Trust Board paper O2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 4 October 2018

COMMITTEE: Quality and Outcomes Committee

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

DATE OF COMMITTEE MEETING: 30 August 2018

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

- **Learning from Deaths quarterly report (Minute 136/18)**
- **LLR Clinical Quality Audit (Minute 137/18)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **the CRO outbreak (Minute 142/18)**

DATE OF NEXT COMMITTEE MEETING: 27 September 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 30 AUGUST 2018 AT 1.45PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Ms V Bailey – Non-Executive Director
Mr A Furlong – Medical Director
Ms E Meldrum – Acting Chief Nurse
Mr B Patel – Non-Executive Director

In Attendance:
Dr A Ahmed – Head of Service, Anaesthetics (for Minute 145/18)
Dr D Barnes – Cancer Centre Clinical Lead (for Minute 152/18)
Ms F Bayliss – Deputy Director of Nursing and Quality, Leicester City CCG
Mr M Caple – Patient Partner
Miss M Durbridge – Director of Safety and Risk
Mr O Gabbar – Deputy Clinical Director, Musculoskeletal and Specialist Surgery Clinical Management Group (for Minute 145/18)
Mrs S Hotson - Director of Clinical Quality
Ms H Stokes – Corporate and Committee Services Manager
Mr M Webster – Head of Estates and Property (on behalf of Mr D Kerr, Director of Estates and Facilities) (for Minute 147/18)

RECOMMENDED ITEMS **ACTION**

136/18 LEARNING FROM DEATHS QUARTERLY UPDATE

Appendix 1 of paper G set out UHL's crude and adjusted mortality rates for the first quarter of 2018-19 – the crude mortality rate for that period was 1.1% with no undue variations. UHL's HSMR was 94, and its SHMI 97. The report also updated QOC on UHL's processes for learning from deaths, and advised that 96% all adult deaths had been reviewed by UHL's Medical Examiners in 2017-18. That figure was 94% for quarter 1 of 2018-19, expected to rise to over 95% in quarter 2. As previously reported, the main themes emerging from Medical Examiner (ME) review related to end of life care and communication around DNACPR decisions.

The paper reminded QOC members that where the ME review identified potential for learning, or the bereaved raised concerns about clinical management, cases were referred on for further internal review using the national mortality review template – in 2017-18 9 deaths had been considered to be 'more likely than not' due to problems in care (death classification 1). In a further 27 instances, problems in care had been considered 'unlikely to have contributed to the death' (death classification 2) – those two classifications amounted together to 1.7% of all UHL deaths. The quarterly report also noted the completion of the LLR clinical quality audit by Mazars, as referred to below (Minute 137/18).

The Medical Director welcomed the good progress being made on learning from deaths. Work by the Director of Safety and Risk and the Head of Outcomes and Effectiveness to review how to link appropriately to the Serious Incident process (reflecting recent national guidance), would be incorporated into a future iteration of the report. **MD**

Recommended – that (A) the learning from deaths quarterly update be discussed at the September 2018 Trust Board (appended to the public summary of this QOC meeting), and **MD**

(B) internal work reviewing how to link to the serious incident process be reflected in a future iteration of the learning from deaths quarterly report. **MD**

137/18 LLR CLINICAL QUALITY AUDIT

The Medical Director briefed QOC on the findings of the LLR clinical quality audit (paper H), undertaken as a follow-up to the 2014 Learning Lessons to Improve Care review. The audit findings were also being presented to CCG Boards. As detailed in the clinical quality audit, the quality of care was rated as adequate, good or excellent in 84% of cases – the Medical Director considered that the audit showed that the LLR system had been focusing on the right actions since the Learning Lessons to Improve Care report and was working on the improvements required for patients across LLR. The clinical quality audit contained 23 recommendations, and the Medical Director highlighted the need for a better system response to frail older patients and a need for appropriate, timely interventions. An LLR system-wide action plan had been developed in response to the recommendations.

