University Hospitals of Leicester NHS
NHS Trust

Trust Board paper K1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 November 2020

COMMITTEE: Quality and Outcomes Committee (QOC)

CHAIR: Ms V Bailey, Non-Executive Director and QOC Chair

DATE OF COMMITTEE MEETING: 24 September 2020

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

- **None.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **Minute 43/20/10 – Perinatal Mortality Report**

DATE OF NEXT COMMITTEE MEETING: 29 October 2020

Ms V Bailey, Non-Executive Director and QOC Chair

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY OUTCOMES COMMITTEE (QOC) MEETING HELD ON THURSDAY 24 SEPTEMBER 2020 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Voting Members Present:
Ms V Bailey – Non-Executive Director (Chair)
Professor P Baker – Non-Executive Director (Deputy Chair)
Mr B Patel – Non-Executive Director
Ms C Fox – Chief Nurse
Mr A Furlong – Medical Director

In Attendance:
Dr D Barnes – Deputy Medical Director (for Minute 43/20/7)
Dr R Bell – Consultant in Intensive Care & Renal (for Minute 43/20/8)
Ms G Belton – Corporate and Committee Services Officer
Ms B O'Brien - Deputy Director of Quality Assurance (for Minute 43/20/4)
Ms S Leak – Director of Operational Improvement (for Minute 43/20/5)
Mr T Palser – Deputy Medical Director (for Minute 43/20/6)
Mr S Pizzey – Head of Strategy and Planning (for Minute 43/20/2)
Mr I Scudamore – Clinical Director (Women's and Children's) (for Minute 43/20/10)
Mr C Walker – Clinical Audit Manager (for Minute 43/20/11)
Ms C West – CCG Representative
Mr M Williams – Non-Executive Director (Observing)

RESOLVED ITEMS

39/20 APOLOGIES

There were no apologies for absence.

40/20 DECLARATIONS OF INTERESTS

Resolved – that it be noted that no declarations of interest were made at this meeting of the Quality and Outcomes Committee.

41/20 MINUTES

Resolved – that the Minutes of the Quality Outcomes Committee meeting held on 27 August 2020 (paper A1 refers) and the QOC Summary from the same meeting (paper A2 refers, as submitted to the Trust Board on 3 September 2020) be confirmed as a correct record.

42/20 MATTERS ARISING

The Chair reviewed the outstanding actions.

In respect of Minute 34/20/9 from 27 August 2020 QOC meeting (re Maternity Safety Update), the Chief Nurse reported verbally to advise that the work to be submitted to QOC in November 2020 related specifically to the Maternity Governance Review Scope. It was agreed to update the QOC MA Log accordingly. **CCSO**

In respect of Minute 25/20/1 from 30 July 2020 QOC Conference Call (re Premises Assurance Model), Ms Bailey, QOC NED Chair, reported verbally to advise that she had emailed the Director of Estates and Facilities re this action and would notify the Corporate and Committee Services Officer with the update, when received. **QOC Chair**

In discussion on this report, the QOC NED Chair requested that the Corporate and Committee Services Officer made enquiries to determine whether a meeting had been arranged between herself, **CCSO**

Mr Mayes, Head of Patient and Community Engagement and the Patient Partners, which the Corporate and Committee Services Officer undertook to do.

Resolved – that the discussion on the matters arising log (paper B) be noted, any associated actions be undertaken and the QOC Matters Arising Log be updated accordingly. **CCSO**

43/20 ITEMS FOR DISCUSSION AND ASSURANCE

43/20/1 COVID-19 Position

The Chief Nurse reported verbally to advise of a very recent Covid-19 outbreak at the Glenfield Hospital (defined as at least two people [either patients or staff] being associated by time and place). This matter was now under investigation within the Trust. This was the second such outbreak, with the investigation into the first earlier outbreak (occurring at the Leicester General Hospital site) now having been closed, with a 28 day surveillance period currently on-going. Further updates would be provided to the Committee as appropriate. The Medical Director reported verbally to advise of a gradual increase in Covid-19 cases being treated within the Trust and of the situation locally, with specific hotspots in Oadby and Wigston. The current alert level remained as previously, however preparations were underway in the event of a surge in cases, with work being undertaken on both step-up and step-down algorithms. Specific note was made of the Trust's response to recent national infection prevention guidance, when a decision had been made on the recommendation of the Trust's Lead Infection Prevention Doctor, to require staff to continue to wear FP3 masks in specific circumstances determined to be on the 'green' (low risk) pathway as this was considered to be the safest option for both patients and staff, whilst continuing to allow an appropriate level of throughput.

