Trust Board paper O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 1 March 2018

COMMITTEE: Quality and Outcomes Committee (QOC)

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

DATE OF COMMITTEE MEETING: 25 January 2018

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 05/18 – Cancer Performance Quarterly Update, and**
- **Minute 15/18 – Imaging Investigation Rejection Working Group.**

DATE OF NEXT COMMITTEE MEETING: 22 February 2018

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, 25 JANUARY 2018 AT 2.30PM 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
Professor P Baker – Non-Executive Director
Mr A Furlong – Medical Director
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman (ex officio)

In Attendance:
Dr D Barnes – Clinical Lead, Cancer Centre (for Minute 05/18)
Mr M Caple – Patient Partner
Ms E Doyle – Interim Chief Operating Officer (until and including Minute 05/18)
Miss M Durbridge – Director of Safety and Risk
Mr M Hotson – Head of Business, Commercial and Contracts (for Minute 16/18)
Mrs S Hotson - Director of Clinical Quality
Mr D Kerr – Director of Estates and Facilities (until and including Minute 9/18 and Minute 16/18)
Dr C Marshall – Deputy Medical Director (for Minute 15/18 and 17/18)
Dr A Rickett – Clinical Director, CSI (for Minutes 15/18 and 17/18)
Ms C Ribbins - Deputy Chief Nurse

RESOLVED ITEMS **ACTION**

01/18 APOLOGIES FOR ABSENCE

Apologies for absence were received on behalf of Ms J Smith, Chief Nurse.

02/18 MINUTES

Resolved – that the Minutes of the meeting held on 21 December 2017 (paper A) be confirmed as a correct record.

03/18 MATTERS ARISING

Paper B detailed outstanding actions from the most recent and previous Quality and Outcomes Committee and Quality Assurance Committee meetings. Members noted the contents of this report.

Resolved – that the action log (paper B), now submitted, be received and noted.

04/18 CARE QUALITY COMMISSION (CQC) INSPECTIONS – UPDATE

Further to Minute 65/17 of 21 December 2017, the Director of Clinical Quality introduced paper C and updated the Committee on:

(a) a summary of the feedback received following the CQC's unannounced inspections at the Trust in November and December 2017;

(b) the Trust's actions and improvement work in place following the CQC's recent Notice in relation the prescription and administration of insulin. The Trust was required to make the improvements by 13 March 2018, further to a which a further CQC review of compliance against the issues relating to insulin was expected, and

(c) the feedback from the CQC's recent well-led review in January 2018. The CQC's final report covering both the unannounced inspection in November 2017 and the well-led report was expected to be released by week commencing 19 March 2018.

A copy of the CQC's latest Insight Report was appended to paper C. In discussion on the specific highlights from appendices B and C, the Committee Chair requested that in future, a summary of significant changes from the CQC's latest Insight Report be provided to the Committee on a monthly basis. **DCQ**

In response to a query from the Patient Partner, the Chief Executive and Deputy Chief Nurse confirmed that the flu vaccination uptake of 77% had been the highest for UHL in recent years. Responding to a further query in respect of the indicator 'Confidence and trust in doctors', the Medical Director advised that the performance outlined in appendix B was based on the CQC's inpatient survey and in respect of national comparison, the Trust was not an outlier.

Resolved – that (A) paper C, updating the Committee on the subject of Care Quality Commission inspections and resulting actions taken in response, be received and noted, and

(B) the Director of Clinical Quality be requested to provide a summary of significant changes from the CQC's latest Insight Report to the Committee on a monthly basis. **DCQ**

05/18 CANCER PERFORMANCE QUARTERLY UPDATE

Dr D Barnes, Clinical Lead, Cancer Centre attended the meeting to present paper D, an overview of the Cancer 62+ day breach findings for quarter 2 of 2017-18 highlighting the individual tumour site data around key themes and actions identified to improve waiting times, where appropriate. In quarter 2 of 2017-18, a total of 158 patients waited over 62 days from referral to first definitive treatment, of these 31 were late tertiary referrals. A number of key themes and contributory factors resulting in the delays had been outlined in paper D. In respect of the factors resulting in avoidable non-clinical delays, actions had been included on the Cancer Recovery Action Plan (RAP). Members noted that the RAP was challenged internally as well as with NHSI and City CCG to ensure a robust approach to performance improvement.

