University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 FEBRUARY 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 22 January 2013

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- None

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

(1) CIP Schemes 2013-14 – update on assessing the impact of quality and management of clinical risk (Minute 04/13/1 refers);
(2) Improving Discharge Processes (Minute 04/13/3 refers);
(3) Compliance with WHO Safer Surgery Checklist (Minute 04/13/5 refers);
(4) Mechanisms for monitoring quality and safety issues within the LLR FM Contact (Minute 06/13/3 refers), and
(5) Review of Trust Board sub-committees (Minute 06/13/7 refers).

DATE OF NEXT COMMITTEE MEETING: 19 February 2013

Mr D Tracy
14 February 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 22 JANUARY 2013 AT 9:30AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Nurse/Deputy Chief Executive
Mr P Panchal – Non-Executive Director (from 04/13/3)
Dr R Palin – General Practitioner (non-voting member)
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – UHL Non-Executive Director and Dean of University of Leicester Medical School

In Attendance:
Ms J Edyvean – Head of Strategic Change (for Minute 04/13/2)
Mr N Doverty – Divisional Manager, Clinical Support (for Minute 04/13/5)
Mrs H Majeed – Trust Administrator
Dr B Collett – Assistant Medical Director
Mrs S Hotson – Director of Clinical Quality
Mr S Leivers – Director of Service Improvement (for Minute 04/13/1)
Mrs C Ribbins – Director of Nursing
Mr P Walmsley – Head of Operations (for Minutes 04/13/2 to 04/13/4 inclusive)

RESOLVED ITEMS **ACTION**

01/13 COMMITTEE'S NEW TITLE

To note that at the 29 November 2012 Trust Board meeting, the Governance and Risk Management Committee had been re-titled as the Quality Assurance Committee (QAC). However, the terms of reference were to be reviewed as part of the Trust Board's review of its Committee structure.

Resolved – that the position be noted.

02/13 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Adviser (non-voting member), Miss M Durbridge, Director of Safety and Risk, Ms C Trevithick, Chief Nurse and Quality Lead, West Leicestershire CCG (non voting member), Mr M Wightman, Director of Communications and External Relations and Mr S Ward, Director of Corporate and Legal Affairs.

03/13 MINUTES

Resolved – that the Minutes of the meeting held on 26 November 2012 (papers A and A1 refer) be confirmed as a correct record.

04/13 MATTERS ARISING REPORT

The matters arising report at paper B highlighted both issues from the most recent meeting and provided an update on any outstanding matters arising since 29 September 2011. The following matters were raised:-

(a) Dr R Palin, GP raised concerns that the Chief Nurse and Quality Lead, West Leicestershire CCG would not be able to attend future QAC meetings as it clashed with the Contract meetings. The Committee Chair suggested that a deputy be **CN&QL, WL CCG**

nominated to attend on her behalf;

(b) Minute 119/12/5 (re. seeking representation from the Probation Service on the UHL Steering Group for the Hate Crime Project) – it was noted that this was not being taken forward, and

(c) Minute 125/12/1(re. process for recording staff attendance at statutory and mandatory training) – the Medical Director advised that the process was being reviewed and ownership arrangements were likely to change. An update would be provided to the QAC in February 2013. **MD**

Resolved – that the matters arising report and the actions above, be noted. **CN&QL, WL CCG /MD**

04/13/1 CIP Schemes 2013-14 – update on assessing the impact of quality and management of clinical risk

The Director of Service Improvement advised that the recommendations in paper C (proposal for the management of clinical risk within CIPs) were drawn up with a view on the proposals likely to arise from the 'Francis Report' which was due to be published imminently. Paper C1 detailed the terms of reference of the CIP Programme and CIP Delivery Boards.

