UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 25 AUGUST 2022 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey - Non-Executive Director QC Chair
Mr A Furlong - Medical Director
Dr A Haynes - Non-Executive Director (until Minute 74/22/5)
Ms J Hogg - Chief Nurse

In Attendance:
Dr R Abeyratne - Director of Health Equality and Inclusion
Ms E Broughton - Head of Midwifery (for Minutes 69/22 and 75/22/2)
Mr M Clayton - Head of Safeguarding (for Minute 74/22/7)
Ms B Cassidy – Director of Corporate and Legal Affairs
Miss M Durbridge - Director of Quality Transformation and Efficiency Improvement
Mr J Jameson - Deputy Medical Director (for Minute 74/22/2)
Mr R Manton - Head of Risk Assurance
Ms A Moss - Corporate and Committee Services Officer
Ms B O'Brien - Deputy Director of Quality Governance
Ms P McParland - Consultant Obstetrician (for Minute 69/22)
Dr G Sharma - Associate Non-Executive Director (non-voting)
Ms J Smith - Patient Partner
Mr J Worrall - Associate Non-Executive Director (non-voting)

	RECOMMENDED ITEMS	**ACTIONS**
69/22	**MORTALITY AND LEARNING FROM DEATHS REPORT**	
	The Medical Director presented the Mortality and Learning from Deaths Report quarterly report (paper C refers). The Trust's Summary Hospital-level Mortality Indicator (SHMI) for 2021/22 was 104 and the Hospital Standardised Mortality Ratio (HSMR) was 97.9 which were both in the expected range. The crude mortality rate for 2022/23 was similar to the pre pandemic rates. The Trust was meeting internal and national standards in respect of the Learning from Deaths process. Cross cutting themes had been referred to relevant Trust Committees and speciality leads to inform quality improvement workstreams. The Medical Director provided three examples of how the learning had been applied to change practice. The Medical Examiner process was being rolled out across LLR and recruitment for Medical Examiners and Medical Examiner Officers underway. Progress had been slow in engaging with primary care and the Trust was now working with Dr Nil Sanganee, ICB Medical Director, to bring practices on board in a phased approach prior to the statutory duty being conferred in 2023. The Trust was providing the Medical Examiner function for Leicestershire Partnership Trust (LPT), and this was working well. Performance, with respect to the Learning from Deaths process had dipped in quarter 1 2022/23 and there was a large number of Structured Judgement Reviews (SJRs) that needed to be completed from 20221/22. Dr A Haynes, Non-Executive Director, asked about the backlog of reviews and whether they were prioritised based on the potential learning. The Medical Director confirmed that was the case. He added that there had been a delay in transferring notes across sites and that the additional post of Medical Examiner at Glenfield Hospital would obviate the need to transfer notes and speed up the process. He noted that it was not thought necessary to base a Medical Examiner at Leicester General Hospital as the number of deaths was relatively low.	

