Trust Board paper P1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 June 2018

COMMITTEE: Quality and Outcomes Committee (QOC)

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

DATE OF COMMITTEE MEETING: 26 April 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 67/18 – the Committee Chair to report to the Trust Board that:-
the CQC action plan had been submitted to CQC on 11 April 2018 and would be shared with the CCGs and NHS Improvement on 26 April 2018.

DATE OF NEXT COMMITTEE MEETING: 24 May 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, 26 APRIL 2018 AT 10:00AM 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 (from Minute 62/18 to Minute 64/18)
Ms V Bailey – Non-Executive Director
Professor P Baker – Non-Executive Director (until Minute 65/18)
Mr A Furlong – Medical Director
Ms E Meldrum – Acting Chief Nurse
Mr B Patel – Non-Executive Director
Mr M Traynor – Deputy Trust Chairman (on behalf of Trust Chairman (ex officio))

In Attendance:
Ms J Ball – Assistant Chief Nurse (for Minute 62/18)
Mr M Caple – Patient Partner
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson - Director of Clinical Quality
Mr J Jameson – Deputy Medical Director (for Minute 62/18)
Mr D Kerr – Director of Estates and Facilities
Ms P Kuchhadia – Clinical Facilitator (for Minute 62/18)
Mr W Monaghan – Director of Performance and Information (for Minute 61/18/1)
Ms K Ward – Matron, Clinical Informatics (for Minute 62/18)

RESOLVED ITEMS **ACTION**

59/18 APOLOGIES FOR ABSENCE

Apologies have been received from Ms C Ribbins, Deputy Chief Nurse and Mr K Singh, Chairman (ex officio) and Ms C West, Director of Nursing, Leicester City Clinical Commissioning Group.

60/18 MINUTES

Resolved – that the Minutes of the meeting held on 29 March 2018 (papers A1 and A2) be confirmed as a correct record.

61/18 MATTERS ARISING

Paper B detailed outstanding actions from the most recent and previous Quality and Outcomes Committee (QOC) meetings. In respect of Minute 40/17 (B) of 30 November 2017, it was noted that a presentation on the Nerve Centre Sepsis Track and Trigger Tool had been scheduled for the QOC meeting that day as it was not proving possible to schedule it at a Trust Board Thinking Day session. Therefore, this action could be marked as closed.

Resolved – that the action log (paper B), now submitted be received and noted and Minute 40/17 (B) be marked as 'closed' as per verbal update provided above. **CCSO**

61/18/1 Planned Care Programme Progress Update – Rollout of PRISM (Minute 221/17/1 of Trust Board on 7 September 2017)

The Director of Performance and Information attended the meeting to present paper C and advised that significant progress had been made on the PRISM pathway and the Approved Referral Pathways (ARPs). Although engagement with clinical teams had been generally good, the current emergency pressures had resulted in some delay in focussing on PRISM pathways. Project management support was being refocused to provide support. The full roll-out of PRISM across all Specialties had initially been planned to be completed by end of March 2018, however, this had now been extended into quarter 1 of 2018-19. In relation to ARPs (formerly known as 'Procedures of low clinical value' (PLCV)), the Planned Care team had been working with Primary Care, Public Health and Clinicians across LLR Clinical Commissioning Group (CCG) in respect of reviewing existing policies. LLR CCG would be commencing a 12 week public engagement process in respect of ARPs. The Committee thanked the teams for the work that had been done to date. The communications strategy in respect of the ARPs would be taken forward by the LLR CCG.

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

62/18 PRESENTATION OF NERVE CENTRE SEPSIS TRACK AND TRGGER TOOL

Mr J Jameson, Deputy Medical Director, Ms J Ball, Assistant Chief Nurse, Ms K Ward, Matron, Clinical Informatics and Ms P Kuchhadia, Clinical Facilitator attended the meeting to give a presentation on the sepsis track and trigger tool. Following the presentation, members commended the intuitive sepsis track and trigger tool noting that the Trust would be in a much better position to monitor real-time performance once it was rolled-out. This tool was already 'live' in haematology and oncology wards. The tool would imminently be rolled out in the Glenfield hospital alongside the diabetes tool and thereafter to the Leicester Royal Infirmary and Leicester General Hospital respectively. It was noted that UHL was the first Trust to roll-out the sepsis tool and the ability to do it at pace was due to bringing IT expertise in-house. Responding to a query, members were advised that once there was full assurance in respect of the electronic sepsis tool, the manual sepsis forms would be removed from clinical areas, however, some manual forms would need to be kept as a 'back-up'. An appropriate communications plan was in place prior to the roll-out of the sepsis tool.

