CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – MARCH 2019

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

Executive Summary

Context

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

(a) the Quality and Performance Dashboard for January 2019 attached at appendix 1 (the full month 10 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities.

Questions

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

Conclusion

1. 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

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	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

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

a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [April 2019 Trust Board]

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: **TRUST BOARD**

DATE: **7 MARCH 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MARCH 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 Annual 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 –January 2019

2.1 The Quality and Performance Dashboard for January 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 10 quality and performance report is published on the Trust's website.

Good News:

2.4 **Mortality** – the latest published SHMI (period July 2017 to June 2018) is 96 and "below expected". **Diagnostic 6 week wait –** standard achieved for 5 consecutive months. **52+ weeks wait –** has been compliant for 7 consecutive months. **Referral to Treatment –** our performance was below the national standard, however, we achieved the NHS Improvement trajectory (which is the key performance measure for 2018/19). **Delayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **12 hour trolley**

wait 0 in January. **MRSA –** 0 cases reported this month. **C DIFF** – below threshold this month. **Moderate harms and above** – December (reported 1 month in arrears) was below threshold. **Pressure Ulcers** - 0 **Grades 4 and 3** reported during January. **Grade 2** was also below threshold for the month. **CAS alerts** – compliant in December. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured Neck Of Femur** –remains compliant for the sixth consecutive month. **Cancelled operations** and **Patients rebooked within 28 days** – we continue to show improvement with our elective cancellations. **Annual Appraisal** is at 91.9%. **TIA (high risk patients)** – 83.5% reported in January.

Bad News:

2.5 **UHL ED 4 hour performance** – was 70.7% for January, system performance (including LLR UCCs) was 79.1%. **Single Sex Accommodation Breaches** – 9 reported in January. **Cancer Two Week Wait** was 80.2% in December. **Cancer Symptomatic Breast** was 26.8% in December. **62 day treatment** was not achieved in December – further detail of recovery actions in is the cancer recovery report submitted to the People, Process and Performance Committee. **Ambulance Handover 60+ minutes (CAD+)** – performance at 13%.**90% of Stay on a Stroke Unit** –77.9% % reported in December. **Statutory and Mandatory Training** reported from HELM is at 88%.

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

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review and a detailed BAF and an extract from the risk register are included in the integrated risk and assurance paper featuring elsewhere on today's Board agenda.

Board Assurance Framework

3.2.1 The BAF remains a dynamic document and all principal risks have been updated by their lead Directors (to report performance for January) and have been reviewed by their relevant Executive Boards during February 2019, where they have been scrutinised ahead of the final version submitted to Board today.

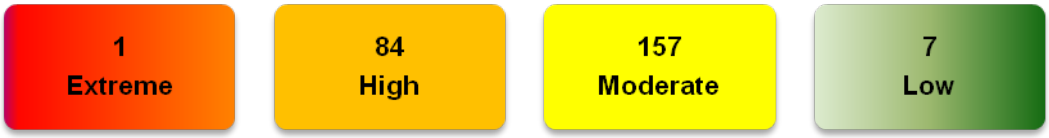
3.2.2 The highest rated principal risks on the BAF are described in the table below:

Principal Risk Description 2018/19	**Risk Rating (IxL)**	**Objective & Lead Director**
PR2: If the Trust is unable to achieve and maintain the required ***workforce capacity and capability*** standards, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, impacting business (quality / finance) and reputation (regulatory duty / adverse publicity).	5 x 4 = 20	Our People DPOP
PR3: If the Trust is unable to achieve and maintain ***financial sustainability***, then it will result in a failure to deliver the financial plan, impacting business (finance & quality) and reputation (regulatory duty / adverse publicity).	5 x 4 = 20	Financial Stability CFO

PR4: If the Trust is unable to effectively manage the ***emergency care pathway***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, impacting business (quality & finance) and reputation (regulatory duty / adverse publicity).	5 x 4 = 20	Organisation of Care COO
PR6: If the Trust does not adequately develop and maintain its ***estate***, then it may result in an increased risk of failure of critical plant, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.	5 x 4 = 20	Key Strategic Enabler DEF

Organisational Risk Register

3.3 The Trust's organisational risk register has been kept under review by the Executive Performance Board and across all CMGs during February 2019 and displays 249 risks:



3.4 Thematic analysis of the organisational risk register shows the most common risk causation theme is workforce shortages. Thematic findings from the risk register are reflective of our highest rated principal risks captured on the BAF.

4. <u>Emergency Care</u>

4.1 Our performance against the four hour standard for December 2018 was 70.7% and 79.1% for Leicester, Leicestershire and Rutland as a whole.

4.2 We saw a total of 21,624 patients in the Emergency Department and Eye Casualty in December, an increase of 1,560 patients (8%) on December 2017. Year to date ED activity growth stands at 6%.

4.3 We have seen an unusually high level of attendances in injuries, child majors and the Children's Hospital. Increased acuity is also evident.

4.4 We continue to perform well against our peers for 'stranded patients' – Delayed Transfers of Care also remain low against the national benchmark

4.5 We have continued to experience challenges in respect of ambulance handover performance. However, in January we have agreed further measures to help speed flow into and through the Emergency Department, and have accordingly revised our escalation protocols. February performance has been much improved.

4.6 System-wide collaboration has improved during peak periods of activity and the Trust has had to declare its highest state of escalation – Level 4 – on three occasions only during January 2019, a significant improvement on the same period last year.

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

5. Staff Residences – Leicester General Hospital

5.1 In February 2019, we sent letters to staff residents of Hospital Close, Leicester General Hospital about our intentions to close down that accommodation. The plans to close this accommodation stem from our inability to invest the necessary capital money (£5m) to bring that accommodation up to standard and in line with statutory regulations, such as fire safety.

5.2 We recognise we have a responsibility to spend public money wisely and we must therefore prioritise using scarce capital to maintain our key clinical infrastructure and replace medical equipment.

5.3 We will continue to go above and beyond to help the affected staff find new homes and that will continue until the last person is rehomed; extending the closure period by a few months if necessary. There are a series of roadshows which have started this week, we are working with private landlords and estate agents who are supporting the process and we are in regular communication with those residents to help them.

5.4 Everyone is aware that our long term plan is to concentrate most of our acute services in new facilities at the Royal Infirmary and Glenfield Hospital. However, that plan is not why we are closing the residential accommodation at the General Hospital. We have been unable for a number of years to afford to upgrade the accommodation. We have had to prioritise upgrading spaces where we treat and care for our patients and we simply cannot afford to maintain these buildings for staff.

