**Trust Board paper S2**

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 August 2017**

**COMMITTEE: Quality Assurance Committee**

**CHAIRMAN: Karamjit Singh, Trust Chairman (Acting QAC Chair for 29.6.17)**

**DATE OF COMMITTEE MEETING: 29 June 2017**

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

**None**

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

**None**

**DATE OF NEXT COMMITTEE MEETING: 27 July 2017**

**Karamjit Singh, Trust Chairman (and Acting QAC Chair for 29 June 2017)**

**Paper A1**

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
# MINUTES OF A JOINT MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE AND THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 29 JUNE 2017 AT 12.30PM TO 1.15PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

**Present:**
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (non-voting member)
Mr A Furlong – Medical Director
Ms M Gordon – Patient Partner
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman
Ms J Smith, Chief Nurse
Mr M Traynor – Non-Executive Director (Chair)
Ms C West, Director of Nursing and Quality, Leicester City CCG (from minute reference 29/17/2)

**In Attendance:**
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Trust Administrator
Mr D Kerr – Director of Estates and Facilities
Mr W Monaghan – Director of Performance and Information
Ms K Rayns – Trust Administrator
Mr P Traynor – Chief Financial Officer (until minute reference 29/17/2)

## RESOLVED ITEMS

### 29/17 JOINT DISCUSSION ON QUALITY AND OPERATIONAL PERFORMANCE

Members of IFPIC and the Quality Assurance Committee (QAC) held their second joint monthly meeting – providing for joint discussion of the monthly quality and performance report and other matters of joint interest.

29/17/1 Month 2 Quality and Performance Report

Executive Directors particularly highlighted the following issues from the 2017-18 month 2 quality and performance report:-

- continued strong diagnostic performance in May 2017 for an eighth consecutive month. The RTT 92% in 18 weeks standard was achieved in May 2017, which was the first time since November 2016;
- the continued welcomed reduction in 52-week waits, which stood at 17 in April 2017 and had reduced to 9 in May 2017;
- cancer performance for April 2017 continued to be encouraging, with 2 week wait and the 31-day standard both remaining compliant. Performance for the 62-day standard had reduced from 86.5% in April 2017 to 83.9% in May 2017 and was predominantly due to late transfers from other centres;
- there had been no cases of MRSA or clostridium difficile during May 2017. Details of the e coli bacteraemia target had been received, as a health economy a 10% reduction was required and this would be built into subsequent reporting mechanisms;
- good progress on avoidable pressure ulcers, with 0 grade 3 or grade 4 pressure ulcers reported in this financial year;
- three single sex accommodation breaches had occurred within the month which were

nearly all linked to ICU stepdown capacity – revised criteria had been agreed with commissioners;
- three Never Events had occurred during May 2017. A Quality Summit had taken place and agreed actions were being progressed;
- fractured neck of femur was achieved for the month for the first time since November 2016 but remained non-complaint year to date. Further work was being undertaken and would be reported at the July QAC meeting, and
- the latest published SHMI for the period January to December 2016 was 101, which remained within the expected range.

Following discussion at the 25.5.17 QAC meeting, further discussion took place around the three Never Events which had taken place during May 2017. The CQC and NHSI had been informed. The Medical Director had chaired all three of the Root Cause Analysis (RCA) meetings and the RCA reports would be reported to EQB and QAC in due course. The Safer Surgery Policy was being rewritten and would be relaunched in Autumn 2017. The Chairman was keen that lessons were learned from the governance work undertaken by the University Hospitals Bristol NHS Foundation Trust. IFPIC/QAC received assurances that work was underway with the respective teams.

In discussion, the QAC Patient Partner sought (and received assurances) that work was underway to address the emergency readmission within 30 days target following a decrease in performance in May 2017. The IFPIC Chair sought (and received assurances) that emergency performance would improve following a challenging two days the previous week with ambulance handovers. At a recent EMAS Quality Summit with the CQC which the UHL Chief Nurse had attended, UHL had been commended for their ambulance handover work and had been asked to share best practice with other counties. New protocols had also been introduced around 12 hour trolley breaches and the UHL Chairman had been invited to attend a meeting with the EMAS Chair.