QOC welcomed this helpful report, noting that the covering sheet and action plan (as now endorsed) would be appended to the public Trust Board QOC summary of this meeting together with a hyperlink to the report in full (including appendices). In response to a query from the QOC Non-Executive Director Chair, the Medical Director advised that the need for wider work re: IT system linkages was now being reviewed by the Director of Strategy and Communications and the Head of Strategic Development. **MD**

<u>Recommended</u> – that (A) the action plan accompanying the LLR clinical quality audit be endorsed and recommend that for Trust Board approval, and **MD**

(B) the LLR clinical quality audit be discussed at the September 2018 Trust Board (appended to the public summary of this QOC meeting). **MD**

<u>RESOLVED ITEMS</u>

138/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr J Adler Chief Executive. Ms F Bayliss, Deputy Director of Nursing and Quality Leicester City CCG, advised that she was now the QOC CCG representative.

139/18 MINUTES

<u>Resolved</u> – that the Minutes of the meeting held on 26 July 2018 be confirmed as a correct record (noting that the Chairman's apologies were already recorded in Minute 118/18).

140/18 MATTERS ARISING

<u>Resolved</u> – that the matters arising log be noted as per paper B.

141/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT – JUNE 2018

The report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a 'level 2 concern' and 'level 1 concern' in the judgement of the Acting Chief Nurse and Corporate Nursing team. Although 1 more ward had triggered a 'level 3' concern in June 2018 than the zero in May 2018, fewer wards had triggered either level 1 or 2 concerns. The Acting Chief Nurse detailed ongoing work to review the structure and function of a number of surgical wards, noting the very challenging casemix in those areas and recognising the pressures upon the service. Progress on this review had been affected by the recent CRO outbreak (Minute 142/18 below refers). Capacity issues continued to be of concern generally (which the Acting Chief Nurse considered was illustrated by the report), and it was recognised that weekends and out-of-hours periods presented particular challenges. QOC agreed with the Acting Chief Nurse that a visible senior/Executive-level presence – both medical and nursing – was invaluable in showing support for staff, especially at night. The Acting Chief Nurse also advised QOC of ongoing measures to maintain and improve hand hygiene on wards.

The Acting Chief Nurse advised that she intended to review the format of the monthly safe staffing report, to ensure that the metrics more closely reflected the physical observation and intelligence data provided to the Corporate Nursing team, and that the nursing vacancy data provided to QOC and the People Process and Performance Committee (PPPC) was appropriately aligned (and reflected all appropriate workforce sectors).

The QOC Chair emphasised the need for momentum in reviewing how establishments were applied in the most appropriate way to meet the needs of the patient and the ward. The QOC Chair also noted the importance of being able to recruit to those establishments, and the Acting Chief Nurse outlined continuing work on different ways of working, including the Tomorrow's Ward initiative. QOC members also commented on the need to review the care environment provided by the Trust, and how this related to the care available to patients once discharged. QOC members queried how the Trust was supporting its staff ahead of winter 2018, and queried whether staff were aware – and able to take appropriate advantage – of the UHL health and wellbeing strategy initiatives available to them. In response to queries from the Patient Partner representative on QOC, the Medical Director advised that UHL's reconfiguration plans would ease pressure on the existing LRI surgical stepdown ward.

<u>Resolved</u> – that an update be sought from NHS Improvement/England on UHL being a "Tomorrow's ward" pilot. **ACN**

142/18 UPDATE ON CARBAPENEM-RESISTANT ORGANISMS (CRO)

A detailed discussion took place on the CRO outbreak within the Trust, noting the background to the outbreak, the measures in place and the actions taken to manage the situation. The outbreak had been included on the Trust's risk register, as appropriate. Taking assurance from Public Health England's positive feedback on UHL's management of the outbreak, QOC noted that this issue would also be covered in the Chief Executive's monthly report to the September 2018 Trust Board. A detailed report would be provided to EQB and QOC once the outbreak was declared closed.

ACN

ACN

In response to a query from the Trust Chairman, the Acting Chief Nurse confirmed that Estates and Facilities colleagues were closely involved in managing the outbreak and delivering the action plan. Noting comments from the Patient Partner representative, the Acting Chief Nurse advised that precautionary advice given to patients and visitors might vary depending on specific clinical circumstances. Stringent hand hygiene and use of personal protective equipment requirements had been reiterated to staff, and the Trust's Infection Prevention and microbiology teams had been available to provide expert and professional advice to wards on a daily basis. In further discussion, QOC commented on the scope for wider academic learning elsewhere from UHL's handling of the outbreak.

