Trust Board paper M1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 12 April 2018

COMMITTEE: Quality and Outcomes Committee (QOC)

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

DATE OF COMMITTEE MEETING: 22 February 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 27/18 – the Committee had taken assurance on the work done to improve the Trust's Haemoglobinopathy Service and that the Committee supported the appointment of an additional Consultant (with a specialist interest in red-cell disorders) to provide a sustainable service for patients within LLR and across the South East Midlands.

DATE OF NEXT COMMITTEE MEETING: 29 March 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, 22 FEBRUARY 2018 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
Professor P Baker – Non-Executive Director (until part-Minute 28/18)
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman (ex officio)
Ms J Smith – Chief Nurse

In Attendance:
Ms R Broughton – Head of Outcomes and Effectiveness (for Minute 36/18 on behalf of the Medical Director)
Mr M Caple – Patient Partner
Mrs S Hotson - Director of Clinical Quality
Mr D Kerr – Director of Estates and Facilities (excluding Minute 27/18)
Mr K Mayes – PPI and Membership Manager (for Minute 26/18)
Ms E Meldrum – Deputy Chief Nurse (for Minutes 28/18-30/18 inclusive)
Ms S Nancarrow – Head of Operations, CHUGGS (for Minute 27/18)
Ms C Ribbins - Deputy Chief Nurse
Ms C Rudkin – Senior Patient Safety Manager (on behalf of Director of Safety and Risk)
Ms C West – Director of Nursing, Leicester City Clinical Commissioning Group

RESOLVED ITEMS **ACTION**

23/18 APOLOGIES FOR ABSENCE

Apologies have been received from Miss M Durbridge, Director of Safety and Risk and Mr A Furlong, Medical Director.

24/18 MINUTES

Resolved – that the Minutes of the meeting held on 25 January 2018 (paper A) be confirmed as a correct record.

25/18 MATTERS ARISING

Paper B detailed outstanding actions from the most recent and previous Quality and Outcomes Committee and Quality Assurance Committee meetings. In respect of Minute 05/18 (C), it was noted that the Clinical Lead, Cancer Centre would be meeting with the Head of the East Midlands Cancer Alliance on 6 March 2018 to address the avoidance of late referrals.

In respect of Minute 05/18 (B), the Chief Executive undertook to discuss with Executive colleagues, the action in relation to 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. The Chief Executive agreed to provide a verbal update on this matter at the QOC meeting in March 2018. **CE**

Resolved – that (A) the action log (paper B), now submitted and the verbal

update, be received and noted, and

(B) the Chief Executive be requested to provide a verbal update to QOC in March 2018, further to discussion with Executive colleagues in relation to 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. **CE**

26/18 TRACKING FEEDBACK FROM ENGAGEMENT

Further to Minute 301/17 of Trust Board on 7 December 2017, the Patient and Public Involvement (PPI) and Membership Manager attended the meeting to present paper C, a proposal for the introduction of a tracking process to monitor feedback and actions arising from PPI activity. The proposal was to capture key issues raised through PPI activity in a spreadsheet detailing the issues raised, Trust personnel responsible, the date a response was requested, details of the response received and any actions taken. This tool would generate a RAG rated score against each issue.

The Patient Partner commended the system, however, suggested that in some cases senior staff should take responsibility for providing feedback on a face to face basis. In response to a suggestion in respect of whether the tracking report from feedback should be built-in with the triangulation of patient feedback report that was provided to PIPPEAC, Mr B Patel, Non-Executive Director advised that it might be better that it was a standalone report given that there were a variety of ways in which the Trust engaged with patient representative groups and the wider public. He noted the need for the report to be comprehensive capturing all areas of PPI activity. It was also suggested that a clear structure needed to be in place, acknowledging that the PPI team would be administering the tool, however, ownership needed to be taken by the team where the issues had been raised. Members supported this proposal. It was suggested that updates on the tracking process be taken to PIPEEAC in the first instance and then to EQB, if required and any themes emerging be presented to QOC. The PPI and Membership Manager with support from Ms C Ribbins, Deputy Chief Nurse was requested to explore the best possible approach to report on this matter to the PIPEEAC/EQB/QOC as suggested above. **PPI & MM**

<u>Resolved</u> – that (A) paper C, updating the Committee on the proposal for the introduction of a tracking process to monitor feedback and actions arising from PPI activity, be received and noted, and

