

**Integrated Performance Report**  
**April 2006**

**Trust Board Meeting**  
**1st June 2006**

## **Integrated Performance Report (IPR) – April 2006**

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# The Leeds Teaching Hospitals NHS Trust

## Overview

This monthly performance monitoring report informs the Trust Board of progress against the core and developmental standards that the Trust must meet under “Standards for Better Health” during 2006/07. It will particularly concentrate on summarising progress towards local and national targets, as these will also be used to compile the Trust’s “Annual Health Check”.

### What’s been happening in April?

- During April, the Trust successfully met the performance standards for revascularisation waits (3 months), Rapid Access Chest Pain Clinics (2 weeks), Outpatients waits (13 weeks) and suspected cancer referrals (98%+ outpatient appointments within 2 weeks).
- Performance in April saw two real improvements for the Trust. Firstly, within A&E, 97% of patients were admitted, transferred or discharged within 4 hours. Although still just short of the 98% standard, this is the best monthly performance seen since October 2005. Provisional data for the first two weeks of May shows that this progress is continuing.
- Secondly, real improvement was seen against the 2 month cancer standard. 79% of patients were treated within 2 months of urgent referral during March, an increase of 8% when compared with the previous month. The Trust aims to be up to the national standard of 95% by the end of June 2006. (*NB: Cancer data is one month behind*).
- After steady improvement over the last 3 months, the percentage of cancer patients treated within one month of diagnosis dipped slightly during March from 95% to 92%.
- April also saw a slight increase in the number of patients waiting longer than 26 weeks for an MRI or CT scan from 14 to 17 patients.
- There was no change in the percentage of patients booked during April when compared with March 2006; 99% of inpatients, day cases and outpatients were booked.
- From April 2006, the waiting times for inpatients and day cases is measured in weeks rather than months. The standard to meet is 26 weeks. During April, there were 2 breaches of the standard (down from 6 last month). The breaches were in Plastic Surgery and Cardiothoracic Surgery.
- The number of operations cancelled for non-clinical reasons on the day of or after admission has dropped from 86 last month to 56 in April; this is considerably better than the monthly average of 112 during 2005/06. The number of reportable breaches of 28 days following a cancellation for non-clinical reasons in April is also well under the average of 38 for 2005/06 at 15 breaches.
- The Department of Health has published a number of new milestones for waiting times that will need to be met over the next two years as Trusts work towards the target of a maximum wait of 18 weeks from GP referral to treatment by December 2008. More information on these milestones is available within the “Issues arising” section of this report.
- This month’s “Focus on” report outlines the Trust’s current performance in the Safety domain within the “Standards for Better Health”. The Trust declared compliance in all bar one of the standards within the domain in its 2005/06 declaration (C4c Decontamination). Whilst the Trust has shown good levels of compliance with these standards, it also recognises that the area of safety is one where work to minimise risk and learning from experience should be ongoing.

## Key commitments:

Domain(s)	Existing Standards & New National Targets	Apr Data	2005/06	YTD position
Governance	Reduce to 4 hours the maximum wait in A&E from arrival to admission, transfer or discharge ( <i>% less than 4 hours</i> )	96.7%	96.6%	Red
Governance	Thrombolysis: 60min call to needle: deliver a 10% increase per yr	<i>Pilot of alternative treatment ongoing</i>		
Governance	Maintain a maximum two week wait from urgent GP referral to 1 <sup>st</sup> outpatient appointment for all urgent suspected cancer referrals. ( <i>% seen within 2 weeks</i> )*	99.8%	99.1%	Green
Governance	Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005 ( <i>% within 1 month</i> )*	92.3%	88.2%	Red
Governance	Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005 ( <i>% within 2 months</i> )*	78.9%	n/a	Red
Governance	Maintain a two week maximum wait standard for Rapid Access Chest Pain Clinics (RACPC) ( <i>% less than 2wks</i> )	100%	100%	Green
Governance	Maintain a 3 month maximum wait for revascularisation ( <i>reported breaches of 3 months</i> )	0	3	Green
Governance	Maintain a maximum wait of 26 weeks for inpatients ( <i>number waiting over 26 weeks</i> )	2	n/a	Amber
Governance	Achieve a maximum wait of 20 weeks for inpatients by 31st March 2007 ( <i>number waiting over 20 weeks</i> )	898	n/a	
Governance	Maintain a maximum wait of 13 weeks for an outpatient appt. ( <i>no. waiting over 13 weeks</i> )	0	n/a	Green
Governance	Achieve a maximum wait of 11 weeks for an outpatient appt. by 31st March 2007- ( <i>no. waiting over 11 weeks</i> )	943	n/a	
Governance	Ensure that by the end of 2005, every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.	99.0% IP/DC	78.3% IP/DC	Green
		98.6% OP	82.3% OP	Green
Governance	Delayed transfers of care to reduce to a minimal level by 2006 ( <i>% delayed, weekly data</i> )	2.1%	2.2%	Amber
Governance	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 ( <i>no. of breaches declared</i> )	15	451	Amber
Governance	Number of operations cancelled, by the hospital, for non-clinical reasons, on the day of or after admission ( <i>no. declared</i> )	56	1,349	Amber
None ( <i>new target</i> )	To ensure that by 2008, nobody waits more than 18 weeks from GP referral to hospital treatment; no patient to wait longer than 26 weeks for an MRI or CT scan ( <i>number 26+</i> )	17	n/a	Red
None ( <i>new target</i> )	To ensure that by 2008, nobody waits more than 18 weeks from GP referral to hospital treatment; no patient to wait longer than 13 weeks for a diagnostic test by 31st March 2007 ( <i>number 13+</i> )	433	n/a	
None ( <i>new target</i> )	Reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline) ( <i>% change in number of occupied bed days for emergency admissions from same point in 2003/04</i> )	-14.6%	-8.2%	Green
None ( <i>new target</i> )	Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available ( <i>number per quarter</i> )	42 (Q4, 05/06)	163	Green

Note: The year to date position is based on both the current position and progress to date. E.g. If the target can be met based on current / recent performance continuing at the same rate, the position is green. \*Cancer data is month behind.

