University Hospitals of Leicester NHS
NHS Trust

Trust Board paper L1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 December 2019

COMMITTEE: Quality and Outcomes Committee (QOC)

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

DATE OF COMMITTEE MEETING: 24 October 2019

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

- **Seven Day Services Submission to NHS England (Minute 118/19/1)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 28 November 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 24 OCTOBER 2019 AT 2.00PM 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 A Furlong – Medical Director
Mr B Patel – Non-Executive Director
Mr K Singh – Trust Chairman *(ex officio)*

In Attendance:
Mr P Aldwinckle – Patient Partner
Dr D Barnes – Deputy Medical Director (for Minute 118/19/1)
Ms E Broughton – Head of Midwifery (for Minute 123/19/1)
Mr M Caple – Patient Partner
Ms L Frith – Lead Nurse for Quality and Contracts, Leicester City CCG
Ms D Heads – Care Quality Commission Inspector (observing)
Ms H Majeed – Corporate and Committee Services Officer
Ms C Rudkin – Senior Patient Safety Manager (on behalf of Director of Safety and Risk)
Ms J Smith – Patient Partner
Ms J Woods – Care Quality Commission Inspector (observing)

RECOMMENDED ITEMS **ACTION**

118/19 KEY ISSUES FOR DISCUSSION AND DECISION

118/19/1 **SEVEN DAY SERVICES BOARD – ASSURANCE SELF-ASSESSMENT REPORT**

Dr D Barnes, Deputy Medical Director attended to present paper C, updating QOC on the 7 Day Services Self-Assessment process and seeking the Committee's endorsement to submit the October 2019 Board Assurance Framework to NHS England ahead of the 28 November 2019 deadline. Following the last audit, it was agreed that a full notes audit across the Trust for Clinical Standard 02 (Time to Consultant Review) and Clinical Standard 08 (On-going review) would not take place for this submission, instead a larger audit for the two areas (General Surgery and CDU) that were most challenged for Clinical Standard 02 would take place.

The compliance rate for General Surgery across Wards 28 and 29 at LGH and SAU at LRI was 66%. The compliance rate was almost entirely determined by the time a patient was admitted as Consultant-led ward rounds took place once a day 7 days a week at 8:00am. As part of the Trust's reconfiguration, when all Emergency General Surgery would be moved to the LRI, a second ward round would take place later in the day and this should deliver the target of 90% of patients to be seen by a Consultant within 14 hours of being admitted.

Respiratory showed an overall compliance rate of 86% (previously 74%), although they were compliant at weekends there was some variation across weekdays. The Respiratory Service had made significant improvements with a Consultant assigned daily to CDU.

Cardiology showed that compliance had not been met across the week or weekends and overall compliance stood at 41%. CDU compliance was 66% with the combination of both the system and manual case note audit. The Cardiology Service was continuing to advertise for new Consultant Cardiologists. The Trust was exploring new models of providing Consultant Cardiology care including the introduction of Consultants with a combined acute medicine and cardiology interest.

In General Surgery and Respiratory Services, all patients had a Senior Review (either Consultant or Registrar) within 14 hours, however, in the Cardiology Service, only 81% of patients received a Senior Review within 14 hours.

In response to a query from Mr M Caple, Patient Partner, the Medical Director advised that a comparison of the Seven Day Services standards with other Trusts was not possible as this information was not available, **DMD**

QOC requested that a clear explanation of the mitigating actions that were being put in place was incorporated into the narrative in future reports. Following discussion, QOC endorsed the 7 Day Services Self-Assessment and recommended it for Trust Board approval on 7 November 2019. **QOC Chair**

<u>Recommended</u> – that (A) the Seven Day Services Self-Assessment submission be endorsed and recommended for Trust Board approval on 7 November 2019 (as presented in paper C), and **QOC Chair**

(B) a clear explanation of the mitigating actions that were being put in place being incorporated into the narrative in future Seven Day Services Board reports. **DMD**

<u>RESOLVED ITEMS</u> **<u>ACTION</u>**

119/19 APOLOGIES

Apologies for absence were received from Professor P Baker, Non-Executive Director, Miss M Durbridge, Director of Safety and Risk, Mr D Kerr, Director of Estates and Facilities.

<u>Resolved</u> – that the apologies for absence be noted.

120/19 DECLARATIONS OF INTERESTS

<u>Resolved</u> – that it be noted that no declarations of interest were made at this meeting of the Quality and Outcomes Committee.

121/19 MINUTES

<u>Resolved</u> – that the Minutes of the meeting held on 26 September 2019 (papers A1 & A2) be confirmed as a correct record.