Resolved – the presentation and verbal update be received and noted.

63/18 ACTING ON RESULTS UPDATE

The Medical Director presented paper D and advised that in respect of implementing a system to improve diagnostic results management, the requirement of input from IT to upgrade ICE before further development could take place had delayed the project considerably. However, upgrade of ICE to the latest version was now taking place. A pilot of Conserus (alert email to Clinician for unexpected imaging results) had gone-well and the go-live date for all Specialities had been set for 14 May 2018.

Resolved – that paper D updating the Committee on the Acting on Results project be received and noted.

64/18 REPORTS FROM THE DIRECTOR OF SAFETY AND RISK: (1) PATIENT SAFETY REPORT – MARCH 2018, (2) COMPLAINTS BRIEFING – MARCH 2018, AND, (3) DUTY OF CANDOUR REPORT

The Director of Safety and Risk introduced the patient safety and complaints briefing reports for March 2018 and the duty of candour report as detailed in paper E. She

reported that in 2017-18, there had been a rise in harm events mainly in those incidents graded as moderate harm. Following an in-depth review of the harms, it had been concluded that a change in the way a specific type of incident was 'graded' accounted for the majority of this increase in comparison to 2016-17. The quarter 4 data was currently being validated and it was reported that it was highly unlikely that there would be any reduction in harm events with or without the Post-Partum Haemorrhage (PPH) incidents in the numbers as aimed for within the Trust's Quality Commitment 2017-18. This outcome should be considered against a considerable fall in harm events achieved over the past three years. Ms V Bailey, Non-Executive Director noted that the number of never events at UHL was being compared with peer Trusts and commented that it was important that genuine learning was derived from never events and that the numbers should not be accepted as a 'norm'.

There had been two SIs in March 2018 which were both never events and a further never event in April 2018 was reported to the Committee by the Medical Director. The Medical Director provided comprehensive detail on the background and actions taken following the never event in respect of unintentional connection of a patient requiring oxygen to an air flow meter when the intention was to connect them to an oxygen flow meter. The never event action plan was being reviewed and would be presented to the Committee in May 2018. **DSR**

There continued to be an increase in the number of complaints related to cancelled operations/appointments, inappropriate/unsafe discharge which was due to emergency activity and bed pressures. In discussion on the concerns relating to patients discharged in advance of TTOs being dispensed, and in some cases in advance of TTO being prescribed, the Committee noted the need for focussed work to identify solutions to the issues raised and the need to maintain safe discharge and the Committee Chair undertook to take this forward with appropriate colleagues outside the meeting. *(Post meeting note: The Chairman had requested a report on the 'safety of discharges' to be presented to EQB and QOC in June 2018.)* **Chair**

There had been a rise in complaints related to ED in March 2018. In relation to the increase in complaints related to the Neurology service, a deep-dive on the issues was being undertaken and an update would be presented to the Committee in due course. **DSR**

The Committee noted areas of challenge from a safety perspective in the judgement of the Director of the Safety and Risk which were particularly in relation to workforce (numbers and skill-mix) and IT system issues. Responding to a query from the Patient Partner on staff morale, it was noted that the 2017 National NHS Staff Survey results were now available and the national results demonstrated a service under strain with staff reporting that they were working under increased pressure and felt less able to deliver a good quality service. It was agreed that the 2017 National NHS Staff Survey results should be circulated to all Patient Partners. **ADWOD**

The Duty of Candour (DoC) quarterly update compliance showed that the Trust was meeting the requirements of DoC. For 2018-19, there would be more robust monitoring of the timeframe between incident grading and DoC full compliance and new escalation of poor performance to reduce gaps in evidence being left open.

The National and Reporting and Learning System (NRLS) guidance required all hip fractures caused by falls in hospital to be reported as major harm and this should not be dependent on the circumstances of the fall. Currently in respect of reporting hip fractures, UHL adjusted the level of harm according to the circumstances of the fall. The Trust needed to fall in line with NRLS recommendations and with effect from 1 April 2018, all falls that resulted in hip fracture would be graded as major harm. Members noted that this would essentially increase the UHL figure for major harms

and therefore would need to be acknowledged in the harms reduction work going forward.