In discussion on this item:

(i) the Director of Clinical Quality noted that the whistle blowing policy was in place and staff had a contractual duty to report concerns. However, she queried whether there was anything further that could be put in place to encourage staff. In discussion, members were reminded about Extension 3636 (the Staff Concerns Reporting Line) and it was suggested that some wording about this be included within the report; **DCQ**

(ii) members particularly made note that the Executive Team had agreed that any CIP scheme with a risk rating of 16 or above or any scheme above the value of £100,000 would require to be signed-off by the Chief Nurse/Deputy Chief Executive and the Medical Director. The Chief Executive suggested that the report be amended to include this requirement; **DSI**

(iii) Ms J Wilson, Non-Executive Director queried the process in place for ensuring quality impact assessments were being undertaken on an on-going basis. It was suggested that quarterly review of schemes with a risk rating of 15 and above and reviews be expedited if the rating increased. The CIP Programme Board received reports providing position of achievement against each scheme. The Director of Service Improvement and the Chief Nurse/Deputy Chief Executive agreed to discuss the process that needed to be put in place and include an update within the report prior to circulating it to the Committee and Trust Board members, and **DSI/CN/ DCE**

(iv) members suggested that consideration be given to presenting this report to the Trust's Audit Committee. **DSI**

Resolved – that (A) the contents of this report be received and noted;

(B) the Director of Clinical Quality to provide the Director of Service Improvement some wording in respect of (Extension 3636 - the Staff Concerns Reporting Line) for inclusion within the report; **DCQ**

(C) the Director of Service Improvement and the Chief Nurse/Deputy Chief Executive meet to discuss the process for on-going assurance that quality impact assessments were undertaken; **DSI/CN/ DCE**

(D) the Director of Service Improvement to update paper C to include the process agreed under point (C) above in addition to the requirement for the sign-off of CIPs prior to circulating it to the QAC and Trust Board members, and **DSI**

(E) the Director of Service Improvement to consider whether paper C needed to be presented to the Audit Committee. **DSI**

04/13/2 CQC Outcome 14 – ED Staff Engagement and Equipment Plan – Update on action plan including 'measurement of success' and progress towards the ideal 6-month outcomes

Ms J Edyvean, Head of Strategic Change, attended on behalf of the Acute Care Division to present paper D, which detailed progress against the ED staff engagement and equipment plan. A number of staff engagement initiatives particularly around communication had been put in place within the CBU. These were detailed in section 2 of the report. An analysis of the equipment required had been undertaken, the required equipment was now in place and processes had been agreed to replace broken/faulty equipment. It was noted that the drug fridges had been replaced (noting that this had been included as a risk on the operational risk register for a considerable period of time).

In discussion on this item, members were advised that attendance had improved at team meetings and staff engagement focus groups. Right Place Consulting who had been appointed to implement UHL's emergency care pathway were also impressed with the communication initiatives that had been put in place. The Director of Nursing highlighted that it was important to listen to staff and address their concerns and ensure that appropriate feedback was provided to them. The Medical Director and the Chief Executive acknowledged this and noted that the 'Listening into Action' approach would be used as a vehicle for supporting service improvement.

Resolved – that the contents of this report be received and noted.

04/13/3 Report on Improving Discharge Processes

The Head of Operations attended to present paper E, an update on progress regarding improving discharge performance. The Acute Care Division had been particularly focussing on improving simple discharge performance. In respect of complex discharges, recent actions had been implemented which had lead to an improvement in the number of delayed discharges.

In discussion on this item, members noted that since the launch of the BED Before 11am project, considerable work to establish and embed a daily discharge planning routine into every inpatient ward had been done. However, progress was disappointing in the discharge trajectory. Work was underway to bring together ICE (Discharge Letters) and EPMA (electronic prescribing) systems which would assist in easier production of TTOs which was a key part of the discharge process. New discharge processes had been established which were centred on the role of a ward based discharge co-ordinator. Like most Trusts, UHL also had a lower rate of discharge at the weekend than during the week. The long term solution was to move to 7 day working for all services and wards.