(B) the PPI and Membership Manager with support from Ms C Ribbins, Deputy Chief Nurse be requested to explore the best possible approach to report on the tracking process to monitor feedback and actions arising from PPI activity to the PIPEEAC/EQB/QOC. **PPI & MM**

27/18 HAEMOGLOBINOPATHY SERVICE UPDATE

Further to Minute 20/17 of 26 October 2017, the Head of Operations, Cancer, Haematology, Urology, Gastroenterology and General Surgery Clinical Management Group attended and introduced paper D, updating the Committee on a number of actions being taken to improve the Trust's Haemoglobinopathy Service.

The Committee noted the various issues summarised in paper D and was pleased with the progress which had been made to date, noting the need for some issues to be the subject of further work. In particular, the Committee supported the recruitment of an additional Consultant (with a specialist interest in red-cell disorders) to provide a **HoO,**

sustainable service for patients within LLR and across the South East Midlands and limit single handed practice. **CHUGGS**

<u>Resolved</u> – that (A) paper D updating the Committee on actions taken to address a number of areas for improvement relating to the Trust's Haemoglobinopathy Service be received and noted, and

(B) an update report on the development of the service be submitted to the August 2018 Committee meeting. **HoO, CHUGGS**

28/18 REPORTS FROM DIRECTOR OF SAFETY AND RISK: (1) PATIENT SAFETY REPORT – JANUARY 2018, (2) COMPLAINTS BRIEFING – JANUARY 2018, AND (3) PATIENT SAFETY WALKABOUT PROGRAMME UPDATE

The Senior Patient Safety Manager highlighted a number of key issues which featured in the patient safety and complaints briefing reports (respectively) for January 2018 including:

(a) five serious incidents had been escalated in January 2018;
(b) an increase in the number of complaints related to cancelled operations which were owing to emergency activity;
(c) the National Sign Upto Safety Campaign had been developing different ways to enable people to talk to each other about working safely, and
(d) the Corporate Patient Safety Team had undertaken an in-depth analysis of the themes of root causes (rather than incident type), identified from SUI investigation reports. This had revealed some themes that warrant further review to better understand emerging risks and related safety actions.

The Safety Walkabouts report identified that in quarter three of 2017-18, there had been a significant reduction in the number of safety walkabouts that had taken place. There had been no walkabouts to the Alliance or Satellite sites and only one at the Leicester General Hospital site. Members were requested to support the Safety Walkabout Programme with a dedicated commitment to engage with it. In discussion on this matter, members requested that the attendance to the programme be made flexible and the dates be circulated well in advance. **SPSM**

<u>Resolved</u> – that (A) paper E now submitted, be received and noted, and

(B) the Senior Patient Safety Manager to ensure that the attendance to the Patient Safety Walkabout Programme was made flexible and the dates were circulated well in advance. **SPSM**

29/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT

Paper F, presented by the Chief Nurse, detailed triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those Wards, triggering Level 1 (19 Wards) and Level 2 (11 Wards) concerns. In December 2017, one Ward (Ward 39, LRI) had triggered as a Level 3 concern as metrics had not been completed for this ward. Ward 22 LRI was no longer a "worry" ward as a result of many months of focused work on nurse recruitment.

The Chief Nurse highlighted in particular:

(a) Registered Nurse vacancies had increased in December 2017 and were reported at 565 WTE;

(b) Clinical areas across all three sites had been feeling pressured due to increased activity over the winter months and all wards were being closely monitored and supported by the Chief Nurse, Corporate Nursing Team and Heads of Nursing during this period. There was a risk that during these times of pressure, the Trust's newly recruited healthcare assistants, newly qualified and overseas nurses feel unsupported but nurse education teams had been able to work alongside new staff to coach and support them as well as contribute to service delivery;
(c) an open day held on 13 January 2018 had been successful and had resulted in 44 Registered Nurse job offers being made on the day (subject to pre-employment checks);
(d) the second cohort of apprentice trainee nursing associates had been recruited, and
(e) Safecare had now been implemented across the nursing workforce and had led to much more focus and proactive work across the Trust to ensure staffing was safe.