Resolved – that (A) paper E now submitted, be received and noted; **DSR**

(B) the revised Never Event Action Plan be presented to the QOC meeting in May 2018; **DSR**

(C) an update following a deep-dive on the issues in the Neurology Service (as there had been an increase in complaints) be presented to the Committee in due course;

Chair

(D) the Committee Chair be requested to discuss with appropriate colleagues outwith the meeting in respect of the need to identify solutions to maintain safe discharge particularly in relation to concerns relating to patients discharged in advance of TTOs being dispensed, and in some cases in advance of TTOs being prescribed, *(Post meeting note: The Chairman had requested a report on the 'safety of discharges' to be presented to EQB and QOC in June 2018.)*, and **ADWOD**

(E) the Acting Director of Workforce and Organisational Development be requested to circulate the 2017 National NHS Staff Survey results to all Patient Partners.

65/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT

Paper F, presented by the Acting Chief Nurse, detailed triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those Wards, triggering Level 1 (15 Wards) and Level 2 (12 Wards) and Level 3 (2 wards) concerns. The two wards which triggered a 'level 3 concern' (wards 17 and 18, LRI) were because metrics had not been completed. It was reported that as part of a clinical quality visit by Commissioners, the Infectious Diseases Unit (IDU) had been highlighted as an area of concern in relation to the poor clinical handover and care of a patient with diabetes transferring from IDU to another medical ward. This ward was now receiving intense support in relation to these areas of concern. The Registered Nurse Vacancies had decreased in month and were reported at 552 WTE. It was noted that hand hygiene compliance had reduced across a number of areas in the Trust. It was suggested that consideration be given to a different way to describe a 'worry' ward. As part of International Nurses Day on 12 May 2018, the Acting Chief Nurse advised that work was in progress to celebrate the contribution that nurses made and requested colleagues support in meeting and distributing gifts to nursing staff on Friday, 11 May 2018. **ACN**

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

(B) the Acting Chief Nurse be requested to give consideration to a different way to describe a 'worry' ward. **ACN**

66/18 PROGRESS REPORT ON INSULIN SAFETY ACTION PLAN

The Acting Chief Nurse presented the Trust's insulin safety action plan (paper G refers) in response to the warning notice issued by the CQC re: insulin following its November 2017 unannounced inspection. She advised that although many actions had been completed to improve insulin safety, sustaining and embedding

improvements was needed and some actions would continue to be closely monitored Corporately. There had been inconsistencies around prescribing and titration of PRN insulin doses and recognising when specialist diabetes referrals/interventions were needed. The insulin safety dashboard and Quality Commitment would continue to provide the Trust with an oversight of insulin safety. The Quality Commitment priority linked to insulin safety for 2018-19 aimed to improve management of diabetic patients who are treated with insulin in all areas of the Trust. The KPIs would be the same as the insulin safety dashboard for ease and consistency in reporting. The Trust had participated in a 'Getting it Right First Time' (GiRFT) review for Diabetes on 25 April 2018. The visit was generally positive with recommendations around coding, diabetes foot pathway, workforce requirements, re-admissions following hypoglycaemia, admission avoidance pathways for patients with diabetes and need to review length of stay for some patient pathways. UHL had also signed up to a national Quality Improvement Collaborative looking at opportunities to focus on improving the timely administration of insulin specifically on wards 42 and 43 at the LRI. Responding to a query, it was noted that five key metrics to monitor insulin safety had been agreed by the UHL Insulin Safety Task and Finish Group and would be presented in the form of a RAG rated dashboard from May 2018. It was also suggested that support from the Leicester Diabetes Centre should be sought for improving clinical practice in respect of diabetes management. **ACN**

<u>Resolved</u> – that (A) paper G, now submitted, outlining the Trust's response to the CQC's notice issued re: insulin following its November 2017 unannounced inspection be received and noted, and

(B) the Acting Chief Nurse be requested to seek support from the Leicester Diabetes Centre for improving clinical practice in respect of diabetes management. **ACN**

67/18 CQC ACTION PLAN

The Director of Clinical Quality presented paper H which provided an action plan (following the CQC inspection reports in respect of their unannounced inspections in November and December 2017 and their well-led review in January 2018) addressing the CQC's 'MUST DO' (59) actions and 'SHOULD DO' (62) actions. The action plan had been submitted to the CQC on 11 April 2018 and would be shared with the CCGs and NHS Improvement on 26 April 2018. An Executive Lead and Senior Responsible Officer had been assigned to each CQC compliance action. Subsequent reports to the Executive Quality Board and the Quality and Outcomes Committee would include a RAG rating indicating whether the action was complete (with evidence), complete (without evidence), overdue, or due in the future.

