Cover report to the Trust Board meeting to be held on 7 November 2019

Trust Board paper F

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

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse Darryn Kerr – Director of Estates and Facilities
Date of meeting:	24 October 2019

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

This report provides a summary of the key public issues considered at the Quality and Outcomes Committee on 24 October 2019:

- **Seven Day Services Board – Assurance Self-Assessment** – Dr D Barnes, Deputy Medical Director attended to present paper C, updating QOC on the 7 Day Services Self-Assessment process and seeking the Committee's endorsement to submit the October 2019 Board Assurance Framework to NHS England ahead of the 28 November 2019 deadline. Following the last audit, it was agreed that a full notes audit across the Trust for Clinical Standard 02 (Time to Consultant Review) and Clinical Standard 08 (On-going review) would not take place for this submission, instead a larger audit for the two areas (General Surgery and CDU) that were most challenged for Clinical Standard 02 would take place. The compliance rate for General Surgery across Wards 28 and 29 at LGH and SAU at LRI was 66%. The compliance rate was almost entirely determined by the time a patient was admitted as Consultant-led ward rounds took place once a day 7 days a week at 8:00am. As part of the Trust's reconfiguration, when all Emergency General Surgery would be moved to the LRI, a second ward round would take place later in the day and this should deliver the target of 90% of patients to be seen by a Consultant within 14 hours of being admitted. Respiratory showed an overall compliance rate of 86% (previously 74%), although they were compliant at weekends there was some variation across weekdays. The Respiratory Service had made significant improvements with a Consultant assigned daily to CDU. Cardiology showed that compliance had not been met across the week or weekends and overall compliance stood at 41%. CDU compliance was 66% with the combination of both the system and manual case note audit. The Cardiology Service was continuing to advertise for new Consultant Cardiologists. The Trust was exploring new models of providing Consultant Cardiology care including the introduction of Consultants with a combined acute medicine and cardiology interest. In General Surgery and Respiratory Services, all patients had a Senior Review (either Consultant or Registrar) within 14 hours, however, in the Cardiology Service, only 81% of patients received a Senior Review within 14 hours. QOC requested that a clear explanation of the mitigating actions that were being put in place was incorporated into the narrative in future reports. Following discussion, QOC endorsed the 7 Day Services Self-Assessment and recommended it for Trust Board approval on 7 November 2019. ***A copy of paper C is appended to this meeting summary.***

- **Maternity Safety update** – the Chief Nurse introduced discussion on this item briefing the Committee on the actions taken, and planned, by the Trust's Maternity Service in response to a variety of national initiatives which, in total, aimed to improve the safety of maternity care. She highlighted that UHL's maternity service had achieved all of the 10 safety standards described in the Clinical Negligence Scheme for Trusts (CNST) requirement for year 2 and thanked the Head of Midwifery and her team for their work on this key project. The Head of Midwifery presented paper D, providing assurance that the Trust's Maternity Service was engaged fully with the national maternity safety strategy and the regional clinical network. The Service was committed to improving safety and had made good progress in implementing transformational change. There was good engagement in the regional clinical network. Although it was a very challenging time for Maternity services with limited resource to support the national agenda, there had been feedback to suggest that UHL benchmarked favourably against peer Trusts in many aspects of the safety work. The QOC Chair commended the maternity services dashboard which now incorporated thresholds related to the safety agenda such as smoking targets, continuity of carer and avoidable admissions to NNU etc. In further detailed discussion, Ms V Bailey Non-Executive Director and

Maternity Safety Champion noted the ever increasing demands on the Maternity Service and the significant amount of work being done and progress made. Responding to a query, it was noted that digitising the 'red book' was a national programme and UHL were involved in the project and were awaiting national instruction and direction. A further update would be provided to QOC in January 2020.