6. Leicester, Leicestershire and Rutland health and social care system – update

6.1 There have been a number of developments at system level to make the Board aware of:

6.2 Following the decision to create a single-management structure across the three local Clinical Commissioning Groups, recruitment is underway for the new joint Chief Executive (Accountable Officer). Interviews will be held on 26th March and I will be a member of the panel.

6.3 The workstreams and programme organisation of the Sustainability and Transformation Partnership (STP), otherwise known as Better Care Together, have been updated to reflect the NHS Long Term Plan, ensure greater coherence and less duplication. The workstreams will now be:

Core programmes:

- Primary care
- Cancer

- Urgent and emergency care
- Integrated community services
- Mental health
- Learning disability
- Children and maternity
- Prevention and health inequality

Enabling programmes:

- Information management and technology
- Workforce
- Finance and contracting
- Communication and engagement

In addition, the System Leadership Team (SLT) has decided to establish a time-limited taskforce for End of Life Care (EOLC), similar to the approach adopted in 2018/19 for Frailty. This is a very positive development as work on EOLC has been somewhat fragmented and lacking in profile. The Frailty Taskforce has now completed its work and an end of programme report will be presented to the next SLT meeting. I will share this as part of my April Board report.

6.4 The SLT has also approved a new Communications and Engagement Strategy, including extensive engagement activity over the coming year. In particular, a large-scale Citizens' Panel is to be established, using funding provided by NHS England.

6.5 Following a series of developmental events during 2018, the SLT has confirmed the terms of reference for a new Partnership Group. This will comprise non-executive, lay and elected representatives from all the partner organisations and will be chaired by a newly appointed Independent Chair in line with the requirements in the NHS Long Term Plan. Recruitment to this role will commence shortly. A timetable of organisational development activity has also been agreed.

7. Quality Strategy (QS)

7.1 Following the discussion of the draft Quality Strategy at the February Trust Board meeting, the final version of the Strategy is attached for approval as appendix 2 to this report.

7.2 The principal changes from the previous draft are as follows:

- A specific statement of Trust Board support for the strategy has been added
- The strapline "Becoming the Best" has been added following a selection process involving our leadership community
- An additional section on patient and public involvement has been added
- The choice of QI methodology has been confirmed
- The role of clinical audit has been clarified

- The relationship between the Quality Strategy and People Strategy has been clarified
- The "unified programme" approach has been further progressed
- The governance arrangements for the strategy have been significantly altered following discussion at a developmental event on 13th February
- Content on the role of research has been added
- Content on equality and diversity has been added

7.3 As stated in the strategy, updates on progress with the implementation of the strategy will be provided through this report.

7.4 The principal area of feedback from the February Board discussion which has not yet been incorporated is risks to implementation. This will be developed alongside the QS Implementation Plan.

8. Conclusion

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

8.2 The Trust Board is recommended to formally approve the new Quality Strategy for implementation.

John Adler
Chief Executive

1st March 2019

Quality & Performance

		YTD Plan	YTD Actual	Jan-19 Plan	Jan-19 Actual	Trend*	Trend Line	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	192	<=12	10	●		Compliant
	S2: Serious Incidents	<37	27	3	2	●		Compliant
	S10: Never events	0	6	0	0	●		Compliant
	S11: Clostridium Difficile	61	52	5	2	●		Compliant
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●		Compliant
	S13: MRSA (Avoidable)	0	1	0	0	●		Compliant
	S14: MRSA (All)	0	1	0	0	●		Compliant
	S23: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	6.7	<5.6	7.0	●		Feb-19
	S24: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●		Compliant
	S25: Avoidable Pressure Ulcers Grade 3	<27	6	<=3	0	●		Compliant
	S26: Avoidable Pressure Ulcers Grade 2	<84	50	<=7	4	●		Compliant
Caring	C3: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●		Compliant
	C6: A&E friends and family - % positive	97%	95%	97%	95%	●		See Note 1
	C10: Single Sex Accommodation Breaches (patients affected)	0	51	0	9	●		See Note 1
Well Led	W13: % of Staff with Annual Appraisal	95%	91.9%	95%	91.9%	●		Mar-19
	W14: Statutory and Mandatory Training	95%	88%	95%	88%	●		Mar-19
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 3	28%	29.0%	28%	29.0%	●		Compliant
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 3	28%	16%	28%	16%	●		Dec-23
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.0%	<8.5%	9.1%	●		See Note 1
	E2: Mortality Published SHMI (Jul 17 - Jun 18)	99	96	99	96	●		Compliant
	E6: # Neck Femurs operated on 0-35hrs	72%	74.2%	72%	87.3%	●		Compliant
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	83.9%	80%	77.9%	●		Feb-19
Responsive	**R1: ED 4hr Waits UHL**	95%	77.3%	95%	70.7%	●		See Note 1
	R2: ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	83.4%	95%	79.1%	●		See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	85.2%	92%	85.2%	●		See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	1.0%	<1%	1.0%	●		Compliant
	R12: Operations cancelled (UHL + Alliance)	1.0%	1.1%	1.0%	1.2%	●		Jun-19
	R14: Delayed transfers of care	3.5%	1.5%	3.5%	1.5%	●		Compliant
	R15: % Ambulance Handover >60 Mins (CAD+)	TBC	4%	TBC	13%	●		See Note 1
	R16: % Ambulance handover >30mins & <60mins (CAD+)	TBC	8%	TBC	14%	●		See Note 1
	RC9: Cancer waiting 104+ days	0	28	0	28	●		Apr-19

		YTD Plan	YTD Actual	Dec-18 Plan	Dec-18 Actual	Trend*	Trend Line	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	91.9%	93%	80.2%	●		Apr-19
	RC3: 31 day target - All Cancers	96%	95.7%	96%	96.1%	●		Jul-19
	RC7: 62 day target - All Cancers	85%	75.8%	85%	82.3%	●		Mar-19

Enablers

		YTD Plan	YTD Actual	Qtr3 18/19 Plan	Qtr3 18/19 Actual			
People	W7: Staff recommend as a place to work (from Pulse Check)		60.7%		60.0%			Not Applicable
	C9: Staff recommend as a place for treatment (from Pulse Check)		70.2%		65.0%			Not Applicable

		YTD Plan	YTD Actual	Jan-19 Plan	Jan-19 Actual	Trend*	Trend Line	Compliant by?
Finance	Surplus/(deficit) £m	(6.7)	(53.0)	2.3	(2.1)	●		Compliant
	Cashflow balance (as a measure of liquidity) £m	1.0	16.6	1.0	16.2	●		Compliant
	CIP £m	33.4	31.1	5.7	5.6	●		Compliant
	Capex £m	22.3	19.5	3.0	4.0	●		Apr-19

		YTD Plan	YTD Actual	Jan-19 Plan	Jan-19 Actual	Trend*	Trend Line	Compliant by?
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96%	98%	96%	●		See Note 3
	Average cleanliness audit score -high risk areas	95%	94%	95%	94%	●		See Note 3
	Average cleanliness audit score - significant risk areas	85%	93%	85%	93%	●		Compliant

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: Quality Commitment Indicators are highlighted in bold. The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Note 2 - Unable to determine compliance dates for these metrics. We have control measures in place to mitigate risks however we have no direct control due over HCAIs.

