

LEEDS TEACHING HOSPITALS NHS TRUST

2007/08 Annual Health Check Quality Improvement Plan

1. Target related Action Plans

Action plans have been reviewed and further developed for those areas where the Trust failed to achieve against existing national targets, new national targets and core standards in the 2007/08 annual health check. These actions are summarised in this Quality Improvement Plan.

Target	1.1 Emergency Care: Maintain the 4 hour maximum wait in A&E from arrival to discharge, transfer or admission
Issues	<ul style="list-style-type: none"> • Since March 2008 the Trust has consistently met the required standard that 98% of all patients attending Accident & Emergency (A&E) are discharged, transferred or admitted within 4 hours of arrival in A&E • Performance against this standard for the first 2 quarters (April-September) of this financial year (2008/09) was 99.5% • Key issues/risks to continued delivery: <ul style="list-style-type: none"> ○ Patients requiring access to Mental Health Services who wait longer than is clinically necessary in A&E ○ Continued delivery during the winter period
Actions	<p>Actions already taken to ensure delivery against this standard:</p> <ul style="list-style-type: none"> • Joint working group between the Acute Trust and NHS Leeds Primary Care Trust (PCT) in place • 10 Key Steps for Improving the Emergency Pathway agreed and implemented • Speciality assessment areas in place • Dedicated ambulance to transfer patients when required between the 2 main hospital sites established • Revised bed management arrangements implemented • On site clinical management for the out of hours period reviewed and strengthened <p>On going actions to ensure continued delivery against this standard:</p> <ul style="list-style-type: none"> • Daily monitoring of performance and enactment of real time actions that are required to ensure the continued delivery against this standard • Continued working with NHS Leeds and the Leeds Partnerships NHS Foundation Trust on the Emergency Pathway for patients requiring access to Mental Health Services to ensure patients do not remain in A&E for longer than is clinically necessary • Agreeing a plan for the winter period to ensure the continued delivery against this standard
Milestones	<ul style="list-style-type: none"> • Winter plan agreed on 3 September 2008 • Joint working with NHS Leeds and the Leeds Partnerships NHS Foundation Trust on the Emergency Pathway for patients requiring access to Mental Health Services has been established

Target	Waiting Times: No patient to wait longer than 6 weeks for a diagnostic test by 31st March 2008
Issues	<ul style="list-style-type: none"> All targets now achieved except specific physiological diagnostics, including Audiology & day case diagnostics ie Endoscopy Risks: <ul style="list-style-type: none"> Consultant recruitment in Neurophysiology a concern locally and nationally No modelling or agreement with commissioners to improve diagnostic waiting times to better than 6 weeks
Actions	<ul style="list-style-type: none"> Diagnostic Primary Targeting List (PTL) developed All waiting lists validated Delivery trajectory agreed internally and with Leeds PCT Additional capacity secured internally and externally via Leeds PCT Weekly performance management of all diagnostics with an over 6 week waiting time Sustainability plans developed for all diagnostics Booking processes being reviewed to streamline access Single, Trustwide waiting lists in place
Milestones	<ul style="list-style-type: none"> No 6 week diagnostic breaches by 31 August

Target/indicator	Waiting Times: 95% cancer patients to be treated within 62 days of GP referral
Issues	<ul style="list-style-type: none"> Thoracic surgery capacity problems High volumes of late referrals from cancer units
Actions	<ul style="list-style-type: none"> Increased thoracic surgery capacity from August 2008 Work with cancer network and SHA to redesign the lung pathways in the cancer units to allow more headroom in surgical pathway, aim to develop network wide pathway that reaches post PET scan multidisciplinary team (MDT) by day 21 (now in place in Leeds) Work with referring Trusts to reduce late referrals from all MDTs Ongoing sustainability plan refreshed each month to ensure any new issues identified are tackled, identify pathways that are at risk and commission project work to resolve these Weekly cancer PTL review meeting to track all patients at risk of breaching 31 and 62 day standards Cancer reform strategy Implementation group established, focusing on the revised and expanded cancer waiting times targets Tumour sites and pathways mapped to a specific clinical Directorate to clarify responsibility and accountability for