- **National 2018 Adult Inpatient Survey Results –** the Chief Nurse presented paper E and advised that overall the results of the survey were positive, for 61 questions UHL was rated 'about the same as other Trusts', for 1 question rated as 'better than most Trusts' and for 1 question rated 'worse than most Trusts'. Members were advised that the results from a number of national patient surveys had been reviewed at the Trust's Patient Involvement, Patient Experience Assurance Committee (PIPEAC) and it had been agreed that a more structured and proactive approach to improving the patient experience as measured through national surveying was required. Therefore, the national patient survey questions would be added to all the current patient feedback surveys which were produced in real time and reported at ward/clinical area level. This would allow good quality feedback data to be available for front-line multi professional teams to act upon. The local survey results would also help monitor the effectiveness of any improvement project from the patient's point of view which was a fundamental part of any quality improvement work. The revised adult inpatient survey was implemented in August 2019 and results would be provided in the next quarterly Patient Experience Report to Executive Quality Board and Quality Outcomes Committee. In response to a query from a Patient Partner, the Chief Nurse highlighted that the 'Safe and Timely Discharge' was one of the Trust's Quality Priorities for 2019-20 and work was in progress in relation to this priority and was being taken forward through the Quality Strategy. The Patient Partners highlighted that they had shown particular interest in the various elements of the Trust's Quality Strategy 'Becoming the Best (BtB)', however, they felt that they had not been involved. In discussion on this matter, the Committee noted the long-term nature of this strategy and highlighted that there had been a delay in recruiting QI project management resource and it was expected that the QI Collaborative would focus on the Safe and Timely Discharge workstream from December 2019. The QOC Chair invited the Patient Partners to give a monthly verbal update to QOC on how the new process for patient partners was working and about their involvement in BtB.

- **Deteriorating Adult Patient Board Update including EWS and Sepsis** – the Medical Director presented an update on the work of the Deteriorating Adult Patient Board (DAPB), noting that this report now also encompassed an update relating to sepsis and diabetes. Particular points for noting were: (1) the delivery of sepsis performance was being maintained (2) the work to validate performance against UHL NEWS guidelines for score 7 and above was in progress, (3) insulin safety training remained below target and was being addressed directly with the CMGs through the Performance Review meetings and the insulin safety e-learning module was being revised. (4) significant progress had been made with insulin and non-insulin drug errors since 2017, and (5) the DAPB was being re-structured and aligned with the Trust's Quality Strategy. In response to a query on the high number of patients experiencing an insulin error, it was noted that UHL had a high level of reporting albeit the level of harm was 'low'. The Committee Chair requested that particular attention be paid to KPIs 5 and 6 on the Insulin Safety Dashboard relating to staff compliance with insulin safety training.

- **Report from the Director of Safety and Risk –** the Senior Patient Safety Manager introduced paper G, updating QOC on the following topics: (1) extended powers for HSIB (2) the introduction of new laws for reporting deaths to the Coroner (3) issues relating to outlying and (4) national changes to the patent safety alerts process. In discussion on the further actions needed to improve the safety of outlying activity, the Medical Director advised that work was underway to revise the Trust's 'Outlying Patients Policy' and have mitigations in place.

- **Resuscitation Committee Report –** the Medical Director presented paper H which provided a quarterly update on the work undertaken by the Resuscitation Committee. The following points were highlighted in particular: - (a) improvement in compliance with resuscitation training, (b) the DNACPR audit showed evidence that DNACPR forms had been completed appropriately in the majority of cases and the reason for the DNACPR decision had been recorded and endorsed in a timely manner. Members were advised that action was needed to improve recording of escalation of treatment on Nerve Centre and for Nerve Centre to accurately reflect the patient's DNACPR status. An action plan was in place to address this.

- **CIP Quality and Safety Impact Assessment –** the Chief Nurse and Medical Director presented paper I advising that a robust process was in place to assess the quality and safety impact of CIP schemes. There had been 8 CIP schemes which had commenced without completing the Q&S impact assessments. 5 out of those 8 CIP schemes did not go ahead. The PIDs for the remaining three schemes which related to premium pay and HR had now been completed. In response to a query, the Chief Nurse confirmed that they also had an oversight of the Estates and Facilities schemes.

- **Review of Board Assurance Framework 2019-20 Principal Risks 2 and 3 –** QOC reviewed BAF principal risks 2 (failure to reduce patient harm) and 3 (serious/catastrophic failure in a specific clinical service), rated at 15 for September 2019. In discussion on principal risk 4, it was noted that the target score had been reduced to 10 for quarter 4 (March 2020). The Chief Nurse advised that approximately 30 wards/departments would have

completed the ward assessment and accreditation programme by end of December 2019. In respect of principal risk 5, the Medical Director advised that the team were trying to prioritise the 'Vital Few' work by reviewing a number of areas including GIRFT validation, serious incidents, workforce data, access targets and financial data. QOC took assurance from the reports on BAF principal risks 2 and 3.