Note 3 - Compliance is dependent on investment

Appendix 2

QUALITY STRATEGY

"BECOMING THE BEST"

MARCH 2019

CONTENTS

1. INTRODUCTION – WHY DO WE NEED A QUALITY STRATEGY

UHL has many strengths, notably a highly committed and caring workforce and a wide range of clinically excellent services. We also have a very large critical mass, having one of the largest catchment populations of any trust in the NHS.

Despite these inherent strengths, we have struggled to achieve and in particular to maintain high standards of performance, whether that be in respect of quality, operational performance or our finances. Rather, we are characterised by many pockets of excellence and sometimes improved performance which is then not sustained. Hence we have been judged by the CQC as "Requires Improvement" in two successive inspections.

There has been much research undertaken into the characteristics of excellent or "outstanding" healthcare organisations. Most recently, these characteristics have been summarised by the CQC in their report "Quality Improvement in Hospital Trusts" (September 2018). This report seeks to learn from trusts which have shown significant, sustained improvement and are now judged to be "good" or "outstanding".

The key characteristics identified by the CQC are:

Clear strategic intent for QI - the QI journey has to start at the top of the organisation, with board members and senior leaders jointly setting out the vision to provide the highest possible quality of care

Leadership for QI - The most important determinant of quality of care is leadership. These trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership *behaviours* and a visible, hands-on approach.

Building improvement skills at all levels – using a systematic framework to build improvement skills at all levels, to facilitate improvement work and to share learning.

Building a culture of improvement at all levels – building a culture of improvement, which enables all staff to make effective and sustainable improvements.

Putting the patient at the centre of QI – the CQC found tremendous synergy when patients, carers, people using services and the public are meaningfully involved and incorporated into QI, alongside an engaged, empowered and enabled workforce.

The system view - True improvement comes when QI is anchored in an understanding of the system and its purpose. It comes where all staff and leaders work together to align the component parts of the system, to achieve high-quality patient care across the end-to-end system. For this purpose by "system" we are referring to the LLR health and social care system, or in some cases the wider sub-regional, regional or national system.

If we compare ourselves, candidly, with these characteristics, it soon becomes clear why we are where we are:

Strategic intent for QI – at a basic level, we do not have an over-arching Quality or Quality Improvement Strategy. Therefore we are not *organised* for or *focussed* on developing the key characteristics in a systematic and resilient way. Of course we have undertaken a great deal of activity which addresses at least some of the required areas, notably through the Quality Commitment approach and a wider range of interventions under the banner of the UHL Way. But overall, these initiatives do not represent a coherent package; hence their patchy impact has perhaps been inevitable.

2. THE PURPOSE OF THIS STRATEGY

The purpose of this strategy is to address the issues identified in the previous section and thus **to facilitate progress towards our ultimate goal - to deliver "Caring at its Best" to every patient, every time.** It provides a framework for conversations across the organisation; those conversations will be important so as to harness the collective expertise of the people in our organisation and to avoid a sense of imposition. Our work thus far has identified six core elements which will frame the conversations. These elements have a strong synergy with the CQC characteristics set out earlier but are also derived from other relevant research and guidance (for example by the Health Foundation, King's Fund and NHS Improvement) and internal consultation in order to develop a coherent work programme . The six elements are:

- Understanding what is happening in our services
- Clear priorities and plans for improvement
- Embedding an empowered culture of high quality care *(including patient empowerment)*
- The right kind of leadership
- Giving people the skills to enable improvement
- Working effectively with the wider system

These core elements are described in more detail later in this document and are shown graphically in Appendix 1.

3. ORGANISATIONAL COMMITMENT

As identified by the CQC, success depends on complete commitment from the top level of the organisation to the approach set out in this strategy. This includes visible championing of the approach and changing the way in which we do things. It also depends on creating the head space for everyone to talk about how best to pursue this ambition – some actions that we need to take are more obvious – others are less clear and here we will need to create space for experimentation and learning. It will also involve stopping doing some things which do not contribute to the approach. The role of the Trust Board and our wider senior leadership is described in more detail in the "Right Kind of Leadership" section.

The Trust Board considered a draft of this Quality Strategy in public at its meeting on 7th February 2019. Following detailed discussion, Board members gave wholehearted, unequivocal and unanimous support to the Strategy.

4. OUR VALUES AND VISION

Although there is much that needs to be changed in our approach, our Values should remain consistent. This year, these Values are ten years old and they have stood the test of time:

- We treat people how we would like to be treated
- We do what we say we are going to do
- We are one team and we are best when we work together
- We focus on what matters most
- We are passionate and creative in our work

We use our Values actively: In recruitment, appraisal and an awards system. They will provide helpful continuity as we develop new approaches, although we will need to review how they are

positioned, reinforced and used in our day-to-day work. As we become a quality improvement- led organisation we will need to think about how we translate these values into behaviours (e.g. what does being 'passionate and creative' really mean – how might our leadership and management approach enable and support creativity – what gets in the way?). These are conversations for us at every level and in every part of the organisation.

Our vision - Caring at its Best – is more problematic. It was probably initially intended to be a statement of intent i.e. we *aim to deliver* caring at its best. But in practice it is used as slogan or strapline (for example on our letterheads and posters) thus conveying the message that we claim that we *are delivering* caring at its best. If we define caring at its best as meaning to every patient every time, this is clearly not the case.

Following internal discussions, it has been agreed that we will retain "Caring at its Best" as our vision statement, reinforcing at every opportunity that this means *for every patient, every time.* This will be complemented by a further strapline which will clearly be improvement orientated. Following a voting process at the Chief Executive Briefing meetings on all three of our main sites (involving around 200 of our leaders), the strapline chosen is **"Becoming the Best"**. In practice, the strapline will become the brand name for the strategy. This is important as evidence from other organisations strongly indicates the advantage of having a universal improvement brand to reinforce the comprehensive nature of the approach. An appropriate logo will be developed to promote "Becoming the Best".