In response to a query from Ms V Bailey, Non-Executive Director, the Chief Nurse confirmed that there were currently no midwifery vacancies in the Trust and a business case was being put in place to increase the midwifery establishment, however, it was challenge to recruit Childrens' nurses and therefore the Trust usually recruited general nurses in paediatrics and provided the appropriate training required. Responding to a query from the Patient Partner, it was noted that sickness absence had increased in the last few months.

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

30/18 PROGRESS REPORT ON INSULIN SAFETY ACTION PLAN

Ms E Meldrum, Deputy Chief Nurse attended the meeting to present paper G, the Trust's response to the CQC's notice issued re: insulin following its November 2017 unannounced inspection. She advised that a significant amount of work had been undertaken in January 2018 to address the concerns raised. The main focus for the Insulin Safety Task and Finish Group had been around the improvement of staff compliance with clinical policies, in particular, the recognition and management of hyperglycaemia and safe insulin prescribing for junior medical staff (and Advanced Clinical Practitioners). Progress was being made in relation to staff knowledge and competence with insulin safety and this should increase further with the introduction of an alternative education package. Mr B Patel, Non-Executive Director suggested that this education package should focus on communicating with diabetic patients who were insulin treated and managed it well. It was noted that the ownership of patients with diabetes treated with insulin was beginning to improve. In response to a further suggestion, it was noted that for patients who preferred to self-administer insulin, an assessment for competency/appropriateness to self-administer their medication would be completed.

These interventions had taken place on the five priority wards highlighted by the CQC, however, key actions would also be delivered to other priority clinical areas in the Trust, i.e. areas that have reported incidences relating to the poor management of hyperglycaemia and/or Diabetic Ketoacidosis (DKA). Members were advised that the EQB had suggested that a proactive approach be taken and information (regarding the actions taken as described above) be shared with the CQC prior to their visit in March 2018.

In response to a suggestion by Ms C West, Director of Nursing & Quality, NHS Leicester City CCG, the Deputy Chief Nurse confirmed that the wider learning and lessons learned from the Insulin Safety Task and Finish Group would be appropriately included in training sessions for pre-registration nurses and medical students.

Resolved – that paper G, now submitted, outlining the Trust's response to the CQC's notice issued re: insulin following its November 2017 unannounced inspection.

31/18 CQC INSPECTIONS UPDATE

The Director of Clinical Quality provided a verbal update advising that the Trust had received the draft CQC inspection reports following their unannounced inspections in November and December 2017 and their well-led review in January 2018. The Trust had been asked by the CQC to check these reports for factual accuracy. The final report was expected to be released by week commencing 19 March 2018.

Resolved – that the verbal update be noted.

32/18 QUALITY COMMITMENT – QUARTER 3 (2017-18) PERFORMANCE REPORT

The Director of Clinical Quality introduced paper H summarising performance as at the end of quarter 3 on the components of the Trust's 2017-18 Quality Commitment.

The Committee noted that paper H included RAG-rated information on performance against the various 2017-18 Quality Commitment work programmes – one programme (insulin priority for 2017-18) had been closed and replaced with a revised Quality Commitment insulin priority for 2018-19, two (Mortality and End of Life Care) rated green, three (Track& Trigger, Anticoagulation and Outpatients) amber and one (Acting on Results) red. Discussions were being held with appropriate colleagues for the provision of project management resource and IT infrastructure support in order to progress some of the priorities which were currently experiencing delays. The Committee noted the current position, current delays and risks to successful achievement of the work programmes as set out in the report. The Committee also discussed the importance of setting appropriate and ambitious Key Performance Indicates (KPIs) for the 2018-19 Quality Commitment.

Resolved – that paper H, updating the Committee on performance against the 2017-18 Quality Commitment as at the end of quarter 3, be received and noted.

33/18 2017-18 QUALITY ACCOUNT

The Director of Clinical Quality advised that paper I was provided to the meeting as a project plan and the first draft of the Quality Account would be presented to the QOC meeting in March 2018. **DCQ**

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

(B) the first draft of the Quality Account be presented to the QOC meeting in March 2018. **DCQ**

34/18 COMPLIANCE ASSESSMENT AND ANALYSIS SYSTEM (CAAS) HIGH LEVEL REPORT

The Director of Estates and Facilities introduced paper J and briefed the Committee on the latest report providing assurance upon the Trust's compliance with Estates and Facilities services' statutory requirements. The Committee noted that the Director of Estates and Facilities' paper was based on information taken from the Trust's Compliance Assessment and Analysis System (CAAS).