**<u>Resolved</u> – that the contents of Joint Report 1 be received and noted.**

29/17/2 **CANCER 2 WEEK WAIT PERFORMANCE**

The Director of Performance and Information provided Joint Paper 2 in response to a question received at the June 2017 Trust Board around provision of analysis behind the patients not seen within the two week standard. It was noted, however, that the two week wait standard had been achieved for the tenth consecutive month despite a 16% increase in referrals over the past two years. The standard was for 93% of patients to be seen within the two week wait period. The breakdown of patients who were not seen within the two week wait period were reviewed for April and May 2017. The Director of Performance and Information was congratulated on maintaining the standard and on being asked to share learning with the NHSI to support other trusts in delivering change.

**<u>Resolved</u> – that the contents of Joint Report 2 be received and noted.**

29/17/3 **CANCELLED OUTPATIENTS APPOINTMENTS**

The Director of Performance and Information provided Joint Paper 3 in response to a question received at the June 2017 Trust Board around provision of analysis of cancelled appointments and time to rebook. The complexity and time-consuming nature of calculating multiple cancellations was noted. The report showed a downward trend since January 2016 despite a growth in the overall number of outpatient appointments per month. Nottingham Univeristy Hospitals NHS Trust were currently the ‘best in class’ for

performance within UHLs peer group with 4% cancelled outpatient appointments. Assurance was sought (and received) that patients were immediately reinstated, rather than referred back to their GP, if their appointment letter was not received. It was suggested that it would be useful to see the financial impact linked to the cancellation of appointments to understand potential efficiencies. In 75% of cases patients were being given 4-6 weeks notice prior to their appointment but there remained some services who found this challenging due to capacity. The Director of Performance and Information had requested permission from both the Business Services Authority and NHS Services on three occasions to email appointments but this had been denied, text messages were, however, being used for appointment reminders. In discussion of this item, it was agreed that quarterly reports on this subject would be provided from September 2017. **DPI**

**Resolved – that (A) the contents of Joint Report 3 be received and noted, and**

**(B) that quarterly reports on Outpatient Cancellations be provided to QAC from September 2017.** **DPI**

## UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
## MINUTES OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 29 JUNE 2017 AT 1.15PM TO 4.00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

**Present:**
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (non-voting member)
Mr A Furlong – Medical Director
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman (Acting QAC Chair on behalf of Col. (Ret'd) I Crowe)
Ms J Smith, Chief Nurse
Mr M Traynor – Non-Executive Director (until minute reference 34/17/2)
Ms C West, Director of Nursing and Quality, Leicester City CCG

**In Attendance:**
Mr J Clarke – Chief Information Officer (for minute references 32/17/1 and 32/17/3)
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Trust Administrator
Mr W Monaghan – Director of Performance and Information (unitl minute reference 32/17/3 excluding 32/17/1)

## RESOLVED ITEMS

### 30/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Col. (Ret'd) I Crowe – Non-Executive Director (Chair); Mr A Johnson – Non-Executive Director; Mr R Moore - Non-Executive Director; Ms E Meldrum - Acting Deputy Chief Nurse, and Mrs S Hotson – Director of Clinical Quality.

### 31/17 MINUTES

**Resolved – that the Minutes of the meeting held on 29 June 2017 (papers A1** **ITA**

**and A2 refer) be confirmed as a true and accurate record, with one minor amendment on page 5 of A1 under the Carers' Charter Update section to read 'Nursing TBC' instead of 'Patient Partner' for action (F).**

**32/17 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 continued to be made in progressing 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.**

32/17/1 EMRAD PACS Action Plan

Papers C and C1, as presented by the Chief Information Officer, provided a progress update following implementation of the EMRAD PACS system in September 2016. Following the last report an East Midlands consortium meeting had taken place to discuss other trust's experience of the system. It was noted that although the system met the warranted environment specification and was exceeding the target for backlog reduction there remained dissatisfaction. The priority would now be to stabilise the system. It was believed that there remained issues around training and infrastructure.