## Key Commitments: Issues arising

- This month, the issues arising section will focus on the new access “milestones” that have been introduced as part of a Trust’s progression towards the 18 week target: To ensure that by 2008, nobody waits more than 18 weeks from GP referral to hospital treatment.
- The two national documents : “Tackling Hospital Waiting: the 18 week Patient Pathway” and the “18 week Patient Pathway Delivery Resource Pack”, both published during May 2006, outline the key milestones that Trusts need to achieve in order to progress towards 18 weeks.

Figure 1: New access milestones

	Current standard	By March 2007	By March 2008	By December 2008
Outpatients	Maximum wait of 13 weeks for an appointment	11 weeks	5 weeks	Maximum wait of 18 weeks from GP referral to treatment
Diagnosics:				
- MRI & CT	Maximum wait of 26 wks	13 weeks	6 weeks	
- All diagnostics	No standard yet			
Inpatients	Maximum wait of 26 weeks for treatment	20 weeks	11 weeks	

- These milestones have yet to be formally confirmed as “hard targets” but the March 2007 milestones are likely to be used as part of the Healthcare Commission’s performance indicators for the 2006/07 Annual Health Check so should be given the same consideration as any other existing target<sup>1</sup>. The March 2008 milestones will remain unconfirmed targets until nearer the time when they will be reassessed to evaluate whether or not they should become national targets<sup>2</sup>. Another target based on referral to treatment (e.g. 22 weeks) may also be introduced by March 2008.

### Outpatients:

- Since the 13 week outpatient target became the standard at the end of December 2005, LTHT has proven able to manage these timescales with only 2 breaches declared over the last 4 months. However, progressing from 13 weeks to 11 weeks then 5 weeks will still be a significant challenge for the Trust.
- As figure 2 (*below*) shows, at the end of April, 5% of patients waiting for an outpatient appointment had been waiting longer than 11 weeks. Whilst this is not a high percentage, when compared with April last year (when the Trust was working towards the 13 week target), only 3% of patients were waiting longer than 13 weeks.

Figure 2: Outpatient waiting times, April 2006

	5+ weeks		11+ weeks		13+ weeks	
	Number	%	Number	%	Number	%
31st April 2006	8,417	47%	943	5%	0	0%

- Although the March 2008 milestone of 5 weeks may not become a national target, it is a good indicator of the scale of the task facing the Trust as it moves towards meeting the 18 week target. At the end of April, almost half of patients waiting for an outpatient appointment had been waiting longer than 5 weeks.
- To date, all waiting times targets relating to outpatients have only included GP-referred outpatients. It appears that the 18 week target will include non-GP referred patients (to be clarified). If this is the case, planning around outpatients will need to take these patients into account. During 2005/06, non-GP referred new outpatient attendances accounted for 39% of new outpatients seen at LTHT.
- Currently, there is no comparative peer data available for these new outpatient milestones; however, it is anticipated that LTHT will not be starting from a significantly different position to its peers. Achieving such considerable reductions in outpatient waiting times will require a commitment to change that will impact on all Trusts.

Diagnostic services:

- To date, the national target has only applied to MRI and CT scans. The milestones of 13 weeks and 6 weeks outlined in figure 1 (*above*), apply to all diagnostic tests.
- As with many new initiatives, the move to all diagnostic tests has created a number of issues relating to the collection and monitoring of this data within the Trust. A project is being set up locally to begin to collate the data needed for this milestone.
- Currently, the Trust reports monthly waiting times for a range of imaging tests: MRI, CT, non-obstetric ultrasound, barium enema and DEXA Scans. For these tests, as at 30th April 2006, LTHT had 2,437 patients waiting. 17 patients had been waiting longer than 26 weeks (1%), 433 patients had been waiting longer than 13 weeks (18%) and 906 patients had been waiting longer than 6 weeks (37%).
- To date, the focus has been on waiting times for MRI and CT scans and progress has been made within this area locally. Over the period, January to March 2006, the number of patients waiting over 26 weeks was reduced from 87 to 14. As at 30th April, this number had risen slightly to 17.
- Although a clear picture of the current position across all diagnostic waits is not yet available, evidence from pilot sites has shown that endoscopy and pure tone audiometry are a particular challenge both in terms of numbers and time spent waiting<sup>2</sup>. However, until the necessary data is available locally, continued improvements within MRI and CT would still impact on progress towards the target as these areas have large numbers of patients waiting.
- From November 2005, patients waiting longer than 26 weeks for a non-urgent MRI or CT scan have been offered the choice of faster treatment at an alternative hospital. This choice has now been extended to include all patients waiting longer than 20 weeks for these scans<sup>2</sup>.

Inpatients:

- From 2006/07, inpatient (and day case) waiting times are being measured in weeks rather than months. As a result, the current inpatient waiting times standard has been changed from 6 months to 26 weeks.
- The new milestones have been set at 20 weeks and 11 weeks at year end over the next two years.
- As the most recent peer data is still only available in months, a proxy has been used for each of the new milestones: 6 months (for 26 weeks), 5 months (for 20 weeks) and 3 months (for 11 weeks). As at 31st March 2006, LTHT was on a par with the identified peers for the percentage of patients waiting 6, 5 and 3 months (*figure 3*).

