Trust Board paper U1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 4 April 2019

COMMITTEE: Quality and Outcomes Committee (QOC)

CHAIR: Col (Ret'd) I Crowe, Non-Executive Director and QOC Chair

DATE OF COMMITTEE MEETING: 28 February 2019

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

- **None.**

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

- **Minute 25/19/1 – Mortality Report**

DATE OF NEXT COMMITTEE MEETING: 28 March 2019

Col (Ret'd) I Crowe, Non-Executive Director and QOC Chair

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY AND OUTCOMES COMMITTEE HELD ON THURSDAY 28 FEBRUARY 2019 AT 1.45PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Ms V Bailey – Non-Executive Director
Ms C Fox – Chief Nurse
Mr B Patel – Non-Executive Director
Mr K Singh – Trust Chairman *(ex officio)*

In Attendance:
Ms F Bayliss - Deputy Director of Nursing and Quality, Leicester City CCG
Mrs G Belton – Corporate and Committee Services Officer
Mr M Caple – Patient Partner
Miss M Durbridge – Director of Safety and Risk
Mr J Jameson – Deputy Medical Director (for Minute 25/19/1)
Mrs S Khalid – Clinical Director, RRCV (for Minutes 25/19/3 and 25/19/4)
Dr C Marshall – Deputy Medical Director (for Minute 25/19/2)

ACTION

RESOLVED ITEMS

21/19 APOLOGIES FOR ABSENCE

Apologies for absence were received from Professor P Baker, Non-Executive Director, Mr D Kerr, Director of Estates and Facilities, Mr A Furlong, Medical Director and Mrs S Hotson, Director of Clinical Quality.

22/19 DECLARATIONS OF INTEREST

Resolved – that there were no declarations of interest.

23/19 MINUTES

Resolved – that the Minutes of the meeting held on 31 January 2019 (paper A refers) be confirmed as a correct record.

24/19 MATTERS ARISING

Members received and noted the contents of the Matters Arising Log (paper B refers). The Chair confirmed the Committee's contentment that, where the completion of actions had been delayed beyond the original date expected, an explanation for the delay had been provided and a revised date confirmed.

Resolved – that the contents of the Matters Arising Log be received and noted.

25/19 KEY ISSUES FOR DISCUSSION / DECISION

25/19/1 Mortality Report

Mr Jameson, Deputy Medical Director, attended to present paper 'C', which detailed the latest information in respect of mortality data.

UHL's crude and risk-adjusted mortality rates and related workstreams were overseen by the Trust's Mortality Review Committee (MRC) chaired by the Medical Director. MRC also maintained oversight of UHL's framework for implementing 'Learning from Deaths', which

included the Trust's Medical Examiner Process, Bereavement Support and Specialty Mortality Reviews using the nationally developed Structured Judgement Review Tool. One of the requirements relating to 'Learning from Deaths' was for Trusts to submit nationally and publish mortality data on a quarterly basis including the number of deaths reviewed / and or investigated, the number of those found to be more than likely due to problems in care and details of learning and actions taken to improve the care of all patients. The Committee received this latter-referenced data as part of paper D (appendix 3 refers – entitled 'Learning from the Deaths of Patients in our Care') and it was agreed that a copy of this appendix would be attached to the summary report arising from this meeting for receipt and noting by the Trust Board at its meeting on 7 March 2019. **CCSO**

UHL's crude mortality rate 18/19 to date (end December 2018) was 1.1% and, whilst the usual seasonal increase in December and January had been observed, both months were below previous years' figures. UHL's latest published SHMI was 96 (covering the 12 months July 2017 to June 2018) and HSMR was also 95 for the same time period. Both these numbers were within the expected range. The next published SHMI for UHL would increase to 99, but would still remain within the expected range. The reasons for the increase in SHMI were being investigated by the MRC, but preliminary review had not identified any particular emerging themes or new contributing patient or diagnostic groups. The Committee was also particularly requested to note the following: (1) significant work had been undertaken to ensure that UHL's mortality rates were closely monitored and that any patient groups with a higher HSMR or SHMI were being reviewed and learning and action taken, where applicable (2) the progress made with screening of adult deaths by the Medical Examiners and completion of Structured Judgement Reviews by Specialty M & Ms (3) capacity issues continued to affect progress with the Learning from Deaths programme and (4) actions had been agreed in response to the recommendations made by Internal Audit which should be completed by the end of June 2019.