In discussion of this item, it was agreed that a paper would be provided to the September 2017 QAC which would include a copy of the original letter recently received from UHL Imaging staff which set out their concerns and a potential solution, and the letter provided from the Chief Information Officer and Medical Director in response to the concerns highlighted. The paper would aim to provide the Committee with assurances around patient safety by detailing any potential or actual patient harm arising following implementation of the new PACS system, which would be provided by the Director of Safety and Risk. It was noted that to date the system had not been the route cause of any Serious Untoward Incident. The report would include a milestoned action plan detailing progress with areas within and outside UHLs control and would outline the work and communications being undertaken to win the 'hearts and minds' of the clinical staff using the system. **CIO/CD CSI/CRP**

**Resolved – that (A) the contents of paper C and C1 be received and noted, and**

**(B) that an update paper be provided to September 2017 QAC.** **CIO/CD CSI/CRP**

32/17/2 Outpatient Clinical Correspondence (Minute reference 180/16/3)

The Director of Performance and Information presented paper D which detailed progress made in achieveing the 2016/17 Quality Commitment to improve the experience of outpatients by achieving the 14 day clinical correspondence standard, and outlined the work being undertaken to reduce the variation in the electronic systems used to generate outpatient letters. During 2016/17 the 75% target of notifying the patients GP within 14-days was met for 10 out of the 12 months.

The paper provided assurances that the Trust would continue to monitor outpatient letter turnaround times and CMG action plans monthly to ensure that the letter standad was being consistently achieved. Further work was, however, required as the target timescale had been reduced for 2017/18 and it was agreed that quarterly **DPI**

progress reports would be required to QAC commencing from September 2017 which detailed both progress against the target and implementation of the options for the new trust wide dictation system.

Problems with an upgrade of the Winscribe dictation system this month had been discussed at length at ESB. The paper outlined the ten transcription services currently in use across the Trust and the primary objective of the Clinical Correspondence Project to reduce the number of electronic system processes currently used within the Trust to three. The Project Board are in the process of evaluating and scoring the responses received from suppliers with regards to the digital dictation and transcription services specification document. Supplier presentations are to take place in July 2017 with final agreement by the end of the July 2017 with regards to the chosen supplier. By the end of this financial year it was anticipated that all specialties would be on the same dictation system. It was noted that as the correspondence target time was reduced, clinicans would require a web-based solution to review and edit letters out of hours.

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

**(B) that commencing from September 2017 a quarterly report be provided which tracks compliance with the 14 day standard, (moving to 10 days and 7 days) and progress with the outpatient correspondence project which will see the implementation of options 1-3 for a new trust wide dictation system by March 2018.** **DPI**

32/17/3 Update on Waiting List Management (Minute reference 180/16/4)

The Director of Performance and Information presented paper E which detailed progress since the previous report in May 2017 with a review of waiting list management. KPMG had been commissioned to review waiting list governance processes, information systems and reports. KPMG would be reviewing 20 indicators, with the first 10 being reviewed in July 2017 and reported at the Audit Committee in September 2017. The report would include the background provided by the Chief Information Officer at this meeting. It was acknowledged that the proposed actions by KPMG were deemed to be reasonable, and that consideration of best in class or the best the Trust can be would be included in the report.

A table top review of the elective pathway from referral through to treatment and discharge of patients has been undertaken. It was acknowledged that 129 risks had been identified across 16 sub processes, 8 of which had been classified as high risk. The report detailed the actions being undertaken to mitigate these risks. The Performance team had provided input with IM&T around the early design work on EPR Plan B which may include a new PAS system. Other user organisations of the current PAS have been approached to understand how they use the PAS and mitigate against risk. In light of the discussions, it was agreed that a review of the Datix risk register score and target risk rating score were required due to the number of risks highlighted to date and potential risks re patient harm. **DPI**

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

**DPI**

**(B) to review and consider increasing the Datix risk register score and target risk rating score in Appendix A, correlated to incidents of patient harm.**

32/17/4 Never Event – Wrong Tooth Extraction – 2017/495 and 2017/6015

The Medical Director presented papers F and G which provided Root Cause Analysis (RCA) reports for two incidents of wrong tooth extractions. It had been identified that both were due to human factors, but very different approaches had been adopted. As a consequence, work was being undertaken around safety culture in theatres. A campaign would be launched in September 2017, following planning over the summer holidays, which would include a relaunch of the Safer Surgery Policy and inclusion of stories of good practice. Learning from both incidents had been shared via the safety portal and to Head's of Nursng and Clnical Directors which would be disseminated to their respective teams. One individual had been reported to the GMC, and the RCA report would consequently be shared with them.

