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: 3 September 2015

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 30 July 2015

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

- **None**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 27 August 2015

Dr S Dauncey
QAC Chairman
26 August 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 30 JULY 2015 AT 3:45PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Colonel Ret'd I Crowe – Non-Executive Director
Mr A Furlong – Acting Medical Director
Ms M McAuley – Assistant Chief Nurse (on behalf of Acting Chief Nurse)
Ms J Wilson – Non-Executive Director

In Attendance:
Mr S Barton – Director of CIP and Future Operating Model (for Minute 74/15/1)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Mr R Moore – Non-Executive Director
Mr K Singh – Trust Chairman

RESOLVED ITEMS

70/15 APOLOGIES

Apologies for absence were received from Dr A Doshani, Associate Medical Director, Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG (non-voting member), Ms C Ribbins, Acting Chief Nurse and Mr M Traynor, Non-Executive Director.

71/15 MINUTES

Members confirmed that the Minutes of the meeting held on 25 June 2015 (paper A refers) was a correct record, subject to the amendment under Minute 64/15, the meeting dates referred to 2016 (not 2015 as currently stated).

Resolved – that the Minutes of the meeting held on 25 June 2015 (paper A refers) be confirmed as a correct record, subject to amendment under Minute 64/15, the meeting dates referred to 2016 (not 2015 as currently stated).

72/15 MATTERS ARISING REPORT

Members received and noted the contents of paper B, noting that those actions now reported as complete (level 5) would be removed from future iterations of this report. Members specifically reported on progress in respect of the following actions:-

(i) Minutes 60/15/10 and 60/15/10a (External Schedule of Visits) - the Director of Clinical Quality advised that these actions had been completed and therefore could be removed from the log;
(ii) Minute 62/15/1 (Patient Experience Triangulation Report) – it was noted that the Clinical Audit Manager would provide the Acting Medical Director with the themes arising from patient feedback in respect of the Discharge Lounge. Therefore this could be removed from the log, and
(iii) Minute 38/15/1 (TTO Error Update) – it was noted that this update would now be presented to QAC in September 2015.

Resolved – that the matters arising report (paper B refers) be confirmed as a correct record.

73/15 QUALITY

73/15/1 Implementation of NICE Guidance within UHL

The Director of Clinical Quality presented paper C on behalf of the Head of Outcomes and Effectiveness. The Trust's Internal Auditors (PwC) had undertaken a review of the 'Implementation of NICE Guidance within UHL' and the report had been classified as low risk with 4 findings. The Audit Committee in January 2015 had requested the Quality Assurance Committee to monitor the process. The Head of Outcomes and Effectiveness had prepared an action plan following the Internal Audit review and QAC was assured that the action plan was progressing appropriately apart from some review of the timelines. The Committee Chair highlighted a typographical error on page 3 where the RAG rating did not correspond to the action. **DCQ**

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

(B) the Director of Clinical Quality be requested to inform the Head of Outcomes and Effectiveness about the typographical error on page 3 of paper C and ensure that it was amended accordingly. **DCQ**

73/15/2 UHL's response to 'Dying without Dignity' Parliamentary and Health Service Ombudsman Report

The Director of Clinical Quality presented paper D, a report providing summary of themes identified from the analysis of complaints relating to care at the end of life that were investigated by the Ombudsman. It was noted that this report was discussed in detail at the EQB meeting on 7 July 2015. Work was underway to link the end of life care training modules on the UHL e-learning portal so that role specific training was easily available for staff to use, although this would not be mandatory initially. Members were advised that Ms C Trevithick, Chief Nurse and Quality Lead, West Leicestershire CCG had recently been appointed as the Senior Responsible Officer for the End of Life Care BCT workstream. Currently, there was no 7 day specialist palliative care service for patients in the community across LLR. Members expressed concern that the report lacked detail on the workstreams in place to address the theme relating to 'communicating with people, their families and each other' and there was a need for focus and detailed work around this. In discussion, the Trust Chairman undertook to facilitate a discussion in September 2015 by inviting a former colleague to provide advice on the workstreams that could be put in place to enhance sensitive and appropriate communication with end of life care patients and their families, etc. **Chairman**

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

(B) the Trust Chairman be requested to facilitate a discussion in September 2015 by inviting a former colleague to provide advice on the workstreams that could be put in place to enhance sensitive and appropriate communication with end of life care patients and their families, etc. **Chairman**

73/15/3 Month 3 – Quality and Performance Update

Paper E provided an overview of the June 2015 Quality and Performance (Q&P) report. The following points were noted in particular:-

(a) the Trust's overall SHMI was currently 99, however, there was a possibility that this might increase in the next quarter;
(b) no grade 4 pressure ulcers had been reported;
(c) improvements in fractured neck of femur performance had been noticed;
(d) in respect of cancer performance, a 'harm assessment' was being undertaken for all breaches exceeding 100 days, and
(e) discussions were underway with the Trust's Facilities Management contractor

regarding the implementation of appropriate cleaning standards.