In discussion on one of the key themes, it was suggested that it might be better to allocate a theatre for robotic surgery rather than allocating the robot for a particular specialty each week. The Medical Director, Interim Chief Operating Officer and the Clinical Lead, Cancer Centre were asked to consider: **MD, ICOO, CL, CC**

(a) allocating the robot to a specific theatre, and
(b) whether the utilisation of the current robot was reaching its capacity and whether a second robot was required.

In discussion on improving working practices in relation to tertiary referrals, it was noted that a new Head of the Cancer Alliance had been appointed and she would be

meeting with the Trust's Cancer Leads to take this matter forward. The Clinical Lead, Cancer Centre would be specifically addressing the avoidance of late referrals with the Head of the Cancer Alliance, as part of these discussions. **CL, CC**

In response to a query from the Director of Safety and Risk, it was noted that breach reviews were undertaken for any delays over 62 days and harm reviews were undertaken for delays over 104 days. Members were advised that 62 Day Cancer Breach Thematic Findings and 104 Day Cancer Patient Harm Reviews were required to be reported to the Trust Board.

The Committee Chair requested a quarterly report on Cancer Outcomes and Harms (i.e. Trust's current position including a comparison with peer Trusts and actions being taken to improve standards) with the first draft of the dashboard being presented to the Committee in March 2018. The Medical Director undertook to inform the Committee Chair if this report did not fit in with the current reporting cycles in place. **CL, CC**

<u>Resolved</u> – that (A) paper D, now submitted, setting out cancer 62+day breach findings for quarter 2 of 2017-18 be received and noted;

(B) the Medical Director, Interim Chief Operating Officer and the Clinical Lead, Cancer Centre be requested to consider allocating the robot to a specific theatre and whether the utilisation of the current robot was reaching its capacity and whether a second robot was required; **MD, ICOO, CL, CC**

(C) the Clinical Lead, Cancer Centre be requested to address the avoidance of late referrals with the new Head of Cancer Alliance, and **CL, CC**

(D) the Clinical Lead, Cancer Centre be requested to present a quarterly report to QOC on Cancer Outcomes and Harms (i.e. Trust's current position including a comparison with peer Trusts and actions being taken to improve standards) with the first draft of the dashboard being presented to the QOC in March 2018. **CL, CC**

06/18 MENTAL HEALTH STRATEGY UPDATE

The Deputy Chief Nurse presented paper E which provided an update on the:-

- mental health work being undertaken across the Trust and UHL's strengthened governance arrangements in respect of mental health, including the Trust's Mental Health Board and the establishment of a Mental Health Operational Forum;
- mental health inspector's feedback following the CQC's unannounced inspections at the Trust in November and December 2017;
- joint CQUIN with Leicestershire Partnership Trust (LPT) for mental health patients attending the Trust's Emergency Department;
- bid for wave 2 transformational funding to expand the provision of liaison mental health services;
- winter resilience mental health funding;
- work in progress to develop a Service Level Agreement (SLA) between UHL and LPT for the provision of Medical and Neuro Psychology services. A recent review of this provision had identified a number of concerns which were currently being addressed, and
- ways in which SUIs, complaints and incidents relating to mental health would be monitored.

A further update was requested to be presented to the Committee in March 2018 with an update particularly on whether the Trust was on-track to achieve wave 2 transformation funding and on the SLA as described above.

Resolved – that (A) paper E, now submitted, setting out the mental health work being undertaken across the Trust be received and noted, and

(B) the Deputy Chief Nurse be requested to present a mental health update to the Committee in March 2018 with an update particularly on whether the Trust was on-track to achieve wave 2 transformation funding and on the Service Level Agreement (SLA) between UHL and LPT for the provision of Medical and Neuro Psychology services.

