**Trust Board paper U**

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: 1 June 2017**

**COMMITTEE: Quality Assurance Committee**

**CHAIRMAN: Colonel (Retired) I Crowe**

**DATE OF COMMITTEE MEETING: 27 April 2017**

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

- **None noted**

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

- **None**

**DATE OF NEXT COMMITTEE MEETING: 25 May 2017**

**Colonel (Retired) I Crowe**
**Non-Executive Director and QAC Chairman**

**Paper A1**

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
# MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 27 APRIL 2017 AT 1PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

**Present:**
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (non-voting member)
Ms S Crawshaw – Non-Executive Director
Mr A Furlong – Medical Director
Mr A Johnson – Non-Executive Director
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman
Mr M Traynor – Non-Executive Director

**In Attendance:**
Ms F Bayliss – Deputy Director of Nursing and Quality, Leicester City CCG (on behalf of Ms C West, Director of Nursing and Quality, Leicester City CCG)
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Trust Administrator
Mrs S Hotson – Director of Clinical Quality
Mr D Kerr – Director of Estates and Facilities
Ms C Marshall – Deputy Medical Director
Ms C Ribbins – Deputy Chief Nurse

## RESOLVED ITEMS

**1/17 APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms L Tibbert, Director of Workforce and Organisational Development; Ms J Smith, Chief Nurse; Dr A Currie, Clinical Director, MSS; Ms C West - Director of Nursing and Quality, Leicester City CCG; Mr J Jameson, Deputy Medical Director; Professor P Baker, Dean of Medical School, University of Leicester and Non-Executive Director, and Mr R Moore, Non-Executive Director.

**2/17 MINUTES**

**Resolved – that the Minutes of the meeting held on 30 March 2017 (papers A1 and A2 refer) be confirmed as a true and accurate record.**

**3/17 MATTERS ARISING**

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings. The Chair noted that good progress had been made in completing actions. No further updates were required for the entries on the Matters Arising log.

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

3/17/1 Car Parking Provision – Windsor Building and Buggy Service

The Director of Estates and Facilities provided a verbal update and tabled a site map of Leicester Royal Infirmary (LRI) which detailed the current and proposed car parking provision at the Trust. This site map was appended to the public QAC summary at the **ITA**

request of the Committee Chair. The Director of Estates and Facilities took members through the proposal. It was noted that parking provision in car park E could not be changed owing to the requirement to have direct access to the boiler house. The Balmoral entrance remained open until further signage to navigate patients around the site had been received. Signage would be reviewed for the whole site now that the new Emergency Department (ED) had been opened, including for multi-storey access and for disabled spaces. There was a discussion around possible abuse of disabled spaces, although it was noted that very few complaints with regards to disabled access were received. In discussion of this item, it was also queried whether the general public were using the new patient multi-storey for purposes not linked to the hospital.

The Disabled Access Group had been re-established and would be assessing the current and future car parking provision at LRI. In discussion of this item, it was agreed that disabled representation was required on the group. Following the opening of the new ED, buggies had been retained outside the Balmoral Building, and were also located at the side and rear of the Windsor Building. **DEF**

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

**(B) that the tabled site map be appended to the public QAC summary for the Trust Board on 4 May 2017, and** **ITA**

**(C) to ensure disabled representation on the Disabled Access Group.** **DEF**

3/17/2 Fractured Neck of Femur/Spines Options Paper

The Medical Director presented paper C, which provided an update on progress with provision of the fractured neck of femur and spine services at LRI. The trauma service at LRI have in the region of 3,000 trauma admissions per year, 800 of which are Fractured Neck of Femurs and approximately 400 are emergency spine cases. The expected standard for operating on hip fracture cases should be within 36 hours from presentation to undergoing surgery against a standard of 72%. The Trust's year to date performance was 71.6%. It was acknowledged that the lack of dedicated theatre sessions for the spinal work was directly impacting on achievement of the Fractured Neck of Femur standard. The original paper to the EQB had proposed using the theatre vacated following the move of vascular services to Glenfield, but following a decision to use the theatre for decant work whilst theatre maintenance took place; the paper had to be reworked to identify alternative options.