Particular discussion took place regarding the application of learning from the DC1 case identified. The Deputy Medical Director and Director of Safety and Risk were requested to confirm outwith the meeting, reporting back to the next QOC meeting, as to whether UHL had discussed this matter with the other Trust involved, in terms of identifying further learning opportunities. Members also noted the valuable learning arising from work undertaken with bereaved families. **DMD/DSR**

Specific discussion took place regarding an emerging theme relating to the cross-site transfer of patients with more than one clinical problem. The Medical Director and Mr Jameson, Deputy Medical Director, were requested to provide a verbal report to the next QOC meeting detailing the Trust's plan to address issues relating to management of cross site transfer of patients, with a detailed paper then to be submitted to a future QOC meeting describing proposals (including reference to policies and SOPs). **MD/DMD**

In concluding discussion on this item, the QOC Chair recognised the significant progress made to date, as described within the report presented, and acknowledged the slight rise in the mortality indices, albeit understanding the reasons for this. The contents of this report were received and noted.

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

(B) the Corporate and Committee Services Officer be requested to append appendix 3 of paper C (entitled: 'Learning from the Deaths of Patients in our Care 2018/19') to the summary of the 28 February 2019 QOC meeting due to be submitted to the Trust Board meeting of 7 March 2019, for formal receipt and noting by the Trust Board; **CCSO**

(C) in respect of the DC1 case identified, the Deputy Medical Director and the Director of Safety and Risk to confirm, outwith the meeting, whether the Trust had discussed this matter with the other Trust involved in the care, in terms of identifying further learning opportunities and report back on this matter accordingly (via the Matters Arising Log) at the next QOC meeting on 28 March 2019, and **DMD/DSR**

(D) the Medical Director and Deputy Medical Director (Mr Jameson) be requested to provide a verbal report to the March 2019 QOC meeting detailing the Trust's plan to address issues relating to the management of cross site transfer of patients, with a detailed paper then to be submitted to a future QOC meeting describing proposals (including reference to policies and SOPs). **MD/DMD**

25/19/2 VTE Prevention Task and Finish Group Update

Dr C Marshall, Deputy Medical Director, attended to present paper 'D, which detailed a second update report from the VTE Prevention Task and Finish Group which had been meeting since early December 2018. The Committee was asked to: (1) note the immediate actions taken in response to a second Coroner's Regulation 28 Prevention of Future Deaths report relating to VTE and (2) note the work being undertaken by the VTE Prevention Task and Finish Group.

In presenting this report, Dr Marshall, Deputy Medical Director, noted the significant progress made since the publication of this report (relating to the undertaking of trust-wide audits, the distribution of a learning bulletin, a review of patient information given at times of admission and discharge etc.), all of which would be the subject of a further report to the next Executive Quality Board meeting on 5 March 2019 and, thereafter, at the next Quality and Outcomes Committee meeting on 28 March 2019. **DMD**

Particular discussion took place regarding (a) the need for consistency in terms of the advice (both written and verbal) given to patients upon admission and discharge and potential means by which such consistency could be achieved, including the fostering of a trust-wide culture such as that already observed in the Women's and Children's CMG in relation to VTE prevention. This matter would be taken forward as part of the Group's quality improvement work (b) progress towards the achievement of quality standard 5, which was being progressed by Ms J Ball, Assistant Chief Nurse (c) relevant links to the Quality Strategy and (d) the fact that all known incidents relating to VTE had been taken into account in the progression of this workstream.

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

(B) the Deputy Medical Director be requested to submit a further update from the VTE Prevention Task and Finish Group to the EQB meeting on 5 March 2019 and, thereafter, to the OQC meeting on 28 March 2019. **DMD**

25/19/3 Delays in Sending Vascular Clinical Correspondence

The Clinical Director (RRCV) attended QOC to brief the Committee in relation to the identification, in January 2019, that a number of clinical letters pertaining to patient interventions, both in-patients and out-patients, had not been sent onto their intended recipients. The report presented (paper E refers) detailed the outcome of the investigation into this matter and the action taken in response, both in terms of addressing the delayed letters (and any consequences of this delay) and means by which to prevent a recurrence, both within this particular specialty and across the wider CMG.

This incident had highlighted system failures in the CMG's administrative processes at a number of levels; individual, team and IT system. The investigation had been completed and actions had been implemented to correct the issues identified. Administrative typing backlogs were being monitored across all specialties, with Respiratory and Cardiology backlogs continuing to be an issue, albeit the reasons for this were known.

In discussing this matter, the Committee considered issues relating to (a) effective communication with GPs, as well as with patients (b) ensuring that staff felt empowered to raise issues of concern, where required, alongside the wider issue of general staff behaviour and communication processes (c) facilitating an effective means by which patients could contact the Trust and ensuring that patients were briefed as to the relevant contact point and (d) consideration of the potential need to take a wider look at administrative processes across the board.