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

**33/17 COMPLIANCE**

33/17/1 Care Quality Commission (CQC) Action Plan Update

In the absence of the Director of Clinical Quality, the Chief Nurse presented paper H, which provided the Committee with an updated report on the CQC compliance actions developed in response to the Trust inspection report, following a CQC inspection in June 2016. Assurance was again provided that robust evidence continued to be sought for each action before they could be closed, via rigorous fortnightly oversight meetings to confirm and challenge the evidence. Since the last QAC report, evidence had been received and reviewed for a further thirty actions which had now been closed. Revised timescales were being agreed for all overdue actions.

There was currently no timescale for completing all of the outstanding actions, as it was acknowledged that some actions could not be closed due to limited funding. It was subsequently agreed that an action plan and report which detailed all 'must do' actions which remained outstanding and explained why the actions could not be closed, such as due to financial constraints, be provided to the October 2017 QAC meeting. The report would also include what actions had been taken to mitigate the risks including appropriate risk assessments. **CN/MD**

It was noted that further monthly updates would be provided on the CQC action plan and that the plan would continue to be closely monitored by regulators and external stakeholders.

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

**(B) that an action plan and report which detailed all 'must do' actions which remained outstanding and explained why the actions could not be closed, such as due to financial constraints be provided to the October 2017 QAC meeting. The report would also include what actions had been taken to mitigate the risks including appropriate risk assessments.** **CN/MD**

33/17/2 Assurance Report for EWS and Sepsis

The Chief Nurse presented paper I, 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. It was acknowledged that significant work continued to be undertaken to recognise and

respond to the deteriorating patient and management of patients. Clarity was sought (and received) around minute reference 20/17/2 of 25 May 2017 which detailed 'one harm tbc' (on page 9 of the report), that on further review it had been confirmed that no harm had actually occurred. Inpatient indicators continued to represent a challenge. IV antibiotics within an hour had decreased in both Inpatients and the Emergency Department for the time period in the report, but since publication this had risen back to previously reported performance in the Emergency Department. A Nervecentre sepsis trigger tool was being adopted which it was anticipated would improve response times and escalation.

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

## 34/17 QUALITY

34/17/1 Nursing and Midwifery Quality and Safe Staffing Report – April 2017

The Chief Nurse presented paper J 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, 13 wards had triggered as a Level 2 concern and 17 wards had triggered as a Level 1 concern. Four wards at LRI triggered as causing particular concern to the Chief Nurse and Corporate Nursing Team. Assurances were provided that all wards were being supported to progress the issues.

Infection prevention metrics continued to be challenging. Details of the new uniform policy had been included with this month's wage slips which included bare below the elbow and hand hygiene; this would be monitored and enforced.

With regards to recruitment, registered nurse recruitment continued to be challenging locally, nationally and internationally, with other countries predicting nurse shortages by 2020. It was reported that there were currently 22,000 nurse vacancies nationally, which would rise to 38,000 by 2030. Vacancies had increased in the Trust in month from 409 whole time equivalents to 505 whole time equivalents in April, which was partially due to additional nursing investment across the Emergency Floor. Models were being developed at a local level to explore alternative skill mixes for ward teams. Currently 300 whole time equivalent vacancies were being filled by nursing bank staff. The Trust currently employed 111 research nurses and options were being explored as to whether joint contracts could be developed to enable research nurses to undertake some ward work, and clinical fellowships were being explored for ward nurses. It was noted that the Director of Research and Innovation was supportive of the approach to develop portfolios for research nurses. Health Care Assistants continued to be successfully recruited. A recent housekeeper recruitment day had attracted 110 attendees. Bespoke training was being offered to trainees.

It was noted that despite the challenges around recruitment, the Trust was not an outlier in terms of this in the East Midlands area, and that despite the pressures, staff continued to provide good quality care. It was acknowledged that in the future more flexible contracts may be required. It was hoped that some of the trainee Nursing Associates may continue their training to become nurses, and the Advanced Practitioner model continued to be developed withint the East Midlands. It was acknowledged that further work was required with LWAG and LWAB to assist the Trust in developing new roles and to increase the number of trainee nursing posts available at Universities.