In relation to complex discharges (delayed transfers of care), the key areas of focus were around patients choosing not to leave UHL until the hospital or nursing home of their choice had an opening, access to residential and nursing homes and access to rehabilitation beds. The Head of Operations advised on the actions that had been put in place to address these issues. Responding to further queries, he also reported on progress in respect of increasing Consultant ward rounds and improving the process for early discharge and discharging patients by 1pm. The Acute Care Division was leading on a project and the Expected Day of Discharge was now put on each bed. Members noted the need for key milestones to be set for the achievement of targets. In response to a query from Mr P Panchal, Non-Executive Director, it was noted that future provision of healthcare was discussed at Emergency Care Network meetings. Responding to a query, Dr R Palin suggested that liaising with Community Hospitals would assist in discharge planning.

The QAC Chair thanked the Head of Operations for attending today's meeting to present this report. The Head of Operations was requested to provide further assurance on this item including a trajectory of performance to the QAC at its March 2013 meeting. **HO**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Head of Operations to attend the QAC meeting in March 2013 to provide a further update on improving discharge processes including a trajectory of performance. **HO/TA**

04/13/4 UHL's arrangements for responding to major incidents

The Head of Operations advised that UHL's major incident plan provided overarching responsibilities to internal staff and external partners. A full time emergency planning officer had been appointed and various aspects of the plan were tested on a regular basis. The plan had recently been presented to the Policy and Guideline Committee, for approval. UHL also proactively linked with external partners to ensure that a LLR wide major incident plan was in place.

Resolved – that the position be noted.

04/13/5 Compliance with WHO Safer Surgery Checklist

The Divisional Manager, Clinical Support attended to present this item and advised that the recent level of performance in respect of compliance with the WHO safer surgery checklist had now reached 99.6% (paper F refers). Formal communication had been sent from the Medical Director to all the Surgeons, Anaesthetists and theatre staff highlighting the need to adhere strictly to Trust policy implementation.

The Division had now moved to daily checks on the ORMIS system to identify non-compliances, in order that the issue could be reported to the Theatre Matron urgently. Some cases where the checklist had not been completed related to urgent cardiac emergencies where the chest was re-opened and the same team had remained 'in situ' throughout. It is possible that in the case of life-saving situations, the theatre team present would return to complete the WHO checklist retrospectively, once the patient has been stabilised. The Committee Chairman noted that if the checklist could be completed retrospectively for cases of life-saving situations then there was no reason that 100% compliance was not being achieved.

The Divisional Manager, Clinical Support advised that the CBU Lead Nurse had contacted Nottingham University Hospitals NHS Trust concerning peer review and sharing of learning in respect of staff engagement with the rationale behind the development of the WHO checklist. Members were made aware that the Trust had been non-compliant for the last 3 months and the need for immediate actions to be in place to resolve the situation was noted. In discussion, it was highlighted that all 3 elements of the checklist needed to be completed in order to be compliant. The Chief Executive commented on practices in other Trusts where only a sample of the compliance was monitored. The Divisional Manager, Clinical Support confirmed that from the outset, UHL had stated that compliance for every patient would be counted.

In discussion, the Chief Executive suggested that the Medical Director and the Chief Nurse/Deputy Chief Executive considered escalation protocols for staff who were not complying with the WHO checklist requirements and an update be provided to the next Quality Assurance Committee. **MD/CN/ DCE**

Professor D Wynford-Thomas, Non-Executive Director queried whether the WHO checklist had brought about any significant difference, it was noted that it had prevented never events.

Resolved – that (A) the contents of this report be received and noted, and

(B) the Medical Director and the Chief Nurse/Deputy Chief Nurse consider escalation protocols for staff who were not complying with the WHO checklist requirements and provide an update to the Quality Assurance Committee in February 2013. **MD/CN/DCE**

04/13/6 Governance Mechanism to Ensure that Readmissions Penalties were re-invested in UHL's services

Resolved – that the Chief Nurse/Deputy Chief Nurse and the Interim Director of Operations discuss this matter at the Cross Divisional Forum and a proposal be presented to the Executive Team with an update to the QAC in February 2013. **CN/DCE/IDO**

