University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 3 May 2018

	Trust Board paper M
Report Title:	Quality and Outcomes Committee – Committee Chair's Report (formal Minutes will be presented to the next Trust Board meeting)
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Reporting Committee:	Quality and Outcomes Committee (QOC)
Chaired by:	Ian Crowe, Non-Executive Director
Lead Executive Director(s):	Andrew Furlong, Medical Director Eleanor Meldrum, Acting Chief Nurse
Date of last meeting:	26 April 2018

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 26 April 2018:

- **Rollout of PRISM** – the Director of Performance and Information advised that significant progress had been made on the PRISM pathway and the Approved Referral Pathways (ARPs). 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 CCGs in respect of reviewing existing policies. LLR CCGs 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.

- **Nerve Centre Sepsis Track and Trigger Tool Presentation** – 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.

- **Acting on Results Update** – the Medical Director 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.

- **Patient Safety Report –** the Director of Safety and Risk 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. 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 never event action plan was being reviewed and would be presented to the Committee in May 2018. 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. 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. Responding to a query 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. 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 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.

- **Nursing and Midwifery Quality and Safe Staffing Report – March 2018** – the Committee noted those wards which had triggered a 'level 2 concern' and 'level 1 concern' in the judgement of the Acting Chief Nurse and Corporate Nursing Team, as set out in paper F. Two wards triggered a 'level 3 concern', Wards 17 and 18, LRI, as metrics had not been completed. 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.

- **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 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. It was also suggested that support from the Leicester Diabetes Centre should be sought for improving clinical practice in respect of diabetes management.

- **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. In a separate discussion, it was suggested that the Patient Partners draw 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".

- **Schedule of External Visits** – paper I 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 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.

- **Quality and Outcomes Committee – Annual Work Plan –** the Committee noted the QOC Annual Work Plan set out in paper J. 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 the Committee in June 2018 and confirmation in respect of when the IP annual report would be available.

- **ED Quality Scorecard –** 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.

- **Any other business** – **Hepatitis C Network and Children's Critical Care Transport Service Peer Reviews** – the Chief Executive reported that there was overall positive feedback following both these peer reviews.

Matters requiring Trust Board consideration and/or approval:

The Committee agreed that the Committee Chair should report to the Trust Board that:-

(a) 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.

Matters referred to other Committees:

None

Date of next meeting:	24 May 2018