UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 25 MAY 2023 AT 2:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey – Non-Executive Director (QC Chair)
Dr R Abeyratne – Director of Health Equality and Inclusion
Mr A Furlong – Medical Director
Mr J Melbourne – Chief Operating Officer
Professor T Robinson – Non-Executive Director
Mr J Worrall - Associate Non-Executive Director

In Attendance:
Ms S Bailey – ICB Representative
Ms D Burnett – Director of Midwifery
Ms S Burton – Deputy Chief Nurse (on behalf of Chief Nurse)
Mr M Clayton – Head of Safeguarding (for Minute 61/23/2)
Ms C Ellwood – Chief Pharmacist
Ms S Favier – Deputy Chief Operating Officer (for Minute 60/23/8)
Ms J Kay – Head of Quality Assurance (for Minutes 59/23/3 and 59/23/4)
Mrs H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Dr P McParland – Consultant Obstetrician (for Minute 59/23/1)
Ms J Pickard – Macmillan Lead Cancer Nurse (for Minute 60/23/1)
Mr S Pizzey – Associate Director of Strategy and Partnerships (for Minute 60/23/6)
Ms C Rudkin – Head of Patient Safety
Ms J Smith – Patient Partner
Ms H Stokes – Corporate and Committee Services Officer
Dr G Xu – Deputy Medical Director

	RESOLVED ITEMS	
54/23	**APOLOGIES**	
	Apologies were received from Ms B Cassidy, Director of Corporate and Legal Affairs; Dr A Haynes, Non-Executive Director; Ms J Hogg, Chief Nurse, and Dr C Trevithick, ICB Representative,	
55/23	**QUORUM**	
	The meeting was confirmed to be quorate.	
56/23	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
57/23	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 27 April 2023 (paper A) be confirmed as a correct record.	
58/23	**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**

	<u>Resolved</u> – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	**CCSO**
59/23	**ITEMS FOR DISCUSSION AND ASSURANCE**	
59/23/1	<u>Mortality and Learning from Deaths Report</u>	
	The Committee received the quarterly report (paper D refers) on mortality rates and progress against the learning from deaths framework which provided assurance in respect of both the national risk adjusted mortality measure (SHMI) and delivery of Death Certification, Medical Examiner (ME) Scrutiny and Case Record Review as per national statutory requirements. The following points were highlighted in particular: i. the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remained within the expected range; ii. although there had been a postponement to the national plans for rolling out the Medical Examiner process to cover all deaths in primary care, UHL had received an increased number of referrals from GP Practices and LOROS. iii. early review of potential learning themes following ME screening had been similar to those identified in 2021-22. A detailed analysis of the themes would be undertaken further to which it would be reported to the relevant Executive-level Committee; iv. three deaths during quarter 4 of 2022-23 had been more likely than not due to issues in care and were currently being investigated as serious incidents, and v. a deep dive was being undertaken of the cases whereby thromboprophylaxis had been identified as a common theme.	
	In respect of perinatal mortality, members were advised that at the time of writing the report, the 2021 national benchmarked data by MBRRACE-UK had not been published and therefore had not been presented to the Mortality Review Committee or Maternity Assurance Committee. The report had been published on 12 May 2023 and the Medical Director verbally advised that UHL's still-birth and neonatal mortality rates remained more than 5% higher than its peer group. Members were advised on further actions that have been agreed following publication of the MBRRACE-UK report. The report would be further discussed at the June 2023 Maternity Assurance Committee and a written report detailing work to date and further actions would be presented to the June 2023 Quality Committee. The one area that was highlighted in the MBRRACE-UK report was that UHL was significantly different in terms of ethnicity of patients. The Director of Health Equality and Inclusion advised members of a draft framework being developed around ethnicity and deprivation, in respect of maternal experiences and outcomes.	
	In summary, the Committee was assured with this update, noting that a number of actions were underway, and a comprehensive report would be presented to the June 2023 Quality Committee, further to which any issues would be escalated to the Trust Board, as appropriate.	**MD**
	<u>Recommended</u> – that (A) the report be endorsed and recommended to the Trust Board for approval, and **(B) following the review of the MBRRACE-UK report, the Medical Director be requested to present a written update detailing work to date and further actions.**	**MD** **MD**
59/23/2	<u>QC Annual Report</u>	
	The QC considered and endorsed the 2022-23 annual report (paper K refers) into the effectiveness of the Committee and recommended it for Trust Board approval. The information contained within the report aimed to provide QC itself and the Trust Board with assurance on an annual basis that QC meetings had covered all essential areas within its remit which were also aligned with best practice and QC's terms of reference. The Committee was 88.5% compliant in respect of its core functions. Regarding the specific duties which were currently not being met, it was agreed that the Corporate and Committee Services Manager would liaise with the Director of Corporate and Legal Affairs and arrange a small task and finish group to review the terms of reference to assure itself of their continuing appropriateness. It was suggested that this group also discussed the relevance of some of the core duties to avoid duplication and ensure good alignment across areas that mattered the most for the Quality Committee. Members were advised	**CCSM**