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

73/15/4 Nursing and Midwifery Report

The Assistant Chief Nurse presented paper F, an update on current nursing and midwifery position within UHL for May 2015.There were 26 wards which failed to achieve the 80% staffing threshold against plan, 3 wards failed to reach 80% by 0.4% in the Registered Nurse category and 23 other wards failed within the healthcare assistant (HCA) role. There had been an increase in wards failing to achieve 80% in month across the HCA role partly due to inability to recruit the same high volume of HCA staff, however, focus was now on recruiting higher quality staff. In comparison to the reported nursing vacancies in April 2015, there had been a slight reduction in May 2015.

Five clinical areas had not achieved the recommended nurse to bed ratio, however, it was noted that safety would not be compromised and beds would be flexed proportionally to the number of staff available, alongside the senior nursing team working clinically to support staffing gaps.

Members were advised that a monthly nursing and midwifery waterfall/bridge chart was being developed to monitor vacancies month on month. An action plan was being developed to improve retention of nursing and midwifery staff.

In respect of the Clinical Measures Dashboard, any wards which had been rated 'amber' for 4 consecutive months would be rated 'red' starting from August 2015. In discussion on ward 17 (orthopaedic ward where spinal patients were admitted), the Director of Safety and Risk advised that this ward would be a pilot for some new safety culture work led by the Patient Safety team. Using a Human Factors model, clinical performance would be examined through a review of teamwork, tasks, environment, behaviours and abilities to better understand the ward culture and outcomes.

In response to a query from Ms J Wilson, Non-Executive Director regarding the steps being taken to encourage the use of bank staff, the Assistant Chief Nurse highlighted the following:-

(a) weekly pay was being considered for bank staff;
(b) increasing rate of pay to top tier of band 5 for 'bank only nursing staff' was also being considered, and
(c) all CMGs were requested to opt-in nurses onto the 'nursing bank' after the completion of the supernumerary period. An opt-out option was available if the nurses preferred to do so.

Responding to a query from the Patient Adviser regarding the mechanism for ensuring the competence level of existing healthcare assistants, the Assistant Chief Nurse advised that she was working with Ms E Meldrum, Assistant Chief Nurse to develop a training programme to take forward that workstream.

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

73/15/5 Friends and Family Test Scores – May 2015

Paper G detailed the friends and family test scores for May 2015. The Committee Chair highlighted that the 'coverage' figures for 'inpatients' and 'maternity' within the table in the executive summary on page 1 of the report had been inadvertently transposed. Members requested the need for focus on using the data collected from outpatient feedback and requested an update on the plans that had been put in place to 'act on the feedback' received. **ACN**

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

(B) Ms H Leatham, Assistant Chief Nurse be requested to focus on using the data collected from outpatient feedback and provide an update on the plans that had been put in place to 'act on the feedback' received from this patient group. **ACN**

73/15/6 Ward Review Tool Quarterly Report

The Assistant Chief Nurse advised that the ward performance review had been designed to ensure all wards could identify their standard of care in order to ensure that it was safe, effective and of high quality to guarantee that the Trust was providing the best care for its patients. Paper H detailed the quarter 4 (2014-15) progress in relation to the ward performance review tool.

As the ward review tool had become embedded across the organisation, there had been:-

(a) clear and sustained improvements across all areas utilising the tool;
(b) each CMG had clearly detailed their focus for the next quarter to support continued improvement, and
(c) the content of the ward review tool would be reviewed and refreshed by end of quarter 2 (2015-16) in order that it could be implemented during quarter 3 of 2015-16. It was also noted that currently there was no ward review tool in place for discharge lounges, outpatients etc.

The Committee Chair noted that the ward reviews were undertaken retrospectively on a quarterly basis and sought assurance that any poor performance in wards should be identified real-time – in response, the Assistant Chief Nurse advised that the ward sisters were reviewing the performance of their wards on a continual basis.