122/19 MATTERS ARISING

In reviewing paper B, the Medical Director advised that in respect of actions 113/19/2 and 113/19/2a (re. waiting lists for Neuropsychology Services) and 113/19/3 (Neurology Services Update) he had liaised with the Clinical Director, ESM and discussions regarding this action were being appropriately taken forward. Therefore, it was agreed that these three actions could be marked as 'closed' on the matters arising log. **CCSO**

In respect of action 92/19/6 (A) (re. providing a detailed Infection Prevention briefing at a future Trust Board thinking day), the Trust Chairman undertook to follow-up this action with the Director of Corporate and Legal Affairs. **Trust Chair**

In respect of action 37/19/3 (re. further update on progress in relation to Acting on Results), the Medical Director advised that the update might need to be deferred to QOC in January 2020. **MD**

<u>Resolved</u> – that the matters arising log be noted, and any actions taken forward by the relevant lead(s). **CCSO**

123/19 ITEMS FOR ASSURANCE

123/19/1 <u>Maternity Safety Update</u>

The Chief Nurse introduced discussion on this item briefing the Committee on the actions taken, and planned, by the Trust's Maternity Service in response to a variety of national initiatives which, in total, aimed to improve the safety of maternity care. She highlighted that UHL's maternity service had achieved all of the 10 safety standards described in the Clinical Negligence Scheme for Trusts (CNST) requirement for year 2 and thanked the Head of Midwifery and her team for their work on this key project.

The Head of Midwifery presented paper D, providing assurance that the Trust's Maternity Service was engaged fully with the national maternity safety strategy and the regional clinical network. The Service was committed to improving safety and had made good progress in implementing transformational change. There was good engagement in the regional clinical network. Although it was a very challenging time for Maternity services with limited resource to support the national agenda, there had been feedback to suggest that UHL benchmarked favourably against peer Trusts in many aspects of the safety work.

The QOC Chair commended the maternity services dashboard which now incorporated thresholds related to the safety agenda such as smoking targets, continuity of carer and avoidable admissions to NNU etc. In further detailed discussion, Ms V Bailey Non-Executive Director and Maternity Safety Champion noted the ever increasing demands on the Maternity Service and the significant amount of work being done and progress made.

Responding to a query, it was noted that digitising the 'red book' was a national programme and UHL were involved in the project and were awaiting national instruction and direction. A further update would be provided to QOC in 3 months' time (i.e. January 2020). **HoM**

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

(B) the Head of Midwifery be requested to provide a further report on Maternity Safety be provided to QOC in January 2020. **HoM**

123/19/2 <u>National 2018 Adult Inpatient Survey Results</u>

The Chief Nurse presented paper E and advised that overall the results of the survey were positive, for 61 questions UHL was rated 'about the same as other Trusts', for 1 question rated as 'better than most Trusts' and for 1 question rated 'worse than most Trusts'. Members were advised that the results from a number of national patient surveys had been reviewed at the Trust's Patient Involvement, Patient Experience Assurance Committee (PIPEAC) and it had been agreed that a more structured and proactive approach to improving the patient experience as measured through national surveying was required. Therefore, the national patient survey questions would be added to all the current patient feedback surveys which were produced in real time and reported at ward/clinical area level. This would allow good quality feedback data to be available for front-line multi professional teams to act upon. The local survey results would also help monitor the effectiveness of any improvement project from the patient's point of view which was a fundamental part of any quality improvement work. The revised adult inpatient survey was implemented in August 2019 and results would be provided in the next quarterly Patient Experience Report to Executive Quality Board and Quality Outcomes Committee.

In response to a query by Ms J Smith, Patient Partner, the Chief Nurse highlighted that the 'Safe and Timely Discharge' was one of the Trust's Quality Priorities for 2019-20 and work was in progress in relation to this priority and was being taken forward through the Quality Strategy.

The Patient Partners highlighted that they had shown particular interest in the various elements of the Trust's Quality Strategy 'Becoming the Best (BtB)', however, they felt that they had not been involved. In discussion on this matter, the Committee noted the long-term nature of this strategy and highlighted that there had been a delay in recruiting QI project management resource and it was expected that the QI Collaborative would focus on the Safe and Timely Discharge workstream from December 2019. The QOC Chair invited the Patient Partners to give a monthly verbal update to QOC on how the new process for patient partners was working and about their involvement in BtB. **PPs**

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

(B) Patient Partners be requested to provide a monthly verbal update to QOC on how the new process for patient partners was working and about their involvement in the Trust's **PPs**

Quality Strategy 'Becoming the Best'.

123/19/3 Deteriorating Adult Patient Board Update including EWS and Sepsis

The Medical Director presented an update on the work of the Deteriorating Adult Patient Board (DAPB) (paper F refers), noting that this report now also encompassed an update relating to sepsis and diabetes. Particular points for noting were: (1) the delivery of sepsis performance was being maintained (2) the work to validate performance against UHL NEWS guidelines for score 7 and above was in progress, (3) insulin safety training remained below target and was being addressed directly with the CMGs through the Performance Review meetings and the insulin safety e-learning module was being revised. (4) significant progress had been made with insulin and non-insulin drug errors since 2017, and (5) the DAPB was being re-structured and aligned with the Trust's Quality Strategy.