	that discussion was already underway in respect of widening the clinical membership of the Quality Committee.	
	<u>Recommended</u> – that (A) the report be endorsed and recommended to the Trust Board for approval, and **(B) the Corporate and Committee Services Manager be requested to liaise with the Director of Corporate and Legal Affairs and arrange a small task and finish group to review the QC terms of reference to assure the continuing appropriateness of the specific duties currently not being met. In addition, discussion to take place on the relevance of some of the core duties to avoid duplication and ensure good alignment across areas that mattered the most for the Quality Committee.**	**CCSM**
59/23/3	<u>Changes to CQC Statement of Purpose</u>	
	Paper N highlighted the following updates to the Trust's CQC Statement of Purpose (a) to include the new location address for the Northampton Renal Dialysis Unit from 30.4.23 (members were advised that due to the short time frame provided by the Service when requesting CQC updates for change of location address, it was agreed with the Chief Nurse for the updated Statement of Purpose to be sent to the CQC and then onto the Quality Committee for retrospective approval and assurance), and (b) to update the nominated individual email address, as the post holder had left the Trust.	
	Members were advised that the Statement of Purpose would have a full review and revision to include the changes in the Trust's strategy and values once the consultation process of 'We are UHL' had been completed. Members suggested that this review be used as an opportunity to review some of the terminology (e.g., Biomedical Research Centre, Clinical Commissioning Groups etc) which were no longer being used.	**HQA**
	<u>Recommended</u> – that (A) the report be endorsed and recommended to the Trust Board for approval, and **(B) the Head of Quality Assurance be requested to update some of the terminology (e.g., Biomedical Research Centre, Clinical Commissioning Groups etc) which were no longer being during the review and revision of the CQC's Statement of Purpose.**	**HQA**
59/23/4	<u>Quality Account 2022-23</u>	
	The Committee received the Quality Account 2022-23 (paper M refers), the annual report from providers of healthcare about the quality of services delivered. The content of the Quality Account was informed by Department of Health guidance (toolkit) and regulations. The toolkit had not been updated therefore the content remained largely unchanged, however, there was a requirement for Integrated Care Boards to assume responsibility for the review and scrutiny of the Quality Account. The ICB had requested for the Quality Account to be presented to the LLR ICB and this had been undertaken. In respect of data quality assurance, QC were advised that the content of the Quality Account was consistent with internal and external sources of information.	
	<u>Recommended</u> – that the report be endorsed and recommended to the Trust Board for approval.	**QC Chair**
60/23	**ITEMS FOR DISCUSSION AND ASSURANCE**	
60/23/1	<u>Quarterly Cancer Harm Report – Quarter 3 2022/23</u>	
	The Committee received paper C, the quarterly report on potential harm to patients waiting for cancer treatment and it was noted that one patient had potential harm recorded in the third quarter of 2022-23, however, this was still to be validated. The Macmillan Lead Cancer Nurse 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. Patient complexity, patient choice and late tertiary referrals were other less avoidable factors for delays to pathways. The need for continued investment in cancer services in terms of workforce, equipment, space, and development of novel and efficient pathways was highlighted. There was a brief discussion regarding the appropriateness of the statement that the report provided assurance	