Resolved – that this verbal update be noted.

43/20/2 COVID-19 Phase 3 Restoration / Recovery

Mr S Pizzey, Head of Strategy and Planning, presented an overview of the final UHL component of the LLR Covid-19 Phase 3 Restoration / Recovery Process (paper C refers). Contained within the phase 3 guidance were a number of key targets / statements including: (1) ensuring the benefits received from the transformation initiated to respond to Covid-19 were 'locked in' (2) to support staff following the first wave of Covid-19 (3) to provide further structure and drive to the tackling of health inequalities (4) to restore the full operation of cancer services to pre Covid-19 levels and reduce 31 day, 62 day and 104 day backlogs (5) to deliver, by September 2020, 80% of last year's activity levels for inpatient and day-case services. By this date, key diagnostics (such as MRI, CT and endoscopy) would need to be at 90% (6) to deliver, by September 2020, 100% of outpatient activity (with a minimum of 25% new and 60% follow-up by non-face-to-face means) and to continue this for the rest of the year (7) to re-launch the e-referral service to primary care and (8) to provide every patient who had been disrupted by Covid-19, clear communication about how they would be treated / supported (between the Trust and their GP) and details of who to contact if their condition changed. Underpinning the afore-mentioned, all providers were asked to treat clinically urgent patients first, followed by long-waiters. The report concluded that within the best case planning scenario, the Trust would be able to meet the NHSE/I Restoration and Recovery levels and, also within the best case scenario, the Covid-19 drive 52 week wait elective backlog would be reduced to 2019 levels by July 2021 or September 2021 in the likely case. Additional financial and workforce resource was required in both the best and likely activity scenarios.

Particular discussion took place regarding patients waiting longer than 52 weeks. There had been no such patients waiting longer than 52 weeks at UHL prior to the Covid-19 pandemic, however there now were and, along with the plans in place to reduce this number, note was also made that the Trust had enrolled the assistance of general practice to review this matter from their perspective, with work also underway to try to understand the mental health impact of these delays on patients. In further discussion, and at the suggestion of Ms Bailey, QOC NED Chair, it was agreed that it would be helpful to differentiate between waits which were specifically as a result of Covid-19 and those which were for other reasons. Ms C West, CCG Representative undertook to discuss further, outwith the meeting, with the Head of Strategy and Planning, the work underway into mental health impact. In concluding discussion on this matter, the Committee noted the recommended restoration and recovery levels, along with the associated performance, workforce and finance implications. The Committee approved the UHL's contributions to the Phase 3 Restoration / Recovery submission.

Resolved – that (A) the contents of this report be received and noted and the Trust's contributions to the Phase 3 Restoration / Recovery submission, as outlined within the report, be approved,

(B) the Head of Strategy and Planning be requested to differentiate (within public communications) between those waits which were due to Covid-19 and those which were for other reasons, and **HoSP**

(C) the Head of Strategy and Planning and Ms C West, CCG Representative, be requested to discuss further, outwith the meeting, the work underway into the mental health impact (of 52 + week waiters). **HoSP /CCG rep**

43/20/3 Quality and Performance Report Month 3

The Medical Director and Chief Nurse presented the Month 4 Quality and Performance report (paper D refers), which provided a high-level summary of the Trust's performance against the key quality and performance metrics and complemented the full Quality and Performance report and the exception reports within that which were triggered automatically when identified thresholds were met. The exception reports contained the full detail of the recovery actions and trajectories, where applicable.

In presenting this report, the Medical Director particularly highlighted that the HSMR (Hospital Standardised Mortality Ratio) had increased and work was underway into understanding the reasons for this. This was an issue being observed nationally and could potentially relate to Covid-19 related deaths not being accounted for within the HSMR – the Trust was working with Dr Foster to seek to gain an understanding of the reasons for the increased HSMR. Ms Bailey, QOC NED Chair, noted that the Committee awaited the outcome of this work in due course.