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

73/15/7 National Adult Inpatient Results

Paper I provided the results of the national inpatient survey which was undertaken at the end of 2014 by the clinical audit team – a postal survey was sent to a sample of 850 patients treated in August 2014 as an inpatient. The report also provided an overview of the feedback received from the 448 patients (54% response rate) returning the 12 page survey. The survey results allowed benchmarking against other Trusts nationally and against ourselves year on year. Results showed UHL to be in the same category generally as other Trusts nationally, no better but certainly no worse than others.

Responding to a query from the Patient Adviser, the Assistant Chief Nurse undertook to seek a response from appropriate colleagues outwith the meeting regarding whether an action plan was in place to resolve 'discharge planning' issues identified through the survey. **ACN**

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

(B) the Assistant Chief Nurse be requested to seek a response from appropriate colleagues and provide a response to the Patient Adviser regarding whether an action plan was in place to resolve the discharge planning issues identified through the national adult inpatient survey. **ACN**

74/15 SAFETY

74/15/1 Report on process for monitoring Cost Improvement Programme (CIP) quality and safety impact assessments

Mr S Barton, Director of CIP and Future Operating Model attended the meeting to

present paper J, an update on the new quality sign off and assurance process for the CIP. He advised that the current process for quality sign off was good, however, the follow-up process was not robust.

Members were advised that all CIP schemes currently had a Project Initiation document (PID). The PID had a section on quality impact assessment (QIA) which had to be completed. Further to this, the QIA's would be signed off by the Acting Medical Director and Chief Nurse. Schemes which required further clarification would be signed-off when clarification had been received. The new process would include a risk score on the completion of quality impact assessment. Following sign off, there would be a monitoring process of related quality indicators. Where there was an adverse variance in indicators and the CIP scheme was analysed to be a root cause, the scheme would be reviewed by Director of CIP, Director of Safety and Risk and the Director of Clinical Quality. This review would lead to agreement of mitigating actions or ceasing of the CIP scheme. This process was approved and it was requested that a quarterly report on progress be provided to QAC starting from October 2015. **DCIP& FOM**

<u>Resolved</u> – that (A) the contents of paper J be received and noted, and

(B) the Director of CIP and Future Operating Model be requested to provide an update on the new process for monitoring CIP quality and safety impact assessments to the Quality Assurance Committee on a quarterly basis starting from October 2015. **DCIP& FOM**

74/15/2 <u>Patient Safety Monthly Report</u>

The Director of Safety and Risk presented paper K, patient safety report highlighting that there had been good progress overall and 100% compliance with CAS reporting and 60 day RCA performance.

One serious incident was escalated in June 2015 which related to 'failure of imaging to report on a cancer'. As there had been a small cluster of serious incidents relating to this theme, the Director of Safety and Risk highlighted that a report had been drafted following a review of this issue. In discussion on this review, the Acting Medical Director with support from the Director of Safety and Risk undertook to liaise with the CSI CMG colleagues and provide an update on actions taken to resolve this matter at the QAC meeting in October 2015. **AMD/ DSR**

Members were also advised that a recent never event relating to a 10 x drug error might now be downgraded following advise nationally.

The Director of Safety and Risk advised that she had presented some video clips to the July 2015 EQB meeting which had been developed by a FY2 doctor as a pilot project to disseminate key safety messages through animated short video clips. She undertook to circulate the video link to members of the Committee. **DSR**

The Trust Chairman noted the need for a mechanism of creating a culture in the organisation which emphasised patient safety highlighting that there were still unacceptable and avoidable harm events occurring within the Trust. In discussion on this matter, it was noted that learning from incidents was cascaded through the Learning from Experience Group. The Committee Chair commented that following a recent ward walkabout, it was felt that Trust staff were reasonably aware of the 'Statutory Duty of Candour' regulation published by the CQC.

<u>Resolved</u> – that (A) the contents of paper K be received and noted;

(B) the Acting Medical Director and the Director of Safety and Risk be requested to liaise with CSI CMG colleagues in respect of the small cluster of serious incidents relating to the 'failure of imaging to report on a cancer' and provide an update on actions taken to resolve this matter at the QAC meeting in October **AMD/ DSR**

2015, and

(C) the Director of Safety and Risk be requested to circulate to QAC members, the link in respect of disseminating key safety messages through animated short video clips. **DSR**

74/15/3 Update on UHL's action plan in response to the external review of the East Midlands Congenital Heart Centre

Further to Minute 32/15 of 30 April 2015, the Acting Medical Director presented paper L, an update on progress in respect of the external review of the East Midlands Congenital Heart Centre (EMCHC). A detailed action plan had been developed by the EMCHC and the action plan and timelines for delivery had been agreed with the External Oversight Assurance Group which included representatives from NHS England and the TDA. A process was in place to monitor progress against the action plan – the QAC were assured of this process. The External Oversight Group was scheduled to meet in October 2015, further to which an update would be provided to QAC. **AMD**

