UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 29 JUNE 2023 AT 3:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey – Non-Executive Director (QC Chair)
Ms S Burton – Deputy Chief Nurse (on behalf of Chief Nurse)
Mr A Furlong – Medical Director
Dr A Haynes – Non-Executive Director
Mr J Melbourne – Chief Operating Officer
Mr J Worrall – Associate Non-Executive Director

In Attendance:
Mr A Best – Consultant Orthopaedic Surgeon (for Minute 73/23/1)
Dr R Bell – Consultant Intensive Care and Renal (for Minute 73/23/2)
Ms D Burnett – Director of Midwifery
Ms B Cassidy – Director of Corporate and Legal Affairs
Ms C Ellwood – Chief Pharmacist
Mrs H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Dr P McParland – Consultant Obstetrician (for Minute 73/23/3)
Ms C Rudkin – Head of Patient Safety (for Minutes 73/23/5 & 73/23/6)
Dr C Trevithick – ICB Representative

	RESOLVED ITEMS	
68/23	**APOLOGIES**	
	Apologies were received from Dr R Abeyratne, Director of Health Equality and Inclusion, Ms J Hogg, Chief Nurse; Professor T Robinson, Non-Executive Director and Ms J Smith, Patient Partner.	
69/23	**QUORUM**	
	The meeting was confirmed to be quorate.	
70/23	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
71/23	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 25 May 2023 (paper A) be confirmed as a correct record.	
72/23	**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, and the QC Non-Executive Director Chair noted work underway to progress the remaining actions as a matter of urgency.	
	In discussion on Minute 46/23/2a (re. Update re. Incident relating to very High-Risk Screening for Patients with Family History of Breast Cancer), the Medical Director advised that the final patient had been screened and no harm had been identified. It was agreed that this action could be marked as closed.	**CCSO**
	Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	**CCSO**
73/23	**ITEMS FOR DISCUSSION AND ASSURANCE**	

73/23/1	Update on VTE Assessment in ED	
	Members noted that some progress had been made in the overall position regarding timely VTE assessment in the ED despite the increase in numbers of patients waiting in ED (paper C refers). A number of initiatives had already been introduced to improve compliance, however, wider actions to reduce long waits in ED were key to ensure full compliance and increased safety. Discussion was underway with colleagues in the Medicine Specialty and Emergency and Specialist Medicine (ESM) CMG regarding the possibility of undertaking VTE assessments at the time of referral including raising awareness of the importance of timely VTE assessment. The Medical Director assured the Committee that this matter was being actively monitored and discussions were being taken forward primarily through ESM CMG PRMs. The upgrade of the Nerve Centre E-prescribing in ED would also bring about the required change and this was being progressed through the E-Hospital Board. The Committee noted the report and requested a further update to be provided to QC in three months' time (i.e., September 2023) on the planned interventions and which of those had started to make an impact.	**Co-Chair, Thrombosis Committee**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Co-Chair, Thrombosis Committee be requested to provide a further update on the VTE assessment in ED re. the planned interventions and which of those had started to make an impact.**	**Co-Chair, Thrombosis Committee**
73/23/2	Organ Donation (OD) Report	
	Members were advised that good progress had been made and UHL was now a level 1 organ donation Trust having consistently facilitated more than 12 donations per year (paper D refers). Ongoing efforts were needed to maintain the level 1 status, with publicity, ongoing support, and training. Whilst the overall rates of referral, Specialist Nurse in OD presence and consent rates remained good, the overall donation rate had fallen to 10 in 2022-23 which was below target. It was considered that this might be a statistical variation with overall reduction across the Midlands, but it was important that the Trust prioritised every opportunity to facilitate donation. The delays in finding emergency theatre space for the donation procedure was one of the challenges.	
	Resolved – that the contents of the report be received and noted	
73/23/3	MBRRACE – UK Report – work to-date and further actions for UHL	
	Paper E provided an update on the work being undertaken to monitor the Trust's neonatal mortality rate and the actions being taken to improve outcomes. In presenting this update, the Consultant Obstetrician specifically referred to the recently published 2021 Perinatal Mortality MBRRACE-UK report and the annual neonatal mortality data. A number of different factors that affected UHL's neonatal mortality rate had been analysed and considered. A brief update on the contributing factors and potential areas for learning was also provided including further actions that needed to be taken. A peer review with Leeds Teaching Hospitals NHS Trust had already been undertaken and the possibility of further partnerships to undertake peer reviews was being explored. This would assist in appropriate scrutiny, not only of the governance and how Perinatal Mortality Review Tool (PMRT) was approached, but equally about understanding the data in a better way. The Medical Director thanked colleagues for all the work that had been undertaken. He suggested that a further overview report which included all the actions that had already been taken and the additional actions that were being progressed be presented to the July 2023 Quality Committee meeting.	**Consultant Obstetrician/ Consultant Neonatologist**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Consultant Obstetrician/ Consultant Neonatologist be requested to provide a further update on perinatal mortality rates summarising actions and future plans.**	**Consultant Obstetrician/ Consultant Neonatologist**
73/23/4	Maternity and Neonatal Assurance Report	
73/23/4 a	Maternity Assurance Committee (MAC) Highlight Report	