07/18 DERMATOLOGY SERVICES ACTION PLAN

The Medical Director presented paper F and provided a comprehensive update on the background of the Dermatology Service and a summary of the never event review and action plan. It was highlighted that the Service had a significant demand and capacity gap which was currently being reviewed. Responding to a query from Professor P Baker, Non-Executive Director in respect of whether plans were in place for a new Psoralen and Ultraviolet A (PUVA) machine, the Medical Director advised that a Managed Equipment Service would need to be established. He highlighted that initially there were 3 PUVA/B machines - one had been decommissioned as it was no longer fit for purpose, another machine was likely to be decommissioned if it broke-down and the last machine was working.

In discussion on an action in the action plan relating to the non-availability of medical records in dermatology clinics, it was noted that a number of actions had been put in place and a further update on this matter would be provided to the Committee in April 2018. In further discussion on the inherent risk of paper based medical records, the wider issue of resources in medical records and the state of the patient notes, it was noted that one of IM&T's strategies for 2018-19 was to implement paperless records in outpatients. A progress report on availability of medical records in clinics was requested to be provided to the Committee in July 2018.

MD

CD, CSI/GM

Resolved – that (A) paper F, now submitted, describing the never event review in the Dermatology Service and the corresponding action plan be received and noted, and

(B) the Medical Director be requested to provide a further update on non-availability of medical records in dermatology clinics be provided to the Committee in April 2018, and

MD

(C) the Clinical Director, CSI and General Manager be requested to provide a progress report on availability of medical records in clinics (in respect of the inherent risk of paper based medical records) to the Committee in July 2018.

CD, CSI/GM

08/18 COST IMPROVEMENT PROGRAMME 2017-18 QUALITY AND SAFETY IMPACT ASSESSMENT UPDATE

The Committee noted the CIP quality and safety impact assessment update for month 8 of 2017-18 (paper G refers). The Medical Director highlighted that there was currently no schemes that had been identified as having and adverse impact on quality. In respect of 2018-19 CIP planning, for schemes worth over £50,000, key

performance indicators had been identified to monitor both the positive and negative impact on patients. In discussion on a query raised by the Director of Safety and Risk, it was noted that a robust process was in place for monitoring quality and safety impact of CIP schemes, however, it was suggested that further assurance could be provided at a Trust Board Thinking Day on how the Trust was assured that quality and safety was not being compromised.

Trust Chairman

<u>Resolved</u> – that (A) paper G, now submitted, providing an update on the risk and potential impact the CIP might have on quality at the end of month 8 of 2017-18 be received and noted, and

(B) the Trust Chairman be requested to give consideration to scheduling a Trust Board Thinking Day to seek assurance in respect of the processes in place for monitoring quality and safety impact of CIP schemes and that quality and safety was not being compromised .

Trust Chairman

09/18 QUALITY AND OUTCOMES COMMITTEE – ANNUAL WORK PLAN 2017/18

Further to Minute 67/17 of 21 December 2017, the Committee received an updated version of its annual work plan 2017/18 (paper H refers). The Director of Safety and Risk requested that quarterly updates on the Freedom to Speak Up, Safety Walkabouts and Duty of Candour be included onto the work plan. In response, the Director of Clinical Quality undertook to update the work plan.

DCQ

<u>Resolved</u> – that (A) paper H, a revised version of the Quality and Outcomes Committee annual work plan 2017/18, be received and noted, and

(B) the Director of Clinical Quality be requested to update the work plan in light of the amendments suggested above.

DCQ

10/18 SAFETY AND QUALITY OF EMERGENCY CARE

The Medical Director introduced paper I appended to which was a copy of the Emergency Department Quality Scorecard for the period ending 31 December 2017.

Members noted that quality concerns remained around performance against the 4-hour emergency care target, trolley waits, re-attendance rates and ambulance handover times. The Medical Director advised that a review of re-attendance rates would be undertaken in future, when resources improved.

<u>Resolved</u> – that paper I, now submitted, setting out the Emergency Department Quality Scorecard for the period ending 31 December 2017 be received and noted.