The current CAAS position was set out in tables 1 and 2 of the report and the areas for priority action had been identified within section 4 of paper J summarised under the following headings:

- asbestos management;
- fire safety;
- electrical systems;
- mechanical systems;
- sustainability;
- contractor management;
- ventilation, and
- CAAS action plans.

In the CAAS February 2018 review, one field (Asbestos) had scored lower and five fields remained static when compared to the previous quarter. Eleven fields had achieved a higher score. There had been little movement in the 'Sustainability' category since the last review, however, no statutory compliance breaches had been reported. The Committee noted the priority actions as set out in the report and expressed its reasonable assurance on the basis of the information presented.

Resolved – that the Compliance Assessment and Analysis System (CAAS) high level report, now submitted (paper J), be received and noted.

35/18 QUALITY AND OUTCOMES COMMITTEE – ANNUAL WORK PLAN 2017/18

Further to Minute 09/18 of 25 January 2018, the Committee endorsed the updated version of its annual work plan for 2018-19 (paper K refers).

Resolved – that paper K, a revised version of the Quality and Outcomes Committee annual work plan 2018-19, be endorsed.

36/18 MORTALITY REVIEW COMMITTEE/LEARNING FROM DEATHS QUARTERLY UPDATE

The Head of Outcomes and Effectiveness (on behalf of the Medical Director) attended the meeting to present paper L , highlighting that UHL's monthly mortality rate had increased to 1.5% in December 2017 in line with the seasonal variation in December 2016. UHL's latest published SHMI at 100 and HSMR at 99 covered the time period July 2016-June 2017. UHL's HSMR had previously been 'above expected' for two diagnoses and one procedure group related to cardiac disease and detailed reviews had not shown any significant concerns with the service. The Mortality Review Committee also managed UHL's framework for implementing 'Learning from Deaths' which included the Medical Examiner Process, Bereavement Support Service and Specialty Mortality Reviews using the nationally developed Structured Judgement Review (SJR) tool. Recognition of patients at 'end of life' continued to be the main theme identified by the Medical Examiners. In relation to the LLR Clinical Quality Audit, only 11 patients' case notes were now being audited due to the complexity of arranging data sharing agreements and access to the

primary care records.

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

37/18 ITEMS FOR INFORMATION

37/18/1 Actions from the Imaging Investigation Rejection Working Group

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

37/18/2 ED Quality Scorecard

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

37/18/3 Health and Safety Services Quarter 3 (2017-18) Report

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

37/18/4 CQUIN and Draft Quality Schedule Update

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

37/18/5 Quarter 3 (2017-18) Claims and Inquests Update

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

38/18 MINUTES FOR INFORMATION

38/18/1 Executive Quality Board

Resolved – that the action notes of the meetings of the Executive Quality Board held on 9 January 2018 and 6 February 2018 (papers R and R1) be received and noted.

38/18/2 Executive Performance Board

Resolved – that the action notes of the meeting of the Executive Performance Board held on 23 January 2018 (paper S refers) be received and noted.

39/18 ANY OTHER BUSINESS

Resolved – that there were no items of any other business raised at this meeting.

40/18 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 March 2018, and

(B) the item of business referred to in Minute 27/18 above – that the Committee had taken assurance on the work done to improve the Trust's Haemoglobinopathy Service and that the Committee supported the appointment of an additional Consultant (with a specialist interest in red-cell disorders) to provide a sustainable service for patients within LLR and across **Chair**

the South East Midlands.

41/18 DATE OF NEXT MEETING

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

**** Post-Meeting Note – Due to an additional Trust Board meeting on 22 March 2018, the QOC meeting has been postponed by a week. Date of rescheduled meeting – Thursday, 29 March 2018 TBC.**

The meeting closed at 4.17pm

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	6	5	83	*B Patel*	6	6	100
P Baker	6	4	66	*K Singh (Ex-officio)*	6	6	100
I Crowe (Chair)	6	6	100	*J Smith*	6	4	66
A Furlong	6	4	66	*C West – Leicester City CCG*	6	2	33

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	6	4	66	*S Hotson*	6	5	83
M Durbridge	6	3	50	*C Ribbins/E Meldrum*	6	4	66

Non-Voting Members

Hina Majeed
Corporate and Committee Services Officer