University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 4 January 2018

	Trust Board paper I
Report Title:	Quality and Outcomes Committee – Committee Chair's Report (formal Minutes will be presented to the next Trust Board meeting)
Author:	Stephen Ward, Director of Corporate and Legal Affairs

Reporting Committee:	Quality and Outcomes Committee
Chaired by:	Ian Crowe, Non-Executive Director
Lead Executive Director(s):	Andrew Furlong, Medical Director Julie Smith, Chief Nurse
Date of last meeting:	21 December 2017

Summary of key matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 21st December 2017:

- **Safety and Quality of Emergency Care** – the Committee received the Emergency Department Quality Scorecard for the period ending 30th November 2017 and noted performance against the indicators set out therein. The Medical Director undertook to liaise with the Clinical Director and Head of Operations for Emergency and Specialist Medicine to ensure that the written report which accompanied the Quality Scorecard better explained actions taken, and planned, in order to improve performance against the specified indicators; the Committee noted also that it was necessary to specify the target to be achieved in relation to a number of the indicators stated in the Scorecard and the Medical Director undertook to attend to their completion, too, in liaison with colleagues.

- **Freedom to Speak Up** – Ms J Dawson, Freedom to Speak Up Guardian attended the meeting and introduced the latest quarterly Freedom to Speak Up report. The Committee supported the proposal that the Freedom to Speak Up Guardian establish a formal work programme for 2018/19, details of which would be reported to both the Executive Quality Board and Quality and Outcomes Committee in due course. In parallel, the Director of Safety and Risk and the Freedom to Speak Up Guardian agreed to undertake a gap analysis against recommendations made by the National Freedom to Speak Up Guardian following her 2017 case review of speaking up processes, policies and culture at Southport and Ormskirk Hospital NHS Trust. The findings would be reported to both the Executive Quality Board and Quality and Outcomes Committee. The Committee noted that the Freedom to Speak Up Guardian would also submit a report on her work to the Trust Board meeting to be held on 4th January 2018, and attend that meeting.

- **Patient Safety Report** – the Director of Safety and Risk highlighted the high number of 'overdue' incidents reported on the Datix system and the Committee endorsed the actions being taken by the Executive Team to ensure that these were closed in a timely fashion by the Clinical Management Groups. The Committee also noted that it was understood that NHS Improvement would be launching a public consultation on a new serious incident framework in 2018 and, when published, details would be reported to both the Executive Quality Board and the Quality and Outcomes Committee.

- **Nursing and Midwifery Quality and Safe Staffing Report – October 2017** – the Committee noted those wards which had triggered a 'level 2 concern' and 'level 1 concern' in the judgement of the Chief Nurse and Corporate Nursing Team, as set out in paper E. No wards had triggered a 'level 3 concern' in October 2017. Registered Nurse vacancies had remained static at 500 WTE in October 2017; time equivalent to 558 WTE had been worked via bank and agency staff in October 2017. Work continued in an attempt to attract more Registered Nurses/Operating Department Practitioners and support staff to work at UHL, as described in the report. The Chief Nurse also briefed the Committee on the work in hand to take forward the concept of 'Tomorrow's Ward' and noted the involvement of academic institutions to evaluate the Trust's pilot project, complemented by a Listening into Action initiative.

- **Clinical Audit – Quarterly Report** – the Committee received the quarter 2, 2017/18 clinical audit report updating on progress against a range of key indicators. The Medical Director advised that he would ask the Clinical Audit Manager to also present the key information broken down by individual Clinical Management Group, to inform discussions on clinical audit at the monthly Quality and Performance Management meetings held between the Executive Directors and Clinical Management Group Senior Management Teams.

- **Care Quality Commission (CQC) Inspections – Update** – paper G updated the Committee on progress against the Trust's action plan in response to the CQC's comprehensive inspection in June 2016; on the final formal action plan in relation to the CQC's unannounced inspection of wards 42 and 43, Leicester Royal Infirmary, in July 2017; on the feedback received following the CQC's recent unannounced inspections at the Trust in November and December 2017; and on the CQC's recent Notice in relation to the prescription and administration of insulin, and the Trust's actions in response. A copy of the CQC's latest Insight Report was appended to paper G. The CQC's well-led review would take place at the Trust on 10th – 12th January 2018.

- **Schedule of External Visits** – paper H updated the Committee on the current status of completed and forthcoming external visits to the Trust and the associated action plans. The information in question had been reviewed at the December 2017 meeting of the Executive Quality Board and actions had been agreed at that time to ensure that evidence was available of the Trust's response to the recommendations made by a number of external bodies. The Director of Clinical Quality explained that a more user-friendly version of the schedule would be available when the Committee next reviewed the position, at the end of the next quarter.

- **Never Event** – under any other business, the Medical Director reported orally and briefed the Committee on a recent Never Event which had occurred during a gynaecological procedure within Theatres at Leicester General Hospital. Based on early investigation, there did not appear to have been any serious or permanent patient harm, but the matter would be thoroughly investigated in the usual way with findings reported to the Executive Quality Board and Quality and Outcomes Committee in due course. Immediate actions had been taken to reinforce to staff the importance of following the relevant policies and procedures, and a Safety Notice had been circulated widely to Medical and non-Medical staff.

Matters requiring Trust Board consideration and/or approval:

The Committee agreed that the Committee Chair should highlight to the Trust Board the Committee's consideration of the most recent quarterly report from the Freedom to Speak Up Guardian (as referenced above), noting that the Freedom to Speak Up Guardian was also due to submit a report on her work to the Trust Board meeting on 4th January 2018, when this summary would be received.

Matters referred to other Committees:

None

Date of next meeting:	25 January 2018