	Members were updated on the key discussions held at the June 2023 meeting of the MAC (paper F1 refers). The focus was on safe care, workforce, intentions around maternity and neonatal improvement programme, and Ockenden assurance/compliance. The MAC had shared insights into perinatal and neonatal surveillance and the reports highlighted the areas of progress and risks to delivery of the key national and regional drivers for change and improvement. The MAC received an update on the JanamApp, and members had confirmed their agreement to support its utilisation and implementation at UHL.	
	Resolved – that the contents of the report be received and noted.	
73/23/4 b	Maternity Safety Annual Report 2022-23	
	Paper F2 provided assurance on maternity safety across UHL in addition to associated risks being highlighted. Members were briefed on actions being taken by Maternity Services to respond to learning following the reporting of serious incidents, patient safety/Datix incidents, complaints, and inquests in the 2022-23 reporting period. An update was provided on Healthcare Safety Investigation Branch (HSIB) referrals/activity including the themes arising from safety recommendations and responses initiated. Members commended the Director of Midwifery and her team for the format of this report which they found very helpful as it summarised all the work being undertaken encapsulated into one report.	
	Resolved – that the contents of the report be received and noted.	
73/23/4 c	Maternity & Neonatal Safety Champion Update	
	Resolved – that paper F3 was withdrawn from the agenda.	
73/23/4 d	Perinatal Quality Assurance Scorecard May 2023	
	The Director of Midwifery advised that her Team were reviewing the technical guidance and the minimum data set to ensure all the detail was captured within the Trust's perinatal scorecard, albeit it was still a draft version (paper F4 refers). She requested any comments or feedback to be provided by members outwith the meeting (by 3 July 2023) so that this could be incorporated into the report for the July Trust Board meeting.	**ALL**
	Resolved – that (A) the contents of the report be received and noted, and **(B) all members be requested to provide comments on the perinatal scorecard so that this could be incorporated into the report for the July 2023 Trust Board meeting.**	**ALL**
73/23/4 e	Maternity Intensive Scheme (MIS)	
	Paper F5 detailed the safety actions under the Maternity Incentive Scheme year 5 standards were published on 31 May 2023. The time-period for compliance was 30 May 2023 -7 December 2023 with 1 February 2024 being the submission deadline. The MIS rewarded Trusts which met 10 safety actions designed to improve the delivery of best practice in Maternity and Neonatal Services. The standards together with the evidential requirements and technical guidance was being reviewed in detail with the Leads, with a view to a project plan being migrated on to MS Projects. The Director of Midwifery advised members that work was ongoing within the Trust and System Partners to be able to achieve the year 5 MIS standards.	
	Resolved – that the contents of the report be received and noted.	
73/23/5	Quality and Safety Performance Report – May 2023	
	The QC considered the monthly patient safety and complaints performance report for May 2023 (paper G refers), noting the work on-going to improve VTE compliance in ED and actions being taken due to the increase in number of Hospital Acquired Pressure Ulcers (HAPUs) in that month. 10 Serious Incidents (SI) had been escalated and there had been an increase in overdue SI actions. The report further advised that there had been a decrease in the duty of candour evidence gaps. Overall risk register performance indicated that 21% of open risks had an elapsed review date and/or actions passed their due date for the reporting period against a target of 10%. The medicines management team continue to work with teams to drive improvement in medicines	