	that the longer waiting cancer patients were being monitored effectively and the terminology used for monitoring harm. In response, the Macmillan Lead Cancer Nurse undertook to liaise with the Associate Medical Director for Cancer outwith the meeting, regarding the need for refining the language on way harm was reported noting that a national defined process was being followed. Cancer performance recovery was noted as a key focus for the Trust by the Chief Operating Officer.	**MLCN**
	<u>Resolved</u> – that (A) the contents of the report be received and noted, and **(B) the Macmillan Lead Cancer Nurse be requested to liaise with the Associate Medical Director for Cancer regarding the need for refining the language on way harm was reported noting that a national defined process was being followed.**	**MLCN**
60/23/2	<u>Quality and Safety Performance Report – April 2023</u>	
	The QC considered the monthly patient safety and complaints performance report for April 2023 (paper E refers), noting that 5 Serious Incidents (SI) had been escalated and the number of Hospital Acquired Pressure Ulcers (HAPUs) had reduced in that month. The report further advised that there had been an increase in the duty of candour evidence gaps and overdue SI actions. Overall risk register performance indicated that 33% of open risks had an elapsed review date and/or actions passed their due date for the reporting period against a target of 10%. Initial indicators covering medicines safety had been included as a new indicator in this month's report, but this would be monitored, and any emerging themes would be included, as appropriate. From a complaints perspective, performance had improved, although it was still under target. The two longest overdue complaints which had a deadline of July and August 2022 respectively were now ready to be signed-off. The QC Chair suggested the need to put in a process whereby if responding to a complaint was delayed beyond a certain time, then it be flagged at an Executive-level. The Early Resolution Team pilot work would commence imminently, and it was hoped that this would reduce the number of formal complaints by providing resolution at an earlier stage for those cases that were appropriate. There had been no new National Patient Safety Alerts received and no CAS alerts had breached their deadlines. A brief update on the mortality data was provided and it was highlighted that further comparative analysis of the diagnosis group 'Septicaemia' would be undertaken. Members were advised that this report had been discussed at the TLT on 23 May 2023 where it was suggested that the 'comments' section of the report included robust actions in terms of who/which Committee would be monitoring the actions.	
	<u>Resolved</u> – that the contents of the report be received and noted.	
60/23/3	<u>NHS Patient Safety Strategy and Patient Safety Incident Response Framework (PSIRF) Update</u>	
	Paper F provided an update on the progress being made to implement the NHS Patient Safety Strategy which included the PSIRF in the Trust. The Patient Safety Strategy and PSIRF Programme Lead secondment post had now been recruited to with a start date of 3 July 2023. The national timeline for transitioning over to PSIRF was Autumn 2023 but latest information from the national team had indicated that that there was no set deadline and providers needed to transition to PSIRF when safe to do so in collaboration and agreement with their ICB. The national requirement was for all staff to undertake the Level 1 eLearning for Health (e-LFH) national patient safety syllabus modules, however, currently it was proposed that this would be an essential to role training. The Head of Patient Safety highlighted that patient engagement was a key aspect of PSIRF, and the need to ensure a uniformed approach across the System. Members acknowledged this noting the need to engage with ICB partners to develop a coherent approach to how Patient Safety Partners were involved in the new safety framework.	
	<u>Resolved</u> – that the contents of the report be received and noted.	
60/23/4	<u>Outcome of the clinically led thematic review of all HAPUs validated for the month of December 2022</u>	
	Members were reminded that recommendations further to an external review (September 2022) due to the increased incidence of HAPUs in quarter 1 and 2 of 2022-23 had been presented to QC in January 2023. The report (paper G refers) being presented to this month's QC was the learning following the clinically led (internal) thematic review of all the HAPUs validated for the month of December 2022 as there had been a further peak of HAPUs between October-December 2022.	

	Following an analysis of the data, the causation behind the majority of HAPUs identified was not dissimilar to previous months in relation to themes. The report detailed the key multi-factorial reasons which had led to the increase in HAPUs in that time and appropriate actions had been put in place to resolve the issues that had been identified. A number of interventions had been enacted to support the reduction in harm. A correlation had been noted between the lack of staff understanding (i.e., training package) on how to use the new product (i.e., mattresses) which were introduced at the LRI and LGH sites and the increase in harms reported. A further expanded comprehensive education and support package had been in place since early January 2023 and had demonstrated that staff now had a much-improved understanding of how the new product worked and should be used. The Quality Committee noted the update and supported the recommendations listed in the report.	
	Resolved – that the contents of the report be received and noted.	
60/23/5	Board Assurance Framework (BAF) Report	
	The QC reviewed strategic risk 1 on the BAF (paper H 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 statutory and mandatory training compliance, quality improvement methodology, and vacancy rates in midwifery services. 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.	
	Resolved – that the contents of the report be received and noted. **.**	
60/23/6	2023-24 Annual Plan – Risks to Delivery	
	At the request of the Trust Board, an overview of the identified 2023/24 Annual Plan delivery risks (paper I refers) was being presented to all Board Committees, to enable the members of each Committee to assess which delivery risks aligned to their Committee as well as identifying if any other risks needed to be included. These risks would be managed through the respective Board Committee, with aggregated overall progress reported quarterly to the Trust Board. QC noted that although none of the 2023/24 annual plan risks were particularly ascribed to it, most of those had an impact on quality and safety. A number of suggestions were made which would be actioned by the Associate Director of Strategy and Partnerships accordingly.	**ADSP**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Associate Director of Strategy and Planning be requested to update the 2023/24 Annual Plan delivery risks as per suggestions provided at the meeting.**	**ADSP**
60/23/7	Deteriorating Patient Board, Resuscitation Committee, and the End-of-Life Steering Group Report and Safer Surgery Update	
	The QC noted the report from the Deteriorating Patient Board (paper J refers)- the Qlik Sense dashboards, focused on objective markers associated with deteriorating patients provided assurance that UHL continued to deliver high quality care for this high acuity cohort. Sepsis remained an ongoing focus for assurance monitoring and quality improvement. