Report by Chief Executive – Monthly Update: December 2019

Authors: John Adler and Stephen Ward Sponsor: John Adler **Trust Board paper E**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for December 2019 is attached. It includes:-

(a) the Quality and Performance Dashboard for October 2019 attached at appendix 1 (the full month 7 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to the Trust Priorities.

Questions

Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding the content of this month's report to the Board.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Yes]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**X**	N/A
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: January 2020 Trust Board
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th DECEMBER 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – DECEMBER 2019**

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1. Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Trust Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2 Quality and Performance Dashboard – October 2019

2.1 The Quality and Performance Dashboard for October 2019 is appended to this report **at appendix 1.**

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 7 quality and performance report is published on the Trust's website.

2.4 ***Good News:***

- **Mortality** – the latest published SHMI (period May 2018 to April 2019) is 99, and remains within the expected range.
- **Diagnostic 6 week wait –** standard achieved for 14 consecutive months.
- **52+ weeks wait –** has been compliant for 16 consecutive months.
- **Delayed transfers of care** - remain within the tolerance.
- **CAS alerts** - compliant.

- **C DIFF** – 7 cases reported this month.
- **Pressure Ulcers** - 0 **Grade 4,** 0 **Grade 3** and 6 **Grade 2** reported during October.
- **Inpatient and Day Case Patient Satisfaction (FFT)** achieved 97% which is above the national average.
- **90% of Stay on a Stroke Unit** – threshold achieved with 90.4% reported in September.
- **TIA (high risk patients) –** threshold achieved with 67.5% reported in October.
- **Fractured NOF** was 79.1% in October, YTD is below target which is 72%.
- **2 Week Wait Cancer Symptomatic Breast** was 97.4% in September.
- **Annual Appraisal** is at 92.4%.
- **Statutory and Mandatory Training** compliance is currently at 95% and has therefore achieved the Trust target.

2.5 ***Bad News***

- **UHL ED 4 hour performance** – 67.0% for October, system performance (including LLR UCCs) was 76.8%.
- **12 hour trolley wait -** 1 breach reported (mental health patient).
- **Ambulance Handover 60+ minutes (CAD)** – performance at 19.6%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the NHSE/I trajectory and 18 week performance was below the NHS Constitution standard at 81.8%.
- **Cancer Two Week Wait** was 90.3% in September against a target of 93%.
- **Cancer 31 day treatment** was 93.0% in September against a target of 96%.
- **Cancer 62 day treatment** was 74.6% in September against a target of 85%.
- **Single Sex Accommodation Breaches** – 3 reported in October.
- **MRSA** – 1 case reported.
- **Cancelled operations OTD** - 1.8% reported in October.
- **Patients not rebooked within 28 days following late cancellation of surgery -** 25.

3. <u>Quality Strategy: Becoming the Best – Update</u>

3.1 Last month, I shared with the Board some of the key themes emerging from feedback following team discussions of Becoming the Best. That feedback has now been provided by over 95% of teams.

3.2 The Executive Team has since reviewed those themes and I set out below our responses:

(a) we recognise we need to ensure a greater focus on patient and public involvement in our strategic change programmes and, consequently, all Trust Priority Lead Directors are to complete a Patient Involvement Assessment, for submission to the Patient and Community Engagement Team;
(b) in addition, all Trust Priority Lead Directors are to undertake a refresh of the 'driver diagrams' for the Priorities for which they are responsible,

(c) noting that the Leadership and Culture Programme Design Phase Synthesis event will be held in January 2020, the Chairman has agreed that we will consider the outcomes at our February 2020 Trust Board Thinking Day. Meantime, 'quick wins' will be implemented – for example, improvements to my monthly Leadership Briefings, with mandated attendance, cascade and feedback.
(d) going forward, all of UHL's staff and leadership development programmes will include appropriate elements relating to Quality Improvement,
(e) Quality Improvement training will be incorporated as part of UHL's statutory and mandatory training programme,
(f) we will develop a framework to ensure that each Improvement Agent has a clear plan for their involvement in Quality Improvement projects,
(g) we will align our clinical audit programme to Becoming the Best,
(h) the Head of Quality Improvement will (i) establish a Quality Improvement Operational Group; (ii) develop formal terms of reference and a workplan for this Group; and (iii) submit a briefing note on key issues arising from meetings of the Operational Group to the Executive Planning Meeting on a fortnightly basis,
(i) the Director of Estates and Facilities is to take forward the implementation of a Becoming The Best 'hub' on the Executive corridor,
(j) we will continue and redouble our efforts to communicate and explain clearly to staff how our investment in Quality Improvement expertise is supporting/will support frontline and corporate staff to make improvements,
(k) we will review the wider meetings structure operating within the Trust in order to release capacity within the organisation,
(l) we will showcase quality improvement projects in our internal briefings and communications to ensure that staff are briefed on the differences which our new approach is helping to bring about.

3.3 I will continue to update the Board monthly on our Becoming the Best progress.

3.4 Our 2019/20 Internal Audit plan includes a review of the implementation of the Quality Strategy. I have attached at **appendix 2** details of the background to, and audit objectives for, this review.

3.5 The outcome of the Internal Audit review will be reported to the Audit Committee, in accordance with usual practice and I will include any key actions arising in this report..

4. <u>Reconfiguration Programme</u>

4.1 Work continues to refresh the Pre-Consultation Business Case (PCBC) with up to date patient activity, financial and bed number information.

4.2 Discussions with colleagues at NHS Improvement/England have indicated that the process to approve the PCBC will take longer than initially anticipated. Due to the restructuring of NHS Improvement/England, a new project team has had to be mobilised to commence the review of the final PCBC.

4.3 In parallel, and given the impending General Election, we have agreed with our Clinical Commissioning Group colleagues to put back our planned engagement with the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny

Committee to discuss our plans for public consultation. We will now meet with the Joint Committee in early 2020.

4.4 We are aiming to commence public consultation at the end of March 2020.

4.5 Notwithstanding the above delays, we now have an agreed timetable for the next key stages. This is set out below:

Date	Milestone	Key people	Notes
18th November	Commence Pre Consultation Business Case (PCBC) review	NHS England/Improvement (NHSE/I)	Orientation session arranged 26/11 (i) General Introduction and (ii) Finance specific. PAU visiting Trust 3/12 to review costings with view to output confirmed by 09/12.
w.c 25th November	Project Check-in - Thursdays	NHSE/I NHSE/I & System	NHSE/I Project Team check-in
16th December	Checkpoint with system	System & NHSE/I	LLR Attendees: Darryn Kerr, Mark Wightman, Nicky Topham, Tim Pearce, Sarah Prema, Richard Morris
20th December	LLR to submit revised PCBC	System	
w.c. 6th January	Review of revised PCBC	NHSE/I	
16th January	Deadline for System Presentation for Regional Panel	System	Summary of the scheme – context and how the Clinical Commissioning Groups (CCGs) are assured that the scheme meets the 5 key tests including financial modelling, capacity & workforce assumptions and high level timeline for key milestones and implementation post-approval
22nd January	**Regional Panel**	System, NHSE/I	To include; CCG Accountable Officer (AO) (Scheme sponsor), Trust Chief Executive (CEO) , Scheme Director, Finance, Clinical, Estate and Engagement Lead (will focus on any outstanding issues relating to the 5 key tests, financial modelling, capacity & workforce)
31st January	Deadline for System Presentation for OGSCR	System	Summary of the scheme – context and how the CCGs are assured that the scheme meets the 5 key tests including financial modelling and capacity & workforce assumptions and high level timeline for key milestones and implementation post approval

11th February	**Oversight Group for Service Change and Reconfiguration meeting**	System, NHSE/I	To include; CCG AO (Scheme sponsor), Trust CEO, Scheme Director, Finance, Clinical, Estate and Engagement Lead. Plus Director of Strategy and Regional Head from NHSE/I. Present case and confirms how scheme meets the 5 key tests as above. Regional confirmation of outcome from Regional Assurance Panel/process
20th March	Anticipated date for Delivery and Quality Performance Committee in Common outcome confirmed	NHSE/I	Expected to be issued via correspondence to CCG AO Date subject to Delivery and Quality Performance Committee in Common (DQPCiC) outcome confirmed
Late March	CCG Governing Board approval	System	Date subject to DQPCiC outcome confirmed
31st March	**Consultation commences**	**System**	**Assuming all approvals in place**

4.6 A 'resource map' is in the course of preparation which will identify in detail the tasks, skills and resources required within the Clinical Management Groups and Corporate Directorates, and Project Team, to deliver the Reconfiguration Programme. Further details will be shared at the Trust Board Thinking Day on 12th December 2019.

4.7 Work is also in hand to establish a formal governance structure for the Programme. Again; further discussions will take place at the Trust Board Thinking Day on 12th December 2019.

4.8 A further report on the Programme will be submitted to the Board on 9th January 2020, to include recommendations to formalise the governance structure of the Programme.

5. <u>Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership – Development of a System Financial Framework</u>

5.1 As discussed at the November Trust Board Thinking Day, work is continuing to establish a radically different System Financial Framework for implementation in 2020/21. For acute services, this will move away from the tariff based approach, and for mental health and community services it will move away from block contracts. Funding will instead be based on expenditure, with financial risk being shared equitably across all the NHS partners. Through this mechanism, it is hoped that plans can be more joined-up and the perverse incentives that currently operate will be removed.

5.2 Following support for the direction of travel from the boards of the 3 Clinical Commissioning Groups, Leicester Partnership Trust and ourselves, the technical

agreement is now being prepared. It is anticipated that formal approval will be sought from partner boards early in the New Year.

6. Emergency Care

6.1 Emergency care pressures have continued unabated during November 2019 and these have impacted on our performance against the 4 hour standard and, of most concern, on our ambulance handover performance.

6.2 October 2019 saw only 32% of ambulance handovers completed within the national 15 minute standard, which was a serious deterioration in our performance. Failure to release ambulances in a timely way has an obvious impact on the ability of the ambulance service to respond to incoming emergency calls.

6.3 The root cause of these problems is a shortfall in medical bed capacity at the Royal Infirmary. In light of this, we have opened our winter capacity earlier than originally planned at both the Royal Infirmary and Glenfield (a total of 56 additional beds). An additional physical ward will shortly become available at the Royal Infirmary and we are assessing whether that could be safely opened given staffing constraints.

6.4 Given the limitations of our capacity, we have once again reviewed our approach to emergency care in the context of our Trust Priorities, 'streamlined emergency care' and 'safe and timely discharge'.

6.5 This work has also been informed by the experience of our 'Perfect Day' initiative at the LRI on 20th November 2019, a site-wide initiative to try and drive discharges to kick-start patient flow and improve our emergency care performance. This involved over 80 non-ward based staff at middle and senior management levels working closely with ward teams to identify, resolve and escalate any avoidable delays in the patient's journey.

6.6 High level themes that emerged from this initiative were as follows:

(a) knowledge of pathways into the community and how they could be accessed – on our wards there was a lack of understanding of the criteria for community pathways, and of the correct ways to access these in a timely manner;

(b) the need for a correct assessment on Day 1 – incorrect/incomplete assessments meant that patients were set on an incorrect path that then needed to be rectified;

(c) correct use of our systems for real time information – to enable fast, accurate decision making we need to be better at recording the status of our patients in our electronic systems;

(d) wards need more structured patient rounds – the staff on ward/board rounds were not always the right people and they were not all taking part in a systematic manner across the hospital;

(e) the process for prescribing and dispensing drugs to take home still needs to be more consistent.

6.7 We are now working on an action plan which will respond to the above themes (and others) and which will form the basis of a revised approach to the two relevant Trust Priorities. I will report further on this at the Board meeting.

6.8 Our emergency care performance continues to be the subject of report by the Chief Operating Officer monthly to the People, Process and Performance Committee. Details of that Committee's most recent discussions are set out in the summary of that meeting which features elsewhere on this Board agenda.

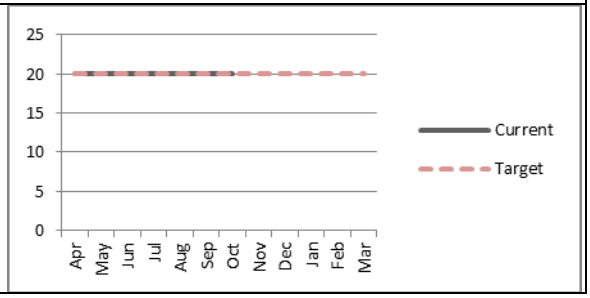
7. Board Assurance Framework (BAF) and Organisational Risk Register

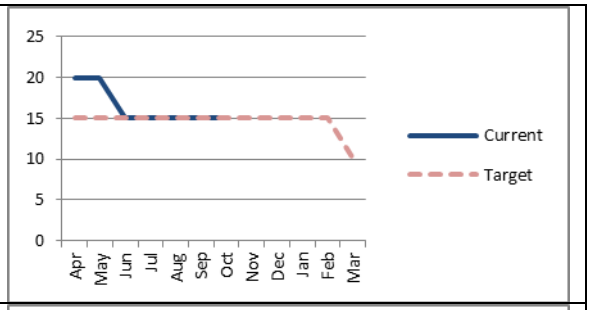
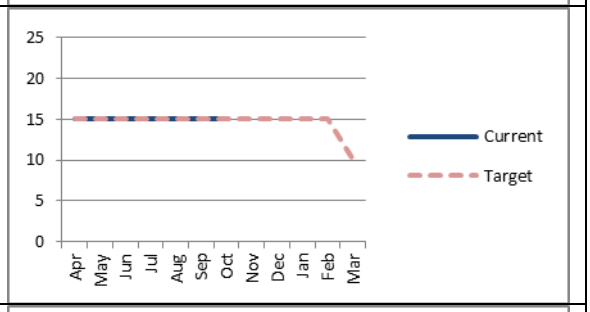
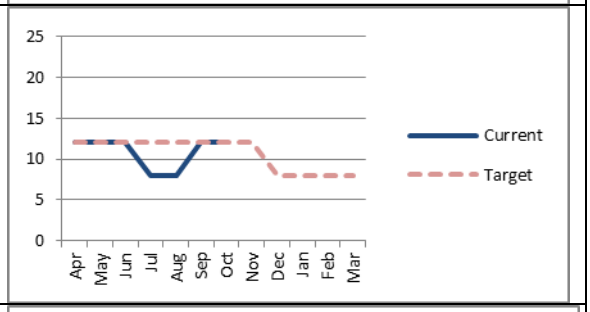
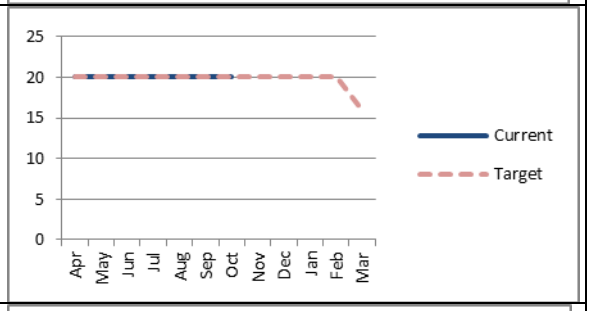
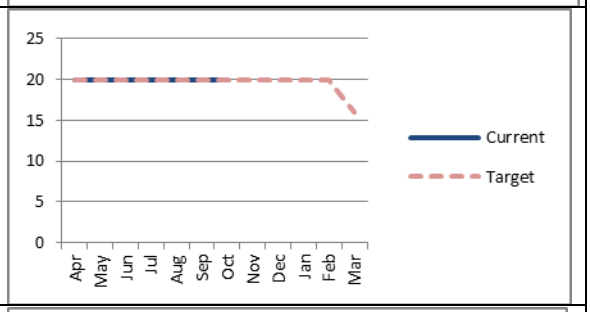
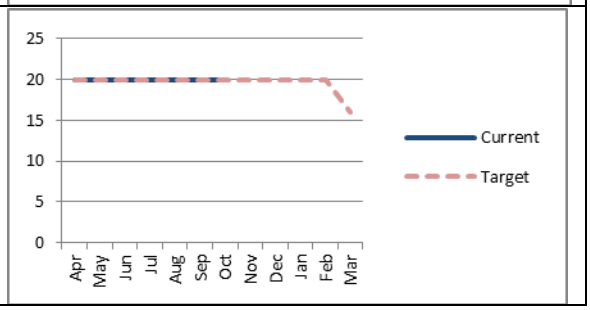
7.1 The Trust Board approved the 2019/20 BAF for quarter two at its meeting in November 2019. Since that meeting, in line with our BAF governance arrangements, all Executive Directors have reviewed and updated their principal risks for the period ending 31st October 2019.

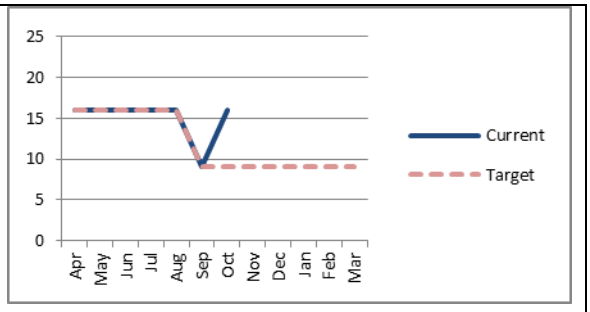
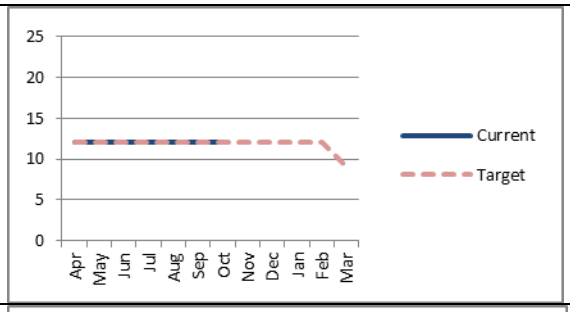
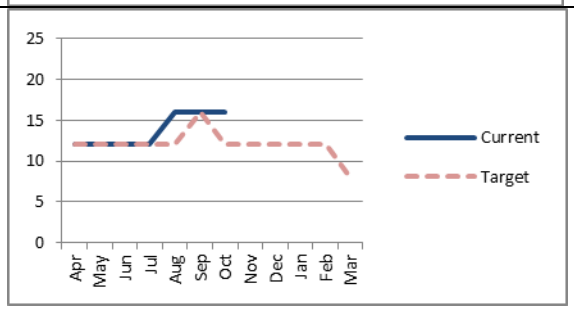
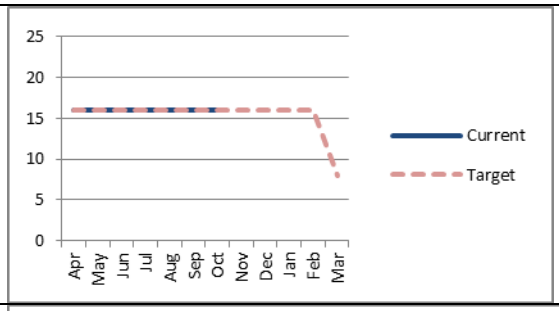
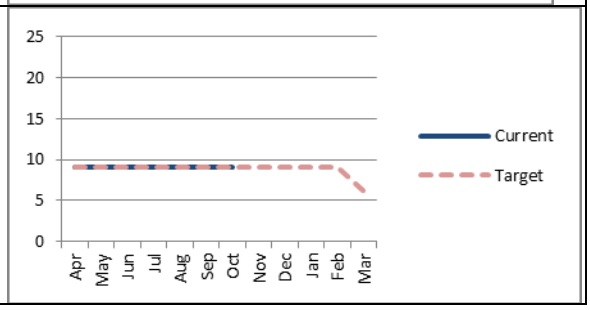
7.2 The highest rated principal risks on the BAF for the reporting period are:

PR No.	Principal Risk Event *If we don't put in place effective systems and processes to deal with the threats described in each principal risk… then it may result in…*	Executive Lead Owner	Current Rating: July (L x I)
1	Failure to deliver key performance standards for emergency, planned and cancer care	COO	5 x 4 = 20
5	Failure to recruit, develop and retain a workforce of sufficient quantity and skills	DPOD	5 x 4 = 20
6a	Serious disruption to the Trust's critical estates infrastructure	DEF	4 x 5 = 20
6b	Serious disruption to the Trust's critical IT infrastructure	CIO	4 x 5 = 20

7.3 Significant changes on the BAF during the reporting period are described in the table below:

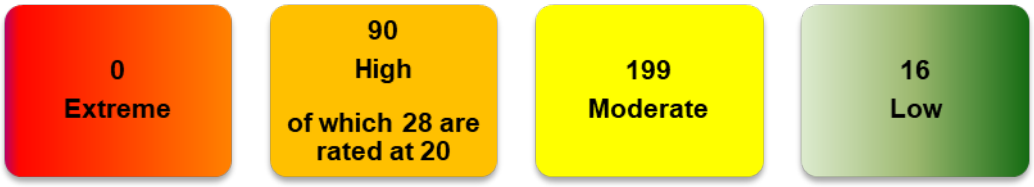
PR No.	Principal Risk Event and changes from previous report	Current Rating (L x I)	Q4 Target (L x I)	Rating timeline
1	Failure to deliver key performance standards for emergency, planned and cancer care No significant change to rating this period	5 x 4 = 20	5 x 4 = 20	

2	Failure to reduce patient harm No significant change to rating this period	3 x 5 = 15	2 x 5 = 10	
3	Serious/catastrophic failure in a specific clinical service No significant change to rating this period	3 x 5 = 15	2 x 5 = 10	
4	Failure to deliver the Quality Strategy to plan No significant change to rating this period	3 x 4 = 12	2 x 4 = 8	
5	Failure to recruit, develop and retain a workforce of sufficient quantity and skills No significant change to rating this period	5 x 4 = 20	4 x 4 = 16	
6A	Serious disruption to the Trust's critical estates infrastructure No significant change to rating this period	4 x 5 = 20	4 x 4 = 16	
6B	Serious disruption to the Trust's critical IT infrastructure No significant change to rating this period	4 x 5 = 20	4 x 4 = 16	

7	Failure to deliver the Trust's site investment and reconfiguration programme within budget The current rating has been amended to 16 (from 9 in Sept) until early draw down of capital announced in September. It is anticipated that the risk score will reduce as the programme progresses through to delivery phase as construction includes a costed risk register.	4 x 4 = 16	3 x 3 = 9	
8	Failure to deliver the e-hospital strategy including the required process and cultural change No significant change to rating this period	4 x 3 = 12	3 x 3 = 9	
9	Failure to meet the financial control total including through improved productivity The risk rating was discussed at FIC in October. The rationale for the current rating is two- fold. Firstly, we have flagged to LLR and NHSI a potential forecast risk to delivery of the Control Total and secondly in the M7 year to date position we have accelerated reserves.	4 x 4 = 16	2 x 4 = 8	
10	Failure to work with the wider system No significant change to rating this period	4 x 4 = 16	2 x 4 = 8	
11	Failure to maintain and enhance research market competitiveness by failing to develop Leicestershire Academic Health Partners No significant change to rating this period	3 x 3 = 9	2 x 3 = 6	

Organisational Risk Register Summary

7.4 The UHL risk register has been kept under review by the Executive Performance Board, the CMG Performance Review Meetings and across all CMGs via their Board meetings during the reporting period and displays 305 organisational risk entries. A breakdown of the risk profile by current rating is shown in the graphic below:



7.5 Thematic analysis across the organisational risk register shows the most common risk causation theme across all CMGs is in relation to workforce capacity and capability. Thematic analysis shows the most common risk effect is potential for harm.

7.6 There have been two new risks rated high (i.e. scoring 15 and above) entered on the organisational risk register during the reporting period and further details are set out at **Appendix 3**.

ID	CMG	Risk Description – New Risks	Current Rating	Target Rating
3549	CMG 5 - MSK & SS	If staffing levels at night time are regularly compromised when a trained nurse is moved from Trauma Wards 17/18 or 32, then it may result in delays with patient treatment, leading to potential harm.	15	6
3512	CMG 8 - The Alliance	If an alternative solution cannot be found to provide imaging cover at Hinckley hospital, then it may result in loss of a portfolio of specialised imaging services including OPD, GP access to plain film x-ray and safe delivery of surgery in theatre, leading to significant financial impact, potential patient harm, significant service disruption and reputational damage.	15	15

8. Health Service Journal Awards 2019

8.1 Huge congratulations to our Leicestershire School of Nursing Associates who won Highly Commended at the latest HSJ Service Awards on 6th November for their initiative - *A Practice Approach to Developing a New Workforce*

8.2 The LLR Nursing Associate Programme is the only one in the country that is practice- led and the Foundation Degree Programme Modules are run by members of the UHL Nursing Education and Practice Learning Team. The Programme is delivered under a collaborative agreement with De Montfort University and funded through the Apprenticeship Levy; it was approved by the Nursing and Midwifery Council (NMC) in September this year and our first cohort of 46 trainees graduated back in the summer, so we have a lot to be proud of this year.

8.3 The Nursing and Midwifery Education and Practice Learning Team have all supported this Programme in some way however specific thanks go to the Programme and Module Team Leaders who have been there from the beginning: Eleanor Meldrum, Annabel Coulson, Claire Agnew van Asch, Ruth Ibbotson, Anna Birks, Marie Knight, Rose Webster and Jane Lawrie.