The Deputy Medical Director was deputy chair of the Oversight Group and the Clinical Director of MSS was dealing with operational matters to progress this issue. In discussion of this item, it was agreed that quarterly reports would be provided to EQB and QAC on this matter, with the first progress report to be received in July 2017. **MD**

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

**(B) that progress reports be provided on this matter quarterly, commencing in July 2017.** **MD**

**4/17 EFFECTIVENESS**

4/17/1 Month 12 Quality and Performance Report

The Deputy Chief Nurse and Medical Director presented paper D, which provided a briefing on quality and performance for March 2017, with particular regard to patient

experience and quality issues. The following points were particularly highlighted:-

*(a)* *MRSA* – there had been three cases of MRSA reported for the year, but all cases had been unavoidable or attributed to a third party;

*(b)* *Clostridium Difficile* – both the month and year to date figures were within the trajectory;

(c) *Never Events* – one had been reported for the month;

(d) *Pressure Ulcers* – there were no Grade 4 pressure ulcers reported this month and Grade 3 pressure ulcers remained within the month and year to date trajectories;

(e) *Inpatient and Day Case Patient Satisfaction (FFT)* – remained at 96% against a Quality Commitment of 97%;

(f) *Single Sex Accommodation Breaches* – there continued to be a reduction in breaches (1 breach in March 2017) from the previous month when 4 breaches were reported;

(g) *Moderate Harm and above* – the Trust remained well within the agreed Quality Commitment monthly thresholds;

(h) *Cancer Two Week Wait* – despite an 8% increase in referrals, the Trust continued to achieve this target for 8 consecutive months;

(i) *Mortality* – the latest published SHMI is 102 and is within the expected range on the funnel. A detailed mortality report would be provided at the May 2017 QAC meeting. A CQC letter had been received in relation to the AMI outlier alert in November 2016 which would be discussed at the May 2017 QAC meeting, and

(j) *Fractured Neck of Femur* – year to date 71.2% was reported for patients operated on within the 35-hour target of 72%. A long-term solution was being identified.

In consideration of this item, there was also a discussion of 62 day cancer performance and the linkage to the Oncology business case.

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

**5/17 COMPLIANCE**

5/17/1 Care Quality Commission (CQC) Action Plan Tracker Update

The Director of Clinical Quality presented paper E, which detailed an updated report on the CQC compliance actions developed in response to the Trust inspection report, following a CQC inspection in June 2016. The Committee noted that monthly progress reports would be provided to the EQB in the form of an actions tracker until all actions were closed. The tracker was appended to the report. Evidence would be required for each action before they could be closed, and this was currently being sought via fortnightly oversight meetings to confirm and challenge the evidence. The CQC received assurances around progress of the actions at monthly meetings with the Chief Nurse and the Director of Clinical Quality.

Following closure of the current tracker, a further action plan would be developed to detail actions for how to move to ‘good’. The Deputy Chief Nurse provided an operational example of what this might look like in terms of work underway around end of life care. Assurance was received that following closure of actions they would be monitored to ensure that they continued to be compliant and mechanisms for how this might be done were discussed.

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

5/17/2 Assurance Report for EWS and Sepsis

The Medical Director presented paper F, providing the Committee with an update on the work programme being undertaken to improve the care of patients with a deteriorating Early Warning Score (EWS) and Red Flag Sepsis trust-wide. Following the sepsis team appointment, a number of indicators for ED had seen improvement, with the majority of indicators amber or green for the whole of February 2017. EObs had now been rolled out to ED. There was more marked variability with the assessment unit and ward figures. Work was underway to digitalise data required to report on the indicators, and resources had been secured for a further 6 months to achieve this. In discussion of this report, it was agreed that a revised report would be circulated owing to duplication of figures in two of the tables. **ITA**

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

**(B) that a revised report be circulated to members correcting the duplication of figures in two of the tables.** **ITA**

**6/17 QUALITY**

6/17/1 Nursing and Midwifery Quality and Safe Staffing Report – February 2017

The Deputy Chief Nurse presented paper G which detailed triangulated information (using both hard and soft intelligence) relating to nursing and midwifery quality of care and safe staffing. This information provided an overview of patient areas to highlight where improvement was required and also to highlight areas of high performance. No wards had triggered as a Level 3 concern and 6 wards had triggered as a Level 2 concern. One ward at LGH and one ward at LRI triggered as causing particular concern to the Chief Nurse and Corporate Nursing Team. It was noted that in both cases these concerns were not around safety.