<u>Resolved</u> – that the contents of this report be received and noted.

25/19/4 <u>Distribution of Cardiology Imaging Results</u>

The Clinical Director (RRCV) briefed QOC regarding the identification, on 21 January 2019, that paper copies of cardiac MR (magnetic resonance), CT (computerised tomography) and Plain Film (chest and abdominal) imaging results had not been received by the Cardiology Administrative team by internal post. The first scan not received dated back to 28 November 2018. It was noted that all of these scans had been reported electronically by Radiology, however the Consultant Cardiologists used the paper report as a prompt to review the tests in the absence, currently, of a robust system to track what tests had been ordered. As a consequence, this had resulted in Consultants not acting upon results in a timely manner.

The report presented (paper F refers) detailed the outcome of the investigation into this matter and the action taken in response, both to address any potential delays in the treatment of individual patients and to prevent a recurrence of such a situation in future. In discussion on this item, the Chief Executive undertook to consider the matter of administrative processes with the Executive Board (point (d) under Minute 25/19/3 above also refers) and report back on this accordingly. He also undertook, as part of this discussion, to consider a single point of access for patients to use when needing to seek assistance from the Trust. **CEO**

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

(B) the Chief Executive be requested to consider the matter of administrative processes with the Executive Board (in light of recent issues which had arisen in both vascular surgery (Minute 25/19/3 above refers) and cardiology specialties (this Minute – 25/19/4 – refers) and report back on this accordingly to the QOC and, within this discussion with executive colleagues, to consider a single point of access for patients to use when needing to seek assistance from the Trust. **CEO**

26/19 ITEMS FOR ASSURANCE

26/19/1 <u>Nursing and Midwifery Quality and Safe Staffing Report</u>

The Chief Nurse presented paper ‘G, which provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a level 3, 2 or 1 concern in the judgement of the Chief Nurse and Corporate Nursing team. In December 2018, 1 ward had triggered a level 3 concern (this was 1 more than in November 2018), there were 7 wards triggering a level 2 concern (this was the same as in November) with 22 wards triggering a level 1 concern (this was the same as in November).

Particular discussion took place regarding staffing challenges in relation to ward 22 LRI (a CHUGGS ward) and the means by which it was intended to try and overcome these, as addressed in an individualised action plan. Mr Caple, Patient Partner, also fed back regarding the outcome of a session held for patients in January 2019 at which they provided feedback about their experiences on ward 22, the majority of which had been quite complimentary about the care received and understanding of the pressures placed on staff, albeit expressing the view that communication could be improved between ITAPS and CHUGGS. Note was also made, in discussion, of the continued monitoring of vacancies within the Children’s Hospital.

The Chief Nurse proposed that future reports to this Committee focused on fill rates, narrative, vacancy data and hot topics, with the scorecard element of the report moved into the Performance Review meetings, which was agreed by the Committee. Note was also made of the need to celebrate success and particular discussion took place regarding an impending celebration relating to the introduction of Nursing Associates. **CN**

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

(B) it be agreed that future such reports to this Committee focus on fill rates, narrative, vacancy data and hot topics, with the scorecard element of the report moved into the **CN**

CMG Performance Review meetings.

26/19/2 Monthly Highlight Report from the Director of Safety and Risk

The Director of Safety and Risk particularly highlighted the following issues in her monthly report (paper H refers):- (1) a review of the quality of serious incident investigations and improvement work intended for 2019/20 in this respect (2) emergency department winter pressure and patient safety concerns. Whilst patient experience was being adversely affected, and the pressure on staff intensified, by the increased level of attendances over the winter period, a review undertaken to-date had concluded that this was not translating into observable increased patient harm or increased SIs. Within discussion on this particular aspect, note was made of the need to remain vigilant in terms of sepsis and of the intended review of winter planned to be undertaken by the Chief Operating Officer (3) themes arising from the GP Concern Transferring Care Safely Process and how these were being addressed, including the potential benefit of convening a half day session with Primary Care colleagues to facilitate more effective two-way communication and (4) a focus on complaints in neurology, due to an increase in the number of such dating back from April 2017 until the present time, the themes from which were being progressed by the Clinical Director of the Emergency and Specialist Medicine (ESM) Clinical Management Group. Mr Jameson, Deputy Medical Director, was requested to liaise with the Medical Director and Clinical Director of ESM to ensure that QOC received an appropriate update on this matter.