Items for noting

- **GIRFT Dermatology Visit – Action Plan Update –** in response to a query, it was noted that 24 Services had had a GIRFT visit. It was agreed that the action tracker from GIRFT visits should be discussed at a future joint PPPC-QOC meeting, and
- **EQPB Minutes 10.9.19 and EQB Actions 8.10.19.**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Seven Day Services Board – Assurance Self-Assessment

Public items highlighted to the Trust Board from this meeting:-

- None

Matters referred to other Committees:

- None.

Date of next meeting:	28 November 2019

7 Day Services Board Assurance

Author: Vicki Hing Project Manager Dan Barnes Deputy Medical Director Sponsor: Andrew Furlong Medical Director

Paper C

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	x
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
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)		
Executive Board - EBQ	08.10.19	Assurance
Trust Board Committee		
Trust Board		

Executive Summary

Context

All Acute Providers are required to undertake a Seven Day Service Self-Assessment against the 4 priority Clinical Standards on a biannual basis which then forms the basis of a Board Assurance Framework (7DS BAF) for sign off by the Trust Board before submission to NHSE. The October 7DS BAF requires submission by 28th November 2019.

Questions

1. What are the results of the General Surgery and CDU Audits for Clinical Standard 02 (Consultant review within 14 hours of admission)?
2. What is the current status of UHL against 7DS 10 Clinical Standards?

Conclusion

1. General Surgery showed 66% compliance to CS 02 (147 patients reviewed) and confirmed that time of patient arrival determined compliance due to daily 8am consultant ward round. However, all patients had a Senior Review (either Consultant OR Registrar) within 14 hours. In cardiology showed 41% compliance against CS 02 (91 sets of notes audited) and 81% received a Senior Review within 14 hours. Respiratory showed 86% compliance (115 notes audited) with 100% receiving a Senior Review within 14 hours.

2.

CS01 Patient Experience	Compliant	CS07 Mental Health	Compliant
CS02 Time to first Consultant Review 77%	Non-Compliant	CS08 On Going Review Once Daily; Weekdays 97% Weekends 87%	Partially Compliant
CS03 Multidisciplinary Review	Partially Compliant	CS08 On Going Review Twice Daily	Compliant
CS04 Shift Handovers	Compliant	CS09 Access to Community and Primary Social Care	Partially compliant
CS05 Diagnostics	Compliant	CS10 Quality Improvement	Compliant
CS06 Consultant Interventions	Compliant		

The four priority standards are met in the specialist network specialities – PICU, STEMI Heart Attack, Hyper Acute Stroke, Emergency Vascular services.

Input Sought

QOC are asked

- To review and recommend sign off to the Trust Board of the Seven-day Service Self-Assessment (BAF) for submission to NHSE as an accurate and true reflection of the current position. **Appendix 1.**
- To consider and support the recommendations made in the attached report**.**

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	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Yes]

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

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

- 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 ?

- If an EIA was not carried out, what was the rationale for this decision? On Going reporting.

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?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: TBC
6. Executive Summaries should not exceed **5 sides** My paper does comply

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Seven Day Services Board Assurance Paper QOC. October 2019

Authors: Vicki Hing Project Manager, Dan Barnes Deputy Medical Director
Sponsor: Andrew Furlong Medical Director

1. Context

The first full submission to NHSE using the Board Assurance Framework for Seven Day Services was in June 2019. The second submission is now due in November 2019 and this paper advises the Board of the Trusts Current State and Progress.

The Trust continues to integrate work supporting the compliance of all the 10 clinical standards into Business as Usual, for example:

- Acutely unwell or deteriorating patients are identified and escalated to the correct Level of clinician / speciality within the appropriate timeframe based on electronic recording of local physiological parameters and a track and trigger system using NerveCentre.
- Board Rounds are an established process across the specialities. Robust shift handover processes are in place across 7 days. This is embedded electronically in NerveCentre for all Nursing staff and in some acute specialities for Medics.
- Red 2 Green is in all areas across 5 days a week.
- There is a robust out of hours on call provision across the Trust over 7 days with a “Hospital at Night” model in place out of hours.
- Where appropriate all patients have MDT discussion recorded in the medical notes or Nervecentre.
- The Integrated Discharge Team (IDT) is a collaborative service bringing together employees from five Health and Social Care Organisations.

Following the last 7DS audit in March 2019, it was agreed that a full notes audit across the Trust for Clinical Standards 02 (Time to consultant Review) and Clinical Standard 08 (on- going review) would not take place for this submission, but to focus on a larger audit for the 2 areas that are most challenged – General Surgery and CDU for Clinical Standard 02.

The paper describes those results.

2. Clinical Standard 02 (Time to Consultant Review)

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

2.1 General Surgery.

The results from the last survey showed that General Surgery across the LRI and LGH were 48% compliant. As part of the Action Plan the Service Level data was discussed with the Service and a further in-depth Audit has taken place.

Results of the Audit:

An audit of notes at the LGH Wards G28 and G29 and at the LRI Ward SAU was completed in real time auditing medical notes Weds 4th September – Tues 10th September. Notes were audited of patients still on the wards the day after being admitted.

		G28	**G29**	**SAU**	**G28A**
Total Number of All admissions	**302**	72	103	95	32
Number of Admissions 3 wards >14 Hr Stay	**230**	69	79	82	
Number of Notes Audited of those >14Hr stay	**147**	55	40	52	
Percentage of notes Audited of those >14Hr stay	**64%**	79%	50%	63%	

Table 1

Table 2 illustrates that overall Surgery were 66% compliant with Clinical Standard 02. This is more in line with previous audits as shown in Table 3.

	Total Y	**Total N**	**Total Audited**	**% Compliant**
G28	42	13	55	76%
G29	27	13	40	68%
RSAU	28	24	52	54%
TOTAL	97	50	147	**66%**

Table 2

	Baseline Assessment	**Mar 16**	**Sept 16**	**Mar 17**	**Jun 18**	**Mar 19**	**Sept 19**
LRI	45%	41%	62%	68%	69%	39%	54%
LGH	33%	40%	46%	52%	64%	53%	73%

Table 3

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Tables 4, 5 and 6 Show the compliance of each ward split by week days and weekends.

G28	Total Y	Total N	Total Audited	% Compliant
WEEK DAYS	30	11	41	73%
WEEKEND	12	2	14	86%

Table 4

G29	Total Y	Total N	Total Audited	% Compliant
WEEK DAYS	20	12	32	63%
WEEKEND	7	1	8	88%

Table 5

RSAU	Total Y	Total N	Total Audited	% Compliant
WEEK DAYS	24	19	43	56%
WEEKEND	4	5	9	44%

Table 6

It is worth noting that the compliance rate is almost entirely dependent on the time that a patient arrives at the hospital. This is demonstrated in the following tables where it is shown the percentage of patients arriving between 7am and 6pm, and 6pm and 7am. The LRI had a different proportion of patients arriving between 7am and 6pm and this is reflected in the compliance.

	Admission Time - ALL	
G28	7am – 6pm	6pm – 7am
Weds	5	5
Thurs	4	3
Fri	2	6
Sat	2	12
Sun	3	3
Mon	3	8
Tues	3	10
Total	22	47
%	**32%**	**68%**

Table 7a

	Admission Times Audit	
G28	7am – 6pm	6pm – 7am
Weds	4	3
Thurs	3	3
Fri	0	6
Sat	2	7
Sun	2	3
Mon	3	6
Tues	3	10
Total	17	38
%	31%	69%

Table 7b

	Compliance	
G28	N	Y
Weds	2	5
Thurs	3	3
Fri	0	6
Sat	2	7
Sun	0	5
Mon	3	6
Tues	3	10
Total	13	42
%	**24%**	**76%**

Table 7c

	Admission Time - ALL	
G29	**7am – 6pm**	**6pm – 7am**
Weds	2	7
Thurs	9	4
Fri	4	7
Sat	6	5
Sun	4	9
Mon	4	8
Tues	5	6
Total	34	46
%	**42%**	**58%**

Table 8a

	Admission Times Audit	
G29	**7am – 6pm**	**6pm – 7am**
Weds	1	3
Thurs	4	4
Fri	1	5
Sat	1	2
Sun	0	5
Mon	2	6
Tues	3	3
Total	12	28
%	**30%**	**70%**

Table 8b

	Compliance	
G29	**N**	**Y**
Weds	0	4
Thurs	4	4
Fri	1	5
Sat	1	2
Sun	0	5
Mon	3	5
Tues	4	2
Total	13	27
%	**32%**	**68%**

Table 8c

	Admission Time - ALL	
RSAU	**7am – 6pm**	**6pm – 7am**
Weds	9	4
Thurs	8	10
Fri	9	7
Sat	1	8
Sun	5	1
Mon	5	6
Tues	7	2
Total	44	38
%	**54%**	**46%**

Table 9a

	Admission Times Audit	
RSAU	**7am-6pm**	**6pm- 7am**
Weds	5	2
Thurs	6	9
Fri	4	5
Sat	1	6
Sun	2	0
Mon	3	3
Tues	4	2
Total	25	27
%	**48%**	**52%**

Table 9b

	Compliance	
RSAU	**N**	**Y**
Weds	5	2
Thurs	6	9
Fri	4	5
Sat	3	4
Sun	2	0
Mon	2	4
Tues	2	4
Total	24	28
%	**46%**	**54%**

Table 9c

Tables 7a, 8a and 9a show ALL the admissions for emergency surgery for the named ward, the numbers by day admitted between the two-time blocks of 7am – 6pm and 6pm – 7am, and the proportional percentage.

Tables 7b, 8b and 9b show all the audited notes for the named ward, the numbers audited in the 2-time blocks of 7am – 6pm and 6pm – 7am, and the proportional percentage.

Tables 7c, 8c and 9c show the compliance (Y = compliant, N = non-compliant) of clinical standard 02 by day in numbers and the overall percentage.)

The surgical teams on both sites conduct a ward round at 8am 7 days a week, meaning that any patient arriving in the hospital between approx. 7am and 6pm may not have a consultant review until the following morning and therefore miss the standard. However, without exception all these patients were reviewed by a Registrar during the day and where appropriate, the patient was discussed with a consultant.

Job plans for the surgeons currently limit time for a second ward round but It has previously been agreed that as part of the reconfiguration of the hospitals when all Emergency General Surgery moves to the LRI, that a second ward round will take place later in the day and this should deliver the target of 90% of patients to be seen by a consultant within 14 hours of being admitted.

2.2. CDU – Respiratory and Cardiology

The results of the last survey showed that CDU was 66% compliant with Clinical Standard 02 - Respiratory were 74% compliant and Cardiology were 57% compliant.

The audit was conducted retrospectively for the 7 days of Weds June 26th – Tues July 2nd. In CDU, NerveCentre was used to initially extract data, as senior reviews (Consultant and SPR) should be entered onto the system.

For this period, the data from NerveCentre showed compliance for Respiratory at 76% and for Cardiology at 22%. In order to further validate the data, the following took place:

- 30 sets of notes of those patients showing to be compliant were audited to validate compliance on the system. All the notes had documentation to support the system outcome.
- The non-compliant notes were requested from medical records to be audited.
- 28 sets of notes for Respiratory of which 26 were audited, and 94 from Cardiology of which 65 were audited showed non-compliance on NerveCentre.

The combined results of the system and manual audit are below.

Table 1 shows the number of emergency admissions in CDU, number of patients with a >14 hours stay and the percentage audited.

		Respiratory	Cardiology
Total Number of All admissions	**412**	174	238
Number of Admissions >14 Hr Stay	**237**	117	120
Number Audited of those >14Hr stay	**206**	115	91
Percentage Audited of those >14Hr stay	**87%**	98%	75%

Table 1

Both specialities increased compliance with the manual audit which may indicate that the information on the system is not always correct. Sometimes the system showed that:

- A review had “not been done” – i.e. not recorded on the system.
- For cardiology when a patient went onto CCU this is then not recorded on NerveCentre.
- A Senior Review completed by Registrar on system within 14 hours then a subsequent consultant review, also within 14 hrs, did not appear on the data set.
- A patient was admitted onto a ward and then seen on a ward during the first 14 hours by a consultant. As this review was on the ward it would not show on NerveCentre.

Table 2 shows, with the combination of both the system and manual note audit CDU total was 66% compliance.

	Total Y	Total N	Total Audited	% Compliant
Respiratory	99	16	115	86%
Cardiology	37	54	91	41%
TOTAL	136	70	206	**66%**

Table 2

The following tables show the results of the combined audit methodology for each specialty by Day of the week and split by weekdays and weekends.

Respiratory	Total Y	Total N	Total Audited	% Compliant
Wed	9	2	11	82%
Thurs	11	3	14	79%
Fri	15	5	20	75%
Sat	17	1	18	94%
Sun	12	1	13	92%
Mon	18	2	20	90%
Tues	17	2	19	89%
Total	**99**	**16**	**115**	**86%**

Table 3

Respiratory	Total Y	Total N	Total Audited	% Compliant
WEEK DAYS	70	14	84	83%
WEEKEND	29	2	31	94%

Table 4

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Cardiology	Total Y	Total N	Total Audited	% Compliant
Wed	6	12	18	33%
Thurs	12	6	18	67%
Fri	5	4	9	56%
Sat	1	10	11	9%
Sun	2	11	13	15%
Mon	2	4	6	33%
Tues	9	7	16	56%
TOTAL	**37**	**54**	**91**	**41%**

Table 5

Cardiology	Total Y	Total N	Total Audited	% Compliant
WEEK DAYS	34	33	67	51%
WEEKEND	3	21	24	13%

Table 6

Table 7 below demonstrates the results of audits for CS02 over the last 3 years.

	Baseline	Mar 16	Jun 16	Sept 16	Mar 17	Sept 17	June 18	Mar 19	Jun19
Respiratory	55%	55%	56 %	53%	50%	65%	81%	74%	86%
Cardiology	36%	38%	30 %	40%	29%	50%	50%	57%	41%
CDU Total		45%	44%	50%	41%	55%	64%	66%	66%

Table 7

Respiratory have made significant improvements with a consultant assigned daily to CDU 7 days a week.

Cardiology has struggled with capacity on CDU but it should be noted that CCU is fully compliant (i.e. twice daily consultant ward rounds) from all previous audits.

2.3 Summary of Results

2.3.1 Surgery

Surgery is non-compliant across week days and weekends. The compliance rate is almost entirely determined by the time a patient is admitted as Consultant led ward rounds take place once a day 7 days a week at 08:00. There is variation across wards, sites and weekdays and weekends, however this variation is reflected in the time of day a patient is admitted. Compliance for Surgery across the 3 wards across 2 sites was **66%.**

Although not required by NHSE, further analysis showed that **100% of all patients audited in general surgery had a Senior Review** (Consultant/Specialist Trainee/ Non-training grade equivalent) within 14 hours.

2.3.2 Respiratory

Respiratory shows meeting compliance at weekends. There is some variation across weekdays with Thursday and Friday being less compliant than Monday and Tuesday. Overall compliance rate is **86%**.

Further analysis showed that **100% of all patients audited in respiratory had a Senior Review** within 14 hours.

2.3.3 Cardiology

Cardiology shows that compliance is not met across the week or weekends. The compliance at weekends is significantly less. Overall compliance is **41%**.

Further analysis showed that **81% of all patients audited in cardiology had a Senior Review** within 14 hours.

2.3.4 Overall Results for NHSE Submission

Clinical Standard 02 Compliance for the submission for NHSE will assume the same percentages for the other major specialities as the case note audit undertaken in March 2019. As Surgery and Cardiology are significantly non- compliant the return will show as a Trust Non -compliant for CS02. As audited numbers for Surgery and CDU were large the effect on the overall Trust result has not been affected despite the improvement in Surgery. See Tables 8 and 9

June 19 Submission	
Medicine	93%
Surgery	48%
Paediatrics	84%
Obs and Gynae	82%
CDU/CCU	66%
Other	72%
TOTAL	77%

Table 8

October 19 Submission	
Medicine	93%
Surgery	66%
Paediatrics	84%
Obs and Gynae	82%
CDU/CCU	66%
Other	72%
TOTAL	77%

Table 9

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3. Priority Clinical Standards 05, 06

Clinical Standards 05 Diagnostics and 06 Consultant Directed Interventions were submitted as being Compliant in June 2019 and will be reported as such for the November submission.

4. Priority Clinical Standard 08 – On Going Review.

No further audit has taken place since June submission and the same results will be reported in the November Submission. We have consistently achieved over 90% compliance across week days and weekends combined, over the last 3 audits. The NHSE submission will show as non-compliant as Weekends showed 87% compliance and Weekdays 97% compliance. The requirement is for both week days and weekends to be 90% compliant.

5. 7DS and Urgent Network Clinical Services

In the last 3 audits up to March 2019 the 4 priority standards have been met in Hyper acute Stroke, Paediatric Intensive Care, SEMI Heart Attack and Emergency Vascular Service**.** The NHSE Report will therefore show compliant. No further audit has taken place since Mar 2019, and is assumed there is no change.

6. Further Updates on other 6 Clinical Standards

6.1 Clinical Standard 01 Patient experience.

Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

No further update for this submission.

6.2 Clinical Standard 03 Multidisciplinary Team review

All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

No further update for this submission

6.3 Clinical Standard 04 Shift handovers

Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

No further update for this submission

6.4 Clinical Standard 07 Mental Health

Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

No further update for this submission

6.5 Clinical Standard 09 Access to Community Primary and Social Care

Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

2019 -2020 Quality Strategy includes:
"We will implement safe and timely discharge for all patients in our care, 7 days a week, by embedding safer discharge process and eliminating avoidable delays".

Focus for this improvement has been determined by:

- Evidence of increased harm
- Patient complaints of poor discharge experience
- GP Feedback/concerns of suboptimal care and inaccurate discharge summaries
- Other Provider (LPT) service concerns of unsafe transfer and required admissions
- Failed discharges/ readmissions due to unsafe transfer of carer

This work is in collaboration with our Health partners and information about progress and achievements will be available for the next submission to NHSE.

6.6 Clinical Standard 10 Quality Improvement

All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Patient outcomes are presented and discussed at all levels of the Trust in a governance structure supported by Trust Board, QOC, EQB. Performance data dashboards and information Quality and Performance Reports are provided and reviewed in CMGs across all professions and Levels of management. Should NHSE require further information to be provided this will be completed but for the purpose of the "Quality" committees this paper is required to assure compliance, therefore have not attached an example as this is familiar territory.

7.0 ACTION PLAN

- Whilst cardiology is continuing to advertise for new consultant cardiologists, the trust is exploring new models of providing consultant cardiology care including the introduction of consultants with a combined acute medicine and cardiology interest
- Cardiology are, where possible, putting an extra senior trainee on CDU at weekends accepting this on a locum basis at present
- Cardiology are working on a design for a 'twilight' senior trainee rota

- To establish an agreed format for weekend management plans to be added to the medical notes, and implement across ALL specialities. This has already been achieved in isolation by paediatrics and ITU. The plan is trial and then implement in other specialities with the initial stage to agree the standard format by December 2019
- General surgery are to explore the feasibility and impact (both clinical and job plans) of conducting a second daily ward round at LRI and LGH to be completed by December 2019
- In the longer term it has previously been agreed that as part of the reconfiguration of the hospitals when all Emergency General Surgery moves to the LRI in 2021, that a second ward round will take place later in the day and this should deliver the target of 90% of patients to be seen by a consultant within 14 hours of being admitted

8.0 Recommendations

- To acknowledge the current 7-day services audit results noting the particular positive progress made by the respiratory service on CDU regarding CS-02
- To agree and accept the action plan
- To accept this paper for subsequent submission to the Trust Board for the 7-day services board assurance framework
- To re audit at a minimum general surgery and cardiology (CDU) in 6 months' time however we are awaiting NHSE guidance on whether a larger general audit is again required

7 Day Hospital Services Self-Assessment

Organisation	University Hospitals of Leicester NHS Trust
Year	2019 October
Period	

NHS

University Hospitals of Leicester NHS Trust: 7 Day Hospital Services Self-Assessment - 2019 October