*Figure 3: Inpatient waiting times as at 31st March 2006, selected peer trusts*

	6+ months		5+ months		3+ months	
	Number	%	Number	%	Number	%
Cambridge University Hospitals NHS Foundation Trust	0	0%	473	6%	2259	29%
Central Manchester & Man. Children's Univ. Hospitals Trust	0	0%	8	0%	320	6%
<b>Leeds Teaching Hospitals NHS Trust</b>	6	0%	452	4%	2625	26%
Sheffield Teaching Hospitals NHS Foundation Trust	0	0%	389	3%	2549	22%
The Newcastle Upon Tyne Hospitals NHS Trust	0	0%	494	5%	2482	24%

Source: DOH website

- Whilst LTHT is starting from a similar point to its main peer group, there are still areas such as Cardiothoracic Surgery and Plastic Surgery that continue to be under pressure in meeting the 26 week standard. Both specialties had a breach of the standard as at 30th April 2006. Trust-wide, the challenge of meeting these new milestones should also not be underestimated. As at 30th April 2006, 898 patients (nearly 9%) had been waiting longer than 20 weeks and 3,603 patients (over a third) had been waiting longer than 11 weeks.

## In Summary:

- Nationally, the 18 week target is recognised as the most ambitious target that the NHS has been set to date<sup>1</sup>. It has financial, operational, administrative and workforce implications that will need to be considered as the Trust progresses through these interim milestones.
- Longer term planning, with the 18 week target in mind, will be just as important as the short term planning that will enable the Trust to meet the reduced waiting times. To date, Trusts have had to balance the impact of decreasing waits in outpatients against the knock on effect of increased numbers being added to the inpatient list in order to meet both sets of targets; the inclusion of diagnostic waits adds another dimension to this planning.
- Current targets for waiting times are a snapshot of the patients waiting for an appointment or treatment on the final day of each month, i.e. if a patient breaches a waiting time standard at any point during the month, it is not reported. The 18 week wait will look at both the snapshot and the actual time waited to assess whether a trust has successfully met the target<sup>1</sup>. This will also need to be taken into account when managing the patient pathway.
- Managing the 18 week target requires that patients are monitored across the whole pathway of care and not in separate stages (e.g. outpatient waiting time). Nationally, there is no IT system in place that can measure the whole patient pathway from GP referral to treatment. Whilst work is underway to provide an IT solution, Trusts currently have no baseline to work with. The biggest concern remains the diagnostic period between first outpatient appointment and the decision to add a patient to the inpatient waiting list. This period, that could conceivably contain a series of diagnostic tests and outpatient appointments, is still largely an “unknown” factor in the progress towards 18 weeks. However, meeting these interim milestones, particularly within diagnostics, will, at least, show progress is being made.

### *Notes:*

<sup>1</sup> *Tackling Hospital Waiting: the 18 week patient pathway. An Implementation Framework, DoH, May 2006*

<sup>2</sup> *18 week patient pathway delivery resource pack, DoH, May 2006*

## Quality Indicators by Domain (last 12 months)

Domain	Indicator	Bench- mark	Apr 2005	May 2005	Jun 2005	Jul 2005	Aug 2005	Sep 2005	Oct 2005	Nov 2005	Dec 2005	Jan 2006	Feb 2006	Mar 2006	Apr 2006	
<b>Safety</b>	Number of risk management (clinical) claims	10	11	11	12	12	10	11	8	18	9	5	9	9	<b>10</b>	
	Number of personal injury claims	6	10	5	5	8	5	5	7	7	3	7	2	6	<b>1</b>	
<b>Clinical &amp; Cost Effectiveness</b>	Number of elective 1st FCEs ( <i>Finished Consultant Episodes</i> ) <i>Excludes well babies</i>	55%	8,483 52%	7,751 50%	8,542 53%	7,910 50%	8,376 52%	8,513 53%	7,971 49%	8,908 53%	7,868 50%	8,576 53%	7,875 52%	9,165 54%	<b>7,490</b> <b>51%</b>	
	Number of non-elective 1st FCEs <i>Excludes well babies</i>	45%	7,734 48%	7,657 50%	7,465 47%	7,946 50%	7,643 48%	7,692 47%	8,190 51%	7,826 47%	7,817 50%	7,659 47%	7,207 48%	7,764 46%	<b>7,254</b> <b>49%</b>	
	Day cases as a percentage of elective 1st FCEs (excluding well babies and including regular day cases)	73%	61%	62%	61%	61%	65%	64%	65%	65%	63%	64%	62%	63%	<b>62%</b>	
	Average length of episode (FCE) excluding day cases (in days)	4.1	4.5	4.3	4.7	4.1	4.4	4.4	4.2	4.3	4.4	4.4	4.4	4.4	<b>4.3</b>	
	Percentage of elective inpatients with a zero length of stay	13%	20%	20%	22%	20%	18%	19%	19%	19%	18%	21%	19%	19%	<b>19%</b>	
	Theatre utilisation: Percentage of elective sessions used	n/a	78%	77%	78%	77%	76%	78%	76%	77%	77%	77%	77%	78%	77%	<b>80%</b>
	DNAs - Percentage of outpatients who did not attend their appt.	11.3%	10.3%	10.8%	10.8%	10.9%	11.1%	11.2%	10.9%	10.3%	11.2%	11.0%	10.3%	10.5%	<b>10.5%</b>	
	Sickness & absence rate: the amount of time lost through absences as a percentage of staff time available (for directly employed NHS staff)	4.4%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	<b>n/a</b>
<b>Governance</b>	<i>See key commitments</i>															
<b>Patient Focus</b>	Number of complaints received by the Trust within each month	96	94	106	98	81	68	97	91	88	96	96	114	127	<b>74</b>	
	Percentage of complaints resolved within 20 working days - year to date	76%	47%	60%	63%	65%	67%	67%	67%	69%	66%	67%	66%	67%	<b>51%</b>	
	Percentage of patients on the declared waiting list currently suspended	5%	5.8%	6.6%	6.5%	6.9%	7.7%	7.2%	6.4%	7.5%	8.2%	6.3%	6.5%	6.7%	<b>6.7%</b>	
<b>Accessible &amp; Responsive Care</b>	Number of declared last minute cancelled operations for non-clinical reasons	55	121	116	135	100	87	111	128	134	109	168	54	86	<b>56</b>	
	Number of patients who have operations cancelled for non-clinical reasons not offered another binding date within 28 days (reportable breaches)	8	33	36	49	44	35	22	45	54	55	19	46	16	<b>15</b>	
	Inpatient and day case waiting times – total declared (waiting & booked)	10,241	11,002	10,612	10,316	10,340	10,008	10,100	10,377	10,260	10,239	10,189	10,174	10,241	<b>10,311</b>	
	Inpatient and day case waiting times – total planned	3,527	3,651	3,713	3,613	3,805	3,741	3,855	3,767	3,445	3,381	3,373	3,482	3,527	<b>3,473</b>	
	Inpatient and day case waiting times – total waiting	13,768	14,653	14,325	13,929	14,145	13,749	13,955	14,144	13,705	13,620	13,562	13,656	13,768	<b>13,784</b>	
<b>Care, Env'ment &amp; Amenities</b>	Percentage of the total acute beds occupied by medical patients (outliers)	n/a	0.7%	0.6%	0.5%	0.2%	0.3%	0.6%	0.4%	0.5%	0.5%	0.4%	0.5%	0.7%	<b>0.9%</b>	