5. OUR IMPROVEMENT METHODOLOGY

One of the key factors in successfully embedding improvement is the adoption of a consistent methodology. As the CQC report states: "in organisations with a QI culture, we see that a clear and consistent method is in use and demonstrable across all areas of the organisation. Commitment to the chosen methodology has resulted in a sustained and embedded culture of QI. The key is not the choice of one methodology over another, but the commitment to a coherent systematic improvement methodology that is anchored in improvement science."

The common features that each methodology includes are:

- Applying "systems thinking" to understand the problem
- Experimentation as a discipline for improvement
- Hands-on, visible leadership as a fundamental practice
- Learning from failure as a positive approach
- A focus on key improvement principles over the tools themselves

Notwithstanding the last of the above bullet points, we will need to identify which methodology to adopt across the organisation. The principal options are:

- Institute of for Healthcare Improvement "model for improvement"
- Lean in Healthcare
- Haelo (from the NHS in the North-West)

An event was held on 13th February 2019 involving Executive Directors and a range of QI and OD subject-matter experts. At this event it was agreed that the IHI Model for Improvement would be the chosen methodology but the UHL version of this would also include elements of Lean. A small sub-group has been tasked to describe what this will look like.

UHL is a highly research active Trust, recruiting over 10,000 patients into clinical trials each year, and with around 1:20 staff members contributing to this research effort. It is well documented that research active Trusts have better outcomes for patients (eg lower SHMI) and a more engaged workforce. Areas of research strength at UHL (cancer, cardiovascular, diabetes, renal, respiratory) also map onto busy and prominent areas of clinical service. The results of research provide evidence that should strongly underpin quality improvement. Indeed, researchers in the Trust work closely with academic partners and are studying not only new interventions and treatments for disease, but also novel pathways and process and improvement methodologies themselves.

Despite this, UHL's research effort is not as visible to staff, patients and carers as it could be and it is not always obvious how research results alter practice. The process of implementing research based innovations into clinical practice can be slow, and thus there is often a gap between important research achievements and the translation of these research findings into quality improvements for patients. Even when this occurs efficiently, visibility may be limited. Thus the Quality Strategy will include the implementation of a refreshed approach across the Trust to raise awareness of UHL's research and its role in supporting improvement activities.

Actions

Complete description of the chosen UHL quality improvement methodology

Integrate research activity with wider QI activity and raise awareness of this

6. CORE ELEMENTS

6a. UNDERSTANDING WHAT IS HAPPENING IN OUR SERVICES

In order to decide what needs to be improved, and to ensure the ongoing quality and safety of all of our services, it is clearly essential to understand what is happening in those services. Broadly speaking, the activities in this element can be divided into two categories:

- Quality control – data tracking, reporting and follow-up
- Quality Assurance – internal and external inspection, corporate assurance structures and processes, accreditation, guidelines and standards

We currently undertake a great deal of activity covering both these aspects, much of which is generated by external regulators and professional bodies. Examples include:

- Regular reports to boards and committees
- Ad hoc/deep dive reports to boards and committees

- Service dashboards (e.g. women's and children's, specialized services, #NOF)
- Peer review, accreditation and inspections (e.g. HTA, MHRA)
- Outcome measures – patient reported, clinician reported
- National registries (e.g. hips, knees and cardiac)
- Mortality data (SHMI and HSMR) and outlier alerts
- Patient feedback – complaints, FFT and other feedback
- Staff and trainee feedback including GMC survey results
- National clinical audit programme
- Local clinical audits
- Inspections by regulators (e.g. CQC and NHSI)
- Reviews by commissioners (quality visits)
- NHSI reviews (e.g. IP)
- Incident and claims data
- Performance data – e.g. Cancer waiting times
- Workforce data
- Safe nurse staffing data
- IP data
- Performance against NICE standards
- Measurement of care bundles (e.g. sepsis)
- Research activity and performance
- Indicators drawn from quality schedule and CQUIN programmes - some organisational others at service level

There are however a number of issues with our current approach. These include:

- Our clinical audit programme, whilst extensive, shows patchy results in terms of impact and is not always aligned to organisational priorities
- We do not consistently use Statistical Process Control tools to properly understand variation
- Reporting tends to be added to incrementally, with very little ever being stopped
- There has been little systematic review of how the reporting fits together as a package and whether it covers the right ground – so we cannot see the full picture
- It is unclear whether some reports are used in practice, or even read, by at least some of their intended audience
- Significant resource is involved in producing reports and in the associated infrastructure
- There have been instances of service failure which have remained undetected until a critical event(s)

-

Actions

A systematic review of our reporting structure and processes to ensure that they are fit-for-purpose and to eliminate non added value activity

Alignment of the our clinical audit programme to the Trust's quality objectives

A process to be introduced to ensure the basic quality and functioning of all our clinical services, combining both quality control and quality assurance elements

All strategies programmes to be required to adopt this element (i.e. a full understanding of the current position as the starting point)

6b. CLEAR PRIORITIES FOR IMPROVEMENT

For the last five years, our priorities for improvements in the quality and safety of our services have been set out in our Quality Commitment, which is the brand that we use for the priorities required to be identified through the national approach to Quality Accounts. The priorities are revised and updated each year through a formal process which takes account of:

- patient and public feedback
- analysis of data e.g. mortality and implementation of care pathways such as pneumonia
- priorities informed by regulators' concerns e.g. sepsis
- the need to have a manageable number of priorities that have the greatest impact (i.e. affect the greatest population)
- priorities driven through the Quality Schedule and CQUIN process
- the need to maximize opportunities to apply for improvement monies where available (e.g. NHSLA bids)

The priorities in the Quality Commitment are generally clearly articulated and expressed quantitatively wherever possible. There is also a comprehensive tracking and reporting process in place.

The Quality Commitment is a well-established and well recognised approach within the Trust. However, there have been instances where the goals contained in the Quality Commitment have not been achieved, or have not been sustained. The diagnosis is that this reflects issues with the overall way in which the organisation approaches quality improvement. Addressing the areas of weakness is the purpose of this strategy.

This strategy is intended to provide a framework for all improvement activity across our organisation. Therefore it will be expected that all improvement programmes meet the same standards as the Quality Commitment has done in terms of:

- Systematic and rigorous identification of priorities
- Quantified and time-bound goals
- Clear tracking, reporting and escalation processes

This will be driven by the adoption of a standard improvement methodology across the Trust (see Section 5).