	The Medical Director reported that the Mortality Review Committee had reviewed the outcomes of SJRs for patients with a serious mental illness. The learning themes were similar to those for all deaths, particularly communication and end-of- life care. The Bereavement Support Service had expanded to include child deaths and cover all adult deaths in both the Trust and LPT. Additional bereavement nurses had been recruited, partially funded by LPT. Ms P Parland, Consultant Obstetrician, reported that the 2021 Stillbirths Review had concluded no deaths were considered to be, more likely than not, due to problems in care. Learning which may or may not have affected the outcome had been identified for six cases. Actions had been taken in response to all issues identified. The Committee noted the plan for external scrutiny of the review process and a selection of cases by a peer: Leeds Teaching Hospitals NHS Trust. Ms J Smith, Patient Partner, asked whether there would be a report from the exercise and whether this could be shared. The Medical Director noted that it would be reported to the Mortality Review Committee and included in the quarterly Learning from Deaths report. Ms V Bailey, Non-Executive Director, OPC Chair, noted that a recommendation from the Ockenden Report was to promote shared learning across trusts and there was a need to be proactive. Ms E Broughton, Head of Midwifery, noted that the 'buddy' arrangements for the Local Maternity Service had been finalised between the Trust and University Hospitals Birmingham and Northampton General Hospitals NHS Trusts. There was a discussion about the data for ethnicity and perinatal deaths. It was noted that a recent review indicated less favourable outcomes for BAME women. This was in line with national findings. Given the low numbers the need to consider data over a longer period was noted. Further work with the Local Maternity and Neonatal System continued in this area. Dr Abeyratne, Director of Health Equality, and Inclusion noted that there was intersectionality with social deprivation and undertook to link with the Maternity Department to discuss this further. Ms B O'Brien, Deputy Director of Quality Governance, observed a discrepancy between the number of stillbirths reported and the number in the Annual Harms Review Report. It was agreed to cross reference the data outside the meeting. *The Mortality and Learning from Deaths report was endorsed and recommended for Trust Board approval. A stand-alone report on that item would be included on the September 2022 Trust Board agenda accordingly.*	**DDQG**
	<u>Recommended</u> – that (A) the Mortality and Learning from Deaths report be endorsed and recommended for Trust Board approval; and **(B) the data for stillbirths collated by the Clinical Management Group and Patient Safety Team be cross referenced.**	**MD** **DQG**
	<u>RESOLVED ITEMS</u>	
70/22	**APOLOGIES**	
	Apologies were received from, Professor T Robinson, Non-Executive Director, Mr J Melbourne Chief Operating Officer, and Ms C Trevithick, ICB Representative.	
71/22	**DECLARATIONS OF INTERESTS**	
	<u>Resolved</u> – that no additional declarations of interests were received.	
72/22	**MINUTES**	

	<u>Resolved</u> – that the Minutes of the Quality Committee meeting held on 28 July 2022 be confirmed as a correct record.	
73/22	**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. Paper B1 provided an update on the action for Minute 63/22/8 Patient Experience Annual Report 2021/22. The Committee noted that there was no obvious explanation for the deteriorating patient experience scores and it did not relate to the Covid-19 pandemic.	
	<u>Resolved</u> – that the matters arising report be noted.	
74/22	**ITEMS FOR DISCUSSION AND ASSURANCE**	
74/22/1	<u>Pertinent Safety Issues</u>	
	The Chief Nurse provided a verbal report on pertinent safety issues, highlighting an increase in Hospital Acquired Pressure Ulcers (HAPUs) and a Serious Incident of note. The Chief Nurse reported that there had been a significant increase in the number of HAPUs in July 22. The reasons for this were various but there had been a change in the personnel involved in validation. The Chief Nurse noted that considerable work was needed, which included an education programme for Nurses and Health Care Assistants. Support was needed for the Tissue Viability Team to ensure appropriate expertise and a Nurse Consultant post had been advertised. An external consultant, with considerable experience in operationalising HAPU reductions, had been commissioned to support the Trust. The Corporate Nursing Directorate was working with Estates and Facilities and Procurement regarding the contract for beds. A report on HAPUs would be presented to the Nursing and Midwifery Board. Mr J Worrall, Associate Non-Executive Director, asked whether there were specific wards or sites where there was a problem. The Chief Nurse considered that the increase was seen across all sites and not specific to a ward. An assessment was being made regarding the potential impact of long waits in the Emergency Department, the heatwave, and the increase in number of beds open. Ms J Smith, Patient Partner, asked whether the pressure ulcers could have been acquired in the community. The Chief Nurse noted that the metric captured those pressure ulcers acquired in a hospital setting. The Chief Nurse reported on a Serious Incident regarding a patient having undergone elective surgery who experienced an air embolism as a result of the central line not being capped off. The prognosis for the patient was poor. The investigation was underway, and the Chief Executive, Chief Nurse, and Deputy Medical Director were meeting with the family.	
	<u>Resolved</u> – that the verbal report on pertinent safety issues be received.	
74/22/2	<u>Deteriorating Patient Board, Resuscitation Committee and the End-of-Life Steering Group</u>	
	Mr J Jameson, Deputy Medical Director, presented the quarterly Report of the Deteriorating Patient Board, Resuscitation Committee, and the End-of-Life Steering (paper D refers). The Deteriorating Patient Report noted the update on sepsis. Outcome data demonstrated a stable position in terms of numbers of patients and outcomes. The mortality rate of 7.4% for patients coded with sepsis compared with 9% for all Trusts. The national Paediatric ICU Getting It Right First Time (GIRFT) Report had been reviewed. The Clinical Management Group had been asked to report back on the action plan to address the 20 recommendations	