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Overall compliance across the 3 sites for UHL was 77%. Main areas of non compliance are General Surgery and Cardiology . An audit of 147 Surgical notes in September and 206 episodes in Respiratory and Cardiology - using notes and NerveCentre for the Audit from June has taken place. The results show an improvement in Surgery since the March Audit - but this is only relelvant to when the patients arrive in the hospital, as predicted in other audits. (See report). Respiratory made an improvement and are almost compliant, but Cardioiology are still challenged in providing a daily consultant presence due to capacity. (5 Consultant posts have still not been recruited to) Discussions with Surgery and Cardiology have taken place. Consultants on Assessment units do have 7 day working in their job plans and Red2Green is in operation in most wards but not all for 7 days Evidence. Job Plans. Audit of Surgery Cardiology and Respiratory Notes, R2G. NerveCentre Data . Ward Rounds Board Round. Previous audits	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All the tests are available on Site over 7 seven days.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	All interventions are available across the Trust	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	As of March 2019 Audit: Patients requiring 1 review per day - Compliance overall on weekdays was 97% and weekends 87%. Overall across all 7 days compliance was 95%. Patients receiving twice daily review were 100% compliant. Daily Board rounds are in place, 95% ofALL clinical areas are reported to have a ward/board rounds across the Trust Monday to Friday. However this reduces to 59% for Monday to Sunday. There are some gaps in weekend consultant presence in some specialities which to date has not been affordable to rectify. Plan: To establish an agreed fromat for a weekend management plan to be added to the medical notes, and implement across all specialities. October 2019. Evidence: Job Plans. Medical Notes Audit. Board Rounds.Ward Rounds. R2G. Deterioating Patients. Quality Commitment Year End Report for Ward/Board Rounds and embedding sandardised R2G Methodology. Annual Report - Improvements in Discharge Processes within LLR 2018/19.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Patient experience: Compliant: Friends and Family survey question in Assessmnt units. To date this has shown to be high 92-95% with little or no variation between week or week end day admission. Patients, family and carers are consulted at each stage of their care pathway. The Integrated Discharge Team continues to work with clinical teams to promote the 4 key questions in their Clinical areas. • What is the matter with me • What is going to happen today • What is needed to get me home • When am I going home . Multidisciplinary team review: Partially Compliant.:(not all MDT Board Rounds are 7 Days) The Board and Ward Round Professional standards have been reviewed and updated. They provide guidance to staff about the standards for Board Rounds. Scheduled MDT Board round 5 days a week Monday- Fri AM 52 weeks a year and in some specialities 7 days a week. Shift Handovers: Compliant: 100% of applicable CMG ward areas (63 wards) are reported to be using the Red2Green principles for highlighting delays in the patient's journey. A new easy view Board Round profile was launched on nerve centre in September 2018 to capture the 'next steps' in the patient's journey. New Policy of clinical Handover is in place - implemented in 2018, Hospital at Night Model is well embedded for handover OOH. Mental Health: Compliant A clear 24/7 referral pathway is in place for Emergency Patients. Clincial Audit 2017/18. Mental Health Referral Pathways 2018. Transfer to community, primary and social care: Significant improvements over last 2 years: not completely compliant over all 7 days.: The Integrated Discharge Team (IDT) is a collaborative service bringing together employees from five Health and Social Care Organisations. There are ward discharge coordinators, 7 day pharmacy, weekend physio and OT in some specialities, a TTO Project running to improve TTO discharage medication, referral to social services across 7 days, a 7 day Carers Trust Discharge response Team, a small number of Discharge practitioners working 7 days across the emergency floor at LRI. Annual Report - Improvements in Discharge Processes within LLR 2018/19. Benchmarked against Quality Standard 136. Quality improvement: Compliant: Quality Strategy. Medical Education Strategy. Quality and Performance reporting at Trust, CMG, service level.Including Outcomes- LOS, Mortality and readmissions. Peformance and Outcomes discussed at all levels of the Trust including: Trust Board: Exec Quality Board: Quality and Performance Board: CMG Boards (Speciality Quality Dashboards): Quality and Performance Dashboards include a Number of thh following: Safe Indicators, Caring Indicators,. Well Led Indicators, Effective Indicators and Responsive Indicator

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
N/A

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.