University Hospitals of Leicester NHS
NHS Trust

**Trust Board paper O**

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD**

**DATE OF TRUST BOARD MEETING:** 7 April 2016

**COMMITTEE:** Quality Assurance Committee

**CHAIR:** Dr S Dauncey, Non-Executive Director (Chair)

**DATE OF MEETING:** 24 March 2016

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 5 May 2016.

**SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:**

- None

**SPECIFIC DECISIONS:**

- None

**DISCUSSION AND ASSURANCE:**

- **Update following review of underperformance of the Fractured Neck of Femur (#NOF) Target** – members were advised that fixed theatre capacity and inadequate flexibility to meet variable demand remained the fundamental issues in achieving the target of operating on all fit and optimised hip fracture patients within 36 hours of admission. The shortfall in Ortho-geriatrician cover was also a key challenge. Principal improvements that were proposed to deliver the target in 2016 were better IT systems support to profile and manage demand, improved deployment and skill mix of the surgical workforce and further improvements in efficient pre-operative patient workup. Members noted the need for a well-articulated recovery plan with appropriate Corporate support in ensuring that infrastructure in terms of flexible theatre list capacity was made available to support the service. It was noted that a meeting had been scheduled for 29th March 2016 to discuss ways to make theatre capacity more flexible and responsive to match variable acute demand. The Chief Nurse undertook to inform the Chief Operating Officer regarding the Committee's concerns and the need for Corporate support to be offered to the CMG in order to assist the achievement of this target. The Committee Chair suggested that an update on this matter should be scheduled on the agenda for all future QAC meetings until members were satisfied that an action plan was in place and progress was being made.

- **Radiology Discrepancy Management** – an update on progress being made against identified improvement actions with regard to Radiology Discrepancy Management was provided. Considering work practices and behaviours from a human factors and ergonomics perspective had been helpful in identifying additional actions that could be taken and improving engagement within the Radiology community. The action plan was making good progress and developmental work was underway to strengthen the quality assurance process. In respect of the 15 actions on the

action plan, 9 were complete, 3 were on-track and 3 were delayed. Two of the delayed actions related to IT actions (i.e. implementation of additional reporting workstations and communicator module within EMRAD). The other non IT delay related to implementation of a professional behaviour pyramid. This had been designed to improve interpersonal dynamics and team communication systems. An update on the 3 delayed actions was requested to be provided to QAC in September 2016. It was noted that, in order to evaluate a reliable method of quality assurance, the Radiology Service was conducting a PDSA cycle whereby up to 5% of reporting activity for CT colon examination was subject to a formal peer review process for a 6 month time period, as commencing from January 2016. CT colon examination reporting had been identified as the first test area as it was a new service implemented this year.

- **Quarterly Update on Cancer Performance including an update on quality dashboard for measuring cancer performance** – the cancer two week wait target had been achieved in December 2015 for the first time in 2015-16 and although January 2016 performance had dipped to 91.4%, it had been delivered in February 2016. Improvement had been made to the 62 day backlog with the latest backlog down to 61 (from a peak of 116 in January). While momentum was growing with regards to backlog reduction, the main pressures remained robust patient pathways and supporting processes (i.e. inadequate theatre capacity). A root cause analysis was undertaken for all 62 day breaches and a harm report was prepared for cancer patients breaching 104 days. The Deputy Medical Director requested the deferral of the production of the quality dashboard to measure cancer performance – this was accepted by the Committee and an update was requested to be provided to QAC in August/September 2016. It was also noted that the Trust's recent emergency care pressures had resulted in a large number of elective surgery cancellations including cancellation of patients due for cancer surgery. A LiA event focussing on cancer was held in November 2015 and the key message from this was that patients needed to leave every appointment knowing what the next step was and having an appointment booked. The Trust had initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites, which would start in April 2016, initially with one tumour site and would be rapidly rolled out to all three.

- **Update on areas where the Trust should be statutorily compliant and whether or not the Trust was achieving this compliance** – in discussion, QAC members confirmed that a report be presented to QAC in May 2016 providing assurance that elements of statutory compliance were being achieved and any further actions that were required to remedy any shortfalls. A review of this data was being undertaken.

- **Report on compliance with CQC Enforcement Notice** – in respect of time to assessment (15 minute standard), 90% was being achieved, however, focus needed to be maintained in respect of this indicator. Progress in respect of effective sepsis management needed to improve and the CQC had queried the data in respect of 30 patients per week being put on the sepsis pathway, highlighting that this was quite high.

- **Update re. CQC Comprehensive Inspection** – a formal Provider Information Request (PIR) had recently been received from the CQC and it was a very lengthy document requesting detailed information on each of the service lines at each of the Trust's hospital sites. The final date for submission was 19 April 2016. Responding to a query on whether the Trust was adequately resourced to complete the PIR, it was noted that there were sufficient resources currently. In preparation for the forthcoming CQC visit in June 2016, a number of engagement sessions with staff had already taken place and a public listening event had been scheduled on 11 May 2016.

- **Mortality Review Committee – Internal Audit Action Plan** – members received and noted the contents of this report noting that progress was on-track.

- **Complaints Performance Report** – the Trust's performance in responding to 10 and 25 day formal complaints in December 2015 was 100% and 95% respectively and 45 day formal complaints in November 2015 was 100%. Members noted the table which provided an update on learning from complaints and concerns. A breakdown on complaints relating to waiting times was also provided. In discussion on the waiting times issues, members advised that there was no insufficient assurance on actions that were being taken to resolve the issues identified through those complaints. It was noted that CMG colleagues needed to be held to account in respect of the

actions that were being taken. The Committee Chair undertook to contact the Director of Performance and Information to relay the concerns raised by the Committee and ensure that an update on actions being taken to resolve this matter was provided to a future meeting of the QAC, as appropriate.

