacial	1	0	1	0
Total	**35**	**12**	**12**	**11**

Number of completed clinical harm reviews in Q2 = 30

Number of outstanding clinical harm reviews in Q2 = 5

Number of Clinical Harms:

The clinical harm review forms received from the MDT Clinical Leads for Q2 have not identified any clinical harm to patients.

The process continues to be monitored via the weekly Cancer Action Board and at Cancer Board.

Avoidable Non-Clinical Factors:

By reviewing each individual 104 day clinical harm form enables avoidable non-clinical factors that contribute to delays, to be identified as illustrated below by tumour site:

Avoidable Non Clinical Factors	**Actions** Specific actions are contained within the Cancer Recovery Action Plan (RAP)
Late tertiary referral post 104 days Length of time to appointments (out-patient / high risk anaesthetic / cardiology) Next steps compliance Delay to oncology / radiotherapy appointments and treatments Robot capacity – prostate	Action 4.0 Action 8.0 Action 15.0 Action 10.0 Action 1.0

Thematic Review of Continuing Contributory Factors:

- Late tertiary referrals post 104 days in urology
- Multiple diagnostic tests and investigations due to multiple patient comorbidities requiring further detailed investigations before treatment
- Length of time to appointments primarily high risk anaesthetic / cardiology including Next Steps compliance.
- Delays to oncology appointment and subsequent treatment
- Capacity delays to robotic prostate surgery

Recommendations

The Executive Quality Board is requested to note this report and the following recommendations:

- CMG Leads are requested to ensure that 104+ day clinical harm process remains a priority and that the forms are submitted to the Cancer Centre within 14 days as per the SOP
- CMG Leads are requested to remain focussed on ensuring that if potential harm is indicated on completion of a clinical review, that this is escalated timely for subsequent investigation in line with policy
- CMG Leads to ensure where potential harm is identified this is discussed at Quality and Safety Boards

Cancer Performance Q2 2017/18 – 104 Day Harm Review Findings

In Q2 a total of 35 patients waited over 104 days from referral to first definitive treatment.

No patient harm was identified and therefore no root cause analysis required.

Key themes have been identified including, late tertiary referrals, capacity for prostate robotic surgery, appointment delays for high risk anaesthetic assessment / cardiology and Next Steps compliance.