In a separate discussion, it was suggested that the Patient Partners drew out some themes from the CQC report and provide an update to QOC in due course on how to improve as an organisation. Patient Partners would be involved in future discussions on moving the Trust's overall rating from "requires improvement" to "good". **PP/DCQ**

<u>Resolved</u> – that (A) the contents of paper H be received and noted, and

(B) Mr M Caple, Patient Partner to arrange a meeting (with support from the Director of Clinical Quality and PPI& Membership Manager) with all Patient Partners to draw out some themes from the CQC report and provide an update to QOC in due course on how to improve as an organisation. **PP/DCQ**

68/18 SCHEDULE OF EXTERNAL VISITS

Paper I, presented by the Director of Clinical Quality, updated the Committee on external visits undertaken at the Trust and the status of action plans formulated by the Trust in response to such visits. The information in question had been reviewed at the April 2018 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. In discussion on the East Midlands Specialist Pharmacy Services / Quality Assurance review of the LRI Aseptic Unit in 2017 which had been RAG rated 'red', the Chief Executive advised that at a recent Capital Group meeting, the Estates Team had undertaken to review the capital works and funding required relating to storage facilities for the aseptic preparation unit.

Resolved – that paper I, now submitted, updating the Committee on the current status of completed and forthcoming external visits to the Trust and the associated action plans, be received and noted.

69/18 QUALITY AND OUTCOMES COMMITTEE – ANNUAL WORK PLAN 2018-19

The Committee received the draft version of the annual work plan for 2018-19 (paper J refers). Given the increase in the number of MRSA bacteraemias reported, the Committee Chair noted the need for an Infection Prevention (IP) assurance report (detailing the themes emerging and the actions being taken) to be presented to EQB and QOC in June 2018 and confirmation be provided in respect of when the IP annual report would be available. **ACN**

Resolved – that (A) paper J, the Quality and Outcomes Committee annual work plan for 2018-19 be noted, and

(B) an Infection Prevention (IP) assurance report (detailing the themes emerging and the actions being taken) be presented to EQB and QOC in June 2018 and confirmation be provided in respect of when the IP annual report would be available. **ACN**

70/18 ITEMS FOR INFORMATION

70/18/1 ED Quality Scorecard

In response to a query from the Medical Director, the Committee agreed that the ED Quality Scorecard was no longer required and it be considered as part of winter planning and be commenced again next winter, as appropriate.

Resolved – that the contents of paper K be received and noted and the verbal update be noted.

71/18 MINUTES FOR INFORMATION

71/18/1 Executive Quality Board

Resolved – that the actions from the meeting of the Executive Quality Board held on 3 April 2018 (paper L) be received and noted.

71/18/2 Executive Performance Board

Resolved – that the action notes of the meeting of the Executive Performance

Board held on 20 March 2018 (paper M) be received and noted.

72/18 ANY OTHER BUSINESS

72/18/1 Hepatitis C Network and Childrens' Critical Care Transport Service Peer Reviews

The Chief Executive reported that there was overall positive feedback following both these peer reviews.

Resolved – the verbal update be noted.

73/18 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 3 May 2018, and

(B) the item of business referred to in:-
Minute 67/18 above – the Committee Chair to report to the Trust Board that:- the CQC action plan had been submitted to CQC on 11 April 2018 and would be shared with the CCGs and NHS Improvement on 26 April 2018. **Chair**

74/18 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality and Outcomes Committee be held on Thursday, 24 May 2018 from 1.15pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 4:00pm

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	1	1	100	E Meldrum	1	1	100
V Bailey	1	1	100	*B Patel*	1	1	100
P Baker	1	1	100	*K Singh (Ex-officio)*	1	0	0
I Crowe (Chair)	1	1	100	*C West – Leicester City CCG*	1	0	0
A Furlong	1	1	100				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	1	1	100	*S Hotson*	1	1	100
M Durbridge	1	1	100	*C Ribbins*	1	0	0

Hina Majeed
Corporate and Committee Services Officer