In presenting her report, the Director of Safety and Risk also made particular reference to the SPC Charts and the in-depth review of these which was undertaken within the Patient Safety Team. Following the publication of a national document relating to SPC and a poor approach, nationally, to patient and family involvement in patient care, particular discussion took place regarding the positive approach to patient and family involvement within UHL and means by which this could potentially be further improved (e.g. by sending draft reports to patients for comment prior to publication of the final version and also by decreasing the use of medical terminology, utilising layman's terms instead). Members received and noted the contents of this report.

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

(B) Mr Jameson, Deputy Medical Director, be requested to liaise with the Medical Director and Clinical Director (ESM) to ensure that the Committee received an update in relation to the neurology service (particularly in relation to the issues raised within the increased complaint numbers regarding this service). **DMD/MD/ CD(ESM)**

26/19/3 Monthly Report from the Director of Clinical Quality

Paper I, as presented by the Chief Nurse in the absence of the Director of Clinical Quality, provided the Committee with (1) a CQC update, including details of the next CQC Provider Engagement meeting and a copy of the latest CQC Insight Report and a summary of the action being undertaken to address outlier or deteriorating indicators and (2) the quarter 3 update for the Quality Commitment. Key risks / issues identified within the quarter 3 position were (a) a large number of competing priorities for IT hardware / mobile devices (b) a number of workstreams dependent on the roll out of IT systems and (c) embedding standardised processes remained inconsistent. Development of the 2019/20 Quality Commitment was underway. Also noted was a recent meeting with the new CQC team and the fact that their initial feedback would feature in the next update report. Note was also made that the Director of Clinical Quality would be meeting with the Deputy Head of Outcomes and Effectiveness to review PROMS (patient related outcome measures) in more detail. The contents of this report were received and noted.

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

26/19/4 Never Event – Wrong Femoral Nail – Investigation Report

The Committee received and noted the contents of the final investigation report (paper J refers) into a Never Event relating to use of the wrong femoral nail (i.e. use of a left sided nail instead of a right sided nail). The Chief Executive undertook to discuss this matter in detail at the Executive

Quality Board meeting due to be held the following week, specifically in relation to the necessity for all staff to follow agreed processes.

<u>Resolved</u> – that (A) the contents of this report be received and noted and

(B) the Chief Executive be requested to discuss this matter in detail at the EQB meeting due to be held on 5 March 2019, specifically in relation to the necessity for all staff to follow agreed processes. **CE**

27/19 ITEMS FOR NOTING

27/19/1 <u>Clinical Audit Quarterly Report – Q3 2018/19</u>

Members received and noted the contents of paper K, which detailed the quarterly Clinical Audit report. It was noted that ten national audits were not currently running to schedule. CMGs were being invited to attend the Clinical Audit Committee on a quarterly basis to ensure appropriate oversight. The QOC Chair highlighted the excellent work undertaken by Trust staff in relation to submissions made for the Clinical Audit Improvement Competition and congratulated the winners.

<u>Resolved</u> – the contents of this report be received and noted.

27/19/2 <u>Learning from Claims and Inquests – Q3 2018/19</u>

<u>Resolved</u> – that the contents of this report (paper L refers – Learning from Claims and Inquests, Q3) be received and noted.

27/19/3 <u>Data Quality and Clinical Coding</u>

<u>Resolved</u> – that the contents of this report (paper M refers – Data Quality and Clinical Coding) be received and noted.

28/19 <u>MINUTES FOR INFORMATION</u>

<u>Resolved</u> – that the following be noted for information at papers N1, N2 and O respectively:-
(1) EQB minutes of 8 January 2019 (paper N1 refers);
(2) EQB actions of 5 February 2019 (paper N2 refers) and
(3) EPB minutes of 29 January 2019 (paper O refers).

29/19 ANY OTHER BUSINESS

<u>Resolved</u> – that there were no further items of business.

30/19 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

<u>Resolved</u> – that the following issues be highlighted to the public 7 March 2019 Trust Board meeting via the public summary of this QOC meeting:-

- **Minute 25/19/1 – Mortality Report (specifically appendix 3 – 'Learning from the Deaths of Patients in our Care 2018/19').** **QOC Chair**

31/19 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality and Outcomes Committee be held on Thursday 28 March 2019 from 1.45pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

<u>The meeting closed at 4.15pm.</u>

Gill Belton - **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2018-19 to date):
Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
I Crowe (Chair)	11	11	100	A Furlong	11	8	73
J Adler	11	6	55	E Meldrum	7	6	86
V Bailey	11	11	100	B Patel	11	10	91
P Baker	11	6	55	K Singh *(Ex-officio)*	11	8	73
C Fox	5	5	100	C West/F Bayliss – LC CCG	11	4	36

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	11	9	82	S Hotson	11	9	82
M Durbridge	11	9	82	C Ribbins	8	2	25