	in the report. It was noted that Dr Sowmya Setty had been appointed as lead clinician for diabetes. The report noted compliance with the deteriorating patient Commissioning for Quality and Innovation (CQUIN) which had set an improvement goal for unplanned admissions to Intensive Care Unit. The report of the Resuscitation Committee addressed training compliance; data for cardiac arrest rates and return of spontaneous circulation, which were stable. The report updated the Quality Committee on the issues relating to defibrillators, following the decision of the supplier to cease support for recently purchased equipment. Replacement defibrillators had been purchased as an interim solution to provide standardised equipment and before the Trust considered replacing the entire fleet in 18 months' time. Another issue, previously discussed by the Committee referred to the efficacy of bleeps. There had been a number of reports on the patient safety system indicating that the bleeps had failed to activate. There had been no patient harm as a result. The Deputy Medical Director noted that the bleeps were tested twice daily and the reasons for the failure were unknown. It was agreed that there was a need to understand the reasons for the failure and consider remedial action as a matter of urgency. The Committee requested a further report. The report of the End-of-Life Steering Group noted progress with training and the increase of establishment and recruitment to a post for Specialist Palliative Care (adults). The Committee had previously been advised of issues relating to syringe drivers (T34 McKinley pumps). It was reported that the issue was no longer one of training in the use of the syringes but ensuring the timely administration. Ms B O'Brien, Deputy Director of Quality Governance, noted there had been an increase in complaints about end-of-life care and it was agreed that she would link up with the End-of-Life Steering Group.	**DMD** **DQG**
	<u>Resolved</u> – that (A) the Deteriorating Patient Board, Resuscitation Committee and the End-of-Life Steering Group Report be received and noted; and **(B) a further report on the operations of bleeps be requested; and** **(C) the Deputy Director of Quality Governance liaise with the Deputy Medical Director and End of Life Streeting Group to consider the complaints regarding end-of-life care.**	**DMD** **DDQG**
74/22/3	<u>Patient Safety Report</u>	
	Ms B O'Brien, Deputy Director of Quality Governance, presented the monthly patient safety report (paper E refers). The Committee noted that 13 Serious Incidents (SIs) had been escalated in July 2022; the circumstances were noted in the report. The Patient Safety Team had closed seven SI investigations that month, and was opening more cases than it was closing as a result of a backlog. The Deputy Director of Quality Governance considered the increased rate of reporting as indicative of a good reporting culture. The validated number of moderate and above harm incidents reported had decreased from June into July 2022. The lack of nursing staff was the highest of the reported Patient Safety Incidents. This was reviewed in detail via the monthly safe staffing report. There had been an improvement in the performance for duty of candour. This was being monitored at the Clinical Management Groups Performance Review Meetings. The Director of Quality Transformation and Efficiency Improvement noted the cluster of cases which had been lost to follow up and asked whether there was further action to take. The Deputy Director of Quality Governance noted that there was an emerging trend relating to endoscopy and that she would be able to provide a clearer picture in next month's report. Mr J Worrall, Associate Non-Executive Director, questioned whether the lack of nursing staff	

