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: 29 August 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 23 July 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:

- **Statutory and Mandatory Compliance Rates (Minute 66/13/5 refers), and**
- **Imaging Performance (discussion under the Quality and Safety Commitment 2012-15) (Minute 67/13/2 refers).**

DATE OF NEXT COMMITTEE MEETING: 28 August 2013

Ms J Wilson
22 August 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 23 JULY 2013 AT 9:30AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director (until part-Minute 68/13/2)
Ms C Ribbins – Acting Chief Nurse

In Attendance:
Ms S Adams – Quality and Safety Manager, Acute Care (for Minute 66/13/3)
Dr B Collett – Assistant Medical Director, Clinical Effectiveness
Ms L Collins – Lead Infection Prevention Nurse (for Minute 66/13/4)
Mr N Kee – Divisional Manager, Planned Care (for Minutes 66/13/1 and 66/13/2)
Mr R Kilner – Non-Executive Director
Ms M Kitching – Director of Transformation, Interserve (for Minute 66/13/4)
Mrs H Majeed – Trust Administrator
Ms S Mason – Divisional Head of Nursing, Acute Care (for Minute 66/13/3)
Mr J Mclean – Clinical Skills Unit Manager (for Minute 66/13/5)
Mr A Powell – Head of Performance and Quality Assurance, NHS Horizons (for Minute 66/13/4)
Ms J Tyler-Fantom – Divisional HR Lead, Planned Care (for Minutes 66/13/1 and 66/13/2)
Mr A Vogel – Emergency Planning Officer (for Minute 66/13/7)
Ms M Wain – Quality and Safety Manager, Planned Care (for Minutes 66/13/1 and 66/13/2)

RESOLVED ITEMS

ACTION

64/13 APOLOGIES

Apologies for absence were received from Miss M Durbridge, Director of Safety and Risk, Mrs S Hotson, Director of Clinical Quality, Ms C O'Brien, Chief Nurse and Quality Officer East Leicestershire and Rutland CCG, Dr R Palin, General Practitioner (non-voting member), Mr P Panchal, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

65/13 MINUTES

Resolved – that the Minutes of the meeting held on 18 June 2013 (papers A & A1 refer) be confirmed as a correct record.

66/13 MATTERS ARISING REPORT

In respect of Minute 44/13 of 21 May 2013, a walkabout of the IVF and Pregnancy Termination clinics had been undertaken on 26 June 2013 – the Committee Chair advised that the Division had taken steps to improve the situation in respect of the co-location of these areas.

Regarding Minute 58/13/5 of 18 June 2013 – the Patient Adviser reported that he had spoken to the Director of Corporate and Legal Affairs who had advised that he would contact the Director of Clinical Quality to let her know that the Patient Advisers wished to be given an opportunity to provide a statement under the 'Statement from Stakeholders and External Auditors' section of the Quality Account in future and this would be considered in the 2013-14 Quality Account preparatory plan.

Resolved – that the matters arising report (paper B) be noted.

66/13/1 Action Plan to Resolve the Issue Relating to Backlog of Clinic Letters

Members from the Planned Care Divisional Team attended the meeting to present paper C, a report to provide assurance that the Division was managing the risk in relation to the implementation of the outsourcing transcription project.

In discussion, the following points were made in particular:-

(a) Mr R Kilner, Non-Executive Director queried the reasons for the 12 week delay in outpatient letters being typed in Ophthalmology - in response, it was noted that the Dictate IT solution was not suitable in this specialty as this product was not able to incorporate non-GP referrers. Substantive staff recruitments were in process in order to clear the backlog. The Divisional Manager, Planned Care agreed to circulate the trajectory for achieving the standard for letters being typed within 2 working days. It was also noted that the clinic organisation in Ophthalmology was also an issue that required focus; **DM,PC**
(b) in respect of ENT and Oncology outpatient letters – a recent server issue had emerged. The Division would be liaising with the Acting Director of IM&T to resolve this;
(c) a lessons learned session would be undertaken before end of September 2013 by the Trust wide Project Board, and
(d) in response to a suggestion by the Patient Adviser, consideration be given to including wording in the letter to patients explaining the reason for the delay. **QSM, PC**

Resolved – that (A) the contents of paper C be received and noted;

(B) the Divisional Manager, Planned Care to circulate the trajectory for achieving the standard for outpatient letters being typed within 2 working days, and **DM,PC**

(C) the Quality and Safety Manager to give consideration to including wording in the letter to patients explaining the reason for the delay in the patient receiving the letter. **QSM, PC**

66/13/2 Recovery Plan for Cancer 62 day performance by tumour site

The Divisional Manager, Planned Care advised that UHL had not consistently achieved the cancer 62 day standard for a number of months. This had led to Commissioners issuing a formal contract query notice in May 2013. Paper D detailed UHL's response to the contract query. Members were advised that an exception report would be included as part of the Quality and Performance report. However, it was noted that the June 2013 performance had delivered the target – slightly above trajectory.