The Chief Nurse particularly highlighted to the Committee the earlier recommencement of indicators relating to patient experience within the quality dashboard (these had been reinstated in June / July 2020, rather than October 2020, as originally planned). She also informed the Committee that UHL had been awarded Acute Trust of the Year in the National Patient Experience Awards, having been winners of three categories and finalists in a further four categories, which the Committee commended. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

43/20/4 Patient Safety Highlight Report

Ms B O'Brien, Deputy Director of Quality Assurance, presented the monthly Patient Safety Highlight report (paper E refers), which detailed information with regard to the following: (1) the key points and recommendations from the Cumberlege review published in July 2020 (2) the themes from incidents / complaints / concerns / compliments related to Covid-19 (the most significant themes from which were about lack of communication given to other staff / patients, documentation and handover of information re a patient's Covid-19 status when the patient was moved) (3) the consultation relating to the National Patient Safety Alerts and (4) the Trust's plans for the WHO Patient Safety Day on 17 September 2020. The report also detailed the latest patient safety report and the latest complaints briefing paper.

During August 2020, there had been three Serious Incidents escalated, no RIDDORS and no lapsed safety alerts. One Never Event had occurred and an investigation into this was on-going. Note was also made during discussion that complaints processing had been paused during April and May 2020, as a result of a national directive, and had resumed in June 2020. Professor Baker, Non-Executive Director, queried what would happen regarding complaints handling in the event of a second Covid-19 wave, in response to which the Medical Director advised that it would be hoped to continue complaints handling during any such period, dependent upon staff availability (noting that clinical staff working in a non-clinical capacity could potentially be redeployed to work clinically where the need arose). Note was made by Mr B Patel, Non-Executive Director, that the themes of the Covid-19 specific complaints were similar to those themes arising pre-pandemic and he queried what further action (if any) could be taken regarding these recurrent themes. In response, the Medical

Director noted that a deep dive had been undertaken into medical complaints, as a result of which it had been concluded that themes from complaints were being summarised in categories which were too generic. Further sub-categories had now been devised, which would provide further detailed information on complaint themes which could potentially assist in determining further action that could be taken in response. In discussion regarding the outcome of the Cumberlege review, the Medical Director noted that UHL was a Regional Centre for pelvic mesh implants as this procedure had to be undertaken by Fellowship-trained Surgeons, of whom UHL employed three such surgeons. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

43/20/5 Cancer Performance Recovery 2019/20

Ms S Leak, Director of Operational Improvement, presented the latest report regarding cancer delivery and performance (paper F refers), noting that this had been and remained a priority for the Trust. Due to the current Covid-19 pandemic there had been changes to cancer pathways, a decrease in activity and an increase in tracking of patients. The changes made followed the National and Tumour-Specific Society recommendations and ensured that patients were safe and received the time critical cancer treatments they required. A return to pre-Covid referral levels and performance was now being observed, which was welcomed. Specific note was made of a complimentary letter received by the Trust from the Regional Team that morning, further details relating to which would be included in the next report. The Trust had achieved 5 standards against the national targets, with the biggest challenge to recover the position with services having decreased capacity due to social distancing, PPE and time between cases for air exchange. The Independent Sector was being utilised with an increase in activity being undertaken and there had been no physical harm as a result of patient delays. The Trust's most significant challenge in terms of cancer performance related to the 31 day performance indicator, against which it had performed poorly both in national terms and against its peer group, however an increase in theatre capacity was now being observed and cancer and urgent patients continued to be prioritised for treatment. Performance was improving in relation to 62 day and 104 day indicators, with performance now at pre-Covid-19 levels due to the hard work of the team and a reduction in referral levels during the first wave of the pandemic.