	had resulted in incidents categorised as 'no harm'. The Chief Nurse considered that there would be a correlation, and this was reflected in the Nursing and Midwifery Safe Staffing report (now incorporated into the Nursing and Midwifery Board Report). For example, the data indicated a correlation between lack of nurse staffing and HAPUs. The Committee considered the need to triangulate safety data with other data to understand the causal factors, identify themes and learning.	
	Resolved – that the Patient Safety Report for July 2022 be noted.	
74/22/4	Annual Review of Moderate Plus Harm Incidents 2021/22	
	Ms B O'Brien, Deputy Director of Quality Governance, presented the annual review of Moderate Plus Harm Incidents 2021/22 (paper F refers). Noting the context of the pandemic the Deputy Director reported that the data for 2021/22 had been compared to 2019/20 and excluded the Hospital Acquired Covid-19 deaths. This enabled a more like for like comparison. The report noted that, in 2021/22 a total of 196 (of the 22,077) Patient Safety Incidents were noted to have caused harm to patients, compared to 139 in 2019/20. The increase was across all harm gradings and most notable in the death category. The Trust had reported 93 Serious Incidents (SIs) in 2021/22 which was a significant increase in the number for 2019/20 when 28 were reported. However, a change in reporting would account for a proportion of the increase, as there had been changes to the way falls were reported and all maternity incidents meeting the Healthcare Safety Investigation Branch criteria were categorised as an SI. In 2021/22, there were 12 incidents reported as causing death, compared to 2 reported in 2020/21, and 3 reported in 2019/20. For 2021/22, the common themes were inpatient falls and maternity incidents. Work would be undertaken to ensure there were improvement workstreams to address the most notable themes. The report on the review of Moderate Plus Harm Incidents would be made bi-annually in future. The Medical Director welcomed the report but noted the need for greater assurance. For example, in relation to the maternity SIs to understand how the learning was being applied. He thought there could be an increase in falls as patients were waiting for longer in the Emergency Department and asked whether there was something specific that could be done for this cohort of patients. Ms V Bailey, Non-Executive Director, QC Chair, agreed with the Medical Director and requested that the themes be triangulated to existing quality improvement workstreams to determine if any additional workstreams or specific work in a clinical service was required. The Director of Quality Governance agreed to report back on the process in three months' time.	**DDQG**
	Resolved – that (A) the Annual Review of Moderate Plus Harm Incidents 2021/22 be noted and received; and **(B) a further report on how the data would be triangulated and process for assurance be made in three months' time.**	**DDQG**
	Note: Dr A Haynes, left the meeting at this point and the meeting was inquorate.	
74/22/5	Quality Improvement at UHL	
	The Director of Quality Transformation and Efficiency Improvement updated the Committee on the Quality Improvement (QI) activities in the Trust (paper G refers).	