## Focus on: Safety

- Safety is the first domain identified in the Standards for Better Health. In 2006/07, the Trust will be assessed on its progress against both the core standards and the developmental standards within the domain by the Healthcare Commission as part of the Annual Health Check.
- It is the responsibility of Trust Boards to satisfy themselves that they are meeting the core standards and where that is not happening, take steps to ensure they are met.

### Summary:

<b>Core Standards</b>	<b>2005/06 declaration</b>	<b>Current status:</b>
C1: Healthcare organisations protect patients through systems that: <ul style="list-style-type: none"> <li>a) Identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.</li> <li>b) Ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.</li> </ul>	Compliant	Compliant
C2: Healthcare organisations: Protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.	Compliant	Compliant
C3: Healthcare organisations: Protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.	Compliant	Compliant
C4: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: <ul style="list-style-type: none"> <li>a) The risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA.</li> <li>b) All risks associated with the acquisition and use of medical devices are minimised.</li> <li>c) All reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.</li> <li>d) Medicines are handled safely and securely.</li> <li>e) The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.</li> </ul>	Compliant	Compliant
	Compliant	Compliant
	Non Compliant	Non Compliant
	Compliant	Compliant
	Compliant	Compliant

- The issue of safety, whether it is of patients or staff, will always be high on the agenda of NHS organisations. This report uses local data, national data and data collected through the local Planning and Performance Framework (PPF) to examine this domain. Based on this available evidence:
  - The Trust has in place all the necessary processes for identifying and learning from safety and reportable incidents. Whilst there have been delays in the processes as CMTs got to grips with their new expanded role in this area, it is hoped that 2006/07 will see more timely and complete recording of incidents that can then be used to make improvements in practice and minimise risk (C1a).
  - LTHT has a good record in reacting to patient safety notices and other alerts. This is coordinated by the Head of Health and Safety and, to date, the Trust has met the timescales for all alerts (C1b).
  - The Trust has guidelines and procedures in place for child protection and has received praise nationally for its dealings with other organisations (C2).
  - The revised policy for Managing the Implementation of New Interventional Procedures is now in place and being followed by CMTs seeking approval for implementing NICE guidance (C3).
  - Having introduced a number of new initiatives and promoted the importance of cleanliness to patients, staff and visitors throughout the Trust, LTHT achieved its target for reducing MRSA in 2005/06. During 2006/07, the Trust is also taking part in a national surveillance project (C4a).
  - In spite of cost limitations, LTHT minimises the risks associated with the acquisition and use of medical devices in a number of ways, for example, by not re-using single use devices, only using devices that are CE marked and developing training plans using CNST (Clinical Negligence Scheme for Trusts) guidelines (C4b).
  - Whilst there are some issues with the current decontamination environments at LTHT, particularly with regard to endoscopy reprocessing equipment, the Trust is working with an external supplier to ensure that the Trust will meet the requirements of the Medical Devices Directive MDD 93/42/EEC by March 2007 (C4c).
  - Data from internal audit and medicines management assessments done as part of the Acute Hospital Portfolio have shown increased adherence to the Trust's Medicines Management Policy. LTHT is also currently implementing its strategy for medicines management and has ensured that staff have documented their acknowledgement of the contents of the Medicines Code (C4d).
  - The Trust's Waste Policy adheres to the Health and Safety Executive guidance and local evidence of good practice in this area is supported through national assessment via the PEAT (Patient Environment Action Team) inspections (C4e).
- Although the Trust has, with good evidence, declared compliance against all but one of these standards, safety is an area where continued development and learning from experience is vital. The Trust has recognised this and actions within the CMT business plans for 2006/07 reflect the importance given to minimising risk where possible.

*2005/06 Declaration: Safety domain: Selected peer trusts*

	C1a	C1b	C2	C3	C4a	C4b	C4c	C4d	C4e
Cambridge Univ. Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓
Central Manchester & Man. Children's Univ. Hospitals Trust	✓	✓	✓	✗	✗	✗	✓	✓	✓
<b>Leeds Teaching Hospitals NHS Trust</b>	✓	✓	✓	✓	✓	✓	✗	✓	✓
Sheffield Teaching Hosp. NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓
The Newcastle Upon Tyne Hospitals NHS Trust	✓	✓	✓	✓	✓	✓	?	✓	✓

Source: Trust websites - ✓ compliant, ✗ non compliant, ? insufficient assurance

## The Standards:

C1: Healthcare organisations protect patients through systems that:	a) Identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.
	b) Ensure that patient safety notices, alerts & other communications concerning patient safety which require action are acted upon within required timescales.