	<p>performance against the targets</p> <ul style="list-style-type: none"> • Revise all tumour site pathways by Directorate and redesign to account for removal of adjustments in Q4 2007/08: complete November 2008 • Develop cross-cutting action plans to improve performance: histopathology plan to deliver 7 day turnaround for all samples and the redesign of Patient Pathway Manager (PPM) database and tracking tool to facilitate improved tracking and mandatory data collection
Milestones	<ul style="list-style-type: none"> • Target to be met from November 2008

Target	Cancelled Operations: From April 2002, all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days or fund the patient's treatment at the time and hospital of the patient's choice
Issues	<ul style="list-style-type: none"> • The Trust reported 212 breaches of the 28 day standard for the year to 2007-08, 15% of all operations cancelled for non clinical reasons • Operational difficulties during the winter period of planning elective lists at a high period of acute activity • Financial risk if a patient chooses to be treated outside the Trust
Actions	<ul style="list-style-type: none"> • Cancelled Operations Steering group established to make quality improvements • Weekly monitoring of cancelled operations in place, monthly performance report circulated to all Divisional management teams • Weekly High Dependency Unit (HDU) operational meetings commenced October 2008 to identify capacity and demand and plan on a weekly basis • Bed predictor tool piloted in neurosurgery to predict acute demand and manage elective capacity • Patient admin review and work programme 2008, including re-booking cancelled operations within 28 days • Directorates implemented new reporting pathways within each specialty with a named individual for cancelled operations • Service Improvement Facilitator appointed to undertake a review all processes in theatres and specialty areas in order to improve the current position • Root Cause Analysis undertaken within each Directorate to identify areas for improvement • Patient access Policy for the prevention and management of Cancelled Operations completed, to be approved at Senior Management Team (SMT) November 2008 • 10 steps for reducing last minute cancelled operations for non clinical reasons approved by the Trust Board August 2008

Milestones	<ul style="list-style-type: none"> • Achieve the Annual Health Check standard by March 2008.
Target	<p>MRSA: Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available (See Core Standard C04a below)</p>
Issues	<ul style="list-style-type: none"> • Leeds Teaching Hospitals trajectory is set at an average of 6 cases per month; Leeds Teaching Hospitals has not been able to maintain this trajectory.
Actions	<ul style="list-style-type: none"> • Detailed action plan developed to reduce Health Care Associated Infection (HCAI); Department of Health (DoH) review in September 2008 identified a number of further actions: performance is monitored and managed through weekly review meetings with Trust clinicians and managers, the Department of Health (DoH), Strategic Health Authority (SHA) and the Primary Care Trust (PCT) • Infection Prevention & Control Committee meets bi monthly, review action plan and agree actions for further improvement, approve policies and review local and national guidance • All staff are aware of their responsibility in reducing HCAI • Root Cause Analysis (RCA) undertaken for all MRSA bacteraemias, challenge meeting led by Divisional General Manager, Divisional Medical Manager and Divisional Nurse • Hand Hygiene profile raised through a range of media, training mandated for all staff, performance managed through hand hygiene weekly audits & reviewed at monthly Trust performance management meetings • Mandatory training programme, including e-learning in place • Releasing Time to Care programme commenced which focuses on improving the quality of care nurses give to patients and on using information to improve performance at ward level. Priority areas for the programme identified based on HCAI risks • Patient Safety Strategy approved by the Board in September, key workstreams include HCAI • Matrons and Clinical Directors are managing performance in key areas to include hand hygiene, the Dress Code and other significant infection prevention policies
Milestones	<ul style="list-style-type: none"> • Leeds Teaching Hospitals will demonstrate month on month reductions with the aim to deliver or further improve on the monthly trajectory figure from November onwards.