05/13 SAFETY AND RISK

05/13/1 Patient Safety Report

The Associate Medical Director presented paper G on behalf of the Director of Safety and Risk. The following points were noted in particular:-

(a) improved 45 day RCA performance;
(b) work was underway to improve the emergency patient flows through Right Place Consulting and all staff with clinical competencies had been invited to undertake clinical work while emergency activity remained high;
(c) continued improvements against the 5 Critical Safety Actions. An electronic system for handover was to be piloted;
(d) action plan from never events work stream was outlined in appendix 1, and
(e) NPSA alert relating to safer spinal (intrathecal) epidural and regional devices – due to delays in neuraxial products becoming available in the market place, there had been delays in clinical evaluation of these products. Three differing types of connectors were now available, discussion would be held with the Finance and Procurement team to identify the best value product. It was anticipated that this would be completed by end of February 2013.

In discussion on this report, members:-

(i) noted the need for the 'current position/evidence' column in the never events action plan to be more precise; **DSR**

(ii) queried whether benchmarking data was available in respect of the NPSA alert relating to 'Right Patient Right Blood' given that the Trust was proposing to close the alert once >75% of relevant staff had demonstrated blood transfusion competencies. The Associate Medical Director agreed to raise this with the Director of Safety and Risk; **AMD/DSR**

(iii) noted that staffing and capacity issues would continue to be monitored and reported to the QPMG, however queried the key performance indicators that needed to be monitored by the QAC. In discussion on this matter, the Chief Nurse/Deputy Chief Executive and the Director of Nursing advised that an open day had been arranged to recruit nurses and provided examples of measures in place to ensure minimum staffing levels were maintained. However, it was also noted that last-minute/short term sickness issues were difficult to fill. The Chief Executive suggested that a monthly report (from February 2013) be provided to the QAC to indicate the intended staffing level and skill mix for each ward and whether this was met. If the standard was not met, then an exception narrative would need to be included within the report, and **CN/DCE**

(iv) were advised that the Trust Board would be receiving an update on the 3 goals and the 5 critical safety actions would be a composite report.

Resolved – that (A) the contents of this report be received and noted;

(B) the Associate Medical Director/Director of Safety and Risk to undertake actions outlined in points (i) and (ii) above, and **AMD/ DSR**

(C) the Chief Nurse/Deputy Chief Executive to present a monthly report to QAC (starting from February 2013) to indicate the intended staffing level and skill mix for each ward and whether this was met, and provide exception narrative if standards were not met. **CN/DCE**

05/13/2 Report by the Director of Nursing

Resolved – that this item be classed as confidential and taken in private accordingly.

05/13/3 Report by the Chief Nurse/Deputy Chief Executive (on behalf of the Director of Safety and Risk)

Resolved – that this item be classed as confidential and taken in private accordingly.

05/13/4 Report by the Associate Medical Director (on behalf of the Director of Safety and Risk

Resolved – that this item be classed as confidential and taken in private accordingly.

06/13 QUALITY

06/13/1 Month 9 Quality Report

Members noted that the due to the timing of the QAC meeting, the regular Quality and Performance report was not available. Paper H1 provided a narrative on the quality aspects of the month 9 quality and performance report. The following was highlighted in particular:-

- the CCG were proposing to review UHL's mortality position. The details of this review/audit were yet to be confirmed;
- an amendment in appendix 1 (2012-13 Quality Schedule and CQUIN schemes – Quarter 3 predicted RAG rating) of the report – 'SSA Breaches' should be rated green;
- one never event would be downgraded, and
- ward health check details would be provided to members prior to safety walkabouts.