- **Patient Safety Report** – the report detailed patient safety data for UHL for February 2016. It was noted that this report was discussed at the EQB meeting in March 2016 and in reference to the Trust's most recent SUIs occurring out of hours, particularly over Bank Holiday weekends, all Clinical Directors had been requested to urgently review the arrangements in place within their CMGs over the upcoming Easter Bank Holiday weekend. Particular note was made of the fact that NHS Improvement had provided further details on the Healthcare Safety Investigation Branch which would come into existence in April 2016 and the fact that a new 'learning from mistakes' league table had been published which rated UHL as 'poor'. Members discussed the particular indicators on which these findings had been predicated, one of which related to four questions posed within the 2015 NHS staff survey. In discussion on the 'learning from mistakes' league table, it was noted that staff needed to be empowered to report concerns and the culture needed change and this would be discussed with CMG colleagues at their respective CMG Quality and Safety Performance Review meetings. It was also noted that an LiA/staff engagement event on this issue would be held. The Director of Safety and Risk reported that UHL had been awarded first place in a recent 'Human Factors, Safety Culture and Sharing Event'.

- **HSE Sharps Improvement Notice – Update** – the Director of Safety and Risk advised that the HSE had extended the deadline to 15 April 2016 by which time the Trust was to meet the requirements of the HSE Sharps Improvement Notice. A reminder communication to Heads of Service (copied to Clinical Directors and Heads of Nursing) emphasising the need for immediate removal of all 'unsafe' sharps had been issued.

- **AQuA Development Programme on 1st and 2nd March 2016 – Action Plan** – members received and noted the contents of this report.

- **Patient Experience Triangulation Report (Quarter 3 – 2015-16)** – the Deputy Chief Nurse advised that the top theme for improvements overall remained around waiting times (for appointments, clinics, Emergency Department and treatment in the department) and was the focus of over a quarter of all feedback for improvements. The year-on-year trend showed that the number of improvements with regards to waiting times had risen for the last two quarters. The data showed a reduction in feedback for improvement around medical care and car parking which was positive. During quarter three, the top 3 themes from the triangulation of patient feedback during quarter 2 were examined. Each Clinical Management Group had provided evidence of their response to these themes and this showed the extensive activity that had taken place over 3 months in response to patient feedback.

- **Friends and Family Test Scores – January 2016** – the 43.8% coverage in Maternity was impressive. The peer analysis for the Inpatient FFT data in December 2015 had ranked UHL in fifth position. It was noted that the Outpatients coverage was an internal target and not a national requirement. The Deputy Chief Nurse advised that consideration was being given to ways by which outpatient coverage could be improved.

- **Items for the attention of QAC from EQB Meeting on 15 March 2016** – received and noted.

- **Nursing and Midwifery Safe Staffing Report** – there was a reduction in the number of Registered Nurse vacancies, however, an increase in the number of Healthcare Assistant vacancies was noted. The use of bank nurses had increased to 60% with a reduction of agency use to 40%. Nurse bank now had the ability to cover the equivalent of 200 registered nurse posts, this was previously 120. An update on the Chief Nurse's view on the wards highlighting any concerns was also provided.

- **CQUIN and Quality Schedule (QS) Quarter 3 Update and 2016-17 CQUIN and QS Schemes** – 13 Quality Schedule indicators had been RAG rated 'amber' and 5 'red'. 4 CCG monitored CQUINs had been rated 'amber' due to perceived lack of progress in quarter 3 of 2015-16. 2 of the

National Schemes (i.e. AKI and Sepsis) had been rated 'red' due to not achieving locally agreed improvement thresholds. The 2016-17 guidance had been published with details of the National CQUIN schemes, the Specialised Services mandated and 'pick list' schemes and also the Local CQUIN schemes 'pick list'. Particular discussion took place on the national CQUINs that would be applicable to UHL.

- **First Draft of Quality Account 2015-16** – members (except the CCG representative) were requested to feedback any comments on the first draft of Quality Account 2015-16 to the Director of Clinical Quality before the end of 1 April 2016.

- **Quality Commitment 2016-17 Update** – it was noted that the 2016-17 Quality Commitment would be included as part of the Trust's Annual Operational Plan 2016/17.

- **Month 11 – Quality and Performance Update** – the Committee received a briefing on quality and performance for February 2016. The main issues highlighted were in respect of #NOF performance, ambulance turnaround times, FFT – ED participation, 1 Grade 4 pressure ulcer and 1 Same Sex Accommodation breach. The latest published SHMI (covering the period June 2014 to June 2015) had fallen to 95 – this compared to a peak of 105. The Cdiff performance remained within year to date trajectory. Concern was expressed in respect of readmissions within 30 days. In response, the Deputy Medical Director acknowledged the concerns and advised that a review was being undertaken.

- **Annual Reports from Adverse Events Committee and Thrombosis Prevention Committee –** received and noted.

- **Any other business** – the report following CQC's inspection of the Trust's Emergency Department in November 2015 was expected to be published week commencing 28 March 2016.

**DATE OF NEXT COMMITTEE MEETING:** 28 April 2016

Dr S Dauncey
29 March 2016