Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 29 SEPTEMBER 2022 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey – Non-Executive Director QC Chair
Dr D Barnes – Deputy Medical Director (on behalf of Medical Director)
Dr A Haynes - Non-Executive Director
Ms B O'Brien - Deputy Director of Quality Governance/Deputy Chief Nurse (on behalf of Chief Nurse)
Professor T Robinson – Non-Executive Director

In Attendance:
Mr R Binks – Deputy Chief Nurse (for Minute 84/22/3)
Ms S Bailey – ICB Representative
Ms E Collins – Lead Infection Prevention Nurse (for Minute 85/22/1)
Ms B Cassidy – Director of Corporate and Legal Affairs
Miss M Durbridge - Director of Quality Transformation and Efficiency Improvement
Mr J Hickman – CYP Services Transformation Manager for ICB (for Minute 84/22/4)
Ms L James – Senior Project Manager (for Minute 85/22/2)
Mrs H Majeed – Corporate and Committee Services Officer
Mr R Manton - Head of Risk Assurance
Ms S McLeod – Head of Operations, W&C (for Minute 84/22/4)
Mr J Melbourne – Chief Operating Officer (for Minutes 84/22/2 and 84/22/3)
Mr M Patel – EPRR Manager (for Minute 84/22/2)
Ms J Smith - Patient Partner
Ms K Williams – Deputy Head of Midwifery (for Minute 85/22/2)
Mr J Worrall - Associate Non-Executive Director (non-voting)

	RESOLVED ITEMS	
81/22	**APOLOGIES**	
	Apologies were received from Mr A Furlong, Medical Director; Ms J Hogg, Chief Nurse and Ms H Hutchinson, Ms C Trevithick, and Ms C West, ICB Representatives.	
81/22	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
82/22	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 25 August 2022 (paper A) be confirmed as a correct record.	
83/22	**MATTERS ARISING**	
	Paper B updated Quality Committee on progress against previous actions. Any updates now provided would be reflected in the next iteration of the log. All '5' rated actions would be removed after this meeting, and the QC Non-Executive Director Chair noted work underway to progress the remaining actions as a matter of urgency.	
	Resolved – that the matters arising report be noted.	
84/22	**ITEMS FOR DISCUSSION AND ASSURANCE**	
84/22/1	Pertinent Safety Issues	
	The Deputy Chief Nurse briefed the QC verbally on pertinent safety issues, advising of some quality concerns highlighted in a ward which had come to light through the ward accreditation process.	

	Members were advised that several actions were being taken to identify the issues and learn lessons from it including the completion of a desktop review of the quality metrics. Members noted that immediate actions had been taken by strengthening the leadership of the ward with new recruits and support from the Corporate Nursing team. A further update would be provided to QC in 3 months' time on the broader learning identified from this issue. .	**DCN**
	<u>Resolved</u> – that (A) the verbal report on pertinent safety issues be received, and **(B) the Deputy Chief Nurse be requested to provide a further update (re. quality concerns highlighted in a ward which had come to light through the ward accreditation process) to QC in 3 months' time on the broader learning identified from this issue.**	**DCN**
84/22/2	<u>Emergency Preparedness, Resilience and Response (EPRR) Annual Report</u>	
	The Chief Operating Officer and the EPRR Manager attended the meeting to present an update on the progress made with the Trust's EPRR arrangements for the period August 2021-August 2022 (paper C refers). NHS England's new Core Standards for EPRR released in August 2022 now required Trust's to update plans annually, provide more frequent training and undertake testing and exercising of all its plans to key personnel. The EPRR Team had completed an annual self-assessment against the new core standards, which provisionally indicated the Trust as being fully compliant against 52 of the 64 standards and partially compliant with the remaining 12 standards. Therefore, while the 2022/23 self-assessment projected the Trust as being 'partially compliant' with the EPRR standards, the EPRR Team had reviewed the new set of core standards with a view to improve to a 'substantially compliant' position (88 – 99%) by August 2023. Members noted the action plan in the report which outlined the actions to become fully compliant against the partially compliant standards and suggested that the timescales for each action be included in a priority order. It was also noted that the Trust's self-assessment was being reviewed externally by ICB colleagues.	
	<u>Resolved</u> – that the progress made against the EPRR work programme and the key priorities for the Trust in the next 12 months relating to EPRR was noted via the EPRR Annual Report. The report was referred onto Trust Board (a stand-alone report on that item was included on the October 2022 Trust Board agenda accordingly.)	
84/22/3	<u>Implementation of Rapid Flow Standard Operating Procedure</u>	
	The Chief Operating Officer presented paper D and sought the Quality Committee's approval to implement an amended version of the UHL's current Rapid Flow Standard Operating Procedure (SOP) which encompassed the principles from the North Bristol NHS Hospital Improving Ambulance Handover Delays model. The SOP described the process of sharing risk across the organisation when the Emergency Department (ED) and Clinical Decisions Unit (CDU) had more patients than it could safely care for and to prevent holding patients on ambulances which had a direct impact on delays to responding to emergencies in the Community. Allocating one additional patient to suitable wards shared this risk across the Trust and reduced risk within the ED and the Community. The rapid flow process would only occur to inpatient areas between 08:00hrs-20:00hrs and 24 hours per day across the assessment wards. A detailed discussion took place on the patient experience and staff morale which would be impacted by this change. In response to queries, it was noted that any datix incidents and complaints linked to this SOP would be continuously reviewed and monitored by CMG Leadership teams. Further to some suggestions made by Mr J Worrall, Non-Executive Director, the Chief Operating Officer undertook to update appendix 1 of the report to be explicit that the rapid flow ward placement locations were all non-ESM wards. In addition, he undertook to include wording in the policy to indicate that if for any reason the patient exiting from the ward was not able to be discharged then the patient would not be returned to ED. In conclusion, the policy was approved on the basis that this was a way of managing risk across an incredibly challenged situation and noted the need for careful monitoring of the processes and outcome particularly around patient experience, quality, and communications. The QC Chair requested that a provisional discussion be scheduled for an update to QC in November/December 2022 from the Chief Nurse in respect of monitoring any quality impacts of this SOP. Any performance implications would be taken forward through the Operations and Performance Committee.	**COO** **CN**
	<u>Resolved</u> – that (A) the Chief Operating Officer be requested to: -	

