**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**MINUTES OF THE QUALITY COMMITTEE (QC) MEETING**
**HELD ON THURSDAY 26 OCTOBER 2023 AT 2:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS**

**Members Present:**
Professor T Robinson – Non-Executive Director (Acting QC Chair)
Dr R Abeyratne – Director of Health Equality and Inclusion
Mr A Furlong – Medical Director
Dr A Haynes – Non-Executive Director
Ms J Hogg – Chief Nurse

**In Attendance:**
Ms R Briggs – Associate Director of Operations Projects (on behalf of Chief Operating Officer)
Professor N Brunskill – Director of Research and Innovation (for Minute 126/23/4)
Ms D Burnett – Director of Midwifery
Ms S Burton – Deputy Chief Nurse
Ms B Cassidy – Director of Corporate and Legal Affairs
Ms C Ellwood – Chief Pharmacist
Ms L Evans – Head of Nursing, Children's (for Minute 126/23/5)
Ms K Lambert – Associate Medical Director for Cancer (for Minute 126/23/1)
Mrs H Majeed – Corporate and Committee Services Officer
Dr R Marsh – Deputy Medical Director (for Minutes 1126/23/2 and 126/23/3)
Mr R Manton – Head of Risk Assurance
Ms C Pheasant – Chief Allied Health Professional
Ms J Smith – Patient Partner
Ms C West – ICB Representative

| | **RESOLVED ITEMS** | |
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| **121/23** | **APOLOGIES** | |
| | Apologies were received from Ms V Bailey, Non-Executive Director (QC Chair), Mr J Melbourne, Chief Operating Officer, and Mr J Worrall, Non-Executive Director. | |
| **122/23** | **QUORUM** | |
| | The meeting was confirmed to be quorate. | |
| **123/23** | **DECLARATIONS OF INTERESTS** | |
| | **Resolved – that no additional declarations of interests were received.** | |
| **124/23** | **MINUTES** | |
| | **Resolved – that the Minutes of the Quality Committee meeting held on 28 September 2023 (papers A1 and A2) be confirmed as a correct record.** | |
| **125/23** | **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. | |
| | **Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.** | |
| **126/23** | **ITEMS FOR DISCUSSION AND ASSURANCE** | |
| 126/23/1 | 104 Day+ Cancer Quality Standard Report – Quarter 4 2022/23 & Annual Summary | |
| | The Committee received the quarterly report (paper C refers) on potential harm to patients waiting for cancer treatment and it was noted that two patients had potential harm recorded in the fourth | |