### C1 a) Patient safety incidents:

- The Trust currently has a lot of infrastructure in place to support this standard; the now well-established Quality structure has set up committees, reports to the Trust Board, shares experience through the Trust-wide “Lessons Learned” bulletins and works with internal audit. Policies are in place relating to Risk Management, IRIs (Incident Reporting), SUIs (Serious Untoward Incident), Complaints, Fair Blame and RIDDOR procedures (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). There are also local processes in place for recording incidents and sending them to the National Patient Safety Agency (NPSA) twice a week.
- Locally, groups such as the Lessons Learned Forum (that has representation from each CMT) and the Incident, Impact & Assessment Group, ensure that learning is shared across the organisation.
- The Trust continues to maintain compliance at Level 1 of the Clinical Negligence Scheme for Trusts (CNST). In March 2006, the CNST General Standards were withdrawn and replaced by the NHSLA Risk Management Standards for Acute Trusts (including specialist hospitals)<sup>1</sup>. It is anticipated that the Trust will be assessed against these standards in 2007/08; 2006/07 will see work ongoing towards meeting these new standards.
- In order for the Trust to monitor incidents and near misses, all relevant data should be put into the Datix Risk Management system. Responsibility for this was devolved from a central team to individual CMTs last year. This has led to a backlog of incidents waiting to be placed on the system; for the year to December 2005, 25% fewer incidents had been input into the database compared with the previous year. This backlog is now being addressed through the use of temporary staff and Heads of CMTs have been asked to review their local arrangements for incident inputting, data validation and reporting arrangements to ensure that incidents are reported in a timely and accurate way<sup>2</sup>. This issue has led to a local risk rating of “medium risk” for compliance with this element of the standard.
- Whilst the Trust clearly has the appropriate policies and processes in place, the uptake and outcomes of following these are of more importance. In terms of outcomes, analysis of the data available on the system (taking the backlog into consideration) suggests that the number of incidents reported in 2005/06 will be higher than in 2004/05. It is believed that this reflects increasing confidence in and knowledge of the Trust’s reporting systems. A positive for the period April to December 2005 is the 27% rise in the number of near miss incidents being reported. This is in line with the Trust’s aim to implement preventative action following a near miss rather than just reactive action following an incident.
- In contrast to this, the Staff Survey 2005 indicates that the Trust still has some way to go in promoting its policies and procedures to staff. The Trust’s score of 84% of staff reporting harmful errors, near misses or incidents was in the lowest 20% of acute trusts in England. Likewise, the staff perception of the fairness and effectiveness of procedures for reporting errors, near misses or incidents was also in the lowest 20% of acute trusts (*see figure 1, below*).

Figure 1: Staff Surveys, issues relating to patient safety and other reportable incidents, selected peer trusts

	% of staff witnessing potentially harmful errors, near misses or incidents in the previous month		% of staff reporting harmful errors, near misses or incidents		Fairness and effectiveness of procedures for reporting errors, near misses or incidents
	2004	2005	2004	2005	
					2005
Cambridge Univ. Hospitals NHS Foundation Trust	50%	47%	92%	90%	3.45
Central Manchester & Man. Children's Univ. Hospitals Trust	48%	46%	91%	93%	3.39
<b>Leeds Teaching Hospitals NHS Trust</b>	<b>44%</b>	<b>47%</b>	<b>88%</b>	<b>84%</b>	<b>3.24</b>
Sheffield Teaching Hosp. NHS Foundation Trust	48%	45%	91%	90%	3.43
The Newcastle Upon Tyne Hospitals NHS Trust	45%	41%	87%	88%	3.32

Source: 2004 & 2005 Staff Survey, Healthcare Commission website; data is weighted to allow comparisons

Notes: 3rd indicator is new for 2005; Scores = 1-5; 1 represents very unfair and ineffective procedures & 5 represents very fair and effective procedures

- When compared with some of its peer trusts, LTHT does not appear to be significantly different but, in spite of having all the necessary processes in place locally, the Trust still has the lowest percentage of staff saying that they report incidents.
- CMT business plans for 2006/07 held within the Performance Management Framework (PMF) clearly state the responsibilities that CMTs have in relation to incident reporting and risk management. Heads of CMT will need to ensure that staff are aware of their individual responsibility for reporting both incidents and near misses and that there is enough resource available to maintain the risk management database without recreating the backlog seen in 2004/05.

#### C1 b) Safety alerts:

- The Safety Alert Broadcast System (SABS) allows safety alerts relating to the safety of equipment, buildings and patients to be spread throughout the NHS quickly. The Trust's Head of Health and Safety has been designated as the nominated contact to receive these alerts and cascade them throughout the Trust.
- Since the spring of last year, trusts are also required to pass back assurance of action relating to alerts through the SAB System within a set timescale. To enable the Trust to do this, a nominated contact within each CMT has been identified to coordinate a single response from their CMT. These procedures have proven to be successful and the Trust is currently working on developing a policy to formalise this process. Currently in draft form, it is hoped that this policy will be in place by July 2006.
- Data from the Department of Health currently shows that LTHT, over the period from April 2004 to April 2006, has received 179 alerts - all have been acknowledged, 165 are either complete or require no further action and 14 are not yet completed<sup>3</sup>. LTHT has met the time deadlines for all alerts to date<sup>4</sup>.

C2: Healthcare organisations:	Protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.
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- The Healthcare Commission carried out a review of child protection arrangements and published its second joint Chief Inspectors' Report on Arrangements to Safeguard Children in July 2005. In this report, LTHT received praise for good practice in this area: "Leeds Teaching Hospitals NHS Trust has clear information sharing protocols with the police and social services. Social workers can access and write notes on medical records."<sup>5</sup>
- The child protection guidance and policies developed over the last year by the Trust are shared across all health organisations in Leeds. They have been designed to complement those already in existence within the Child Protection Manual available to all health professionals in Leeds via the Leeds Healthcare Pathways website.
- The Trust's Child Protection Awareness and Training Strategy outlines the relevant minimum level of training that each staff group should receive. Training on child protection is routinely available to staff

in the Trust; data on staff trained in child protection during 2005/06 shows 350 staff attending Level 1 Child Protection Training and 506 staff attending Child Protection Updates training.