	It was reported that the Trust had adopted the IHI Model for Improvement approach, in 2019. The methodology was described. Since then, the Transformation Team had sought to build improvement capability across the organisation. The training and development activities were outlined noting that there was still work to do to embed the approach in the Trust. To provide more direct improvement support to operational areas, the 'Improvement Collaborative' approach was piloted in July 2021 in Vascular and Endoscopy. This involved a member of the QI Team leading an improvement project with the local area support.	
	Resolved – that report on Quality Improvement at UHL be received and noted.	
74/22/6	Safer Surgery and Never Events Action Plan	
	The Medical Director presented an update on the key elements of the Safe Surgery work-stream, Never Event action, and from the Consent and Patient Information Committees. (paper H refers). In 2021-22 there had been nine Never Events; and in the first quarter of 2022-23 there were three Never Events. The report noted the collaboration with other trusts to share learning and best practice; the support available to staff involved in incidents; and the good progress with the Safe Surgery Quality Assurance and Accreditation Programme. A thematic analysis of 15 Never Events had identified recurrent (two instances or more) or novel themes that required additional actions. These were: ➢ Shift-changeovers ➢ Patient factors: Complex or deteriorating patients contributing to cognitive overload of staff ➢ Individual staff factors: Cognitive overload due to either working in pressurised environments or due to patient factors ➢ Policy not followed ➢ Work as imagined versus work as done ➢ Positive Patient Identification ➢ Issues relating to care during the Covid-19 pandemic. ➢ Stop and Pause moments not done correctly ➢ Site marking ➢ Five Steps to Safer Surgery: A failure to adequately complete the Team Brief, Sign In or Time Out was a factor in a number of cases. ➢ Forms not having the correct checks ➢ Non-verbal cues: In three cases non-verbal cues served to causes confusion – e.g. placing important imaging equipment on the wrong side of the patient. ➢ Lack of help: only one person completing important checks with no challenge from an assistant. ➢ Out-patients: the cultural perception that the protocols performed in theatres did not apply in an outpatient procedural area. ➢ Leadership: Lack of a named individual taking charge in a procedural area was a common theme. ➢ Equipment ➢ Education and training: cases ➢ Staff Empowerment ➢ Modification of accountable surgical items ➢ Organisational level: delayed roll out of QA programme. Two additional workstreams had been added to the Never Event reduction action plan. The report noted the progress with the e-consent project and patient information.	

	Ms V Bailey, Non-Executive Director, QC Chair, asked how the thematic analysis from the Never Events would be communicated across the Trust. The Medical Director undertook to discuss this with the Lead Deputy Medical Director.	
	Resolved – that the Safer Surgery and Never Events Action Plan be received and noted.	
74/22/7	Safeguarding Report – Quarter 2 2022/23	
	Mr M Clayton, Head of Safeguarding, presented the quarterly update on safeguarding activities (paper I refers). The report provided assurance and updates to demonstrate compliance with all elements of the NHS contract 2022/23 and in addition with local, regional and national guidance relating to safeguarding children and adults. The Head of Safeguarding described some of the challenges for the services, notably improvements required to strengthen information sharing between midwives and health visitors, work to improve responses for children abandoned in the Emergency Department and the challenges in the recruitment and retention of administration staff. The report noted service developments which included maintenance of performance standards against PREVENT and the use of the records system Systm1 to improve information sharing with primary care services for midwifery safeguarding. The Committee noted the challenge with respect to children abandoned in the Emergency Department. Whilst the previous protocol had worked, there had been a recent case which indicated that it had not been effective. The Chief Nurse reported that there would be a System review and agreed to share the report when available.	**CN**
	Resolved– that (A) Safeguarding Report Quarter 2 2022/23 be received and noted; and **(B) that the System review of abandon children be shared with the Committee when available.**	**CN**
74/22/8	Board Assurance Framework (BAF)	
	Mr R Manton, Head of Risk Assurance, presented the second iteration of the BAF risk that pertained to the Quality Committee. It was agreed to undertake further work on the risks prior to submission to the Trust Board.	**DCLA**
	Resolved – that (A) the report on Board Assurance Framework be deferred.; and **(B) further work be undertaken to define the risks for the Quality Committee prior to submission to the Trust Board.**	**DCLA**
75/22	**REPORTS FROM UHL BOARDS**	
75/22/1	Nursing and Midwifery Board (NMB) Report – July 2022	
	The Chief Nurse presented the NMB report (paper K refers) noting that the last meeting of the NMB had been cancelled for operational reasons. The Chief Nurse reported a vacancy rate of 12.9% for Adult and 11.8% for Children's Registered Nurses. The rate for Healthcare Support Workers was 14.5%. The Registered Midwife to birth ratio funded establishment was 1:25, However, vacancies and absence had impacted, and the ratio was reported as 1:28 for June 2022. Staffing continued to be challenging requiring daily mitigation plans.	