	• **update appendix 1 of the SOP to make it explicit that the rapid flow ward placement locations were all non-ESM wards, and** • **include wording in the SOP to indicate that if for any reason the patient exiting from the ward was not able to be discharged then the patient would not be returned to ED** **(B) the Chief Nurse be requested to provide an update to QC in respect of monitoring any quality impacts of this SOP.**	**COO** **CN**
84/22/4	Children & Young Peoples (CYP) LLR Design Group – Quality & Performance Update	
	The Head of Operations, W&C and the CYP Services Transformation Manager for ICB attended the meeting to present paper E, a detailed update on the establishment of the CYP Quality and Performance (QP) Subgroup which reported to the CYP LLR Design Group and membership included partners from across the health and social care sector in LLR. Members were advised that developments had been made collaboratively and a consistent and objective process had been implemented by system partners within the CYP QP Subgroup. This had enabled the group to better understand the current CYP risks and to focus resources in areas where it would have the most impact and benefit to the LLR population. This collective work had reduced the likelihood of duplication or omission and enabled the group to identify interdependencies with other system groups so that members could collaborate on key projects related to CYP service transformation. The terms of reference and a Quality, Performance and Risk Management framework were in place and were being finalised. Members commended the approach taken and noted the need for the 'next steps' to have traction and defined outcomes. It was agreed that a further update would be provided to QC in 6 months' time. The QC Chair undertook to take an action to discuss with the Chief Nurse and Medical Director on the way forward in respect of these workstreams and whether QC was the correct forum for this in order that there was no duplication.	**HoO, W&C** **QC Chair**
	Resolved – that (A) the contents of the report be received and noted; **(B) the Head of Operations, W&C be requested to provide a further update to QC in 6 months' time, and** **(C) the QC Chair be requested to discuss with the Chief Nurse and Medical Director on the way forward in respect of monitoring the CYP service transformation workstreams and whether QC was the correct forum for this.**	**HoO, W&C** **QC Chair**
84/22/5	Patient Safety Report – August 2022	
	The Deputy Director of Quality Governance/Deputy Chief Nurse presented the August 2022 patient safety report (paper F refers). QC noted that 6 serious incidents (SI) had been escalated in August 2022. The validated number of moderate and above harm incidents reported decreased from July into August 2022. A decrease in the rate of reported patient safety incidents had been seen despite the increase in attendances. The lack of nursing staff incidents was the highest of the reported patient safety incidents. The two notable patient safety themes arising from SI investigations were in respect of anticoagulation and waiting list management/ failure to follow up in the endoscopy service. Incidents with evidence gaps in duty of candour was now discussed at CMG Performance Review meetings. No CAS safety alerts had breached its deadline during this reporting period. Mr A Haynes, Non-Executive Director made an observation in respect of the increase in the number of serious incidents relating to falls, however, reports elsewhere on the agenda indicated a decrease in the falls rate. In discussion on this matter, the Deputy Chief Nurse undertook to follow-up with the Falls Group via Ms S Burton, Deputy Chief Nurse to understand whether there was an underlying issue and provide assurance in respect of reporting falls and the resulting harm. The QC Chair expressed concern over the processes in place to close the loop on organisational learning that the Trust required staff to undertake and the changed behaviour from it particularly in relation to 'failure to follow-up'. In response, the Deputy Chief Nurse advised that preliminary discussion had taken place at the Adverse Events Committee regarding ways to embed learning from incidents. The QC Chair requested that there be further discussion with Executive colleagues on the assurance process to determine whether the learning was happening and having an impact.	**DCN** **DCN/DMD/ CN/MD**
	Resolved – that (A) the patient safety report for August 2022 be received and noted;	