An additional issue is that a large number of quality improvement priorities are currently identified through the Quality Account and CQUIN processes. Although in isolation each of these priorities will

be each be valid, having a large number has a dilution effect which impacts on the most important priorities as identified in the Quality Commitment. It should be noted however that some CQUIN priorities are nationally mandated.

The other programmes and strategies which currently exist also have clear action plans, although the identification of quantified, time-bound goals is perhaps the characteristic which is observed least consistently. **The proposed future relationship between our existing programmes is described in Section 7.**

Actions

Seek to minimise the number of quality improvement priorities which are not part of the core programme

All strategies/programmes to be required to clearly identify their plans for improvement in accordance with the above criteria

6c. THE RIGHT KIND OF LEADERSHIP

The CQC report "Quality Improvement in Hospital Trusts" states that "the most important determinant of quality of care is leadership. These trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership behaviours and a visible, hands-on approach."

There are three key aspects of leadership which need to be right in order to support our journey to excellence. These are:

- Skills acquisition
- Development, inclusivity and talent management
- Behaviours

The aspect with which we have arguably had least success is behaviours. There is substantial anecdotal evidence that the behaviours of our leaders are not consistent and do not always drive or encourage the right culture of continuous improvement. This issue and the actions to address it are addressed more fully in Section 6d of this strategy. It is important to note that leadership here includes the Trust Board itself. One approach that may well be helpful is the IHI High Impact Leadership Model, which covers how leaders think, what leaders do and where leaders focus their efforts.

The engagement of our clinical leadership will be a crucial part of our improvement process. It is essential that clinicians or all disciplines understand that the adoption of a quality improvement approach is not a threat but rather a complement to existing approaches such as clinical audit and research. This appreciation will very much depend on our clinical leadership understanding, embracing and promoting the approach, in the same way as the broader leadership community will need to.

Our detailed approach to leadership development, inclusivity and talent management will be set out in the forthcoming People Strategy. Skills acquisition is addressed in Section 6e of this strategy and the delivery aspect of this will be included in the People Strategy. A draft of the People Strategy has been considered at a Trust Board Thinking Day and the final version will be considered by the Trust Board at its March 2019 meeting alongside the final version of this Quality Strategy. There is full alignment between these two documents.

A key aspect of developing the right kind of culture and leadership is having the right approach to equality and diversity. We have been making progress on this, focussing initially on race equality, through the implementation of the E&D Integrated Action Plan. This now forms part of the People Strategy and will continue to be driven through the CEO-chaired E&D Board.

Actions

Revise People Strategy and present to PPP Committee and Trust Board

Require all strategies/programmes to follow the leadership approach described in the People Strategy

Consider the IHI High Impact Leadership model as part of our QI methodology choice

6d. EMBEDDING AN EMPOWERED CULTURE OF HIGH QUALITY CARE

Essentially, successful, sustained improvement requires not only the right skills/methodology but also the right culture. Such a culture is characterised by features such as:

- Trust boards working hard to create a culture where staff feel valued and empowered to suggest improvements and question poor practice
- Staff are empowered to drive improvement and break down barriers between teams
- Leadership models QI behaviours
- All staff understand the purpose of the organisation and actively focus on improvement in "value streams"
- Obstacles to improvement are dealt with and organisational systems and processes are aligned to facilitate this

Feedback from our CQC inspections indicates that our staff have a good understanding of the values and vision of the organisation. But scores for engagement and empowerment remain moderate. This is despite a five year Listening into Action (LiA) programme and the more recent broadening into the UHL Way, including Better Teams (BT). Where LiA and BT have been deployed (which is on 200+ projects) there have frequently been good or excellent results. But the use of these tools has not succeeded in changing the culture of the organisation *across the board*. Three particular issues can be identified: Firstly, if the culture of an area is particularly difficult (especially if the issues relate to leadership style) our current tools have struggled to address this. Secondly, the tools have mainly been used in areas which have volunteered to participate and so the most difficult issues/areas may have been missed. The first two issues are most likely a product of the third i.e. the UHL Way is a (good) set of tools rather than a whole organisation strategy for improvement. This would suggest that a more radical or fundamental approach is required, hence this Quality Strategy.

We are currently participating in the Culture and Leadership Programme (CLP). This is described in more detail in the People Strategy but it will be central to the QS. The programme includes an extensive diagnostic phase and then identification of specific interventions. These interventions will then form the key actions within this element of the QS.

The CLP has an extended timescale and it will be important to see visible change as soon as possible following the "launch" of this strategy. To facilitate this, we will use the "Culture Web" tool (Johnson and Scholes) to identify a range of quick win, high visibility, changes that we can make whilst we undertake the comprehensive diagnostic and intervention development involved in the

CLP. A schematic of the Culture Web is at Appendix 2. It is likely that these quick wins will include changes to the way in which the key elements of the corporate architecture (Board, Thinking Days, Committees, Executive Boards) are organised. This is so as to lead from the top and ensure that we are having the right kind of conversations to impact positively on the culture of the organisation.

A further vital element of the cultural agenda is the way in which we work with patients and the public. As mentioned in Section 6, patients need to be at the heart of QI activity. This cannot be said to be the case within our organisation at present. There is also a further piece development work to do to identify how we can considerably "upscale" patient and public involvement, using the principles in the "ladder" produced by NHS England.

The importance of patient involvement is such that we have considered whether it would be appropriate to have a core element of this strategy specifically for it. We have however concluded that it will be more impactful to apply the principle of involvement to all of the six elements; see section 10 for more detail.

Actions

Participation in the Culture and Leadership Programme and development of key interventions

Use the Culture Web to identify early quick wins/ high visibility changes to support strategy launch

All strategies/ programmes will be required to consider cultural issues/interventions in their development

All strategies/programmes to be subject to a set of patient/ public involvement tests/questions

6e. GIVING PEOPLE THE SKILLS TO ENABLE IMPROVEMENT

In order to ensure that a standard improvement methodology is used effectively and embedded across the organisation, it is self-evident that people need to have skills in the deployment of that methodology. But not everyone needs to have the same level of skills so a "pyramid of capability" will be developed. An example of such a pyramid is at Appendix 3.

It will be necessary to be very explicit about the skills required at each level and to mandate acquisition of those skills (unless already possessed). Once again, this is will be very different from our previous approach, where skills acquisition has, at least to some extent, been voluntary and therefore patchy. It should be noted here that such an approach is resource-intensive (see Section 12).