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| | quarter of 2022-23. Members were advised that further to a review, one of these patients had 'no harm recorded due to the pathway' and the other one was still to be validated. The Associate Medical Director for Cancer presented the report and advised that the key themes for delay in this period were outpatient capacity in Urology and Oncology Services, complex patient pathways and capacity for diagnostic tests. Although template biopsy capacity for prostate cancer patients had improved, it remained an issue. Increasing demand due to patients being brought through their prostate pathways more quickly was being balanced by the additional in-house capacity that had been put in place. Urology outpatient capacity was also an issue and partly reflected the drive to facilitate long waiters through the pathways more quickly. Additional oncology capacity (i.e., mobile treatment centre) had been put in place at the Glenfield hospital site. The effect of Covid-19 had largely depleted, reconfiguration had embedded in, and the Service were keen to maximise the surgical robot capacity. Members noted the annual summary for 2022-23 and it was highlighted that the outstanding reviews would be progressed imminently. The Committee was assured that the investment in Cancer Services would increase Urology and Oncology capacity, thereby making progress in the right direction. | |
| | **<u>Resolved</u> – that the contents of the report be received and noted.** | |
| 126/23/2 | <u>Thrombosis Committee Update including an Update on VTE Assessment in the Emergency Department (ED)</u> | |
| | The Deputy Medical Director presented paper D and advised that some progress had been made in the overall position regarding timely VTE assessment in the ED. The performance was at 35.2% in September 2023, which was a slight reduction from August 2023 but an improvement from July 2023. This improvement had been mainly driven by the medical in-reach team. The in-reach team covered 83% of the eligible patients and their performance (of ensuring patients received their assessment within the time frame) stood at 45%. A quality improvement (QI) pilot project (i.e., Clinician undertaking VTE assessment at the point of decision to admit) within ED was about to commence and it was expected that this would significantly improve compliance. The performance of 'VTE assessment completed on admission' was at 97.1% for quarter 1 of 2023-24, which was above the agreed threshold (>95%) against the Quality Schedule. A Paediatric VTE assessment on Nervecentre had been introduced on 24 October 2023, which meant all patients admitted to UHL would now receive a VTE assessment thereby being complaint with NICE guidelines. Discussions were underway with Nervecentre regarding an issue relating to alerts not coming through when paused or stopped anticoagulation medication was re-introduced to patients and was expected to be resolved by January 2024. | |
| | Responding to a query, the Deputy Medical Director undertook to liaise with colleagues to triangulate mortality data for long waiters in ED. The Committee noted the report and requested a further update to be provided to QC in three months' time (i.e., January 2024) particularly regarding the QI project. | **DMD**<br><br>**DMD** |
| | **<u>Resolved</u> – that (A) the contents of the report be received and noted;**<br><br>**(B) the Deputy Medical Director be requested to triangulate mortality data for long waiters in ED, and**<br><br>**(C) the Deputy Medical Director be requested to provide a further update on VTE assessment in ED to QC in three months' time (i.e., January 2024), particularly regarding the Quality Improvement project.** | **DMD**<br><br>**DMD** |
| 126/23/3 | <u>Review of Patients Boarded or Rapid Flow to Wards</u> | |
| | The Deputy Medical Director advised that the Trust had enacted a more robust rapid flow and boarding policy to reduce patients waiting for a long time on an ambulance. A review of mortality and readmission for this cohort of patients had concluded that rapid flow and boarding of patients enabled a significant reduction in ambulance waits and reduced the risk in the community (paper E refers). It showed a sustained 85% reduction in ambulance waits. There had not been an increase in mortality or readmission due to rapid flow. However, it did not influence the long waits in the Emergency Department and had not mitigated the risk of increased mortality due to this. | |
| | **<u>Resolved</u> – that (A) the contents of the report be received and noted, and** | |

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| | **(B) an update on this discussion be highlighted to the Trust Board (for information), via the QC escalation report.** | **Acting QC Chair** |
| 126/23/4 | Report from the Director of Research and Innovation | |
| | **Resolved – that this Minute be classed as confidential and taken in private accordingly.** | |
| 126/23/5 | Report from the Head of Nursing, Children's | |
| | **Resolved – that this Minute be classed as confidential and taken in private accordingly.** | |
| 126/23/6 | Perinatal Mortality: MBRRACE Summary Report/Actions | |
| | On behalf of the Clinical Director, Women's and Children's, the Director of Midwifery presented paper H, summary of actions taken following the publication of the 2021 MBRRACE report. An internal review of the data and a peer review had been undertaken. The themes from these reviews indicated that babies were smaller and were sicker than in previous years and a number of deaths were related to complex babies transferred into UHL with cardiac issues. As part of the deep dive into the data, it was identified that there was a need for a review of the way the Trust's IT systems recorded postcodes. This was required to identify the impact from the areas of deprivation so that health inequalities could be targeted to drive the required change. This work was in progress but had not been resolved in time for the 2022 data submission. There was a planned expansion of the obstetric medical workforce. A demand and capacity review of the specialist diabetes service was underway to allow development of business cases, given the high rates of gestational diabetes, particularly in the South Asian population in Leicester. The Trust was in the early stages of exploring the formation of a 'Consortium' of super- specialised centres so that there was a pool of experience when external scrutiny was needed. Proactive engagement was being progressed with NHS England Deputy Director of Public Health to request support and review of the UHL data from an epidemiological perspective. The Local Maternity & Neonatal System (LMNS) Board development session was scheduled on 7 November 2023. An update from this session and an update on the System-wide Equity Strategy was requested to be provided to the QC in November/December 2023. | **CD, W&C/DoM** |
| | **Resolved – that (A) the contents of the report be received and noted;**<br><br>**(B) the Clinical Director, Women's and Children's and the Director of Midwifery be requested to provide an update from the Local Maternity & Neonatal System (LMNS) Board development session and an update on the System-wide Equity Strategy to QC, and**<br><br>**(C) an updated version of the Quality Committee report be appended to the QC escalation report, for the information of the Trust Board.** | **CD, W&C/DoM**<br><br>**MD** |
| 126/23/7 | Endoscopy Surveillance Recovery | |
| | The Associate Director of Operations Projects presented paper I which highlighted the ongoing risk for the overdue endoscopy surveillance backlog and the actions being taken to mitigate this. The CMGs and Specialty Teams had agreed some actions to address the process and administrative issues that had led to delays with the booking process within the Endoscopy department. Additional staffing arrangements had also been made to address the capacity issues in the endoscopy units. The service had implemented the accurx texting platform to contact all overdue surveillance patients. Patients who did not respond via this method would be contacted by an outgoing phone call. In terms of oversight and governance, a central dashboard was being developed which would provide a consolidated endoscopy waiting list position. The Medical Director also requested that a sense check across other waiting lists be undertaken to ensure that the issues identified above were not happening elsewhere in the Trust. A further update would be provided to QC in December 2023. | **DCOO**<br><br>**DCOO/ HoO, CHUGGS** |
| | **Resolved – that (A) the contents of the report be received and noted;**<br><br>**(B) a sense check across other waiting lists be undertaken to ensure that the issues identified in Endoscopy were not happening elsewhere in the Trust, and** | **DCOO**<br><br>**DCOO/** |