- Taking into consideration that children are visitors or patients in all parts of the Trust, information and training is not limited to staff dealing directly with children. During the last year, flow charts outlining the “cause for concern” referral process that contain relevant contact numbers for any member of staff with a cause for concern have been made available.
- As part of their business plans, CMTs are to ensure that these flow charts are circulated, staff receive the level of training they require and that all staff know how to access the Child Protection Manual.

C3: Healthcare organisations:	Protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.
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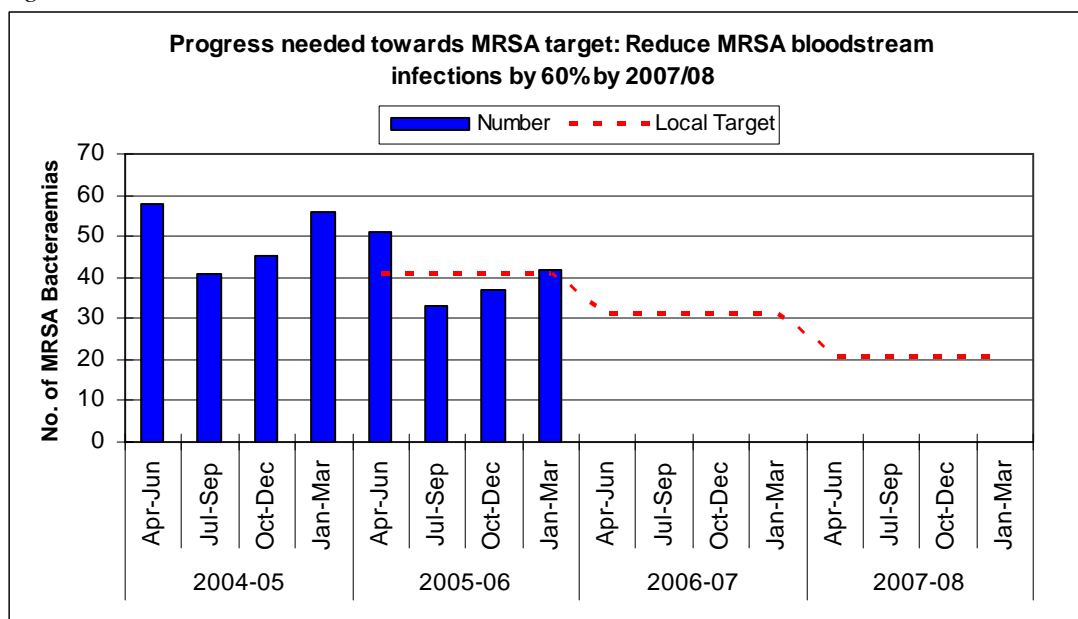
- In March 2006, the Trust Board approved the revised Policy for Managing the Implementation of New Interventional Procedures. The policy was rewritten to simplify the procedures for CMTs and to ensure that it is robust. It clearly sets out the responsibility of individual CMTs to adhere to the approval process for the use of these procedures and to ensure that the Director of Quality is kept informed. The Director of Quality is then responsible for briefing the Chief Executive in line with NICE guidance. This policy is supported by the NHS Litigation Authority<sup>6</sup>.
- Since the policy was completed, there have already been examples of the new local procedures for implementing NICE new interventional procedure guidance being followed correctly. These include, robotically assisted minimally invasive surgery in children (March 2006) and pulmonary radiofrequency ablation (April 2006).
- The Trust also has a process in place for disseminating new procedure guidance to the appropriate clinical directors and uses the Performance Management Framework (PMF) as the source for assurance that CMTs are both implementing NICE interventional procedures guidance and following the Trust’s policy.
- The replacement for CNST, the NHSLA Risk Management Standards for Acute Trusts, will assess the robustness of the systems that a trust has in place to monitor overall compliance with NICE guidance as part of the “Learning from Experience” standard; the Trust will need to ensure that it is prepared for this<sup>6</sup>.

C4: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	a) The risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA.
	b) All risks associated with the acquisition and use of medical devices are minimised.
	c) All reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.
	d) Medicines are handled safely and securely.
	e) The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

C4 a) Hospital acquired infection:

- The current national target is to reduce MRSA bloodstream infections by 60% by 2007/08 against the 2003/04 baseline. This equates to a 20% reduction each year from 2005/06 onwards to decrease the number of infections locally from 204 to 82.
- Figure 2 shows the progress needed towards this target from April 2005 onwards. In 2005/06, LTHT needed to try to ensure there were no more than 163 over the course of the year. Bearing in mind that the numbers are likely to fluctuate, as a rough guide, the Trust needed to reduce MRSA levels to an average of 41 per quarter. The Trust succeeded in achieving the 20% reduction with 163 MRSA bacteraemias during the year.
- For 2006/07, in order to achieve the 20% reduction, the Trust needs to ensure that there are no more than 122 MRSA bacteraemias.

Figure 2:



- The number of MRSA bacteraemias serves as an indicator of adherence to infection control policies and hygiene standards within hospitals. However, in specialist trusts, such as LTHT, MRSA rates tend to be higher than single specialty or general acute trusts due to higher numbers of vulnerable patients seen within specialist trusts and the likelihood of more invasive and high-risk specialist care.
- As can be seen from figure 3, LTHT does have a higher number of MRSA bacteraemia reports than the identified peers but its rate, based on occupied bed days, shows that it is comparable with these other specialist trusts. Both the number and rate for LTHT has shown a drop over the two six month periods; this suggests that the actions the Trust has been taking are having an impact.