ACN

<u>Resolved</u> - that (A) an update on the CRO outbreak be included in the Chief Executive's monthly report to the September 2018 Trust Board; **ACN**

(B) a detailed report be provided to EQB and QOC once the CRO outbreak was declared closed, and **ACN**

(C) consideration be given to the scope for wider academic learning (elsewhere) from UHL's handling of the CRO outbreak. **ACN**

143/18 REPORT FROM THE DIRECTOR OF SAFETY AND RISK

Paper D from the Director of Safety and Risk provided updates on (i) the updated never event action plan; (ii) safety governance and culture; (iii) capillary blood gas reporting; (iv) 2017-18 Serious Incident themes; (v) the patient safety report for July 2018; (vi) the complaints performance report for July 2018, and (vii) safety walkabouts.

The patient safety report for July 2018 set out an assessment of UHL's position and practices in relation to the findings of the January 2018 national independent review of Liverpool Community Health NHS Trust. The QOC Chair welcomed this information and noted that despite the

assurance provided by that assessment, UHL was not complacent and was reviewing any interventions thought necessary – a further update on that work would be provided to the September 2018 QOC. **DSR**

Although noting progress on Never Events (none in either July 2018 or August 2018 to date), the Patient Partner representative on QOC queried how Patient Partners could play a more proactive role in gauging awareness of Never Events. In response, the Director of Safety and Risk confirmed that she would forward a copy of the Never Events walkabout template to the Patient Partner representative, noting that Executive Directors had committed to undertaking 2 such walkabouts. A copy of the Never Event poster was also included in the report at paper D. **DSR**

With regard to the themes from the complaints performance report for July 2018, QOC sought assurance that appropriate processes/triggers were in place across elective specialties to flag multiple cancellations and ensure that patients were appropriately followed up – assurance would be sought accordingly from the Director of Performance and Information. **DSR**

In further discussion, the Director of Safety and Risk confirmed that the capillary blood gas reporting issue had now been resolved.

Resolved – that (A) the previously-agreed review of UHL arrangements re: the Gosport document also now incorporate the findings from the national independent review of Liverpool Community Health NHS Trust – outcome of that review to be reported to the September 2018 QOC; **DSR**

(B) a copy of the Never Events walkabout template be provided to the Patient Partner representative on QOC, and **DSR**

(C) assurance be sought from the Director of Performance and Information that appropriate processes/triggers were in place across elective specialties to flag multiple cancellations and ensure that patients were appropriately followed up. **DSR**

144/18 ACTING ON RESULTS UPDATE

Although noting the Medical Director's comments that paper E was for noting only (and his confirmation that the Acting on Results work formed part of the wider e-hospital project reported to the People, Process and Performance Committee), the QOC Chair reiterated his wish for this item to remain on the QOC agenda. The next quarterly update would therefore be provided as scheduled in November 2018. **MD**

Resolved – that the acting on results work continue to be reported to QOC on a quarterly basis. **MD**

145/18 FRACTURED NECK OF FEMUR UPDATE

Mr O Gabbar, Deputy Clinical Director Musculoskeletal and Specialist Surgery (MSS), and Dr A Ahmed, Head of Service for Anaesthetics, attended to update QOC on plans to improve performance within the fractured neck of femur service, recognising the very significant challenges faced by that service (paper F). They considered that the care pathway itself was appropriate, and that a clinically-owned plan jointly between MSS and the Critical Care, Theatres, Anaesthetics, Pain Management and Sleep [ITAPS] Clinical Management Group – with dedicated and consistent input – was crucial to improving performance. The Head of Service Anaesthetics also commented on the need for appropriate ED input, and noted the challenges in providing a 24/7 service when working cross-site. A 2-week pilot would begin in October 2018 providing more anaesthetics and surgical continuity, and looking to run longer weekend operating sessions than was currently the case. To further change mindsets, the Medical Director noted a recent decision to treat fractured neck of femur patients as emergencies, which was welcomed. In response to a CCG query, the Deputy Clinical Director MSS advised that 90% of cases were undertaken by the time the 48 hours reporting metric applied.

QOC recognised the need for a cultural and behavioural change, supported the actions outlined,

and emphasised the need for any solution to be a sustainable one. The Trust Chairman considered that the proposed pilot would be a useful model in moving away from silo working, and the Medical Director advised that fractured neck of femur performance was discussed at the performance review meetings for both MSS and ITAPS Clinical Management Groups.