In discussion on imaging being a significant factor in the diagnostic pathway and the potential shortfalls in imaging capacity – it was noted that the Divisional Manager, Acute Care was undertaking a demand/capacity work and further discussion would take place at the Cancer Action Board on 29 July 2013. The Divisional Manager, Planned Care and the Associate Medical Director agreed to liaise outside the meeting in respect of linking the imaging work stream with the work that BCG were undertaking. **DM, PC/ AMD**

Mr R Kilner, Non-Executive Director noted that one of the actions for 'Gynaecology' was that an additional theatre list was required each week – however, he commented that historically, Gynaecology did not have a high theatre utilisation rate. In response, members were advised that this had significantly improved over recent months. The Divisional Manager, Planned Care highlighted that the Theatre Board had found ways of identifying an additional session at the LRI from 1 September 2013 (as currently stated on the action plan) but that an earlier commencement date would be explored. **DM,PC**

Resolved – that (A) the contents of paper D be received and noted;

(B) the Divisional Manager, Planned Care to ensure explore possibilities of bringing forward the commencement date for the additional gynaecology session, and **DM, PC**

(C) the Divisional Manager, Planned Care and the Associate Medical Director to liaise outside the meeting in respect of linking the imaging work stream with the work that BCG were undertaking. **DM, PC/ AMD**

66/13/3 Acute Care Divisional Update on Complaints Performance and Progress in Achieving 10% reduction in formal complaints in 2012-13

Representatives from the Acute Care Division attended the meeting to present paper E, the Division's complaint activity regarding formal complaints relating to nursing, medical care and staff attitude. The overall activity with regard to complaints/concerns as a whole was significantly rising in addition to the complexity of the complaints.

In discussion on medical care complaints, it was noted that this was predominantly related to the communication of medical care and diagnosis. However, the Division were giving consideration to better ways of coding the investigation as in many cases post-investigation review concluded that a different category could be applied.

Mr R Kilner, Non-Executive Director queried the steps being taken to resolve medical care communication issues – in response, the Medical Director advised that this was discussed at appraisal and an action plan would be put in place. However, for any serious complaints, the action plan would be put in place immediately.

Responding to a query from the Patient Adviser, it was noted that the Division had a considerably lower proportion of reopened complaints. A number of meetings were now arranged between complainants and senior teams which had proved useful in resolving issues and thereby decreasing complaints being reopened. The involvement of junior doctors in complainant meetings had also been positive. The complaint responses were also appropriately quality assured by the Quality and Safety Team.

Resolved – that the contents of paper E be received and noted.

66/13/4 Transformation of UHL Cleaning Services – Interserve Cleaning Regime

Ms M Kitching, Interserve Transformation Director, Mr A Powell, Head of Performance and Quality Assurance, NHS Horizons Property and Facilities Management Partnership and Ms L Collins, UHL Lead Infection Prevention Nurse attended the meeting to brief the Committee on the planned transformation of cleaning services across UHL (paper F refers).

Following the award of the contract to Interserve in December 2012 and mobilisation from 1 March 2013, UHL had mainly received services on a 'business as usual' basis. The contract was now moving into the transformation phase to meet the new methodology and service delivery models submitted by Interserve in their acceptance bid.

Members noted that 'communications' had been a major issue. In discussion on this aspect, the Interserve Transformation Director acknowledged that it could have been better and agreed to forward all communication messages to the UHL Chief Executive that had previously been sent to staff. **ITD**

The QAC requested that a high level report listing the standards that were being measured and the performance against those standards be presented to the Executive Performance Board and Quality Assurance Committee, as appropriate. **ITD/ HPQA**

Resolved – (A) that the contents of paper F be received and noted;

(B) the Interserve Transformation Director to forward all Interserve communication messages to the UHL Chief Executive that had previously been sent to staff, and **ITD**

(C) a high level report listing the cleaning standards and the performance against those standards be presented to the Executive Performance Board and Quality Assurance Committee, as appropriate. **ITD/ HPQA**

66/13/5 Statutory and Mandatory (S&M) Training Compliance Report

Further to Minute 55/13/3 of 18 June 2013, Mr J Mclean, Clinical Skills Unit Manager attended the meeting to present paper G, a position statement on statutory and mandatory training compliance for 2012-13 and an update on the resuscitation compliance.