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| | **(C) a further update on this matter be provided to QC in December 2023 including an update on the above action.** | **HoO, CHUGGS** |
| 126/23/8 | Quality and Safety Performance Report – September 2023 | |
| | The QC considered the monthly patient safety and complaints performance report for September 2023 (paper J refers), noting that the clinical coding issues which had affected the accuracy of the July and August VTE risk assessment report had been resolved, and a re-run of the reports showed no material difference in compliance rates. The number of hospital acquired pressure ulcers (HAPUs) remained stable but the level of harm continued to decrease, with no category 3 or 4 HAPUs in-month. The Trust-level falls resulting in moderate or above harm peaked in September 2023 and reviews for those were underway. 3 Serious Incidents (SI) had been escalated. The report further advised that there had been an increase in the duty of candour evidence gaps, a data cleansing exercise had been undertaken and the numbers were expected to decrease. The number of overdue SI actions were comparable to the previous month due to a large cohort of actions that were due at the end of July 2023. Overall risk register performance indicated that 20% of open risks had an elapsed review date and/or actions passed their due date for the reporting period against a target of 10%. There had been 7 new risks entered on the risk register during the reporting period. Specific areas of focus in respect of medication safety, included sustained refusal of prophylactic dalteparin and timely administration of Parkinsons' medicines. Outpatient FFT score had improved whilst the inpatient score had slightly reduced but was above national average. Performance for formal complaints remained stable. The Trust had launched the PALS service with an aim of reducing the number of formal complaints. A review of system and processes was on-going, action plans post-complaint response would be developed and monitored through the patient experience team. The Head of Patient Experience had recently commenced in post. The Committee were assured with this update provided by the Chief Nurse. | |
| | **Resolved – that the contents of the report be received and noted.** | |
| 126/23/9 | NHS Patient Safety Strategy and Patient Safety Incident Response Framework (PSIRF) Update Report | |
| | The Deputy Medical Director presented paper K on behalf of the Head of Patient Safety. The report provided an update on the progress being made to implement the NHS Patient Safety Strategy (which included the PSIRF) in the Trust. The introduction of PSIRF created an opportunity to focus resources on a set of locally agreed UHL safety priorities as part of the PSIR Plan (PSIRP). The PSIRP identified the ways in which Patient Safety Incident Investigations (PSIIs) would be conducted and the alternative response types that would be used. This would allow focus of resources more effectively onto higher quality/more proportional responses to patient safety incidents rather than high volumes of standardised root-cause analysis based PSIIs. NHSE had requested Trusts to ensure that the Learn from Patient Safety Events (LFPSE) compliant software was in place, it was noted that the IM&T team were working to get this matter resolved by upgrading the Trust's Datix system. The national requirement was for all staff to undertake the Level 1 NHS patient safety syllabus e-learning on Essentials of Patient Safety, and it was expected that the Trust would be able to achieve this. The recruitment of Patient Safety Partners was also a requirement for the implementation of the framework, and adverts would be published by December 2023. In respect of linking this framework with the transformation programme, it was noted that the focus would be on making a difference so that care was delivered better and safer for patients. | |
| | The proposed transition date of 1 April 2024 and progress update on the workstreams to meet the project and national deadlines, was noted. The report was referred onto Trust Board, and it was noted that a standalone report on this had been included on the public Trust Board agenda for 9 November 2023. | **Acting Chair** |
| | **Resolved – that (A) the contents of the report be received and noted, and**<br><br>**(B) the Patient Safety Incident Response Plan be endorsed and referred on to the Trust Board for noting.** | **Acting Chair** |
| 126/23/10 | Cost Improvement Programme Quality Impact Assessments (QIAs): 2023/24 Quarter 2 review | |