The Director of Operational Improvement made reference to a mis-communication over the Psycho-Oncology service which had changed to a single point of access, rather than direct referral. LPT and the CCG were managing the communications to patients in order to ensure that access was clear. UHL would monitor to ensure that patients were able to access the service and in a timely manner. Mr B Patel, Non-Executive Director, queried what action was being taken in response to the finding that patients within LLR tended to present late to cancer services, leading to poorer outcomes. The Director of Operational Improvement confirmed that the Trust was an outlier in terms of late presentation of patients and work was underway by LLR partners to investigate the reasons behind this – Ms C West, CCG Representative, undertook to seek an update on this specific matter which she would email to QOC members for information. The contents of this report were received and noted. **CCG Rep**

Resolved – that (A) the contents of this report be received and noted, and

(B) Ms C West, CCG Representative, be requested to seek an update on the work underway by LLR partners to determine the reasons behind LLR patients presenting late to cancer services and email this to QOC members for information, when available. **CCG Rep**

43/20/6 Integrated Quality Assurance System – Proposed

Mr T Palser, Deputy Medical Director, presented a report (paper G) which documented the development of a new comprehensive method for assessing individual service quality, which would improve the Trust's continuous quality improvement processes and, for the first time, use a combination of hard and soft data sources. The report provided an initial overview of how it was envisaged that the process would work, including intelligent use and integration of existing data sources, including soft intelligence, expansion of automated continuous monitoring techniques, careful choice of service-specific metrics meaningful to patients and clinicians and service-level ownership of the process. In presenting this report, Mr Palser particularly highlighted the following in

his presentation of the report (1) this would be a proactive process and at granular service level (2) this process would utilise data already collected by the Trust in a smarter way and (3) it would integrate soft intelligence (from user's and staff's own impressions of a service) which would be integrated into the Trust ensuring that equity was built in. The Medical Director noted the intention to develop a Proof of Concept utilising a couple of services as pilot sites, thereafter determining how this could be scaled up if proven successful.

Particular discussion took place regarding how the CCGs could link in with this work, noting the need for data integration within and across systems and Mr Palser and Ms West undertook to discuss this further outwith the meeting. Ms V Bailey, QOC NED Chair, commented on the links to the Quality Strategy and noted that it would be helpful, as this work progressed, to determine if it would have provided early notification of any previous service issues the Trust may have had. The Committee received and noted the contents of this report and approved the process described. It was agreed that an update on progress would be presented to the Committee in three months' time.

Resolved – that (A) the contents of this report be received and noted and the process described be approved,

(B) Mr Palser, Deputy Medical Director and Ms West, CCG Representative, be requested to discuss further, outwith the meeting, how CCGs could link in with the work described within the report (in light of the need for data integration within and across systems), and **DMD/ CCG Rep**

(C) the Deputy Medical Director be requested to present an update to the Committee re the Integrated Quality Assurance System in 3 months' time. **DMD**

43/20/7 VTE Thromboprophylaxis Task and Finish Group Update

Dr D Barnes, Deputy Medical Director, presented an update on the work of the VTE Prevention Task and Finish Group (paper H refers), which built upon the outstanding actions highlighted in the previous update report from January 2020 and the future Trust direction of VTE prevention and treatment strategy and governance.

Covid-19 had resulted in significant challenges in progressing elements of the work programme, however positive progress had continued to be made in multiple work streams. There had been sustained positive performance for VTE assessment and investigation of Hospital Acquired Thrombosis against the Quality Schedule which was above the agreed thresholds of >95% (with a score of 98% achieved at the end of the year). The NerveCentre (NC) eMeds pilot, including VTE assessment and piloting, was commencing in September 2020 in Renal Medicine. Further progress had been made on creating an electronic dashboard for the VTE prevention quality indicators. Electronic reporting of prescribing thromboprophylaxis in patients deemed high risk following VTE assessment and was now provisionally available for all the medical admissions units at the LRI and GH. The format of this data would be standardised and shared monthly with the Clinical Management Groups (CMGs) to be discussed at the Quality and Safety Boards with a focus on those patients deemed high risk but with no apparent thromboprophylaxis prescribed. The report recommended that the next trust-wide VTE prevention audit was carried out after the NC eMeds roll out, which would allow 3 of the 4 quality indicators to be robustly captured electronically and then, going forward, would form part of the overall VTE prevention dashboard. Assurance around patients robustly receiving VTE prevention information remained a challenge, with reliance, at present, upon an annual manual audit for data, however the aim was for electronic reporting using the nursing discharge checklist within NC. It was proposed that a QI approach was taken to address this challenge going forward, however this would require CMG engagement given that this process was delivered at ward level with particular involvement of the nursing teams. The VTE assessment process for long waiters in ED had been suspended during the height of the Covid-19 pressures. In light of the new way of working in ED, the process would be reviewed to determine if it was still fit for purpose. With the support of the Medical Director, going forward the UHL VTE Prevention T&F Group and Anticoagulation Committee would be amalgamated into a single UHL Thrombosis Committee to unify the Trust's thrombosis strategy and governance processes. As part of the process two new Consultant Clinical Leads had been appointed after competitive interview. New membership, Terms of Reference and a work programme would be established to include the latest CQC recommendations. Each CMG would be requested to provide a representative for this

Committee, as supported by members when this report was presented at EQB on 8 September 2020.