In discussion on this report, Mr R Kilner, Non-Executive Director expressed disappointment over the statutory and mandatory compliance rates. The Medical Director acknowledged that it had been challenging to acquire junior doctor engagement in attending S&M training courses.

The Chief Executive advised that an update on statutory and mandatory training compliance would be routinely included in the Q&P report in future and discussed at Executive Performance Board meetings. The Medical Director noted the need for focus particularly in progressing compliance in Resuscitation, Fire and Information Governance courses.

Ms J Wilson, Committee Chair reported that the poor compliance rates would be reported to the Trust Board meeting in July 2013 and a steer from the Director of Human Resources would be sought in respect of how this issue should be monitored. **Chair**

Resolved – that (A) the contents of paper G be received and noted, and

(B) the poor statutory and mandatory compliance rates be reported to the Trust Board and a steer from the Director of Human Resources be sought in respect of monitoring this issue. **Chair**

66/13/6 Mortality Update

The Medical Director presented paper H, UHL's mortality report including Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI). Consultant level outcomes had been published for 8 specialties and all Trusts were obliged to make this data available via their websites. UHL's HSMR for April 2012 to March 2013 was 96.1. Following the annual rebasing, Dr Fosters had predicted UHL's HSMR for 2012-13 would be 101 (within expected control limits). The results of the LLR Mortality Review were expected to be available in September 2013 – a report would be presented to QAC in October 2013. It was suggested that paper H should be circulated to the Trust Board. **MD** **MD**

Resolved – that (A) the contents of paper H be received, noted and circulated to the members of the Trust Board, and **MD/TA**

(B) the results of the LLR Mortality review be presented to the QAC in October 2013. **MD/TA**

66/13/7 Emergency Planning Annual Report

The Emergency Planning Officer attended the meeting to present paper I, a report

providing assurance that the Trust was compliant with legislation and guidance in relation to emergency preparedness. The priorities for 2013-14 were detailed in section 6 of the report.

Responding to a query, members were advised that training had been developed in line with new occupational standards for staff involved in incident planning and response. The Emergency Planning Officer had undertaken a training need analysis for different staff groups and provided assurance that training would be provided to the appropriate staff. It was also noted that he will be working with Interserve and IBM to ensure appropriate resilience arrangements were developed, integrated and tested.

Resolved – that the contents of paper I be received and noted.

67/13 QUALITY

67/13/1 Month 3 – Quality and Performance Update

Paper J provided an overview of the June 2013 quality and performance report highlighting key metrics and areas of escalation or further development where required.

The following were highlighted in particular:-

(a) performance for time to surgery within 36 hours for fractured neck of femur patients was below the target of 70% - this was due to unprecedented demand. An exception report would be included within the next Q&P report;
(b) 95% threshold for VTE risk assessment within 24 hours of admission had not been achieved – it appeared that the issues were in relation to data recording. An exception report would be included within the next Q&P report; **MD**
(c) in response to a comment from the Committee Chair in respect of the 5 critical safety actions particularly ' Relentless attention to Early Warning Score triggers and Actions' and 'Acting upon Results' – the Associate Medical Director advised that discussions had been held with Divisions and a plan was in place to take it forward and progress would be monitored appropriately;
(d) MRSA – zero cases reported in quarter 1 of 2013-14. An Infection Prevention Committee would be reconvened (currently the 'Infection Prevention' agenda was discussed as part of the Quality and Performance Management Group);
(e) Friends and Family (F&F) test – performance had fallen from 73.9 in May 2013 to 64.9 in June 2013. However, June 2013 figures were consistent with the 66.4 score in April 2013. Comparative data from the Department of Health was expected to be published at the end of July 2013. Responding to a query, it was noted that the process to simplify the F&F test questionnaire had commenced and the revised questionnaire would be available in late September/October 2013, and
(f) pressure ulcers – a contract query notice from Commissioners had been received (Minute 68/13/1 below refers).