11/18 REPORTS FROM DIRECTOR OF SAFETY AND RISK: (1) PATIENT SAFETY REPORT – DECEMBER 2017, (2) COMPLAINTS BRIEFING – DECEMBER 2017 (3) DUTY OF CANDOUR REPORT 2017 AND (4) NEW NHSI NEVER EVENT FRAMEWORK (2018)

The Director of Safety and Risk highlighted a number of key issues which featured in the patient safety and complaints briefing reports (respectively) for December 2017 including:

(a) two serious incidents including one never event had been escalated in December 2017;

(b) importance of all staff following national and local checking processes, the need to improve the quality of clinical documentation and the importance of local leadership for safety , and
(c) an increase in the number of complaints related to cancelled operations which were owing to emergency activity. In response to a query from the Patient Partner in respect of feedback from the Independent Complaints Review Panel in relation to complaint responses, the Director of Safety and Risk advised the feedback was used in training sessions with the PILS team and undertook to further progress this matter with the Patient Partner outwith the meeting.

Members were advised that the Trust was compliant with the statutory requirements for Duty of Candour except for one aspect which was being followed-up with Clinical Management Group colleagues.

The Director of Safety and Risk provided a brief verbal update on the revisions to the Never Events policy and framework and highlighted the following in particular:-
(a) the removal of the option for Commissioners to impose financial sanctions on Trusts reporting never events, and
(b) revisions to the list of never events including two additional types of never events.

<u>Resolved</u> – that paper J now submitted, be received and noted.

12/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT

Paper K, presented by the Deputy Chief Nurse, detailed triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those Wards, triggering Level 1 (14 Wards) and Level 2 (11 Wards) concerns. In November 2017, no Wards had triggered a Level 3 concern. In response to a query from the Patient Partner in respect of Ward 22, LRI featuring as a Level 2 concern ward for a number of months, the Deputy Chief Nurse provided assurance that continued support was being provided to this ward to ensure newly qualified nurses were settling into their role and were completing supernumerary period. The leadership of the ward had also recently been changed.

The Deputy Chief Nurse highlighted in particular:

(a) Registered Nurse vacancies had increased in November 2017 and were reported at 543 WTE, and

(b) Safecare was now implemented across the nursing workforce and had led to much more focus and proactive work across the Trust to ensure staffing levels were safe. The daily staffing meetings provided oversight of staff working in all clinical areas thereby resulting in managing staffing levels appropriately.

<u>Resolved</u> – that paper K, now submitted, detailing triangulated information relating to nursing and midwifery quality of care and safe staffing, be received and noted.

13/18 RETAINED GUIDEWIRE NEVER EVENT

Paper L detailed the investigation report for a never event relating to a retained guidewire in August 2017. The contents of this report were noted.

<u>Resolved</u> – that paper L be received and noted.

14/18 NEVER EVENT ACTION PLAN UPDATE

The Medical Director advised that a Never Event Safety Summit had been set up following a number of never events within the Trust. The Summit had resulted in developing a Never Event Action Plan which was outlined in paper M. A key component of the action plan was the implementation of the new Safer Surgery Policy, supported by a Stop the Line Campaign. The action plan would be monitored as part of the Quality Commitment for 2018-19.

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

15/18 IMAGING INVESTIGATION REJECTION WORKING GROUP

The Clinical Director, CSI attended the meeting to present paper N, a report on the actions taken under the auspices of the Imaging Investigation Rejection Working Group to prevent further occurrences of the rejection of requests for imaging, leading to patient harm. The Working Group had dealt with all the actions within its remit and some actions had been transferred to relevant Committees and increased service engagement had been planned with CCGs. The Committee Chair requested that a list of the non-completed actions and the Committees that would be taking those forward be provided to the Quality and Outcomes Committee, for information. **CD, CSI**

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

(B) the Clinical Director, CSI be requested to submit to the QOC, a list of the non-completed actions on the action plan for the IIRWG and the Committees that would be taking those forward, for information. **CD, CSI**

16/18 FACILITIES UPDATE

Mr M Hotson, Head of Business, Contracts and Commercial attended the meeting to present paper O, a report on the Estates and Facilities performance data for the provision of key services across UHL. The previously reported plateaued performance standards had continued and remained short of overall targets across services apart from Patient Catering. Financial pressures continued to challenge the maintenance of standards and the pace of service development required to progress improvement. Responding to a query from the Committee Chair, the Director of Estates and Facilities undertook to present an updated report on the theatre refurbishment programme to the Committee in February 2018. **DEF**