Target	Convenience and Choice
Issues	<ul style="list-style-type: none"> • The Trust has worked throughout the last year publishing its services through the National Choose and Book system. • The pace of implementation has been slow and thus at the end of March 2008 showed a low number of published services available through Choose and Book for Direct Booking • Consequently the indicator for slot unavailability referenced a small sub set of services • The Trust had not put in place a mechanism for the update of the NHS choices website
Actions	<ul style="list-style-type: none"> • Implement Direct booking for all eligible services by December 2008 • Develop process for regular review of slot unavailability and the increase of slot poll ranges as required • Identify the current update mechanism for the NHS choices website including the identification of the data set required • Design process to ensure a regular update process is in place • Enable feedback from key stakeholders and build this into the feedback process
Milestones	<ul style="list-style-type: none"> • All eligible services live December 2008 • Process for publishing to NHS choices to be in place December 2008 • Process for Slot unavailability to be in place by November 2008 • To be fully compliant by 31 March 2009

2. Standard-related Action Plans

Target/Standard	C4a: Healthcare Associated Infections
Issues	<ul style="list-style-type: none"> • Compliance with the Code of Practice on Healthcare Associated Infections, which is part of the Health Act 2006. Trust 77% compliant at time of 2007/08 declaration • Actions linked to estate part of 3 year improvement plan • Currently above trajectory of 6 MRSA bacteraemias per month • Currently above trajectory for Clostridium <i>difficile</i> infection (CDI)
Actions	<ul style="list-style-type: none"> • Progress against the Code of Practice for the prevention and control of HCAI self-assessment tool reviewed quarterly: Trust action plan based on Code of Practice reviewed monthly • Infection Prevention & Control Committee meets bi monthly, terms of reference revised, review action plan and agree actions for further improvement, approve policies and review local and national guidance • New Divisional Management arrangements in place and fully implemented June 2008: clear reporting mechanisms in place to manage infection prevention and control issues. All staff are aware of their responsibility in reducing HCAI • Divisional Infection Prevention & Control groups established • Commenced Root Cause Analysis (RCA) on clusters of CDI, including processes for shared learning • Opened CDI isolation ward at LGI, September 2008, cohort ward at SJUH to open in December 2008 • Hand Hygiene profile raised through a range of media, training mandated for all staff, performance managed through weekly audits & performance management framework • Releasing Time to Care programme commenced, which focuses on improving the quality of care nurses give to patients and on using information to improve performance at ward level. Programme of work on ward environment included • Patient Safety Strategy approved by the Board in September, key workstreams include HCAI • Data on CDI available at ward level on a weekly report • New posts appointed, include antimicrobial consultant pharmacist and matron
Milestones	<ul style="list-style-type: none"> • Improved compliance with Health Act by March 2009 • Monthly review of action plan to ensure actions delivered

Target/Standard	C4c: Decontamination
Issues	<ul style="list-style-type: none"> Decontamination of all flexible endoscopes is undertaken locally in the Trust. The endoscope reprocessing equipment does not all comply with technical guidance HTM 2030, a plan to achieve full compliance has been approved to include appropriate replacements and re-organisation of services
Actions	<ul style="list-style-type: none"> Trust sterile services units transferred to an off -site provider, B-Braun Sterilog. Review of all endoscopy reprocessing completed 2007 and business plan approved, including future provision of endoscopy services Validation of Automated Endoscope Reprocessing (AER) in Clarendon Wing completed 31 December 2007 Steris 1 reprocessors audited 2007 and recommendations made for best practice and implemented High risk equipment removed 2007 Business case for AER centralisation completed 31 December 2007 Clarendon Wing and Bexley Wing endoscopy reprocessing HTM 2030 compliant: david Beevers Day Unit (DBDU) to be compliant March 2009 - business case approved New Bexley Wing endoscopy department opened April 2008 Business case for 4th endoscopy reprocessor for Clarendon Wing approved 2008 All re-usable instrument decontamination services transferred to B-Braun Sterilog, a compliant service provider. Centralised sterile services transferred to B-Braun Sterilog from Leeds Dental Institute, Wharfedale General June 2007, St James's and Chapel Allerton in February 2008, LGI in September 2008 St James's hospital (autoclaving) transferred by 31 October 2007 Risk issues at Chapel Allerton resolved June 2008 AER centralisation to be implemented during 2008/9.
Milestones	<ul style="list-style-type: none"> Continue to progress towards compliance with Standard C4c in 2008/09