Resolved – that the contents of paper J be received and noted and exception reports for any areas rated 'red' on the dashboard be included within the subsequent Q&P report. **MD**

67/13/2 Quality and Safety Commitment 2012-15

The Medical Director (on behalf of the Director of Clinical Quality) presented paper K, a report on the 2013-14 Quality Commitment. A Quality Commitment dashboard had been developed and included the 3 core metrics for tracking performance against the 3 goals (save lives, avoid harm and improve care so that our patients recommend us). It was noted that the respiratory pathway had been successfully launched at the start of July 2013 and good achievements to date had been made in respect of the patient centred care.

In discussion on the review of Imaging Services – it was noted that imaging investment proposals were scheduled to be presented at the August 2013 Finance and Performance Committee, however it was suggested that a report on 'Imaging Performance and Improvement Plans' should be presented to the Quality Assurance Committee. Discussion took place about the internal waits, work undertaken by BCG and a separate modelling work being progressed by the Acute Care Division. The Medical Director and Associate Medical Director were requested to brief the Division on the requirement of a report to the QAC which needed to be presented to the Committee in September 2013. Mr R Kilner, Non-Executive Director requested that this report should also include an update on processes in place to improve imaging turnaround times and response to the organisational needs together with trajectories for improvement. Further to the detailed report being presented to QAC, an overview report would need to be presented to the Trust Board in October 2013**.** **MD/AMD /ACD** **MD**

Resolved – that (A) the contents of paper K be received and noted, and

(B) the Medical Director and Associate Medical Director be requested to brief the Acute Care Division on the requirement of the QAC in respect of a report on 'Imaging Performance and Improvement Plans' including trajectories for improvement to be presented in September 2013, and **MD/AMD /ACD**

(C) an overview report be presented to the Trust Board in October 2013. **MD**

67/13/3 CQC Consultation

Paper L provided a briefing note on CQC's consultation on changes to the way the CQC regulated, inspected and monitored care. The consultation would run until 12 August 2013 and a number of organisations would be providing a response (by 12 September 2013) including the AUKUH. UHL would contribute to the AUKUH response. The Committee Chair queried the processes the Trust was using to consult with the Networks, Patient Advisers, Partners etc. – the Associate Medical Director agreed to raise this query with the Director of Clinical Quality. A copy of UHL's response to the AUKUH be provided to the QAC in September 2013, for information. **AMD** **DCQ**

Resolved – that (A) the contents of paper L be received and noted;

(B) the Associate Medical Director to raise the QAC's query with the Director of Clinical Quality in respect of appropriate process was being followed within the Trust to consult in respect of the CQC's consultation, and **AMD**

(C) UHL's response to the AUKUH in respect of the CQC's consultation be provided to the QAC in September 2013, for information. **DCQ/TA**

68/13 SAFETY

68/13/1 Update on data reported in the NHS Safety Thermometer (ST) regarding 'harms' and Hospital Acquired Pressure Ulcers

The Acting Chief Nurse presented paper M, an update on the NHS Safety Thermometer prevalence results for June 2013. She advised that the Commissioners had issued a contract query notice for pressure ulcers in order to seek further assurance of the Trust's ability to achieve zero avoidable grade 2, 3, and 4 ulcers. A remedial action plan would be signed off at the Contract Performance Meeting in July 2013 and would be presented to the QAC in August 2013. In response to a query from the Committee Chair in respect of the 2013-14 action plan for the elimination of avoidable pressure ulcers that had been presented to the QAC in June 2013 (Minute 57/13/1 of 18 June 2013 refers), the Acting Chief Nurse advised that the remedial action plan would be detailed, specific to areas, performance management based and would be included as an addendum to the NHS ST report presented to the QAC in August 2013. The Chief **ACN** **ACN**

Executive requested that the trend data in respect of avoidable pressure ulcers (incidence) and falls be included within the Quality and Performance report dashboard – the Acting Chief Nurse agreed to liaise with the Assistant Director of Information and action this.

Resolved – that (A) the contents of paper M received and noted;

(B) the remedial action plan for the elimination of avoidable pressure ulcers be included as an addendum to the NHS ST report presented to the QAC in August 2013, and **ACN/TA**

(C) the Acting Chief Nurse to liaise with the Assistant Director of Information to include trend data in respect of avoidable pressure ulcers (incidence) and falls within the Quality and Performance report dashboard. **ACN**

68/13/2 Nursing Workforce Report

Paper N provided an overview of the nursing workforce position for UHL. In response to a query from the Acting Chief Nurse, the Chief Executive confirmed that he was happy for this report to be sent to the Commissioners prior to it being discussed at the QAC.