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| | The Committee noted the 2023-24 quarter 2 position for QIAs of CIP schemes (paper L refers) and were assured by the controls that were in place. | |
| | **Resolved – that the contents of the report be received and noted.** | |
| 126/23/11 | Report from the Chief Nurse | |
| | **Resolved – that this Minute be classed as confidential and taken in private accordingly.** | |
| 126/23/12 | Board Assurance Framework (BAF) | |
| | The QC reviewed strategic risk 1 on the BAF (paper M refers) around a framework to maintain and improve patient safety, clinical effectiveness and patient experience which was aligned to the committee and its work plan. The Committee noted the updates in the month, including reference to a plan to improve the Trust's CQC rating for the safe domain, an implementation plan to adopt PSIRF, and a plan for roll-out of patient and carer involvement in care via Shared Decision making. There were no changes proposed to risk scores this month: current rating is 20 (likelihood of almost certain x impact of major), target rating is 6 and tolerable rating is 12. | |
| | **Resolved – that the contents of the report be received and noted.** | |
| **127/23** | **REPORTS FROM UHL BOARDS** | |
| 127/23/1 | Patient Safety Committee (17.10.23) Report | |
| | The Committee noted the update from the October 2023 Patient Safety Committee (paper N refers) and the assurance it provided. The Medical Director highlighted the following points in particular: -<br>(a) Diabetes Care Accreditation Programme (DCAP) – the Trust had signed up to this pilot programme which would enable provision of high-quality standards needed to provide safe care for inpatients with diabetes;<br>(b) Quarterly patient experience report – noted;<br>(c) Radiation Safety Annual report 2022 – actions against the main areas of risk would continue to be tracked through the Radiation Safety Committee. Members noted that there were sole advisors in several roles in the Leicester Radiation Safety Services. Recruitment challenges for these roles had led to a requirement to train staff, which was a long process. It was suggested that opportunities to work with other Trusts be explored;<br>(d) CQC steering group update and CQC Preparedness Project – membership was being strengthened including increased frequency of these meetings, and<br>(e) RRCV CMG Quality and Safety Board Update – actions being taken to address the TAVI backlogs, a written report would be presented to QC in November 2023. It was suggested that data relating to health inequalities in TAVI be presented to QC in three months' time (i.e., January 2024 | **MD**<br><br>**DMD**<br><br>**MD/DoHE &I** |
| | **Resolved – that (A) the contents of the report be received and noted;**<br><br>**(B) the Medical Director be requested to liaise with the Head of Radiation Protection in respect of exploring opportunities to work with other Trusts given the recruitment challenges re. sole advisors in several roles in the Leicester Radiation Safety Services;**<br><br>**(C) the Deputy Medical Director be requested to present a written report to QC on actions being taken to address the Transcatheter Aortic Valve Implantation (TAVI) backlogs, and**<br><br>**(D) the Medical Director and the Director of Health Equalities and Inclusion be requested to present the data relating to health inequalities in TAVI to QC in three months' time (i.e., January 2024).** | **MD**<br><br>**DMD**<br><br>**MD/DoHE &I** |
| 127/23/2 | Nursing, Midwifery and AHP Committee Summary Report | |
| | The Committee noted the contents of paper O which detailed the discussion of the MAC in October 2023. The following points were highlighted in particular: -<br>(a) Saving Babies Lives Care Bundle Version 3 evidence had been submitted to the Local Maternity & Neonatal System (LMNS) and LLR Integrated Care Board (ICB) following publication of new bundle on 31 May 2023, and the tool on 31 August 2023. Following review with external | |