Actions

Develop a UHL skills pyramid (potentially using the NHSI Dosing Guide)

Identify staff at each level of the pyramid

Develop and implement delivery programme

All strategies/programmes will be required to evidence their use of the chosen methodology

6f. WORKING EFFECTIVELY WITH THE WIDER SYSTEM

The CQC have observed that truly patient-centred care cannot come from a single organisation view, but with the recognition that high-quality care is only delivered when all parts of the health system work effectively together. Health and social care organisations are complex, adaptive systems. QI methods recognise this, and help leaders and teams lead systematic improvement in this context. Moving beyond organisational and functional boundaries and traditional hierarchies requires systems thinking. Clarity on the purpose of QI focuses improvement activity on delivering high-quality patient care, and often results in wider consideration of patient experience and their journey into and through healthcare services. As improvement teams experiment and problem solve, the patient journey is understood across internal and external organisational boundaries. Ultimately this leads to collaboration and improvement across functional boundaries to improve patient care – where improvement teams are thinking and working across the system.

Within LLR, there have been, and continue to be, good examples of collaborative, cross-boundary, improvement work. Examples include the frailty and multi-morbid pathway improvement programme and the work to reduce the number of stranded patients and improve discharge processes. There has also been substantial co-ordination of leadership development work so as to ensure that different parts of the system have a common approach, thus facilitating further collaboration. Having said that, there is no common QI methodology universally in use and there are undoubtedly cultural issues that get in the way of progress.

Actions

Work with the wider system to encourage the adoption of a common QI methodology and use of the 6 core elements/drivers approach (to become the LLR Way)

Review the CQC interim report on whole system reviews for lessons from elsewhere

Identify a clear programme of cross-system improvement activity

Widen participation of our staff in system-wide projects

Require all strategies and programmes to consider the system-level elements/implications of their work

7. APPLYING THE CORE ELEMENTS – A UNIFIED PROGRAMME OF IMPROVEMENT

We currently have five Strategic Objectives. These are:

Primary Objective:

- Safe, high quality, patient-centred, efficient care

Secondary Objectives:

- Our people
- Research and education
- Partnerships and integration
- Strategic enablers

These objectives are accompanied by a summary description of what each involves. They are the means by which we seek to deliver our Five Year Plan – Delivering Care at its Best and are

complemented by our Annual Priorities which are set out in our Annual Operating Plan and categorised under each objective.

We also have a range of strategies as follows. Some of these are in development or being revised/ updated:

- Quality Commitment
- E-hospital
- Reconfiguration
- Efficiency/Productivity Financial (recovery)
- People
- Estates
- Performance/Operational Improvement (ED, RTT, Cancer)
- Research
- Education
- System working
- Nursing
- Communications and engagement
- Patient and Public Involvement
- Quality (this strategy)

It will be noted that there are three strategies listed here which do not currently exist. These are Efficiency/Productivity/Financial (where we have a Productivity Improvement Programme but not a strategy as such, and then a separate Financial Recovery Strategy, Performance/Operational Improvement (where similarly we have action plans but not a strategy) and System Working. Note also that the Quality Commitment is a rolling improvement programme rather than a quality strategy.

Whilst through the above approach we have in place a coherent set of plans for change and improvement, the different elements of these plans in practice operate fairly separately. Thus there are separate plans within the Quality Commitment, the operational improvement programmes such as Emergency Care, the Productivity Improvement Programme and so on. Our various strategies also have their own implementation plans. Although efforts have been made to ensure that all these plans are "joined up", they cannot be described as a fully integrated package.

Following discussion, it is now recommended that we move to a "unified programme" approach. This will involve a single programme incorporating all the key things that we need to do and of course using the overall approach set out in this strategy. Since the Trust Board considered the draft of this strategy, further work has been undertaken on what a "unified programme" could look like. The focus has been on using our priorities for 2019/20 as the basis for discussion. These will be considered elsewhere on the agenda of the March Trust Board meeting but the essential features are:

- A small set of Quality Priorities
- A small set of Enabling Priorities
- Management of these priorities through a single programme approach, with universal application of the core elements and QI methodology
- A smaller set of supporting programmes/strategies (the key activities of which in any year will feature in the above annual priorities)

As a consequence of this unified approach, separate programme brandings (including the Quality Commitment) will no longer be used.

It should be noted that the principal risk with the unified programme approach is that it becomes too diffuse. This is of concern as evidence from elsewhere indicates that it is best to focus on a small number of key priorities in order to maximise impact. To avoid this, the number of Quality and Enabling priorities in any one year will be kept as small as possible. A key element of this will be to organise our work around a clear, compelling, goal.

The development of the unified programme will be at the heart of the 2019/20 planning process. As part of this, discussions are taking place via Executive Boards, Trust Board Thinking Days and ultimately the Trust Board itself. Once the Annual Operating Plan has been finalised, a narrative document similar to the "Delivering Caring at its Best" document will be produced in April 2019 to complement the formal AOP.

As referenced above, there will still be a need for topic-specific strategies to support the unified programme. But all programme and strategic activity will:

- **be required to use the six core elements as their basic structure, so as to ensure a consistent approach.** Each strategy must include a driver diagram which starts with these elements in order to demonstrate compliance
- **be required to use the improvement methodology developed as part of the implementation of this QS**

The Annual Operating Plan will continue to describe the key actions that will be taken within each of our priorities in any given year, as well as key activity, financial and service development plans.

8. THE FUTURE OF THE UHL WAY

The UHL Way has been developed over the last 3 years and currently comprises:

- Better Engagement (Listening into Action)
- Better Teams
- Better Change (our current improvement methodology)
- UHL Academy
- Pulse Check

The successes and limitations of LiA and Better Teams have been described earlier in this strategy. Better Change has not by any means been universally adopted. And the UHL Academy has delivered much useful development activity but this has not been positioned within an overarching approach. Thus the UHL Way has essentially been a set of tools rather than a comprehensive strategy. Many of these tools will continue to be used within the approach set out in this strategy, but within a much more explicit and rigorous overall approach. Thus the branding identified through the process described in Section 4 will be used and the UHL Way brand will no longer be used.

9. ENGAGEMENT AND COMMUNICATION

It is hopefully self-evident that engagement with both patients and staff is central to every element of this strategy. There will therefore be no separate "engagement plan", but rather engagement will be embedded within our core activities in implementing this strategy. An example of this is the diagnostic phase of the CLP, which involves a range of specific engagement activities.

Conversely, it will be very important that we consistently and relentlessly communicate what is happening about every element of this strategy, and also what is happening within the unified programme described in Section 7. This will require careful planning, rigorous execution and appropriate resourcing.