Figure 3: MRSA: Number of bacteraemia reports and rates per 1,000 occupied bed days for selected peer trusts, latest available data

	October 2004-March 2005		April 2005-September 2005	
	Number	Rate	Number	Rate
Cambridge University Hospitals NHS Foundation Trust	61	0.36	57	0.34
Central Manchester & Manchester Children's University Hospitals Trust	30	0.17	31	0.17
<b>Leeds Teaching Hospitals NHS Trust</b>	101	0.27	84	0.22
Sheffield Teaching Hospitals NHS Foundation Trust	52	0.16	57	0.18
The Newcastle Upon Tyne Hospitals NHS Trust	42	0.16	29	0.11

Source: DOH website; rate for 05/06 is based on 2004/05 bed days and is subject to revision

- These actions have included, the launch of an outbreak control plan in September 2005, a half day study day, “know your bugs”, hand hygiene challenge week, an infection control newsletter and an update session for non-clinical staff. The Trust is also taking part in a national surveillance project collecting information on healthcare acquired infection.
- During 2006/07, LTHT will continue to show its commitment to patient safety by implementing the 5 high impact interventions outlined in the Department of Health’s toolkit “Saving Lives”<sup>8</sup>. These include preventing surgical site infection and care of ventilated patients. It is intended that, through the use of clinical interventions and an action planning tool, “Saving Lives” will help trusts to embed infection control across each ward, department or unit. Every CMT in the Trust has been asked to identify at least one high impact intervention to implement in their area.
- The Trust also recognises that there is still much to be done in order to achieve another 20% reduction over the year. All CMTs need to develop an MRSA action plan, contribution to the Infection Control Committee needs to increase, further development of patient / visitor information is required to encourage public involvement in preventing and controlling infection in hospital, improvements in out

of hours cleaning in clinical areas and the cleaning of patient care equipment must be sustained and a review of the patient journey is necessary from an infection control perspective to minimise patient movement.

- In terms of cleanliness, the Trust has a strong track record in the PEAT assessments (Patient Environment Action Team), LTHT scored 4 out of 5 in the 2005 assessment. The Acute Hospitals Portfolio on Ward Staffing, published in July 2005, also gave LTHT a strong rating for cleanliness of equipment. This included lifting and handling equipment, commodes, drip stands and crash trolleys<sup>9</sup>.
- For the first time, the 2005 Staff Survey asked a question on the availability of hand washing materials for staff, patients and visitors to the trust. The score for LTHT was in the lowest 20% of acute trusts in England. However, following recommendations made by the Leeds City Council Scrutiny Committee, the Trust audited the placement of alcohol hand gel dispensers and made these dispensers available at any previously omitted areas<sup>10</sup>.
- There are many factors that contribute to infection levels, including antibiotic use, staffing levels, patient movements between wards in hospitals and transfers between hospitals. Whilst it is impossible to prevent every hospital acquired infection, the improvements made at LTHT over the last year clearly highlight the commitment of the Trust to this patient safety issue.

#### C4 b) Acquisition and use of medical devices:

- Although the Trust does not have one over-arching body responsible for medical devices, it does have evidence that risks associated with the acquisition and use of medical devices are being managed.
- Inspections of wards at the Trust carried out as part of the Acute Hospitals Portfolio on Ward Staffing raised no issues about the safety of “sharps” bins and confirmed that regular checking of the crash trolley was being carried out<sup>9</sup>.
- When compared with other acute trusts, the 2005 Staff Survey results show that LTHT was average for the percentage of staff who have suffered a work related injury. The more detailed results (that have not been adjusted for benchmarking purposes) show a breakdown of elements of this indicator relating to injuries from needlestick and sharps and exposure to dangerous substances; this again suggests LTHT to be average when compared to this peer group.

Figure 4: Staff Survey, staff who had been injured or felt unwell, selected peer trusts

	% of staff who have been injured or felt unwell as a result of the following problems at work:			
	2004: Needlestick & sharps	2005: Needlestick & sharps	2004: Exposure to dangerous substances	2005: Exposure to dangerous substances
Cambridge Univ. Hospitals NHS Foundation Trust	3%	6%	2%	4%
Central Manchester & Man. Children's Uni. Hospitals Trust	3%	4%	4%	2%
<b>Leeds Teaching Hospitals NHS Trust</b>	<b>3%</b>	<b>3%</b>	<b>3%</b>	<b>3%</b>
Sheffield Teaching Hospitals NHS Foundation Trust	3%	4%	3%	2%
The Newcastle Upon Tyne Hospitals NHS Trust	2%	6%	4%	4%

Source: 2004 & 2005 Staff Survey, detailed results; Healthcare Commission website; this data has not been weighted to allow more accurate comparisons between trusts

- As the Trust owns more than 50,000 items of medical equipment and uses thousands of devices, this presents challenges in planning replacement, maintenance and training, all of which are critical to managing the risks, particularly given the financial constraints on trusts. The biggest issues for the Trust are cost-related: replacement of equipment and releasing nursing staff for training. Therefore, LTHT has systems in place to control and prioritise its actions.
- Currently there is a trust-wide medical equipment group and a number of product selection groups. Training plans have been developed along CNST guidelines and purchases are prioritised using an evidence-based approach. The Trust’s purchasing handbook is also available on the intranet.
- In terms of standards, almost all in-house maintenance services are covered by ISO9000 clinical engineering certification and it is Trust policy only to purchase or hire devices that are CE marked and not to re-use single use devices. The former policy is enforced by Supplies and the latter by the quality procedures in place within the Sterile Services department.