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

34/17/2 Reports from the Director of Clinical Quality including (1) Clinical Audit Quarterly Report, and (2) Policies and Guidelines Update

In the absence of the Director of Clinical Quality, the Chief Nurse presented paper K, which was comprised of two reports which had previously been discussed at the EQB. The first section of the report provided a quarterly update on clinical audit, which reported that the clinical audit programme continued to operate below the target level of 90%, with 87% achieved at the end of the year, although there were variations between Clinical Management Groups (CMGs) with four CMGs and twenty-none specialities achieving the target. Next month the HQIP and CQC would be launching a new initiative called National Clinical Audit Benmarking (NCAB) which would make available an array of National Clinical Audit results on-line from each organisation. The first six audits to be published were: (1) Upper GI surgery, (2) Lower GI surgery, (3) Lung cancer treatment, (4) Vascular surgery, (5) Hip fracture, and (6) Intensive care. Plans for involving patients more in audit continued to be implemented and training sessions for involving patient partners in clinical audit and improvement methods had been arranged for later in the month. It was noted that metrics produced by Clinical Audit could be used to populate data for a 'model hospital' and to make improvements to the monthly Quality and Performance report.

The second section of the report provided an update on performance against outstanding policies and guidelines. It was noted that outstanding policies and guidelines were being carefully tracked and more rigour had been added to following up on progress. It was acknowledged that whilst progress had been made, there remained a large number of policies that required signifant work (168 or 17% passed their review date). Executives met monthly with CMGs to progress. Further work was required to ensure that policies and guidelines were useable and fit for purpose and the Medical Director outlined a simpler process and format for policies and guidelines.

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

34/17/3 The Future Approach to CQC Inspection and Regulation

In the absence of the Director of Clinical Quality, the Chief Nurse presented paper L, which provided a summary of the key points from the June 2017 Care Quality Commission publication: 'How CQC monitors, inspects and regulates NHS trusts'. Since the publication all trusts had been issued with a handbook which detailed the new process. It was noted that between now and Spring 2019 all trusts would have an unannounced visit to core services. The CQC Insight Dashboard would replace the hands on intelligence report with a rating which would be updated on a quarterly basis. It was noted that the CQC inspections would involve the well-led domain and the Committee agreed that the Chief Nurse would undertake preparatory work into the well-led domain for discussion at a future Trust Board Thinking Day. It was noted that Chief Executives, Chief Nurses and Medical Directors would be expected to undertake at least one inspection at another trust. **CN**

The QAC was specifically asked to note: (1) the changes to the CQC's monitoring and inspection model, (2) the recommendation that a Trust Board Thinking Day be dedicated to the new CQC monitoring and inspection model, (3) that the outputs from CQC Insight would be shared with QAC once available, (4) the increased burden of inspection on the organisation both in the preparation for and during a future CQC

inspection, and (5) the level of burden on trusts from regulation remains high and the CQC would need to work with others to align activity and reduce duplication.

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

**(B) that preparatory work would be undertaken into the Well-led Domain for discussion at a Trust Board Thinking Day.** **CN**

34/17/4 2017/18 Quality Commitment update

The Chief Nurse and Medical Director presented paper M which provided an update on the 2017/18 Quality Commitment, which set out the trust's quality improvement plan for the current year. It was noted that each of the Quality Commitment aims had an overarching Key Performance Indicator (KPI) and were supported by a number of high priority work streams with their own KPIs. Following a recent review o of the 2016/17 Quality Commitment by the Trust's internal auditors, a number of recommendations had been made. QAC was specifically requested to: (1) note the current position with regards to the development of KPIs and the underpinning action plans, and (2) note that Senior Responsible Officers had been asked to identify the respources required to both deliver their Quality Commitment key priority work stream and adopt the UHL Way tools and techniques. Resourcing gaps would be reported in the next Quality Commitment update to to EQB and QAC.