9. Conclusion

9.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

John Adler
Chief Executive

29th November 2019

Quality and Performance Report Board Summary October 2019

This dashboard uses icons to indicate if a process is showing special cause or common cause variation. It also indicates whether the process is able to meet any stated target. Here is a key to the icons

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of the rules are present then the metric is showing common cause variation.

- An upwards or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits .

Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

Green indicates that the metric has passed the monthly or YTD target while **Red** indicates a failure to do so.

The trend shows performance for the most recent 13 months.

Data Quality Assessment - The Data Quality Forum panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The forum provides scrutiny and challenge on the quality of data presented against the dimensions of accuracy, validity, reliability, timeliness, relevance and completeness.

Quality and Performance Report Board Summary October 2019

Domain	KPI	Target	Aug-19	Sep-19	Oct-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	0	1	0	2	?			May-17
	Overdue CAS alerts	0	0	0	0	1	?			Nov-19
	% of all adults VTE Risk Assessment on Admission	95.0%	97.8%	98.2%	98.2%	98.1%	P			Nov-16
	Emergency C-section rate	TBC	17.8%	21.6%	18.9%	19.4%				TBC
	Clostridium Difficile	108	6	14	7	61	?			Nov-17
	Clostridium Difficile Rate per 100,000 bed days	TBC	13.7	33.1	16.0	20.2				TBC
	MRSA Total	0	1	0	1	2	?			Nov-17
	E. Coli Bacteraemias Acute	TBC	11	6	5	58				Jun-18
	MSSA Acute	TBC	2	4	2	20				Nov-17
	All falls reported per 1000 bed stays	6.02	5.2	4.5		4.7	?	L		Jun-18
	Avoidable pressure ulcers G4	0	0	0	0	0	P			Aug-17
	Avoidable pressure ulcers G3	3	0	1	0	1	P			Aug-17
	Avoidable pressure ulcers G2	7	2	5	6	35	?			Aug-17
	Dementia assessment and referral - Percentage to whom case finding is applied	TBC	89.3%	88.4%		87.7%				TBC
	Dementia assessment and referral - Percentage with a diagnostic assessment	TBC	71%	55%		56%				TBC
	Dementia assessment and referral - Percentage of cases referred to specialist	TBC	100%	100%		100%				TBC

Domain	KPI	Target	Aug-19	Sep-19	Oct-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	TBC	78%	78%		76%				Aug-17
	Single Sex Breaches	0	0	0	3	10	?			Dec-16
	Inpatient and Daycase F&F Test % Positive	96%	97%	97%	97%	97%	P			Jun-17
	A&E F&F Test % Positive	94%	94%	93%	92%	94%	?			Jun-17
	Maternity F&F Test % Positive	96%	96%	94%	96%	94%	?			Jun-17
	Outpatient F&F Test % Positive	94%	95%	95%	95%	95%	?			Jun-17
	Written complaints	TBC	223	201	264	1535				Sep-17

Domain	KPI	Target	Aug-19	Sep-19	Oct-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	TBC	61.0%	61.0%		60.0%				Sep-17
	Turnover Rate	10%	9.1%	8.9%	8.9%	8.9%	P	H		Nov-17
	Sickness Absense	3%	3.8%	3.7%		3.8%	F			Oct-16
	% of Staff with Annual Appraisal	95%	91.9%	92.8%	92.4%	92.4%	F			Dec-16
	Statutory and Mandatory Training	95%	93.0%	95.0%	95.0%	95.0%	F	H		Dec-16
	Nursing Vacancies	TBC	13.6%	12.2%		12.8%				Dec-17

Quality and Performance Report Board Summary October 2019

Domain	KPI	Target	Aug-19	Sep-19	Oct-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	99	100	99	99	99 (Jun 18 May 19)				Sep-16
	Mortality 12 months HSMR	99	93	92	95	92 (Jun 18 to May 19)				Sep-16
	Crude Mortality Rate	TBC	0.9%	1.1%	1.0%	1.0%				Sep-16
	Emergency Readmissions within 30 Days	8.5%	8.9%	9.1%		9.0%				Jun-17
	Emergency Readmissions within 48 hours	TBC	1.0%	1.1%		1.1%				TBC
	No of #neck of femurs operated on 0-35hrs	72%	47.4%	69.2%	79.1%	69.5%				Jul-17
	Stroke - 90% Stay on a Stroke Unit	80%	88.0%	89.5%		88.2%				Apr-18
	Stroke TIA Clinic Within 24hrs	60%	72.4%	57.1%	67.5%	68.0%				Apr-18

Domain	KPI	Target	Aug-19	Sep-19	Oct-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	69.7%	71.4%	67.0%	71.9%				Sep-18
	ED 4 hour waits Acute Footprint	95%	79.4%	80.1%	76.8%	80.3%				Aug-17
	12 hour trolley waits in A&E	0	0	0	1	1				Mar-19
	Ambulance handover >60mins	0.0%	10.1%	8.1%	19.6%	8.9%				TBC
	RTT Incompletes	92%	81.6%	82.0%	81.8%	81.8%				Nov-16
	RTT Wating 52+ Weeks	0	0	0	0	0				Nov-16
	Total Number of Incompletes	64,404	65,903	66,629	66474	66,474				TBC
	6 Week Diagnostic Test Waiting Times	1.0%	1.0%	0.8%	0.8%	0.8%				Mar-19
	Cancelled Patients not offered <28 Days	0	26	26	25	147				Jul-18
	% Operations Cancelled OTD	1.0%	1.3%	1.2%	1.8%	1.2%				Jul-18
	Delayed Transfers of Care	3.5%	1.6%	1.7%	2.2%	1.7%				Oct-17
	Long Stay Patients (21+ days)	135	169	185	193	193				TBC
	Inpatient Average LOS	TBC	3.5	3.4	3.2	3.4				TBC
	Emergency Average LOS	TBC	4.4	4.4	4.7	4.5				TBC

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	91.8%	91.4%	90.3%	92.3%				Jan-19
	2WW Breast	93%	91.9%	97.4%	97.4%	94.5%				Jan-19
	31 Day	96%	92.9%	88.5%	93.0%	92.8%				Jan-19
	31 Day Drugs	98%	100%	100%	98%	99.4%				Jan-19
	31 Day Sub Surgery	94%	86.7%	91.6%	75.2%	83.8%				Jan-19
	31 Day Radiotherapy	94%	97.0%	95.0%	91.7%	96.3%				Jan-19
	Cancer 62 Day	85%	76.3%	72.3%	74.6%	74.7%				Jan-19
	Cancer 62 Day Consultant Screening	90%	85.3%	82.1%	91.4%	84.5%				Jan-19