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| | colleagues, LMNS supported a position of 41% compliance (noting this to be reasonable progress due to the complexity and detailed requirements). ICB colleagues were working with UHL to agree key performance targets to triangulate and gather evidence to achieve full compliance of the bundle;<br>(b) the new Maternity & Neonatal Quality Improvement Programme (MNIP) had been launched which had 4 workstreams encapsulating the priorities as part of NHE 3-Year plan, whilst aligning actions and recommendations from Ockenden, CQC, Maternity Intensive Scheme, and Empowering Voices, and<br>(c) first external assurance meeting with the ICB and NHS regional team scheduled on 6 November 2023 to review the progress of the CQC action plan. | |
| | **Resolved – that the contents of the report be received and noted.** | |
| **128/23** | **LLR QUALITY BOARD** | |
| 128/23/1 | Feedback from and escalation to LLR System Quality Board | |
| | There was no update on this agenda item. | |
| **129/23** | **ITEMS FOR NOTING** | |
| | The following report was received and noted.<br>• Integrated Performance Report – Month 6 2023-24 (paper P). | |
| | **Resolved – that the contents of paper P be received and noted.** | |
| **130/23** | **ANY OTHER BUSINESS** | |
| | There were no items of any other business. | |
| **131/23** | **IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD** | |
| | **Resolved – that the following update be brought to the attention of the Trust Board: -**<br>• an update on the discussion re. Review of Patients Boarded or Rapid Flow to Wards (Minute 126/23/3 above refers) be highlighted to the Trust Board (for information), and<br>• the Patient Safety Incident Response Plan (Minute 126/23/9 above refers) be endorsed and referred on to the Trust Board. | **Acting QC Chair** |
| **132/23** | **ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH** | |
| | None | |
| **133/23** | **DATE OF THE NEXT MEETING** | |
| | **Resolved – that the next meeting of the Quality Committee be held on Thursday 30 November 2023 from 2pm via Microsoft Teams.** | |

The meeting closed at 3:28 pm

Hina Majeed – Corporate and Committee Services Officer

**Cumulative Record of Members' Attendance (2023-24 to date).**

**Present**

| *Name* | *Possible* | *Actual* | *% Attendance* |
|---|---|---|---|
| *V Bailey (Chair)* | *7* | *5* | *71* |
| *R Abeyratne* | *7* | *6* | *86* |
| *A Furlong* | *7* | *6* | *86* |
| *A Haynes* | *7* | *5* | *71* |
| *J Hogg* | *7* | *5* | *71* |

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| *J Melbourne* | *7* | *6* | *86* |
| *G Sharma (until 30.4.23)* | *1* | *0* | *0* |
| *T Robinson* | *7* | *4* | *57* |
| *J Worrall* | *7* | *6* | *86* |

**In attendance**

| *Name* | *Possible* | *Actual* | *% Attendance* |
|---|---|---|---|
| *D Burnett* | *7* | *6* | *86* |
| *S Burton (from May 2023)* | *6* | *5* | *83* |
| *B Cassidy* | *7* | *4* | *57* |
| *G Collins-Punter* | *6* | *0* | *0* |
| *C Ellwood (from May 2023)* | *6* | *4* | *67* |
| *S Harris* | *7* | *0* | *0* |
| *J McDonald* | *7* | *0* | *0* |
| *R Manton* | *7* | *7* | *100* |
| *R Mitchell* | *7* | *0* | *0* |
| *B Patel* | *7* | *0* | *0* |
| *C Pheasant (from July 2023)* | *4* | *3* | *75* |
| *C Rudkin* | *7* | *6* | *86* |
| *J Smith (PP)* | *7* | *3* | *43* |
| *M Williams* | *7* | *0* | *0* |
| *Gang Xu (from May 2023)* | *6* | *3* | *50* |
| *ICB Representative* | *7* | *7* | *100* |