Particular discussion took place regarding the 'Nurse to Bed Ratios' and members queried the reasons for the wards that had been rated 'red' – in response, the Acting Chief Nurse advised that the 'red' rating applied if the ratio fell below the agreed nurse to bed ratio, however different rules also applied to specific areas (base ward, specialist ward, HDU and ITU). The Committee Chair requested that a key be included to reflect this. She also requested that mitigation plans be included to the existing exception reports for wards that had been rated 'red'. The Chief Executive expressed concern that the sign-off of ward nurse staffing levels and budgets had not yet been completed – it was noted that the work in respect of the agreed and budgeted ward establishment would be completed by end of July 2013. **ACN**

Mr R Kilner, Non-Executive Director commented that currently there were 355 vacancies in nursing and the agency expenditure was £4.5m per year.

Resolved – that (A) the contents of paper N be received and noted, and

(B) the Acting Chief Nurse to ensure that a key is included to reflect the rules applied for wards that were rated 'red' and mitigation plans be included to the existing exception reports for these wards. **ACN**

68/13/3 Patient Safety Report

The Associate Medical Director presented the patient safety report (paper O refers) on behalf of the Director of Safety and Risk. Members were advised that previously allegations were not reported unless it was proven, however, Commissioners had requested that all allegations needed to be reported. The Medical Director and the Director of Safety and Risk would be liaising with the CCGs to agree a position.
In discussion, members were advised that if a medical trainee was involved in a Serious Untoward Incident, then this would be reported to the Director of Clinical Education in order to ensure that such information was put on record.

Resolved – that the contents of paper O be received and noted.

68/13/4 Report by the Acting Chief Nurse

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

68/13/5 Update on Statutory Guidance to Safeguard Children

Further to Minute 57/13/9 of 18 June 2013, re. new statutory guidance 'Working Together to Safeguard Children 2013' in respect of the single timescale to ensure that once a safeguarding referral was received by Social Care, they had only one day in which to make an immediate assessment and report back to the referrer with their decision – the Acting Chief Nurse advised that discussions were being held with Local Authorities in respect of the compliance aspects of this new timescale.

Resolved – that the verbal update be noted.

68/13/6 Critical Safety Actions – Acting on Results

Paper Q provided an update on implementation of policy for management of diagnostic testing procedures.

Resolved – that (A) the contents of paper Q be received and noted, and

(B) the Associate Medical Director to provide a further update to the QAC in October 2013. **AMD/TA**

68/13/7 Electronic Prescribing and Medicines Administration Update

Further to Minute 57/13/8 of 18 June 2013, the Associate Medical Director reported that it had been agreed that the EPMA system should be continued on the Acute Medical Unit. She also advised that the roll-out at the LRI would be completed and the roll-out to the Glenfield Hospital would be currently ceased (until hardware issues were resolved and hand held devices were bought). Some concerns from Anaesthetists had been raised which were being dealt with appropriately. The Committee Chair requested that an update on EPMA be included within the Patient Safety reports presented to QAC. **AMD**

Resolved – that (A) the verbal update be noted, and

(B) monthly updates on EPMA be provided to the QAC via the Patient Safety report. **AMD**

69/13 MINUTES FOR INFORMATION

69/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 26 June 2013 (paper R refers) be received and noted.

69/13/2 Executive Performance Board

Resolved – that the action notes of the Executive Performance Board meeting held on 25 June 2013 (paper S refers) be received and noted.

70/13 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

71/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board on 25 July 2013:-

- **statutory and mandatory compliance rates (Minute 66/13/5 refers), and**
- **imaging performance (discussion under the Quality and Safety**

Commitment 2012-15) (Minute 67/13/2 refers).

72/13 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting be held on Wednesday, 28 August 2013 at 12:00noon in the CJ Bond Room, Clinical Education Centre, LRI.

<u>The meeting closed at 12.26pm.</u>

Cumulative Record of Members' Attendance (2013-14 to date):

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*4*	*2*	*50*	*R Palin**	*4*	*3*	*75*
*M Caple**	*4*	*4*	*100*	*P Panchal*	*4*	*3*	*75*
S Dauncey	*1*	*1*	*100*	*C Ribbins*	*3*	*2*	*66*
K Harris	*4*	*2*	*50*	*J Wilson*	*4*	*4*	*100*
S Hinchliffe	*1*	*1*	*100*	*D Wynford-Thomas*	*4*	*3*	*75*
*C O'Brien – East Leicestershire/Rutland CCG**	*4*	*2*	*50*				

** non-voting members*

Hina Majeed, **Trust Administrator**