In response to a query on the high number of patients experiencing an insulin error, it was noted that UHL had a high level of reporting albeit the level of harm was 'low'. In discussion, it was agreed that a detailed breakdown and narrative on the insulin errors would be included in the next iteration of the DAPB report to QOC. **MD**

The Committee Chair requested that particular attention be paid to KPIs 5 and 6 on the Insulin Safety Dashboard relating to staff compliance with insulin safety training.

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

(B) a detailed breakdown and narrative on the insulin errors be included in the next iteration of the DAPB report to QOC. **MD**

123/19/4 Monthly Safety Update (Report from the Director of Safety and Risk)

The Senior Patient Safety Manager introduced paper G, updating QOC on the following topics: (1) extended powers for HSIB (2) the introduction of new laws for reporting deaths to the Coroner (3) issues relating to outlying and (4) national changes to the patent safety alerts process. In discussion on the further actions needed to improve the safety of outlying activity, the Medical Director advised that work was underway to revise the Trust's 'Outlying Patients Policy' and have mitigations in place.

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

123/19/5 Resuscitation Committee Report

The Medical Director presented paper H which provided a quarterly update on the work undertaken by the Resuscitation Committee. The following points were highlighted in particular: - (a) improvement in compliance with resuscitation training, (b) the DNACPR audit showed evidence that DNACPR forms had been completed appropriately in the majority of cases and the reason for the DNACPR decision had been recorded and endorsed in a timely manner. Members were advised that action was needed to improve recording of escalation of treatment on Nerve Centre and for Nerve Centre to accurately reflect the patient's DNACPR status. An action plan was in place to address this.

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

123/19/6 CIP Quality and Safety Impact Assessment

The Chief Nurse and Medical Director presented paper I advising that a robust process was in place to assess the quality and safety impact of CIP schemes. There had been 8 CIP schemes which had commenced without completing the Q&S impact assessments. 5 out of those 8 CIP schemes did not go ahead. The PIDs for the remaining three schemes which related to premium pay and HR had now been completed. In response to a query, the Chief Nurse confirmed that they also had an oversight of the Estates and Facilities schemes.

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

123/19/7 **Review of Board Assurance Framework 2019-20 Principal Risks 2 and 3**

QOC reviewed papers J1 and J2, BAF principal risks 2 (failure to reduce patient harm) and 3 (serious/catastrophic failure in a specific clinical service) respectively, rated at 15 for September 2019. In discussion on principal risk 2, it was noted that the target score had been reduced to 10 for quarter 4 (March 2020). The Chief Nurse advised that approximately 30 wards/departments would have completed the ward assessment and accreditation programme by end of December 2019. In respect of principal risk 3, the Medical Director advised that the team were trying to prioritise the 'Vital Few' work by reviewing a number of areas including GIRFT validation, serious incidents, workforce data, access targets and financial data. QOC took assurance from the reports on BAF principal risks 2 and 3.

Resolved – that the contents of papers J1 and J2 be received and noted.

124/19 ITEMS FOR NOTING

GIRFT Dermatology Visit – Action Plan Update (paper K refers) **–** in response to a query, it was noted that 24 Services had had a GIRFT visit. It was agreed that the action tracker from GIRFT visits should be discussed at a future joint PPPC-QOC meeting, and **MD**

Resolved – that (A) the following reports be received and noted and the action above in respect of paper K be taken forward:- **MD**
(1) GIRFT Dermatology Visit – Action Plan Update (paper K), and
(2) EQPB Minutes 10.9.19 and EQB Actions 8.10.19 (papers L1 and L2).

125/19 ANY OTHER BUSINESS

125/19/1 Re-structuring of LLR CCG Senior Management

The Lead Nurse for Quality and Contracts, Leicester City CCG advised that as part of the re-structuring of senior management, the LLR CCGs had appointed a single Accountable Officer who would commence in post on 11 November 2019.

Resolved – that the verbal update be noted.

126/19 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following item be highlighted to the Trust Board via the summary of this Committee meeting: **QOC CHAIR**

(i) Seven Day Services submission to NHS England.

127/19 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality and Outcomes Committee be held on Thursday 28 November 2019 at 1.15pm (joint session) in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 4.25pm Hina Majeed – **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2019-20 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
I Crowe (Chair)	7	7	100	C Fox	7	6	86
J Adler	7	6	86	A Furlong	7	6	86
V Bailey	7	7	100	B Patel	7	6	86
P Baker	7	5	71	K Singh *(ex officio)*	7	6	86

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*

P Aldwinckle (PP)	4	4	100	M Durbridge	7	6	86
F Bayliss (CCG – up to end of June 2019)	3	0	0	L Frith (CCG – from July 2019)	4	4	100
M Caple (PP)	7	5	71	J Smith (PP)	4	3	75