Responding to a query from Ms J Wilson, Non-Executive Director, members were advised that there had been a significant increase in the number of patients being admitted with grade 2 pressure ulcers which was a contributory factor for the delay in the availability of mattresses. Discussion was being held with suppliers to resolve this issue. A full update on progress with the data reported in the NHS Safety Thermometer regarding 'harms' would be presented to the QAC in February 2013. **CN/DCE**

Resolved – that (A) the contents of this report be received and noted, and

(B) an update on data reported in the NHS Safety Thermometer regarding 'harms' be presented to the QAC meeting in February 2013. **CN/DCE/ TA**

06/13/2 Quality and Safety Commitment

Following the approval of the 2012-15 Quality and Safety Commitment by the Trust

Board in December 2012, the Chief Nurse/Deputy Chief Executive advised verbally that workshops for each of the 3 goals (reducing mortality, reducing harm and patient centred care) had been held on 11 January 2013 to confirm priorities, leads and timescales. Plans for Divisional and CBU visibility through presentations had been arranged. A further report would be presented to the QAC meeting in February 2013.

Resolved – that an update on progress with the Quality and Safety Commitment be provided to the QAC meeting in February 2013. **CN/DCE/ TA**

06/13/3 Mechanisms for monitoring quality and safety issues within the LLR Facilities Management (FM) Contract

The Chief Nurse/Deputy Chief Executive advised that the report had been prepared by the Acting Head of Facilities to provide an update on the proposals and initiatives in place to maintain and enhance current quality standards in the future delivery of FM services for all participating bodies on the LLR Shared Services project (paper I refers).

In discussion on whether escalation processes were in place to report consistent failure in achieving key performance indicators, it was noted that the Executive Team would be kept informed on the progress of the contract. However, the Chief Nurse/Deputy Chief Executive agreed to check if an escalation process for the Trust Board to be informed was in place.

Responding to a query from Dr R Palin, GP on whether there were catering services in ED, the Director of Nursing advised that the main priority was for staff to be attending to patients, however, staff needed to be proactively offering/directing patients' family/carers with appropriate catering (i.e. hot drinks, water, sandwiches etc.) facilities.

Resolved – that (A) the contents of this report be received and noted, and

(B) the Chief Nurse/Deputy Chief Executive to check with the Acting Director of Facilities whether an escalation process was in place to inform the Trust Board if there was consistent failure in achieving key performance indicators in respect of the LLR FM Contract. **CN/DCE**

06/13/4 Quarterly CQUIN Update

Paper J provided a summary of quarter 2 performance for both CQUIN and Quality Schedule indicators and provided details of the predicted RAG rating for quarter 3 of 2012-13. As specified under Minute 06/13/1 above, the amendment to RAG rating of SSA breaches was noted. Responding to a query, it was noted that the final position for quarter 3 would be available in April 2013 (as it was required to be signed-off by the three CCG Boards). **CN/DCE**

Resolved – that the final position of quarter 3 (2012-13) performance for CQUIN and Quality Schedule indicators be provided to the QAC in April 2013. **CN/DCE/ TA**

06/13/5 Update on Quality Governance

The Director of Clinical Quality presented paper K, which provided an update on the various assessments and the associated timeframes, as an integral component of the FT application process was assessment against the Quality Governance framework. Members were briefed on the internal self assessment, external verification of the Trust's quality governance arrangements and the SHA's review of these arrangements.

In response to a query raised by the Committee Chairman in respect of the external verification by RSM Tenon, it was noted that encouragingly there were 'no surprises' in terms of the findings and a number of the recommendations were already subject to action planning as part of the Trust's own quality governance self assessment.

Resolved – that the contents of this report be received and noted.

06/13/6 CQC Update following visits

Paper L provided an update of compliance at all 3 sites following scheduled unannounced visits by the CQC. It was noted that the CQC would update its website to indicate compliance position in relation to outcome 21 re. Termination of Pregnancy service at LGH.

Mr P Panchal, Non-Executive Director queried whether unannounced visits were expected further to the forthcoming publication of the 'Francis Report', in response – the Director of Clinical Quality advised that the CQC would be visiting the main sites of each Trust every year. The CQC would rate the Trust's performance through their quality risk profile – this would be presented to the QAC, when available. The Chief Nurse/Deputy Chief Executive highlighted that a Quality Surveillance Group meeting comprising of representatives from the CCGs, CQC and Monitor was due to be held. A completed profile would be developed from this Group and it was anticipated that any areas rated 'red' would expect an unannounced visit from the CQC.