Terms of reference

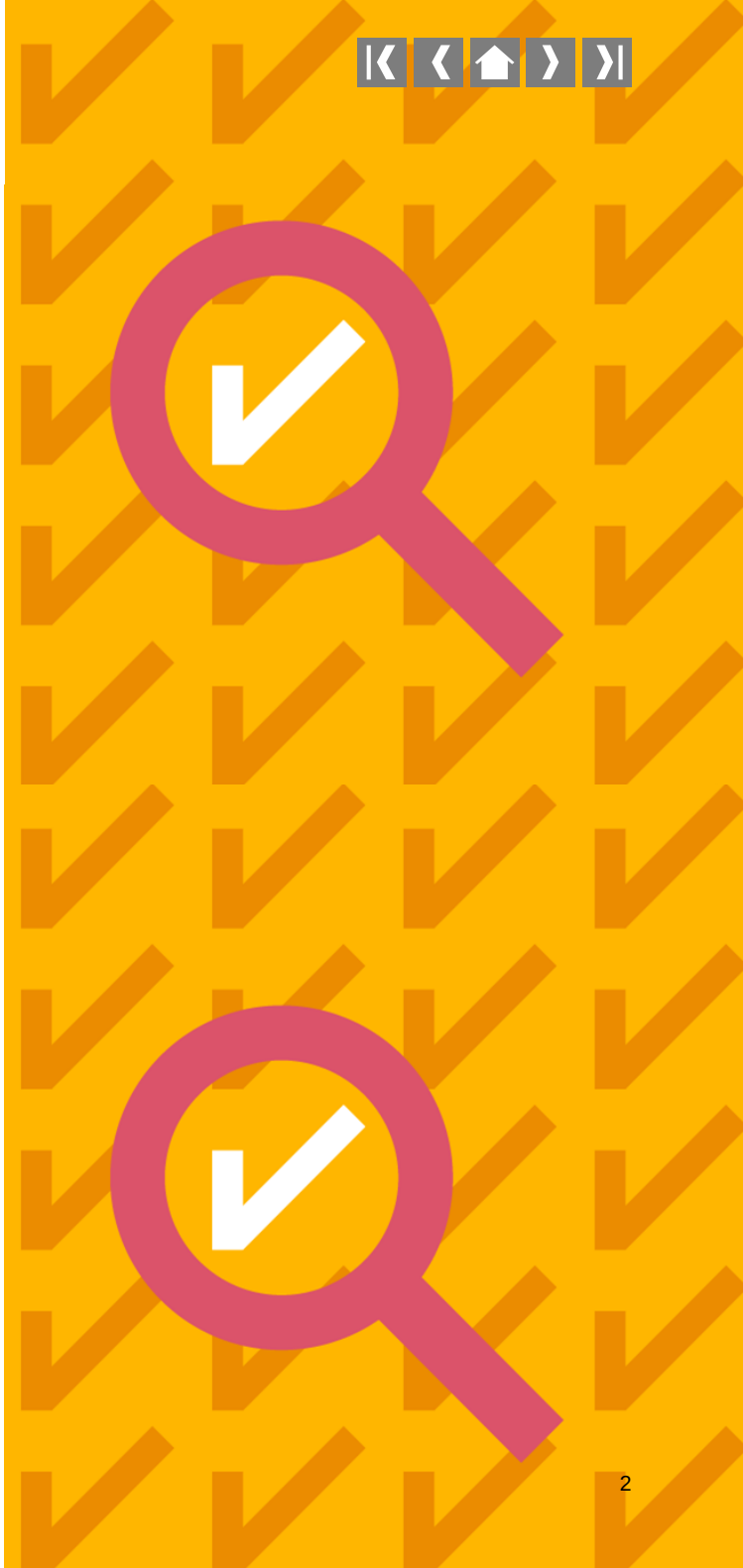
Review of the Quality Strategy

University Hospitals of Leicester NHS Trust
Final
November 2019

Click to launch

pwc

Contents



Background and audit objectives

This review is being undertaken as part of the 2019/2020 internal audit plan approved by the Audit Committee.

Background and audit objectives

The Trust has developed a Quality Strategy covering 2019 to 2022. The purpose of this strategy is to facilitate progress towards the Trust's ultimate goal - to deliver "Caring at its Best" to every patient and to provide a quality improvement framework which will help the Trust to deliver sustained high performance in areas including quality and operational performance.

The Trust has set out six core elements to the framework which will be delivered through a programme of work (see 'Quality Improvement Approach' below). These elements are underpinned by the Trust's values and integral to the framework is patient and public involvement. There are six quality priorities and six supporting priorities that the Trust will be delivering through the Quality Strategy, as set out in the diagram below.

Background and audit objectives

For the last five years, the Trust's priorities for improvements in the quality and safety of its services have been set out in its Quality Commitment, whilst other priority schemes were captured in its 'Annual Priorities'. This year and for the future the Trust has changed that approach in favour of a unified set of priorities all of which are designed to improve quality and safety, either directly or in a supporting way.

Our audit work will focus on a sample of two of the quality priorities, as agreed with management, and two of the supporting priorities. In our review of the priorities, we will assess the governance structure in place, the reporting on the priorities that occurs and the performance indicators in place to measure the Trust's progress against the priorities.

We will also consider progress and the adequacy of programme management arrangements in place around delivery of the overall quality strategy, which includes delivery of the six core elements of the Quality Improvement approach, along with consideration of how the Trust is ensuring continued Public Patient Involvement throughout.

Our review will also consider how well aligned the overarching reporting to the Trust Board on Quality and Performance is to the priorities.