The Committee received and noted the contents of this report and expressed support for the proposals outlined above. In discussion, it was agreed that, in light of the clear action plan in place, the Committee would be content to receive a further report on progress for assurances purposes within the next 4 – 6 months (the specific timescale was to be determined in discussion outside the meeting between Mr A Furlong, Medical Director and Dr D Barnes, Deputy Medical Director).

Resolved – that (A) the contents of this report be received and noted and the proposals described within the report be supported and

(B) the Deputy Medical Director be requested to submit a further report on progress within the next 4-6 months (the specific timescale to be determined in discussion between the Medical Director and Dr Barnes, Deputy Medical Director). **DMD/ MD**

43/20/8 Organ Donation Bi-Annual Report

Dr R Bell, Consultant Intensive Care and Renal, presented a report (paper I refers) which provided an update on Organ Donation and specifically the effect of the Covid-19 pandemic on organ donation and transplantation. Despite the pandemic, the Trust had continued to support organ donation throughout the year achieving a similar number of donors this year compared to last year. In light of the pandemic, the update submitted included data from April 2019 to February 2020 (therefore excluding the period most impacted by Covid-19). From 23 consented donors, the Trust facilitated 13 actual organ donors resulting in 31 patients receiving a transplant during the 11 month period. This was in comparison to 14 organ donors, resulting in 34 patients receiving a transplant, over the 12 month period 2018/19. Since February 2020, the Trust had facilitated organ donation in two patients. Every donation was a reflection of the altruism of the patient and their family and a testament to the care and professionalism of colleagues across the Trust who facilitated this lifesaving process. During the Covid-19 pandemic, the number of potential donors decreased as people who died with, or were suspected to have the infection, could not be considered as organ donors.

Despite the pandemic, in May 2020 the law relating to organ donation changed in England to one of deemed consent. The education programme surrounding this was delayed as a result of the pandemic and therefore practice around the law change had not yet been embedded. It was intended to continue to promote organ donation within the Trust over the coming months to help ensure as many people as possible were aware of the law change and understood the need for donation. Some of the new content which NHSBT had been posting nationally sought to reassure people that it was still their choice whether or not to be an organ donor. The Trust wished to support and help spread this message by sharing this content through its own media channels. To this end, a nominated contact within the Trust's Communications Team had been sought by the Organ Donation Team and agreed when this matter was discussed at EQB on 8 September 2020.

Professor Baker, Non-Executive Director, acknowledged the frustrations regarding the pandemic's effect on communication of the law change. Also acknowledged was the improvement in the number of donors at UHL over the past couple of years compared to previous years. In discussion, and as a response to a suggestion made by Mr M Williams, Non-Executive Director, Ms V Bailey, QOC NED Chair requested that Dr Bell discussed with Ms H Leatham, Assistant Chief Nurse and Mr S Ward, Director of Corporate and Legal Affairs, the possibility of having a Patient Story relating to Organ Donation at a future Trust Board meeting, which could also serve to highlight the recent law change regarding Organ Donation. The contents of this report were received and noted, and it was agreed that this report would continue to be submitted to EQB and QOC on a bi-annual basis. **C,IC&R**

Resolved – that (A) the contents of this report be received and noted,

(B) Mr R Bell, Consultant Intensive Care and Renal, be requested to discuss with Ms Leatham, Assistant Chief Nurse and Mr Ward, Director of Corporate and Legal Affairs, the possibility of having a patient story relating to organ donation at a future Trust Board meeting, which could also serve to highlight the recent law change regarding organ donation, and **C,IC&R**

(C) a further update be submitted to EQB and QOC in six months' time (therefore March 2021). **C,IC&R**

43/20/9 Safe Surgery and Invasive Procedures

The Medical Director presented a quarterly update on the Safe Surgery and Invasive Procedures part of UHL's Quality Strategy (paper J refers). This report now incorporated consent and patient information which formerly reported separately to EQB and QOC. The Safe Surgery work streams in the Quality Strategy were now as follows: consent, patient information, Five Steps to Safer Surgery, Training and Education and LocSSIPS (Local Safety Standards for Invasive Procedures).