A detailed progress report on the actions outlined would be provided to both the Executive Quality Board and QOC in October 2018. **MD**

<u>Resolved</u> – that a detailed progress report on the actions planned be provided to the October 2018 EQB and QOC. **MD**

146/18 UHL QUALITY COMMITMENT – QUARTER 1 POSITION

The Director of Clinical Quality advised that a simplified RAG rating was now in place in the 2018-19 Quality Commitment (paper I), which included a look-forward to likely year-end delivery. The QOC Chair commented on the number of red and amber ratings – although acknowledging this point the Director of Clinical Quality emphasised the need to look at the year-end forecast as well as the current quarter 1 position. QOC also noted that the Strategy team was providing additional support for a number of Quality Commitment workstreams, including the Stop the Line project; improving patient involvement in care and decision-making; embedding Red2Green methodology and senior clinician-led daily ward/board rounds, and improving the management of diabetic patients treated with insulin in all UHL areas. The Medical Director commented that UHL's existing change resource was relatively light.

<u>Resolved</u> – that the position be noted.

147/18 COMPLIANCE ASSESSMENT AND ANALYSIS SYSTEM (CAAS)

The Head of Estates and Property attended to introduce the high-level overview for the CAAS metrics across a range of KPIs for estates and facilities, noting that CAAS supported both the NHS Premises Assurance Model (PAM) and the mandatory annual Estates Return Information Collection (ERIC). The position was reviewed each month by the Facilities team, as part of the overall assurance process. In discussion, QOC voiced concern over a number of fire safety issues where 'non-conformance' was indicated, and requested that a view be sought from the Director of Estates and Facilities on the particular issue of independent Board assurance re: fire management, to clarify what was required. In response to a further query from the Medical Director, the Head of Estates and Property also outlined the challenges facing Fire Officer recruitment, given the small pool of appropriate professionals. He noted, however, the good progress made on internal fire warden training. **HE&P**

QOC also noted the need for appropriate discussion of the CAAS report by Executive groups such as the Health and Safety Committee prior to QOC review. Although circulated for the August 2018 EQB meeting, it had been as an item for noting rather than for substantive discussion. Non-Executive Directors suggested it would be helpful to receive further assurance from the Director of Estates and Facilities that the fire safety assessment undertaken following the Grenfell Tower tragedy had not changed. Although noting the high-level nature of the report (as now explained by the Head of Estates and Property), the QOC Chair agreed to contact the Director of Estates and Facilities outside the meeting to discuss its format and purpose on the QOC agenda, noting QOC's view that the report should also outline intended solutions to any identified challenges. **QOC CHAIR** **QOC CHAIR**

<u>Resolved</u> – that (A) a view be sought from the Director of Estates and Facilities on the particular 'non-conformance' issue of independent Board assurance re: fire management, to clarify what was required on that issue; **HE&P**

(B) assurance be sought from the Director of Estates and Facilities that the fire safety assessment undertaken (re: UHL) following the Grenfell Tower tragedy had not changed, and **QOC CHAIR**

(C) discussions take place with the Director of Estates and Facilities outside the meeting re: the format of CAAS report and its purpose on the QOC agenda, noting QOC's view that **QOC**

the report should also outline intended solutions to any identified challenges. **CHAIR**

148/18 REPORT FROM THE DIRECTOR OF CLINICAL QUALITY

Resolved – that this item be classed as confidential and taken in private accordingly.

149/18 CARE QUALITY COMMISSION (CQC) ACTION PLAN

The Director of Clinical Quality updated QOC regarding 2 outstanding issues on the CQC action plan, acknowledging that there was further work to do on the issue of Deprivation of Liberty Safeguards – this was a national issue, however. With regard to the second outstanding issue, QOC noted that the updated Interpreting and Translation Policy was scheduled for review at the September 2018 Policy and Guideline Committee. QOC received assurance that no actions on the CQC action plan were closed unless there was appropriate supporting evidence accompanying them.