The priorities selected for this review are as follows:

	Priorities selected for review	Shorthand version
	Quality Priorities	
1	We will provide high quality and timely diagnosis & treatment for patients on cancer pathways by redesigning those pathways in conjunction with our partners	Improved cancer pathways
2	We will consistently implement the safest practice for invasive procedures, with a focus on consent, NatSSIPS and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong	Safe surgery and procedures
	Supporting Priorities	
3	We will begin implementation of our new Quality Strategy, focussing initially on developing the right culture, leadership and skills to encourage and enable improvement	Quality Strategy development
4	We will implement our People Strategy, with a focus on attracting and retaining the staff that we need and developing new roles where these will help improve care	People Strategy implementation

Audit scope and approach

Scope

We will review the design and operating effectiveness of key monitoring controls in place during the period 1 April 2019 to 30 November 2019. The sub-processes, risks and related control objectives included in this review are:

Sub-process	Objectives	Risks
Review of overall Quality Strategy		
Quality Strategy delivery (including Quality Improvement approach)	• A robust programme management methodology is applied in delivering the Quality strategy • Roles and responsibilities are clearly set out and work programmes / action plans are in place for driving forward the six core elements of the Quality Improvement approach • There is a clear governance structure in place with regular reporting to oversee delivery of the Quality Strategy • Where issues are identified in delivery of the Quality Improvement approach, there is a clear escalation process in place • Public and Patient involvement is considered throughout the development and delivery of the Quality Strategy	• There is a lack of robust governance and programme management around delivery of the Quality Strategy • Where issues are identified in delivery, these are not resolved on a timely basis • Patients and public are not appropriately engaged in developing and delivering the Quality Strategy
Review of priorities		
Governance around the priorities	• Each Priority has a clearly defined governance structure in place including assigned Executive Leads and Lead Officers • Each Priority has been clearly allocated to appropriate committees/groups to oversee progress being made against the priority • Any issues identified preventing progress towards delivering the Priority are identified and escalated through the Trust's governance structure on a timely basis	• The Priorities do not have clearly assigned leads resulting in a lack of ownership and ultimately a failure to deliver the change required • Progress against the Priorities is not being appropriately overseen leading to a lack of accountability for performance and ultimately a failure to deliver the change required
Reporting on priorities	• Reports are produced on a regular basis that provide sufficient and appropriate detail on a) the actions being taken to ensure the Priorities are delivered and b) progress to-date in delivering the Priorities • Reports are provided to appropriate Trust employees on a timely basis to enable review and challenge of the content and for Executive Leads/Lead Officers to be held to account	• Reports are not being produced on a regular basis to Trust employees that provide sufficient appropriate information to enable an assessment of progress being made against the Priorities leading to a lack of accountability for performance and ultimately a failure to deliver the change required

Audit scope and approach

Sub-process	Objectives	Risks
Review of priorities (continued)		
Measuring performance against priorities	• Each Quality and Supporting Priority has clearly defined performance indicators that appropriately measure the progress the Trust is making in delivering the priorities	• Performance indicators for the Quality and Supporting Priorities are not clearly defined resulting in ambiguous performance reporting and limiting the ability of Trust employees to make an assessment of progress being made against the Priorities leading to a lack of accountability for performance and ultimately a failure to deliver the change required
Overarching reporting to Trust Board	• Information produced for the Trust Board on Quality and Performance, including performance indicators, is clearly aligned to the performance indicators used to measure progress against the Quality Priorities • Actions are being taken to ensure the Trust is on track to deliver the priorities and reporting to Trust Board gives assurance that actions are being taken and changes are happening.	• Performance Indicators used to report on Quality and Performance to the Trust Board are not aligned to those used to measure performance against each of the Quality and Supporting Priorities which could result in inappropriate conclusions/decisions by the Trust Board. • Where priorities are not on track to be delivered, there is a lack of appropriate actions to address this and a lack of reporting to provide assurance around actions being taken

Limitations of scope

This review will focus on only those processes and controls outlined in the above table. Our work will be performed on a sample basis and will not cover all the Trust priorities. Our findings and conclusions will be based on the sample reviewed. We will not provide a view as to whether the priorities chosen by the Trust are appropriate.

Audit approach

Our audit approach is as follows:

- Obtain an understanding of the processes and controls in place for each of the areas identified on slides five and six through a discussion and walkthrough with the Executive Lead/Lead Officer; and
- Test the operating effectiveness of the key controls identified from the work performed above.

Internal audit team and key contacts

Internal audit team

Name	Title	Role	Contact details
Ali Breadon	Partner	Head of Internal Audit	alison.breadon@pwc.com
Charlotte Wood	Senior Manager	Internal Audit Senior Manager	charlotte.l.wood@pwc.com
Tom Hann	Manager	Internal Audit Manager	thomas.o.hann@pwc.com

Key contacts – University Hospitals of Leicester NHS Trust

Key contacts – Overall Quality Strategy

Name	Title	Contact details	Role
John Adler	Chief Executive	John.adler@uhl-tr.nhs.uk	Lead on overall programme management
Rebecca Brown	Chief Operating Officer	Rebecca.brown@uhl-tr.nhs.uk	Lead on 'Understanding what is happening'
Colin Moorhouse	Head of Quality Improvement	Colin.moorhouse@uhl-tr.nhs.uk	Programme manager for Quality Strategy and lead on 'Skills for improvement'
Mark Wightman	Director of Strategy and Communications	Mark.Wightman@uhl-tr.nhs.uk	Executive Lead on 'Working with the wider system' and PPI
Rachna Vyas	Deputy Director of Strategy	Rachna.vyas@uhl-tr.nhs.uk	Lead on 'Working with the wider system'
Karl Mayes	Head of Patient and Community Engagement	Karl.mayes@uhl-tr.nhs.uk	Lead on PPI

Key contacts – Review of priorities

Priority	Executive lead	Lead officer
Quality Priorities		
Safe surgery and procedures	Andrew Furlong, Medical Director	Colette Marshall, Deputy Medical Director
Improved cancer pathways	Rebecca Brown, Chief Operating Officer	Samantha Leak, Director of Operational Improvement
Supporting Priorities		
Quality Strategy development	John Adler, Chief Executive	Colin Moorhouse, Head of Quality Improvement
People Strategy implementation	Hazel Wyton, Director of People and OD	Bina Kotecha, Assistant Director of Learning and OD & Joanne Tyler-Fantom, Deputy Director of HR

Timetable and information request

Timetable

Fieldwork start	End of November 2019
Fieldwork completed	End of January 2020
Draft report to client	TBC – 2 weeks from closing meeting
Response from client	2 weeks from issue of draft report
Final report to client	1 week from receipt of management response

Agreed timescales are subject to the following assumptions:

- All relevant documentation, including source data, reports and procedures, will be made available to us promptly on request.
- Staff and management will make reasonable time available for interviews and will respond promptly to follow-up questions or requests for documentation.

Please note that if University Hospitals of Leicester NHS Trust requests the audit timing to be changed at short notice and the audit staff cannot be deployed to other client work, University Hospitals of Leicester NHS Trust may still be charged for all/some of this time. PwC will make every effort to redeploy audit staff in such circumstances.