With regards to recruitment, 105 new Health Care Assistants commenced in post in March 2017, 39 adult newly qualified nurses from De Montfort University commenced in post on 20 March 2017 and 120 finalist student nurses were interviewed in March 2017. Of the 39 newly qualified nurses commencing in post, 8 nurses have dual registration, mental health or learning disability registration. The Centre for Clinical Practice and Leicestershire School of Nursing was officially opened on 10 March 2017. Successful completion of the IELTS requirement for overseas nurses continued to prove challenging, although it was welcomed that the NMC were now giving applicants an additional attempt to achieve this requirement. It was noted that Brexit had not had as significant an impact on staff retention as had been originally anticipated. Agency and bank rates remained variable by CMG, but work was underway to fill substantive posts.

The Infection Prevention metrics continued to be challenging to ward staff, but the Corporate Infection Prevention Team were providing support to improve practice and performance. Cross-auditing and peer challenge were taking place in wards with poor performance. There was a discussion around hand hygiene in general public spaces.

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

6/17/2 Reports from the Director of Clinical Quality including (1) Clinical Audit Report (2) Sentinel Stroke National Audit Programme (SNNAP), and (3) Human Tissue Authority (HTA) – LRI Mortuary

The Director of Clinical Quality presented paper H, which was comprised of three reports

which had previously been discussed at the EQB. The first section of the report detailed clinical audit work. The Clinical Audit Committee continued to meet on a quarterly basis, although it was noted that attendance had been low at the previous two meetings. The Committee had been working to raise awareness of its work. The report detailed delays or problems with progression of National Clinical Audits, which had been escalated to the relevant clinical areas and to the EQB. A plan to engage patients more in clinical audit had been approved which included development of an internet page for clinical audit.

The second section of the report provided a summary of UHLs performance against the Sentinel Stroke National Audit Programme. In discussion of this item it was noted that Intra-arterial (thrombectomy) treatment was not currently provided at UHL, but would require further investigation into potential provision in the future.

The third section of the report provided a summary of actions in response to the Human Tissue Authority (HTA) site visit inspection with regards to the Trust's Post Mortem Licence. Whilst the HTA had found that the LRI met the majority of the HTA standards, one major and four minor standard shortfalls had been identified. The major shortfall related to the condition of the flooring in the PM Suite. The HTA is to refer this matter to the HSE for consideration. An action plan had been submitted in response to the findings, and the HTA had requested monthly updates. Funding for the flooring had been confirmed and plans were currently being developed for temporary closure of the unit whilst the work was undertaken. In discussion of this item, it was agreed that a further report on this matter would be provided to QAC following a report to the EPB. A further action related to identifying the reason behind the increased activity at the unit was also agreed. **DCQ** **DCQ**

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

**(B) that a further report on this matter be provided to QAC following a report to EPB, and** **DCQ**

**(C) to identify reasons behind the increased activity at this unit.** **DCQ**

**7/17 SAFETY**

7/17/1 <u>Report from the Director of Safety and Risk including (1) Patient Safety Report – March 2017, and (2) Complaints Performance Report – March 2017</u>

The Director of Safety and Risk presented paper I which detailed two sections, (1) patient safety and (2) complaints performance for March 2017. The complaints and performance reports were only briefly discussed to enable a presentation of safety improvements to take place, with particular regards to maternity. It had been noted that a number of incidents across the country had occurred in relation to babies suffering from hypoxic-ischemic encephalopathy (HIE) which is a brain injury linked to inadequate oxygen to the brain. The Trust had been successful in receiving funding from the NHSLA to develop safety videos for staff which included a video in relation to learning from this. The videos would be made freely available to other NHS Trust's in an attempt to share learning and best practice, and would be presented at four conferences over the coming months.

A Time Escalation Decision (TED) bear would be placed in each delivery room as a visual prompt to staff. The Director of Safety and Risk was congratulated on the high quality work. In discussion of this item, it was agreed that the videos would be shown at the public Trust Board in June 2017 in the patient story section of the agenda to raise public awareness of the work which had been undertaken. Further work had been identified in relation to producing a maternity in labour score, and this was being **DSR**

progressed with midwives.

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

**(B) that the patient safety videos be shown at the public Trust Board in June 2017 in the patient story section of the agenda to raise public awareness of the work which had been undertaken.** **DSR**

7/17/2 Report from the Medical Director 1

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

7/17/3 Report from the Medical Director 2

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

**8/17 PATIENT EXPERIENCE**

8/17/1 Friends and Family Test Scores – February 2017

The Deputy Chief Nurse provided paper L, a summary of the friends and family scores. The report detailed the Friends and Family Test score and coverage for February 2017. The Trust had achieved the expected coverage within inpatients, outpatients and maternity services. With regards to the Friends and Family Test score, in February 2017 97% of patients recommended the Trust. In discussion of this item themes and peer analysis were discussed. The report had been discussed in further detail at the April 2017 EQB meeting.