Actions

Develop a Quality Strategy Engagement and Communication Plan

10. PATIENT INVOLVEMENT AND ENGAGEMENT

The involvement of patients, their families and carers will form a central component of this strategy. This is consistent with our ambition to encourage an organisational culture in which the patient voice is at the very centre of our service development, management and evaluation. This commitment mirrors the CQC's clear expectations that users of our services are "actively engaged and involved in decision-making to shape services and culture".

The methodology advocated in this strategy will encourage all quality improvement initiatives to begin with a consideration of who needs to be involved, and how that will be accomplished. Thus discussions about a specific strategy or programme could include:

- What intelligence have you captured from patients about what is happening in this service?
- How have you gathered the views of patients about their experience through the whole system?
- How have you involved patients in determining your priorities for improvement?
- How will you involve patients, their families and carers in this work?
- How will you ensure that patients are able to participate in your discussions to enable meaningful participation in your work?
- What will be the scope for patient input to influence the outcome of the project?

If patients are to be meaningfully involved this needs to happen as early as possible and throughout the life of a project, rather than presenting patient representatives with a *fait accompli* for endorsement. Through this strategy we are making a commitment for "co-production" with patients from the outset. Such an approach recognises that the vital "business intelligence" our patients can provide will positively influence our quality improvement journey and help us to provide the best hospital services for our local population.

Actions

Update the Patient and Public Involvement Strategy to align with the Quality Strategy

Work with our Patient Partners to determine how best to use their expertise within the approach described in this strategy

11. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

We have recently introduced a new Accountability Framework for our Clinical Management Groups and Corporate Directorates. A partial Well-Led review (incorporating a Board Review) has also been undertaken which indicated broadly that our assurance systems and processes were fit for purposes. These two elements of our corporate architecture will therefore remain in place. However, as referenced earlier, it will be important to change the *conversations* that take place within those structures so that they focus on the things that are important within the framework provided by this strategy.

Following discussion at the event with Executive Directors and QI/OD subject matter experts on 13th February, the following governance structure will be adopted:

- The programme board for the Quality Strategy itself will be the **Executive Strategy Board**. This board will report progress direct to the **Trust Board** through the Chief Executive's Report
- An **Expert Reference Group** will be established to advise on the implementation and further development of the strategy
- A **Change Network** will be established; this will be a much larger group, representing a cross-section of the organisation. This is part of the approach used by the Culture and Leadership Programme in order to assist with the diagnostic phase and cultural shift
- The Executive Planning Meeting will provide oversight of the progress of the Quality Strategy Implementation Plan (see Section 13), ensuring that it is core business

The implementation of this strategy and the unified programme approach described in Section 7 will have significant implications for the organisation of our teams and for lead roles. This for two principal reasons:

- We will be seeking to work in a more integrated way, which implies more integration of, or at least closer working between, the teams involved
- We will need to add capacity/skills if we identify deficits

On the basis that form should follow function, we will identify the appropriate future team structure and lead roles once we have developed the unified programme. It will be necessary to do this reasonably quickly in order to maintain the momentum which has developed as we have been working on this strategy, and which is indeed manifested in much of our existing improvement activity.

Actions

Convene the Expert Reference Group

Develop the Change Network

Implement EPM, ESB and Trust Board programme management and reporting

Identify team roles and structures once the unified programme has been developed

12. RESOURCE REQUIREMENTS

As previously identified in this strategy document, there is a considerable amount of existing activity already being undertaken which is relevant to the approach described here. Thus there will be significant scope to both continue existing work and to redeploy existing resource to focus more closely on the core elements identified here. However, the Executive Team has concluded that it will not be possible to effectively implement this strategy within existing resources. The key areas which have so far been identified that are thought will require additional resource include:

- Key corporate roles
- Improvement skills training
- Communications
- Patient involvement
- Business intelligence
- External specialist support

In order to generate sufficient financial headroom to properly resource this strategy, the Executive Team has agreed to incorporate a £1m indicative investment as part of 2019/20 financial planning. The deployment of this investment will be agreed by the Executive Strategy Board.

Actions

Undertake further resource requirement analysis and produce formal costing

Confirm Trust Board support for £1m investment through 2019/20 Financial Plan approval

13. MEASURING SUCCESS

It will of course be important to be able to measure whether this strategy is working. Given that the aim of the strategy is to ensure that we deliver caring at its best to every patient every time, success can be judged in multiple ways. If we are judged to be "Good" or "Outstanding" overall by the CQC, this would certainly be regarded as success. But there will be a range of measures which we can monitor in term of our journey towards our goal. We already measure many of these e.g. mortality rates, harm indicators, achievement of performance targets, patient satisfaction, staff satisfaction. It is proposed that we should select a relatively small number of metrics to form a Quality Strategy Dashboard, to be regularly reported to the Trust Board as part of updates on the progress of this strategy.

In addition to the QS Dashboard, we will develop a comprehensive Quality Strategy implementation plan to manage and monitor the actions set out in this strategy and others that are developed as we go forwards. A report on progress against this plan will once again form part of reporting to the Trust Board.