The CQC Insight report in its entirety was appended to paper L, and QOC suggested that it would be helpful for future iterations of the action plan update to advise whether any listed changes in UHL's position against the CQC Insight indicators were as anticipated. The Trust Chairman noted that the Trust Board was also focusing on how to progress from 'requires improvement' to 'good', through discussion at the monthly Trust Board thinking days. **DCQ**

Resolved – that future iterations of the CQC action plan specify whether any listed changes in UHL's position against the CQC Insight indicators were as anticipated. **DCQ**

150/18 CLINICAL AUDIT QUARTERLY UPDATE – 2018-19 QUARTER 1

In response to a query from the QOC Chair, it was confirmed that quarter 1 clinical audit progress for 2018-19 was on track. QOC noted a slight shift in focus, with the Trust's clinical audit team also now becoming more involved in quality improvement projects. The QOC Chair received assurance that the Clinical Audit Improvement Awards would be appropriately publicised.

Resolved – that the position be noted.

151/18 SCHEDULE OF EXTERNAL VISITS

Paper N comprised a RAG-rated report on external visits. Given that the previously-identified issues persisted, the QOC Chair requested that a member of the Estates team be involved in the forthcoming LRI aseptic suite visit, to clarify the storage constraints. The QOC Chair also emphasised the need to mitigate known non-compliance issues as far as possible ahead of such visits. **DCQ**

Resolved – that the Estates team be appropriately involved in the forthcoming LRI aseptic suite visit, to clarify the storage constraints. **DCQ**

152/18 CANCER QUALITY OUTCOMES DASHBOARD PROPOSAL

Further to Minute 79/18/2 of 24 May 2018, Dr D Barnes UHL Cancer Centre Clinical Lead introduced the updated cancer quality outcomes dashboard (paper O), now reworked to align more closely to the format of the CQC Insight report. In response to a query from the QOC Non-Executive Director Chair, the UHL Cancer Centre Clinical Lead advised that no 'unknowns' had emerged through the dashboard (which was welcomed). The dashboard also indicated a number of areas where UHL was performing better than the national average. QOC noted, however, that the national drive to increase cancer referrals was likely have a significant activity impact on UHL.

Although welcoming the dashboard, QOC agreed that further work was needed to understand the data in terms of UHL's underlying performance – the author agreed that trend information would be key to this, and noted his intention to include UHL's interquartile position in the end of year

iteration (to be presented to the May/June 2019 QOC once available). In response to a query from the Patient Partner representative on QOC, the Medical Director agreed to consider the most appropriate way in which to share such data with patient groups, noting the need to include appropriate explanatory context and narrative. **CCCL** **MD**

<u>Resolved</u> – that (A) UHL's interquartile position (for the main tumour sites) be included in the end of year iteration of the dashboard, to be presented to the May/June 2019 QOC (once available), and **CCCL**

(B) consideration be given to the most appropriate way in which to share such data with patient groups, noting the need to include appropriate explanatory context and narrative. **MD**

153/18 QUALITY AND OUTCOMES COMMITTEE – ANNUAL WORKPLAN 2018-19

<u>Resolved</u> – that the latest iteration of the QOC workplan 2018-19 be noted.

154/18 MINUTES FOR INFORMATION

<u>Resolved</u> – that the following Minutes be noted for information:-
(A) Executive Quality Board Minutes from 3 July 2018 and actions from 7 August 2018 (papers Q1 and Q2), and
(B) Executive Performance Board Minutes from 24 July 2018 (paper R).

155/18 ANY OTHER BUSINESS

There were no other items of business transacted at the meeting.

156/18 IDENTIFICATION OF KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

<u>Resolved</u> – that the following issues be highlighted to the September 2018 Trust Board via the public summary of this QOC meeting:- **QOC CHAIR/ CCSM**
(1) Learning from deaths quarterly report (Minute 136/18 – recommended item);
(2) the LLR clinical quality audit (Minute 137/18 – recommended item), and
(3) the CRO outbreak (Minute 142/18).

157/18 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality and Outcomes Committee be held on Thursday 27 September 2018 from 1.15pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

<u>The meeting closed at 4.40pm</u> Helen Stokes – **Corporate and Committee Services Manager**

Cumulative Record of Members' Attendance (2018-19 to date):
Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	5	2	40	A Furlong	5	5	100
V Bailey	5	5	100	E Meldrum	5	5	100
P Baker	5	2	40	B Patel	5	5	100
I Crowe (Chair)	5	5	100	K Singh *(Ex-officio)*	5	2	40
				C West – Leicester City CCG	5	0	0

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	5	4	80	S Hotson	5	4	80
M Durbridge	5	5	100	C Ribbins	5	2	40