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

8/17/2 Triangulation of Patient Feedback – Quarter 3 2016/17

The Deputy Chief Nurse presented paper M, which detailed a number of different strands of patient feedback via complaints, verbal complaints, GP concerns, NHS Choices, patient opinion, Friends and Family Test scores, Message to Matron, and Message through a Volunteer. The data suggested that the main area for improvement was waiting times, per a quarter of all feedback received. This was a 15% increase from the same quarter in the previous year. The main theme being fed back to matrons was around environmental issues. A reduction in complaints and concerns had been seen around facilities, nursing care, administration/ appointments, medication, and staffing numbers.

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

8/17/3 The Lived Experience of Hospital Discharge – Action Plan

The Deputy Chief Nurse, and Head of Nursing and Clinical Lead Red2Green presented paper N. The purpose of the paper was to provide the Health and Wellbeing Board with a summary of the actions that UHL and its partners had taken in response to the five key recommendations outlined within 'The Lived Experience of Hospital Discharge' report. The five recommendation were: (1) timely medication, (2) training, (3) cultural change, (4) inclusive approach and (5) feedback loop. Progress with each of the recommendations was discussed in detail. The survey had captured themes from

discussions with 300 patients and 40 staff. It was noted that progress had already been made with some of the recommendations but that further work was required to embed and sustain.

In discussion of this item, the Head of Nursing/Clinical Lead for the Red2Green Initiative was invited to attend a Patient Partner meeting. A future report on Red2Green would be discussed at the EPB and the Trust Board in due course.

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

**9/17 ITEMS FOR INFORMATION**

9/17/1 New and Innovative Procedures Authorisation Group Annual Report

**Resolved – that paper O be received and noted.**

**10/17 MINUTES FOR INFORMATION**

10/17/1 Executive Quality Board

**Resolved – that the matters arising of the meeting of the Executive Quality Board held on 4 April 2017 (paper P refers) be received and noted.**

10/17/2 Executive Performance Board

**Resolved – that the notes of the meeting of the Executive Performance Board held on 28 March 2017 (paper Q refers) be received and noted.**

10/17/3 QAC Calendar of Business

**Resolved – that the QAC Calendar of Business (paper R refers) be received and noted.**

**11/17 ANY OTHER BUSINESS**

11/17/1 None noted.

**12/17 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**

**Resolved – that a summary of the business considered at this meeting be presented to the Trust Board meeting on 4 May 2017, and no items were noted as needing to be brought to the attention of the Trust Board.**

**13/17 DATE OF NEXT MEETING**

**Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday 25 May 2017 from 1.00pm until 4.00pm in the Board Room, Victoria Building, Leicester Royal Infirmary.**

The meeting closed at 4.04pm.

Sarah Everatt
**Interim Trust Administrator**

**Cumulative Record of Members' Attendance (2017-18 to date):**

*Voting Members*

| *Name* | *Possible* | *Actual* | ***%** attendance* | *Name* | *Possible* | *Actual* | ***%** attendance* |
|---|---|---|---|---|---|---|---|
| *J Adler* | 1 | 1 | 100 | *R Moore* | 1 | 0 | 0 |
| *S Crawshaw* | 1 | 1 | 100 | *B Patel* | 1 | 1 | 100 |
| *I Crowe (current Chair)* | 1 | 1 | 100 | *K Singh* | 1 | 1 | 100 |
| *A Furlong* | 1 | 1 | 100 | *J Smith* | 1 | 0 | 0 |
| *A Goodall* | 1 | 0 | 0 | *M Traynor* | 1 | 1 | 100 |
| *A Johnson* | 1 | 1 | 100 | *C West – Leicester City CCG* | 1 | 0 | 100 |
| *K Kingsley – Leicester City CCG* | 1 | 1 | 100 | | | | |

*Non-Voting Members*

| *Name* | *Possible* | *Actual* | ***%** attendance* | *Name* | *Possible* | *Actual* | ***%** attendance* |
|---|---|---|---|---|---|---|---|
| *M Caple* | 1 | 1 | 100 | *D Leese – Leicester City CCG* | 1 | 0 | 0 |
| *M Durbridge* | 1 | 1 | 100 | *C Ribbins* | 1 | 1 | 100 |
| *S Hotson* | 1 | 1 | 100 | *L Tibbert* | 1 | 0 | 0 |