Resolved – that the contents of this report be received and noted.

06/13/7 Appreciative Enquiry Action Plan – Progress

Further to Minute 111/12/5 of 22 October 2012, the Director of Clinical Quality advised that most of the actions arising from the April 2012 Appreciative Enquiry visit to UHL had been completed and any outstanding work streams in the action plan were being progressed through existing governance arrangements (paper M refers).

Dr R Palin, GP expressed concern that though the action plan was being taken as signed-off by the Trust, he queried whether the actions had actually been in place and whether the necessary changes had been made to improve performance. In response to this concern, the Executive and Non-Executive Directors of the Committee provided assurance that a number of work streams were being progressed in the background to ensure that actions were being completed. The purpose of the report was only to provide an audit trail on the recommendations arising from the Enquiry. A brief update on Right Place Consulting's emergency care pathway implementation programme was provided. A wider piece of work on staff engagement in ED and Assessment Units was being undertaken. Emergency Care performance was regularly discussed by the Executive Team, Finance and Performance Committee and Trust Board meetings.

Ms J Wilson, Non-Executive Director advised that a review of Trust Board sub-committees was currently being undertaken and that the Trust would consider ways of providing assurance to CCGs through these Committees.

Resolved – the contents of this report and the additional verbal information be received and noted.

06/13/8 Report by the Chief Nurse/Deputy Chief Executive

Resolved – that this item be classed as confidential and taken in private accordingly.

07/13 ITEMS FOR INFORMATION

07/13/1 Outstanding Actions on the Operational/Divisional Risk Register

Resolved – that this report (paper N refers) be received and noted and timescale be included for the action relating to 'Communications' in the last page of the **RAM**

report.

08/13 MINUTES FOR INFORMATION

08/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 28 November 2012 (paper O refers) be received and noted.

09/13 ANY OTHER BUSINESS

09/13/1 Contribution to Quality made by Volunteers

Mr P Panchal, Non-Executive Director suggested that an update on contribution to quality by volunteers would be helpful. In response, the Director of Nursing advised that a complete review of the Volunteer Services had been undertaken and she agreed to provide him with a copy of the report outside the meeting. She advised that the impact on quality from volunteers was included with the patient experience updates to the Committee. It was also noted that recognition ceremonies for volunteers was held annually. **DN**

Resolved – that (A) this verbal information be noted, and

(B) the Director of Nursing to forward a report on the review of volunteer services to Mr P Panchal, Non-Executive Director. **DN**

10/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be highlighted verbally to the 31 January 2013 Trust Board by the QAC Chair:-

(1) CIP Schemes 2013-14 – update on assessing the impact of quality and management of clinical risk (Minute 04/13/1 refers);
(2) Improving Discharge Processes (Minute 04/13/3 refers);
(3) Compliance with WHO Safer Surgery Checklist (Minute 04/13/5 refers);
(4) Mechanisms for monitoring quality and safety issues within the LLR FM Contact (Minute 06/13/3 refers), and
(5) Review of Trust Board sub-committees (Minute 06/13/7 refers).

11/13 DATE OF NEXT MEETING

Resolved – that the that the next meeting be held on Tuesday, 19 February 2013 at 9:30am in the Large Committee Room, Main Building, Leicester General Hospital.

The meeting closed at 12.05pm.

Cumulative Record of Members' Attendance (2012-13 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Tracy (Chair)	9	8	88.8%	P Panchal	9	6	66.6%
J Adler	1	1	100%	C Trevithick*	8	6	66.6%
J Birrell	5	0	0%	S Ward	9	5	55.5%
D Briggs*	8	2	25%	M Wightman	9	4	44.4%
M Caple*	9	5	55.5%	J Wilson	9	7	77.7%

K Harris	9	7	77.7%	D Wynford-Thomas	9	5	55.5 %
S Hinchliffe	9	8	88.8%				

* non-voting members

Hina Majeed
Trust Administrator