Information request

- Copies of the governance structures in place for overseeing the Priorities
- Copies of minutes and papers for the meetings involved in the above governance structures since 1 April 2019

Thank you

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In the event that, pursuant to a request which University Hospitals of Leicester has received under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004 (as the same may be amended or re-enacted from time to time) or any subordinate legislation made thereunder (collectively, the “Legislation”), University Hospitals of Leicester]is required to disclose any information contained in this document, it will notify PwC promptly and will consult with PwC prior to disclosing such document. University Hospitals of Leicester agrees to pay due regard to any representations which PwC may make in connection with such disclosure and to apply any relevant exemptions which may exist under the Legislation to such [report]. If, following consultation with PwC, University Hospitals of Leicester discloses any this document or any part thereof, it shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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190219-133533-JS-OS

	CMG	Opened	Review Date	Risk Description	Risk Causation & Impact	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score
3549	CMG 5 - MSK & SS	22/10/2019	31/01/2020	If staffing levels at night time are regularly compromised when a trained nurse is moved from Trauma Wards 17/18 or 32, then it may result in delays with patient treatment, leading to potential harm.	Cause: Trauma wards are established for 3 registered nurses on the Night shift. This is the numbers that are required to safely manage the workload. It is not uncommon to have one of the wards depleted to two trained nurses to cover another area. The department receives/has: Trauma admits emergency unplanned admissions directly from ED which includes a full nursing admission. Movement of outliers in the middle of the night which often is facilitated by moving trauma arou the unit to make beds available on ward 18 for other specialties. Patients requiring treatment that will require two trained nurses I.E Variable rate insulin for NBM patients. Controlled drug administration for pain relief and high numbers of IVAB administration due to the surgical nature of patients. Patients often in an acute post-operative stage of care including spinal surgery hip surgery and mixed trauma requiring RN care. Lengthy drug rounds that can last two hours due to age of patients and medical co-morbidities administrating poly pharmacy. Bleep holder who has to commit time to unit management always depletes the RN nursing hours available on one ward each night this pressure increases with the on-going level of bed pressures. Pressure on nursing staff to still be discharging patients on the night shift due to regular delays in ambulances. High numbers of patients with dementia on the unit . High numbers of pts triggering as frail. Effect: Harm: Delays in treatments/reviews Patient safety will be compromised Staff will have an unmanageable workload Staff will not be able to exercise choice in taking a break away from the clinical area Nurse to bed ration (RN) is not maintained Nursing tasks rolled over to the morning shift impacting the next day Increase in incident reporting due to harm levels rising Reputation: Patient Experience figures decline. Staff do not recommend us as a place of employment	Preventive: Ward mangers roster 3 trained nurses on the night shift before filling all other shifts Twilight put out on 18 as a temporary measure but now have withdrawn this as not successful resulting in a substantive being moved and continuing to deplete the nurses. Acuity updated on handover Detective: Matrons attempt to protect nurse from being moved give rationale regarding areas at staffi meetings. Monitoring incident forms. Silver nurse informed. Corrective: CMGs being able to safely staff their wards with contingency plans.	Moderate	Almost certain	15	Silver nurse is keeping a log of wards running on two nurses - 31/01/20 Matron to articulate reasons for staff to be left in situ at the staffing meetings - 31/01/20 To promote awareness within the CMG regarding dependency of the patients to eliminate the culture of moving staff from trauma - 31/01/20	6
3512	CMG 8 - The Alliance	23/10/2019	31/10/2020	If an alternative solution cannot be found to provide imaging cover at Hinckley hospital, then it may result in loss of a portfolio of specialised imaging services including OPD, GP access to plain film x-ray and safe delivery of surgery in theatre, leading to significant financial impact, potential patient harm, significant service disruption and reputational damage.	The plain film static imaging Service has ceased in Hinckley due to unsafe old equipment and risk of harm to staff. This links to risks 3090 - The condition of Hinckley Estate which has been on the risk register since September 2017, and 3504 (previously 2809) Lack of access to capital funding which has been on the risk register since March 2016. The Imagining intensifier in theatres remains operational as does the Ultrasound service. If an alternative solution cannot be found to provide imaging cover in theatre and imaging requirements in OPD then there is a risk that: 1. There will be no direct access / GP access for plain film imaging at Hinckley and Distric hospital; patients will therefore be required to travel to Coalville or Glenfield hospital for plain film imaging 2. Lost swabs, needles and medical equipment in theatre will not be able to be located using imaging (a potential Never Event) 3. Plain film assessment of the anaesthetised patient will no longer be available to check for complications related to anaesthetic (e.g. pneumothorax) 4. Patients may need to stay anaesthetised on the theatre table for longer whilst awaiting a radiographer to travel from another site, or may need to be transported as an emergency to LRI for imaging 5. Delays or cancellations of other cases on the theatre list may occur whilst waiting for Imaging support from other sites 6. Disruption to the day to day business of outpatients will occur. 7. Inconvenience for patients being asked to travel to other sites for imaging prior to or after their OPA 8. Patent may need to have an additional follow up OPA which otherwise would not be needed due to lack of available imaging on the day. 9. Clinicians not being able to request imaging at the time they need it 10. Damage the reputation of the Alliance - patients may not want to be treated at Hinckley 11. Financial impact of loss of income 12. Activity may be lost from LLR to George Elliott Hospital due to patient / GP choice.	Preventive: 1. Team brief to identify specific patient issues and assess if a risk if X-ray is not available 2. Strict swab and needle counts in theatre for every procedure in line with Safer Surgery guidance. 3. All equipment accounted for before the patient is closed and leaves theatre 4. GP's advised of alternative arrangements 5. Visiting consultants advised of alternative arrangements 6. Patients asked to attend other sites for an x-ray / imaging procedure in advance of their OPA. Detective: 7. Missing swabs and needles are noted and acted upon before the patient leaves theatre. 8. Image intensifier available to make an initial assessment of a situation in theatre when radiographer available 9. Use of magnetic needle finder for needles dropped outside the patient (floor / bed) 10. Admin check and note patients who have not had the necessary imaging prior to their OPA and escalate to manager Corrective: 11. GP's advised of alternative arrangements 12. Visiting consultants advised of alternative arrangements 13. Patient transfer to Glenfield Hospital or LRI for further investigation of missing swabs and needles 14. Patients to be booked into an appointment at the nearest hospital of their choice,(Coalville or Glenfield) or attend the direct access service at GH for routine elective plain film x-rays	Moderate	Almost certain	15	Risk tolerated: Alliance to work with CSI on contingency plan to cover theatre for lost needles / swabs in theatre. Update 13.11.19: UHL have agreed to fund 2 new x-ray machines and any building work required to install these. This will then allow the service to restart. Review January 2020. C Carr	6