	safety indicators. Initial indicators covering blood traceability had been included as a new indicator in this month's report. From a complaints' perspective, performance had declined but a number of actions were being taken to improve position. The Early Resolution Team pilot work (which provided resolution of complaints at an earlier stage for those cases that were appropriate) had commenced which had reduced the number of formal complaints received. The Committee Chair requested an update on this work to be included in a future version of this report, when appropriate. Members were advised that this report had been discussed at the Patient Safety Committee (PSC) on 27 June 2023. In discussion on the NHS Resolution (NHSR) Claims scorecard, the PSC had requested the Head of Patient Safety and Assistant Director of Corporate and Legal Affairs to provide data to the Executive Team which they could use at CMG PRMs in relation to the work required by CMGs to triangulate their NHSR Claims scorecard with complaints and serious incidents and agree a way forward to gain assurance. Responding to a query, it was noted that work was underway to link the learning and themes from the data analysis undertaken in this report with the NHS Patient Safety Strategy and Patient Safety Incident Response Framework (PSIRF) and the Trust's transformation programme.	
	Resolved – that the contents of the report be received and noted.	
73/23/6	Quarter 4 2022-23 Complaints Report	
	The Head of Patient Safety presented paper H, the quarter 4 complaints report which provided themes and trends from the complaints and concerns received in that quarter. This allowed focused specialty or wider organisational actions to be developed and implemented to improve quality and safety. Members were briefed on the key updates as listed in the report. The number of formal complaints in quarter 4 had slightly increased in comparison to quarter 3. The Gynaecology Service had received the most complaints and concerns and ENT Service had the largest rise in the number of complaints and concerns received in quarter 4. A number of actions to improve the position had already been taken by the Gynaecology Service and a decrease in complaints in quarter 1 of 2023-24 was being seen. The top themes were in relation to medical care, staff attitude and nursing care. The Independent Complaints Review Panel had been re-established this year. A Head of Patient Experience was being appointed who would be focussing on the management of complaints.	
	Resolved – that the contents of the report be received and noted.	
73/23/7	Board Assurance Framework (BAF)	
	The QC reviewed strategic risk 1 on the BAF (paper I 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. There are no matters of concern from the strategic risk or significant changes proposed to the content this month. The committee noted the updates made in the month in red text in the BAF, including reference to the awaited Maternity services care inspection report. There were no changes proposed to the scores of this risk: Current rating is 20 (likelihood of almost certain x impact of major), target rating is 6 and tolerable rating 12. A risk of deterioration in score following CQC's visit to Maternity Services was noted.	
	Resolved – that the contents of the report be received and noted.	
73/23/8	Quality Committee Terms of Reference	
	The following changes were proposed to the QC Terms of Reference (paper J refers): - (a) as the Patient Involvement and Patient Experience Committee (PIPEC) now reported to NMAHPC (the reference to QC receiving quarterly assurance reports from PIPEC be removed); (b) inclusion of any deputies or Heads of Professional Services being invited to attend as observers (non-voting members), and (c) inclusion of the review of the clinical audit programme.	**DCLA**

	Resolved – that (A) the contents of the report be received and noted, and **(B) the Director of Corporate and Legal Affairs be requested to update the QC terms of reference as per the changes listed above.**	**DCLA**
74/23	**REPORTS FROM UHL BOARDS**	
	There were no reports scheduled for this meeting.	
75/23	**LLR QUALITY BOARD**	
75/23/1	Feedback from and escalation to LLR System Quality Board	
	• UHL was now a level 1 organ donation Trust.	
76/23	**ITEMS FOR NOTING**	
	The following items were received and noted. • Patient Safety Committee – Workplan and Terms of Reference (papers K & K1) • Integrated Performance Report – Month 2 2023-24 (paper L), and • Update on Health Equality and Inclusion (paper M).	
	Resolved – that the contents of papers K-M be received and noted.	
77/23	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
78/23	**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: - • The minor changes to the QC terms of reference (Minute 74/23/8 above refers) be highlighted to the July 2023 Trust Board, for information.	**QC Chair**
79/23	**ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH**	
	It was noted that the following report had not been received in line with the Committee's work plan: • Transfusion Committee Update (deferred to July 2023); • Learning from SIs/Harms – Quarterly Report (deferred to July 2023), and • NICE Annual Report 2022- 23 (deferred to July 2023 due to shortened duration of the meeting.)	
80/23	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 27 July 2023 from 2pm via Microsoft Teams.	

The meeting closed at 4:00 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)	*3*	*3*	*100*
R Abeyratne (from December 2022)	*3*	*2*	*66*
A Furlong	*3*	*2*	*66*

A Haynes	*3*	*2*	*66*
J Hogg (from May 2022)	*3*	*1*	*33*
J Melbourne (from December 2022)	*3*	*3*	*100*
G Sharma (from December 2022) **	*1*	*0*	*0*
T Robinson	*3*	*1*	*33*
J Worrall (from December 2022) **	*3*	*3*	*100*

** Changed from attendee to member

In attendance

Name	*Possible*	*Actual*	*% Attendance*
B Cassidy (from December 2022)	*3*	*2*	*66*
G Collins-Punter (until May 2022 and from December 2022)	*3*	*0*	*0*
S Harris (from December 2022)	*3*	*0*	*0*
J McDonald (from December 2022)	*3*	*0*	*0*
R Manton (from December 2022)	*3*	*3*	*100*
R Mitchell (from December 2022)	*3*	*0*	*0*
B Patel (from December 2022)	*3*	*0*	*0*
C Rudkin (from December 2022)	*3*	*3*	*100*
J Smith (PP)	*3*	*1*	*33*
M Williams (from December 2022)	*3*	*0*	*0*
ICB Representative	*3*	*3*	*100*