	(B) the Deputy Director of Quality Governance/Deputy Chief Nurse be requested to follow-up with the Falls Group via Ms S Burton, Deputy Chief Nurse to understand whether there was an underlying issue (as there was an increase in the number of serious incidents relating to falls) and provide assurance in respect of reporting falls and the resulting harm, and **(C) in respect of processes in place to close the loop on organisational learning that the Trust required staff to undertake and the changed behaviour from it particularly in relation to 'failure to follow-up', further discussion be held with Executive colleagues on the assurance process to determine whether the learning was happening and having an impact.**	**DCN** **DCN/DMD/ CN/MD**
84/22/6	Complaints Report Quarter 1 2022-23	
	The QC noted that that the number of formal complaints and concerns in quarter 1 of 2022-23 had slightly decreased in comparison to the previous quarter (paper G refers). The top complaint themes related to medical care, waiting times and staff attitude. The process for triaging re-opened complaints had been changed. No new Parliamentary & Health Service Ombudsman (PHSO) enquiries had been received in this quarter. One complaint was upheld by the PHSO in August 2022 in respect of clinical care and related to a case that was handled by the complaints team in 2020. Members were advised that significant work was being undertaken to improve the complaints performance position both in terms of additional resource and improved data provision to CMGs. A number of comments were made particularly in respect of the need to demonstrate empathy and compassion in the complaint responses and quality assessment of responses prior to it being sent to the complainant. The QC Chair requested that a brief standalone report be produced to outline the overall approach to the improvement of the complaints process as she was aware of several strands of improvement including those outlined in this report.	**DCN**
	Resolved – that (A) the complaints 2022-23 quarter 1 report be received and noted, and **(B) the Deputy Director of Quality Governance/Deputy Chief Nurse be requested to produce a brief standalone report to outline the overall approach to the improvement of the complaints process (noting that there were several strands of improvement including those outlined in the complaints quarter 1 report).**	**DCN**
84/22/8	Board Assurance Framework (BAF)	
	Resolved – that contents of paper H be received and noted.	
85/22	**REPORTS FROM UHL BOARDS**	
85/22/1	Trust Infection Prevention and Assurance Committee (TIPAC) Update	
	The Lead Infection Prevention Nurse presented paper I, and update from the TIPAC which covered the infection prevention activity outcomes, healthcare associated infection data alongside mandated trajectories during quarter 1 of 2022-23 and overarching national changes in the management of Covid-19 and UHL's response to this. A further update would be provided in 3 months' time.	**LIPN**
	Resolved – that (A) the Trust Infection Prevention and Assurance Committee (TIPAC) Update be received and noted, and **(B) the Lead Infection Prevention Nurse be requested to provide a further update to QC in 6 months' time.**	**LIPN**
85/22/2	Maternity Safety Report	
	The Deputy Head of Midwifery, presented the Maternity Safety Report (paper I1refers) which provided an update on progress of the maternity safety agenda, including an update on progress against the recommendations in Ockenden and Saving Babies Lives highlighting areas of challenge and actions required to achieve compliance. The maternity quality scorecard was also provided.	

	Resolved – that Maternity Safety Report be received and noted.	
86/22	**LLR QUALITY BOARD**	
	Resolved – no reports to be referred to the LLR Quality Board from this QC this meeting.	
87/22	**ITEMS FOR NOTING**	
87/22/1	Cost Improvement Programme Quality Impact Assessments Review Quarter 1 - 2022/23	
	Resolved – that the contents of paper J be received and noted.	
87/22/2	Integrated Performance Report (IPR) – 2022/23 Month 5	
	Resolved – that the contents of paper K be received and noted.	
88/22	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
89/22	**IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**	
	Resolved – that the implementation of an amended version of the UHL's current Rapid Flow Standard Operating Procedure (SOP) (Minute 84/22/3 above refers) which encompassed the principles from the North Bristol NHS Hospital Improving Ambulance Handover Delays model, be highlighted to the Trust Board for information.	**QC CHAIR**
90/22	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 27 October 2022 from 2pm via Microsoft Teams.	

The meeting closed at 3.53pm Hina Majeed – Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2022-23 to date).

Voting Members

Name	*Possible*	*Actual*	*% Attendance*
V Bailey (Chair)	6	6	100
A Furlong	6	5	83
A Haynes	6	5	83
J Hogg (from May 2022)	5	4	80
E Meldrum (until May 2022)	1	1	100
T Robinson	5	3	60

Non-voting members

Name	*Possible*	*Actual*	*% Attendance*
B O'Brien	6	4	67
M Durbridge	6	6	100
G Collins-Punter (until May 2022)	2	1	50
G Sharma	6	4	67
J Smith (PP)	6	4	67
J Worrall	6	6	100
C Trevithick/C West/ H Hutchinson/S Bailey (ICB Representative)	6	5	83