	The Chief Nurse reported that 88 'red flags' had been recorded on the patient safety system in in June 2022 relating to shortfalls in nursing staff. No harms were reported for these incidents. There had been 207 inpatient falls reported in June 2022(compared to the 174 falls in May 2022. One fall had resulted in moderate harm. It was reported that the Head of Nursing for Recruitment, Retention and Pastoral Care had been appointed.	
	Resolved – that the Nursing and Midwifery Board (NMB) Report (July 2022) be received and noted.	
75/22/2	Maternity Safety Report	
	Ms E Broughton, Head of Midwifery, presented the Maternity Safety Report (paper L refers). The report set out a summary of the two completed Healthcare Safety Investigation Branch reports; new 72-hour reports for Quarter 1 2022/23; and an update on progress of the Maternity Safety Agenda. The Head of Midwifery noted the challenges in achieving compliance for safety training and that extra training days had been scheduled. With respect to the Maternity Services dataset, problems in accurate reporting were noted and improvements to the E3 IT system was planned. Evidence for four standards had been submitted to the Clinical Negligence Scheme for Trusts (CNST) and an assessment of compliance was expected in September 2022. The workforce had been reviewed and further investment was required to meet midwifery standards. This would be considered as part of the establishment review in September 2022. The vacancy rate had reduced as 18 posts had been recruited to. The report set out the risks and challenges. These included the requirement for the 'Continuity of Carer'. The further roll-out had been suspended and would be recommenced when the vacancy rate reached 5%. There were risks related to out of hours theatre cover for Leicester General Hospital second theatre provision and elective theatre capacity. This had been added to the Trust's Risk Register. The Head of Midwifery reported on the multi-disciplinary harms review for postpartum haemorrhages and a cluster review on specific cases which resulted in hysterectomies. This would be reported in the next maternity safety report. It was noted that there had been an increase in postpartum haemorrhages and a new tool to review incidences had been introduced.	
	Resolved – that Maternity Safety Report be received and noted.	
76/22	**LLR QUALITY BOARD**	
	Ms V Bailey, Non-Executive Director, QC Chair, proposed that the Never Events and Safe Surgery Action Plan be referred to the LLR Quality Board together with a summary of this meeting.	
	Resolved – that the Never Events and Safe Surgery Action Plan be referred to the LLR Quality Board together with a summary of this meeting.	**QC Chair**
77/22	**ITEMS FOR NOTING**	
77/22/1	Integrated Performance Report (IPR) – 2022/23 month 4	
	Resolved – That the Integrated Performance Report (IPR) – 2022/23 month 4 be noted.	

66/22	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
67/22	**IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**	
	<u>Resolved</u> – that (A) the item in Minute 69/22 above be recommended to the Trust Board for approval, and **(B) the items in Minutes 74/22/4 and 74/22/6, above be highlighted to the Trust Board for information.**	**QC CHAIR** **QC CHAIR**
68/22	**DATE OF THE NEXT MEETING**	
	<u>Resolved</u> – that the next meeting of the Quality Committee be held on Thursday 28 September 2022 from 2pm via Microsoft Teams.	

<u>The meeting closed at 4.01pm</u> Alison Moss – Corporate and Committee Services Officer

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

Voting Members

Name	*Possible*	*Actual*	*% Attendance*
V Bailey (Chair)	5	5	100
A Furlong	5	5	100
A Haynes	5	4	750
J Hogg (from May 2022)	4	4	100
E Meldrum (until May 2022)	1	1	100
T Robinson	4	2	50

Non-voting members

Name	*Possible*	*Actual*	*% Attendance*
B O'Brien	5	3	60
M Durbridge	5	5	100
G Collins-Punter (until May 2022)	2	1	50
G Sharma	5	4	80
J Smith (PP)	5	3	60
J Worrall	5	5	100
C Trevithick/C West/ H Hutchinson (ICB Representative)	5	4	80