**35/17 SAFETY**

35/17/1 Report from the Director of Safety and Risk including (1) Patient Safety Report – May 2017, (2) Complaints Performance Report – May 2017, (3) Duty of Candour Update, and (4) Involving Employees in Improving Standards of Care

The Director of Safety and Risk presented paper N which was comprised of four sections, (1) patient safety, (2) complaints performance, (3) Duty of Candour update, and (4) involving employees in improving standards of care. The patient safety report provided the patient safety data for May 2017 and noted that against a 2016/17 Quality Commitment target of reducing harm (moderate and above) by 5% the Trust had reduced the actual number of harm incidents (moderate and above) by a pleasing 41% and had therefore far exceeded the target.

There continued to be a prominent theme of failure to recognise and escalate the deteriorating patient, and lack of a robust process for review of test results in serious incidents this month. There continued to be 100% CAS compliance and no alerts had breached their deadline during the reporting period.

Clinical Management Groups at EQB had been asked to note their complaint activity, performance and to address the route cause of complaint themes. Feedback had been received from the Independent Complaints Review Panel and CMGs had been asked to consider this when responding to complaints and concerns. There had been one partially upheld Parliamentary and Ombudsman (PHSO) complaint. In discussion of this item it was agreed that the Director of Safety and Risk would be asked to write to the new Parliamentary Ombudsman with an invitation to attend UHL to meet with the relevant teams. **DSR**

During quarter four 2016/17 there had been no breaches with the full requirements of the Duty of Candour and the Corporate Patient Safety team continued to provide support to staff across the Trust with the Duty of Candour requirements.

In discussion of the involving employees at work section, it was noted that EQB had discussed the report at length, and that a task and finish group, chaired by the Chief Executive, was being set up to progress the issues highlighted in the report. The QAC was specifically requested to: (1) receive the report detailing concerns raised during the third quarter of 2016/17 and the actions taken, (2) consider whether sufficient action was being taken on the key themes raised, (3) note that staff are supported to raise concerns and are informed of the outcomes, where appropriate, (4) note that the Freedom to Speak Up Guardian had commenced in post, and (5) note that whistleblowing information was shared between Regulators and Commissioners to triangulate information.

In addition to the reports, five issues were highlighted for the attention of QAC members – (1) three Never Events in May 2017 (detailed the themes identified from the events and the immediate actions put into place, EQB were asked to consider if staff understood what a Never Event was and if this could happen in their areas); (2) Healthcare Safety Investigation Branch (HSIB) (established to improve patient safety through effective and independent investigations, are now accepting self-refferals for investigation in addition to identifying appropriate incidents to review); (3) Rejected investigations in imaging (a working group has been established to review the imaging process, identify potential errors and recommend urgent safety actions, following 3 SUIs and one Regulation 28 letter related to this); (4) Life QI (a web software platform has been developed to support and manage quality improvement work in health and social care), and (5) Overdue Serious Incident Reports (two have been identified as having not met the NHSE deadline). In discussion of these additional issues it was agreed that a report a demonstration of the Life QI software platform would be provided to the July 2017 QAC meeting, and that a report on findings of the working groups set up to investigate rejected images would be provided to the September 2017 QAC meeting. **DSR** **DSR**

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

**(B) that the Director of Safety and Risk be asked to write to the new Parliamentary Ombudsman with an invitation to attend UHL to meet with the relevant teams;** **DSR**

**(C) that a demonstration be provided of the Life QI software platform developed to support ad manage quality improvement, at the next QAC meeting, and** **DSR**

**(D) that a report be provided to the September 2017 EQB and QAC meetings around the findings of the working group set up to investigate rejected investigations in imaging.** **DSR**

35/17/2 <u>RCS Invited Review of the OMFS Service – Update Report</u>

The Medical Director presented paper O which provided an update on the Oral and Maxillo-Facial Surgery (OMFS) service following an invitation by the trust for the Royal College of Surgeons (RCS) to review the department following concerns raised after a HEEM visit. The RCS review team had visited the Trust for two days in November 2016 and following verbal feedback received at the time of the visit on their preliminary findings the decision had been taken to immediately suspend all respective cancer surgery of the oral cavity and oropharynx pending a further indepth review of clinical records by the RCS in December 2016 and a further review in March 2017. The RCS report was received in April 2017 and concluded that ablative and reconstructive cancer surgery of the oral cavity and oropharynx should continue to be

suspended until such point as it could be demonstrated that a robust action plan had been taken to improve the standard of care that the OMFS service was able to provided.