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

(B) the Director of Estates and Facilities to present an updated report on the theatre refurbishment programme to the Committee in February 2018. **DEF**

17/18 ACTING ON RESULTS QUARTERLY UPDATE

Dr C Marshall, Deputy Medical Director attended the meeting to present paper P , an update on progress against the 2017-18 Quality Commitment to implement revised processes to improve diagnostic results management. The Deputy Medical Director advised that although the Acting on Results programme had made progress in some supporting areas, the main element of developing ICE and using the Mobile Version 7 had been significantly delayed owing to IT issues relating to product configuration. Therefore, a full rollout of Mobile ICE would not be delivered by March 2018 as

previously envisaged. Therefore, for the remainder of 2017-18, focus would now shift to encouraging the changes required to enable Clinicians to file the results on ICE. This would require a detailed communication and engagement plan. CONSERUS (messaging of unexpected findings in radiology) was now operational and being piloted in Respiratory Medicine.

Acting on Results had been included in the first draft of the 2018-19 Quality Commitment to enable this work to continue to fruition. In response to a request to support inclusion of this work into next year's Quality Commitment, the Medical Director noted that one of the IT priorities for 2018-19 was to support the Quality Commitment work streams. The Chief Executive took an action to liaise with the Chief Information Officer in respect of (a) the need for dedicated IT resource to take forward the upgrade to ICE 7 and building an interface between ICE and Patient Centre, (b) on-going resource to resolve issues when the upgraded system was in place, (c) resources required to assist Clinicians to file the results on ICE (which was being done on a temporary basis until the Mobile ICE solution was fixed), and (d) ownership of various IT systems used within the Trust. **CE**

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

(B) the Chief Executive be requested to liaise with the Chief Information Officer in respect of :- **CE**
(a) the need for dedicated IT resource to take forward the upgrade to ICE 7 and building an interface between ICE and Patient Centre;
(b) on-going resource to resolve issues when the upgraded system was in place;
(c) resources required to assist Clinicians to file the results on ICE (which was being done on a temporary basis until the Mobile ICE solution was fixed), and
(d) ownership of various IT systems used within the Trust.

18/18 #NECK OF FEMUR UPDATE

The Medical Director presented paper Q, a report on performance against the agreed standards for operating on patients with fractured neck of femurs within 36 hours of presentation and the challenges that still remained. Although, there had been progress and improvement on a number of issues, sustainability had proven difficult, primarily due to demand and capacity. An action plan had been appended to paper Q.

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

19/18 MINUTES FOR INFORMATION

19/18/1 Executive Quality Board

Resolved – that the action notes of the meetings of the Executive Quality Board held on 5 December 2017 and 9 January 2018 (papers R and R1) be received and noted.

19/18/2 Executive Performance Board

Resolved – that the action notes of the meeting of the Executive Performance Board held on 19 December 2017 (paper S refers) be received and noted.

20/18 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

21/18 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be presented to the Trust Board meeting on 1 February 2018, and

(B) the item of business referred to in Minute 05/18 above - the 62 Day Cancer Breach Thematic Findings and 104 Day Cancer Patient Harm Reviews be highlighted to the Trust Board by the Committee Chair, and

(C) the item of business referred to in Minute 15/18 above - that the Imaging Investigation Rejection Working Group had completed its work and all actions had either been dealt with or had been transferred to existing workstreams, be highlighted to the Trust Board by the Committee Chair, and

22/18 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality and Outcomes Committee be held on Thursday, 22 February 2018 from 1.30pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 4.40pm

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	5	4	75	*B Patel*	5	5	100
P Baker	5	3	60	*K Singh (Ex-officio)*	5	5	1001
I Crowe (Chair)	5	5	100	*J Smith*	5	3	60
A Furlong	5	4	75	*C West – Leicester City CCG*	5	1	20

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	5	3	60	*S Hotson*	5	4	75
M Durbridge	5	3	60	*C Ribbins/E Meldrum*	5	3	60

Non-Voting Members

Hina Majeed
Corporate and Committee Services Officer