#### C4 c) Decontamination of medical devices:

- In the 2005/06 declaration, there were two areas of concern for the Trust. The first was the Sterile Services Department at St James'. This was because the DoH stated that all decontamination processing units (local and central) must be compliant with the Medical Devices Directive MDD 93/42/EEC by 31 March 2007 and the St James' Sterile Services Department did not meet this standard.
- However, as the St James' facilities do not process reusable medical devices for any third party, full compliance to the MDD 93/42/EEC is not required. The facility also has clean/dirty segregation, complies with ISO EN 9001: 2000 and has fully validated equipment and strong management arrangements in place. Between January and March 2005, new washers/disinfectors were also installed at the St James' facility.
- The LGI facility is currently compliant with MDD 93/42/EEC by registration with ISO EN 13485:2003 and ISO EN 9001:2000.
- Looking ahead, LTHT has chosen to transfer the risks associated with the DoH directive and decontamination generally to a commercial supplier (B Braun) who will ensure that their facility is fully compliant with all relevant standards relating to decontamination. As part of their business plans for 2006/07, CMTs are reviewing the impact that this change to an off-site provider will have.
- The second area of concern was the Trust's reprocessing facilities for flexible endoscopes. These are not compliant with the Medical Devices Agency Devices Bulletin DB 2002 (05) and, following an audit of all automated endoscope reprocessing equipment in use at the Trust, led to the decision to declare non-compliance against this standard in the 2005/06 declaration.
- One of the main reasons for declaring non-compliance was the fact that the Steris System 1 endoscope processors used at the Trust do not comply with Health Technical Memorandum HTM 2030. HTM 2030 is the NHS standard governing the washing and disinfection of surgical and dental instruments. There were also issues about the environments in which endoscope reprocessing occurs.
- During 2006/07, processes are in place to manage the risks at St James', a new endoscopy unit is being built at the LGI, the Wharfedale endoscopy unit remains compliant and plans are in place both to replace the endoscope processor at the oesophageal clinic at Seacroft and to upgrade the environment of the clinic. The transfer to an off-site provider for decontamination, mentioned above, will ensure long term compliance with all relevant standards.
- The Medicines and Healthcare products Regulatory Agency (MHRA), through its medical devices alerts (MDA/2005/001), recommends that adverse incidents involving medical devices are reported through their adverse incident reporting system; this includes any issues around decontamination. The Trust is registered with the MHRA and does report such incidents to them.

#### C4 d) Medicines Management:

- During 2005, the Pharmacy CMT launched the Medicines Management Strategy and appointed a Deputy Chief Nurse for Medicines Management to ensure successful implementation of the strategy. Recommendations from internal investigations into serious untoward incidents which have occurred with medicines at LTHT and the Safe & Secure Handling of Medicines Project have also been incorporated into the strategy. Implementation of the strategy will be via a multi-disciplinary steering group.
- The Trust's Medicines Management Policy was also successfully re-launched last year; data from internal audit and the medicines management assessments completed as part of the Acute Hospital Portfolio have shown increased adherence to the policy within the Trust. The Acute Hospital Portfolio on Medicines Management shows that LTHT compares well with its peer teaching hospitals in medicines management, for example, LTHT scored 5 out of 5 for both double checking when prescribing, preparing or administering medicines and for controlled drug management<sup>11</sup>.
- The main area for improvement identified within the Trust has been the transport and storage of drugs. Audits of the storage and security of drugs were carried out at the different sites over the course of last year and a number of recommendations suggested. This has led to improvements in safe storage but has also highlighted that further investment is needed in some areas.
- The Pharmacy CMT does provide feedback to other CMTs on incidents and reviews of medicine-related issues. This has led to changes in intrathecal delivery of opioids and plans being drawn up to reduce further risk with potassium chloride, ophthalmic injections and chemotherapy agents. As part of their business plans, CMTs have agreed to review any IRIs (incident reports) relating to medicines and

develop and implement action plans to reduce future risks. Within Pharmacy itself, compiled information and common themes on errors are disseminated to pharmacy staff on a regular basis using briefing notes and newsletters.

- The Trust's Medicines Code, also re-launched last year, is intended to ensure that medicines are used in a safe and effective way that minimises risks to both patients and staff. The Code describes the law, best practice and current guidance for the use of medicines as issued by the relevant professions and is made available to all staff on the intranet. The re-launch of the Medicines Code also involved getting all staff to document their acknowledgement of the contents of the code to ensure that the information within it was disseminated as widely as possible.
- As stated in 'Building a Safer NHS' "medication errors occur when human and system factors interact with the complex process of prescribing, dispensing and administering drugs to produce an unintended and potentially harmful outcome"<sup>12</sup>. However, LTHT has both put in place and audited the processes and policies necessary to limit the risks where possible.

#### C4 e) Waste:

- Unless it is properly managed, waste can cause significant risks to patients, staff and visitors. Safe handling, transportation and disposal of waste is, therefore, a priority.
- LTHT has, in place, a Trust Waste Policy that covers all aspects of the Health and Safety Executive (HSE) guidance on the safe disposal of clinical waste.
- All clinical waste is consigned for incineration and all waste generated at ward and department level (clinical and non-clinical) is tagged with a unique traceable tag. When needed, the Trust also has a specialist contractor responsible for collecting and consigning other "special" waste such as unused chemicals.
- LTHT is also part of the Yorkshire Clinical Waste Consortium which conducts audits of the route used for clinical waste intended for incineration. This provides the Trust with evidence that waste is being disposed of appropriately.
- Further evidence of good practice can be found in the strong scores achieved by the Trust in recent PEAT (Patient Environment Action Team) inspections.

#### Notes:

<sup>1</sup> [NHSLA Risk Management Standards for Acute Trusts, Draft, March 2006](#)

<sup>2</sup> [LTHT Risk Management Strategy & Policy report to the Trust Board, April 2006](#)

<sup>3</sup> [DoH data, SABS website](#)

<sup>4</sup> [LTHT SABS monitoring report](#)

<sup>5</sup> [HCC Chief Inspectors' Report on Arrangements to Safeguard Children, July 2005, HCC website](#)

<sup>6</sup> [Trust Board Quality Sub Committee report, September 2004](#)

<sup>7</sup> [NHSLA Risk Management Standards for Acute Trusts, Draft Summary of Standards, March 2006](#)

<sup>8</sup> [Saving Lives: a delivery programme to reduce healthcare associated infection \(HCAI\) including MRSA](#)

<sup>9</sup> [LTHT Acute hospitals portfolio: Ward Staffing, July 2005](#)

<sup>10</sup> [Scrutiny Committee comments for final declaration 2005/06](#)

<sup>11</sup> [LTHT Acute hospitals portfolio: Medicines Management](#)

<sup>12</sup> [Building a Safer NHS for patients: Improving medication safety, January 2004](#)