The report made twenty-three recommendations which were shared with external regulators and commissioners, and a multi-agency OMFS Oversight Group, chaired by the Trust's Chief Executive, was established to oversee progress with the work strands. The Group has met on three occasions since April 2017 and included representatives from NHSI, NHSE, LCCCG, Health Watch and a Trust Non-Executive Director. Eighty-five patients or their relatives had been contacted to offer them a face to face meeting with a senior OMFS clinician and specialist nurse to discuss the reports findings and any concerns they may have. Thirty patients or relatives had made contact, fifteen had been seen and a further four were to be seen in the following week. In discussion of the report it was agreed that a further progress report would be discussed at the September 2017 QAC meeting. **MD**

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

**(B) that an update report be provided to the September 2017 QAC meeting following a meeting of the Oversight Committee in August 2017.** **MD**

**36/17 PATIENT EXPERIENCE**

36/17/1 Sepsis Presentation for the National Patient Safety Awards

Dr J Parker the Sepsis Clinical Lead was in clinic, so the Chief Nurse presented paper P, the ten minute presentation used for the National Patient Safety Award pitch to the panel for 'recognising and responding to the deteriorating patient'. The presentation outlined the three reasons why the team thought that they should win the award, which were: (1) sustained culture change on a grand scale, (2) the huge magnitude of change, and (3) that the Trust was achieving their ambition. It also included the ambition of the Trust, following the release of 200 balloons from a patient who had survived sepsis, to signify the 200 lives that could be saved. It outlined the work that had taken place in the past two years and the progress achieved towards this aim, and provided feedback received from patients who had been under the Trust's care for sepsis. The culmination of this work had been that there had been an additional 152 survivors from sepsis who would not otherwise have survived during the past 18 months. The Committee congratulated the team on the significant progress that had been made.

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

**37/17 ITEMS FOR INFORMATION**

37/17/1 No items were noted for information.

**38/17 MINUTES FOR INFORMATION**

38/17/1 Executive Quality Board

**Resolved – that the notes of the meeting of the Executive Quality Board held on 6 June 2017 (paper Q refers) be received and noted.**

38/17/2 Executive Performance Board

**Resolved – that the notes of the meeting of the Executive Performance Board held on 23 May 2017 (paper R refers) be received and noted.**

38/17/3 QAC Calendar of Business

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

**39/17 ANY OTHER BUSINESS**

39/17/1 None noted.

**40/17 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 6 July 2017, and no items were noted as needing to be brought to the attention of the Trust Board.** **Cttee Chair**

**41/17 DATE OF NEXT MEETING**

**Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday 27 July 2017 from 1.15pm until 4.00pm in the Board Room, Victoria Building, Leicester Royal Infirmary.**

The meeting closed at 3.53pm.

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* | 3 | 3 | 100 | *R Moore* | 3 | 0 | 0 |
| *S Crawshaw (until May 2017)* | 2 | 2 | 100 | *B Patel* | 3 | 3 | 100 |
| *I Crowe (current Chair)* | 3 | 2 | 67 | *K Singh* | 3 | 3 | 100 |
| *A Furlong* | 3 | 3 | 100 | *J Smith* | 3 | 2 | 67 |
| *A Goodall* | 3 | 0 | 0 | *M Traynor* | 3 | 3 | 100 |
| *A Johnson* | 3 | 2 | 67 | *C West – Leicester City CCG* | 3 | 1 | 33 |
| *K Kingsley – Leicester City CCG* | 3 | 0 | 0 | | | | |

*Non-Voting Members*

| *Name* | *Possible* | *Actual* | *% attendance* | *Name* | *Possible* | *Actual* | *% attendance* |
|---|---|---|---|---|---|---|---|
| *M Caple* | 3 | 3 | 100 | *D Leese – Leicester City CCG* | 3 | 0 | 0 |
| *M Durbridge* | 3 | 3 | 100 | *C Ribbins/E Meldrum* | 3 | 2 | 67 |
| *S Hotson* | 3 | 2 | 67 | *L Tibbert* | 3 | 0 | 0 |