Work had progressed regarding consent including the purchase of four new updated consent training modules on HELM which have gone live in August 2020. A new supplementary consent form and patient information leaflet regarding Covid-19 had been developed and was now in use. An electronic (e)-consent options appraisal was taking place. Good progress had been made in adding patient information to the YourHealth database and website with 900 leaflets now live. The team had undertaken successful health literacy online events and also a tweetorial to improve engagement. Two projects were currently being piloted in relation to Five Steps to Safer Surgery: (1) Safety 2 Project to improve the team brief and debrief led by Andrew Hughes and (2) WHOBARS – a tool to assess the quality of checklist administration in theatres. With regard to training and education, the HELM online training for nasogastric tube insertion had been updated and made essential to job role for doctors. The next quality and safety half day was scheduled for 9 October 2020 after a period of suspension due to the pandemic. An in-depth LocSSIPs strategy had been written and approved by the Safe Surgery and Invasive Procedures Board. A thorough review of the LocSSIP dashboard had also taken place. The LocSSIPs team were making good progress in systematically addressing areas of poor compliance with LocSSIPs. The quality assurance programme was in development to support gaining assurance that processes were implemented in clinical areas. An e-checklist module on NerveCentre for nasogastric tube insertion was now live throughout the trust and was now the mandated way of signing off a tube as "safe to feed". Future work included development of an e-consent system, a communications campaign around Patient Information to highlight that YourHealth was the repository for information, a suite of video training tools in how to do the Five Steps to Safer Surgery was under development, a communications campaign to raise awareness of LocSSIPs and development of a Quality Assurance system for LocSSIPs based on the UHL Accreditation and Assessment programme and aligned to the five CQC domains.

Ms V Bailey, QOC NED Chair, whilst acknowledging the many frameworks and processes in place, noted that the defining issue was often one of human factors (i.e. whether a process was followed or not) and queried how this aspect could be addressed. In response, the Medical Director advised that the Safety 2 Project should assist in this respect. Ms Bailey, QOC NED Chair acknowledged that these were stressful times due to the pandemic and the Medical Director commented on the tendency to 'layer' processes rather than strip these back – this was an element which he undertook to discuss further with Dr C Marshall, Deputy Medical Director. The contents of this report were received and noted. **MD**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Medical Director be requested to discuss the matter referenced above with Dr Marshall, Deputy Medical Director. **MD**

43/20/10 Perinatal Mortality Stillbirth Cluster Review Update

The Clinical Director for Women's and Children's presented an update on the outcome of the Stillbirth Cluster Review (paper K refers). Themes around maternal diabetes and scheduling of ultrasound scans had been identified in the review. The risk factors of maternal age > 40 years, maternal diabetes, fetal growth restriction and verbal communication issues (where English was not spoken as a first language) were recurrent themes and it had been agreed at the Mortality Review Committee to highlight the communication issues at the Local Maternity Services Board, as it was considered that wider system work would be needed to robustly address this issue. The Clinical Director (W&C CMG) noted that he was the SRO for the Local Maternity Services Board and would ensure relevant themes would be raised and addressed there. Mr M Williams, Non-Executive Director, queried how UHL compared to its peers in terms of perinatal mortality, in response to which the Clinical Director (W&C CMG) confirmed that UHL had performed better than the mean in the most recent reports received. QOC received and noted the contents of this report, endorsing the thorough review undertaken and the actions taken to date, noted that continued monitoring would be undertaken through the Perinatal

Mortality Oversight Steering Group and Mortality Review Committee and noted that a further update would be provided as part of the Learning from Deaths quarterly report in November 2020.