Actions

Develop Quality Strategy Dashboard

Develop Quality Strategy Implementation Plan

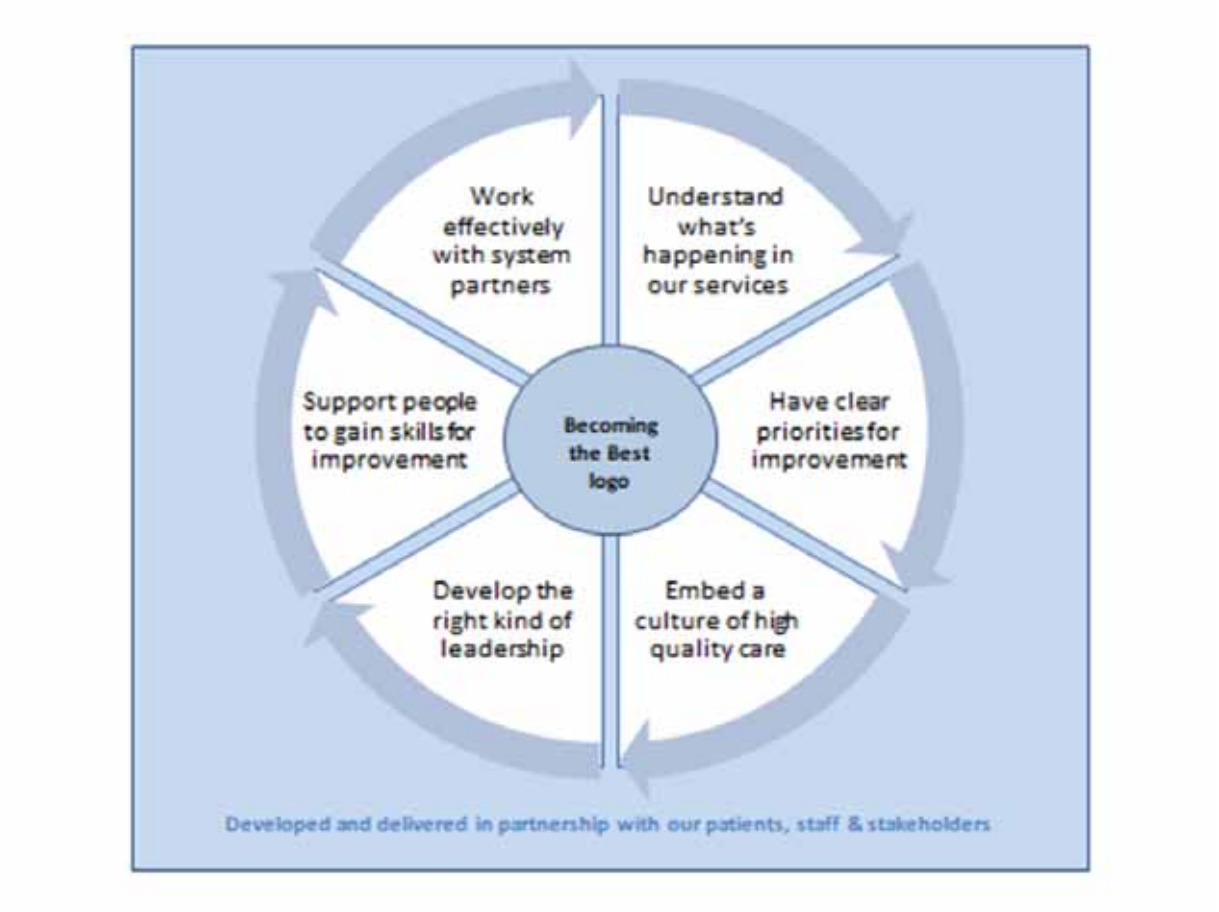
14. NEXT STEPS

This strategy is intended to provide a clear framework for how we will achieve our goal for delivering caring at its best to every patient, every time, and thus become at outstanding organisation. In doing so, it seeks to candidly address those things that have held us back up to now, and explicitly to learn from best practice elsewhere.

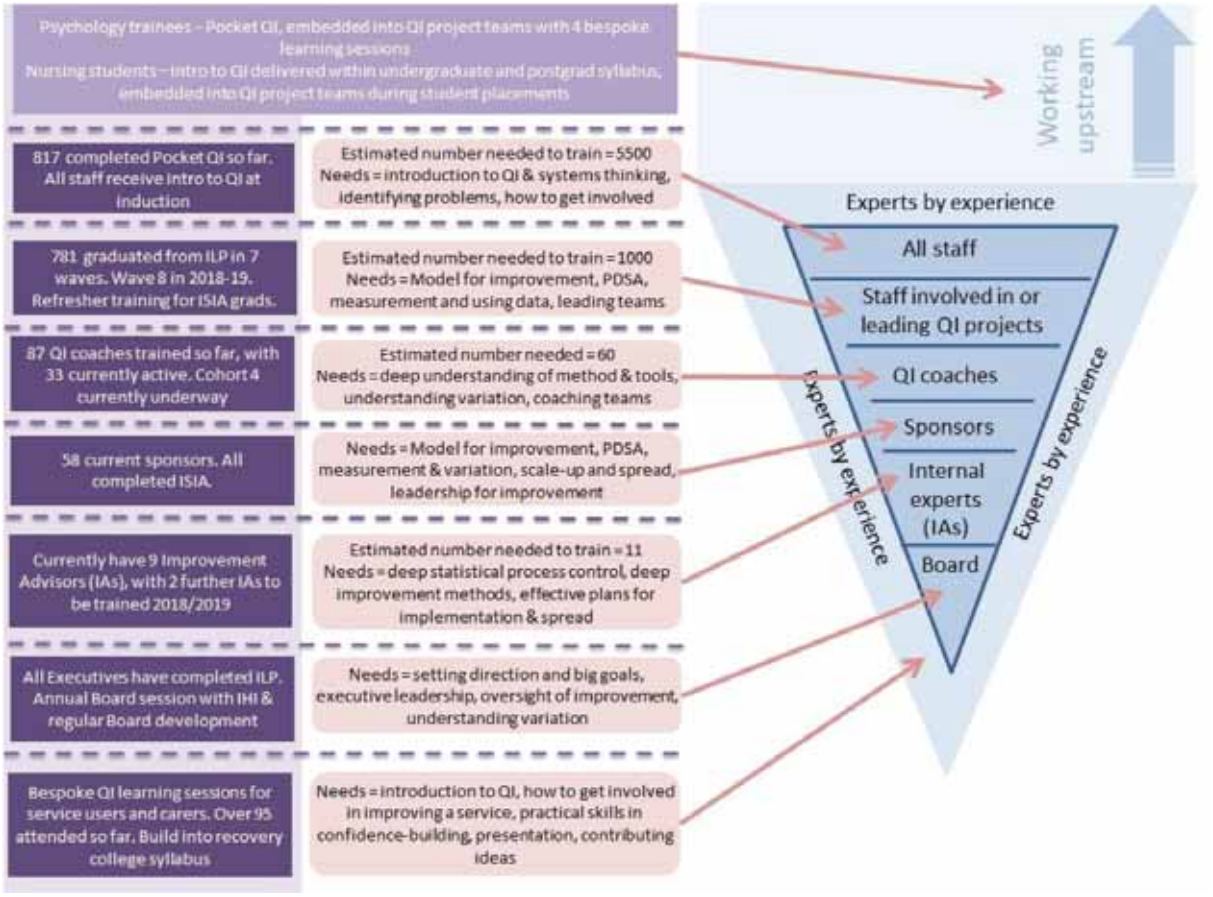
Although "**what"** we need to do is clear, we will need to continuously engage our patients and staff in developing the "**how".** These conversations will be central to our approach as we go forward.

Following approval, this strategy, the QS Implementation Plan will be developed, incorporating the actions identified in this document (to describe how we will improve). This will run in parallel to the development of the 2019/20 Annual Operating Plan which will describe the unified improvement programme (to describe what we will be improving).

APPENDIX 1 – QUALITY STRATEGY CORE ELEMENTS



APPENDIX 2 – AN EXAMPLE SKILLS PLANNER



Courtesy of East London Foundation NHS Trust

APPENDIX 3 – THE CULTURE WEB