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

(B) an update on progress in respect of the action plan following the external review of the East Midlands Congenital Heart Centre be presented to QAC in October 2015. **AMD**

75/15 ITEMS FOR THE ATTENTION OF QAC FROM EXECUTIVE QUALITY BOARD (EQB)

75/15/1 EQB Meeting of 2 June 2015 – Items for the attention of QAC

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

75/15/2 EQB Meeting of 7 July 2015 – Items for the attention of QAC

The Director of Safety and Risk highlighted the following in particular from the EQB meeting on 7 July 2015:-

(a) UHL's response to 'Dying without Dignity' Parliamentary and Health Service Ombudsman Report – this was also discussed at the QAC meeting on 30 July 2015 (Minute 73/15/2 above refers) ;
(b) Mental Health CQC Action Plan – the action plan that had been developed following the multi-agency mental health crisis care inspection which was piloted by the CQC. A comprehensive review of interface issues between UHL and LPT for mental health services for UHL patients would be undertaken;
(c) Transplant Laboratory Accreditation Action Plan – work was underway to progress the actions in the action plan and the service was confident that the actions would be implemented within the 8 week deadline, and
(d) Duty of Candour Implementation – work was in progress to address the requirement for NHS provider bodies registered with the CQC to comply with a new Statutory Duty of Candour. However, some areas had still been rated 'red'/ 'amber'.

Resolved – that the verbal update be received and noted.

76/15 MINUTES FOR INFORMATION

76/15/1 Executive Performance Board

Resolved – that the action notes of the 23 June 2015 Executive Performance Board meeting (paper N refers) be received and noted.

76/15/2 Inquests and Claims Report

Paper O provided an update on claims and inquests in respect of quarter 1 of 2015-16. In response to a query from the Chief Executive, the Director of Safety and Risk advised that an update on Regulation 28 letters received by the Trust was usually provided to the Executive Quality Board and any exceptions were reported to the Quality Assurance Committee. Further to a detailed discussion on the process for QAC to be notified of Regulation 28 letters, the Chief Executive suggested that a discussion be held with the Director of Corporate and Legal Affairs (author of the report) outwith the meeting in respect of the assurance process for oversight of Regulation 28 letters both at an Executive and Board level. **CE/ DCLA**

It was noted that actions agreed following the receipt of Regulation 28 letters were monitored through the Adverse Events Committee. The Acting Medical Director suggested that a flowchart on the assurance process be developed and presented to QAC, for approval. It was noted that currently, all Regulation 28 responses were reviewed by the Acting Medical Director and Acting Chief Nurse. The Chief Executive noted the need for discussion outside the meeting regarding whether the Director of Safety and Risk should have a part in putting together a response to Regulation 28 letters, given that the issues mainly raised were in relation to safety and risk. The Chief Executive undertook to liaise with the Director of Corporate and Legal Affairs regarding the role of the Adverse Events Committee in ensuring that actions following the receipt of Regulation 28 letters were being appropriately monitored. **CE/ DCLA**

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

(B) the Chief Executive be requested to discuss with the Director of Corporate and Legal Affairs (author of the report) outwith the meeting in respect of the assurance process for oversight of Regulation 28 letters both at an Executive and Board level, and **CE/ DCLA**

(C) the Chief Executive to liaise with the Director of Corporate and Legal Affairs regarding the role of the Adverse Events Committee in ensuring that actions following the receipt of Regulation 28 letters were being appropriately monitored and whether the Director of Safety and Risk should have a part in putting together a response to Regulation 28 letters, given that the issues mainly raised were in relation to safety and risk. **CE/ DCLA**

76/15/3 NIPAG Annual Report

Resolved – that the contents of paper P be received and noted;

77/15 ANY OTHER BUSINESS

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

78/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that there were no items to be highlighted to the Trust Board.

79/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 27 August 2015 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 5:45pm.

Cumulative Record of Members' Attendance (2015-16 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	4	2	50%	*C Ribbins*	4	1	25%
S Dauncey (Chair)	4	3	75%	*J Wilson*	4	4	100%
A Furlong	4	3	75%				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	4	3	75%	*K Singh*	4	4	100%
I Crowe	4	4	100%	*M Traynor*	4	3	75%
C O'Brien – East Leicestershire/Rutland CCG	4	2	50%	*R Moore*	4	4	100%

Hina Majeed
Trust Administrator