Resolved – that (A) the contents of this report be received and noted, and

(B) the Clinical Director, Women's and Children's be requested to ensure that relevant themes from the review were raised and addressed at the Local Maternity Services Board. **CD, W&C**

43/20/11 Clinical Audit Update

Mr C Walker, Clinical Audit Manager, presented a quarterly update in respect of clinical audit work undertaken within the Trust (paper L refers). Clinical Audit was both an important quality improvement and assurance process. In line with its Becoming the Best (BtB) strategy, the Trust continued to develop its large programme of work across the Trust to help ensure the provision of safe care and improvement of patient outcomes.

UHL continued to have a large number of projects registered on its Clinical Audit and other QI programme (n= 2758 project cycles registered since April 2017). 30% of the projects were mandated. During quarter 1 of this financial year a record number of new project plans were reviewed and approved (n=237). The main contributing factor behind this was over 100 projects into the management and impact of COVID-19 were registered. Over 60% of the projects linked to one of the Quality Priorities, with Care Pathways being the most common to date (32% of projects).

As part of the Trust's BtB Quality strategy this year, new project stages for assurance and improvement had been introduced to help ensure that results were acted upon and changes measured as part of the same project cycle which would also reduce paperwork. The Clinical Audit team and Clinical Audit Lead clinicians had developed an improvement plan with the aim to increase the proportion of projects undertaken within UHL that resulted in positive outcomes – improving patient care or providing assurance that standards were being met. There remained a backlog of national clinical audit (NCA) reports where a response from the CMGs had not been provided. In light of the pandemic and BtB strategy, the Clinical Audit team were currently testing a new process to help ensure a timelier reporting process within the Trust on NCA reports once they had been published, which would feed into the CQC work programme. The process also linked with Data Protection / National Patient Opt-Out, the latter of which came into play next month.

Further to the last report on Clinical Audit, it had been agreed that the clinical audit programme and Clinical Audit team would form part of the Transformation team and report to the Director of Quality Transformation and Efficiency Improvement. Work would continue to ensure the assurance and improvement work were aligned and actions taken as appropriate.

The Committee received and noted the contents of this report expressing support for the work detailed within the paper and assurance regarding the oversight being provided by EQB in the current absence of Clinical Audit Committee meetings. The Committee undertook to receive the next quarterly report at the appropriate time interval and Ms V Bailey, QOC NED Chair, requested that the next report contained information as to the follow up processes in place to provide assurance that actions were completed and thereafter closed accordingly. **CAM**

Resolved – that (A) the contents of this report be received and noted, with support expressed for the work detailed within the report and assurance provided regarding the oversight being provided by EQB and

(B) the Clinical Audit Manager be requested to detail, within the next quarterly update report to QOC, information as to the follow up processes in place to provide assurance that actions were completed and closed thereafter accordingly. **CAM**

43/20/12 Patient Experience Report

The Chief Nurse presented the Patient Experience Quarter 1 2020/21 update report (paper M refers), and specific note was made of the outcome of the 2019 National Maternity Patient Experience Survey, which demonstrated significant improvements made by the Trust, the results of which would be taken forward by the Women's and Children's CMG and the Patient Involvement, Patient Experience Assurance Committee. Also highlighted within the report were the additional ways which the Trust had enabled relatives to keep in touch with patients during the visiting restrictions in place due to the Covid-19 pandemic and also the measures put in place to allow the continued receipt of

patient and carer feedback during the pandemic.

Resolved – that the contents of this report be received and noted.

44/20 ITEMS FOR NOTING

44/20/1 Executive Quality Board (EQB) Action Notes

Resolved – that the EQB action notes from the meeting held on 8 September 2020 (paper N refers) be received and noted.

45/20 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

46/20 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be highlighted to the 1 October 2020 public Trust Board via the summary of this Committee meeting: **QOC Chair**

- **Minute 43/20/10 – Perinatal Mortality Stillbirth Cluster Review**

47/20 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Outcomes Committee be held on Thursday 29 October 2020 from 2pm via Microsoft Teams.

The meeting closed at 4.00pm

Gill Belton - **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2020-21 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	6	6	100	C Fox	6	5	83
P Baker	6	5	83	A Furlong	6	5	83
R Brown	0	0	0	B Patel	2	2	100
I Crowe	0	0	0	K Singh *(ex officio)*	0	0	0

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	0	0	0	J Smith	0	0	0
M Durbridge	5	5	100	C Trevithick/C West (CCG - from January 2020)	6	6	100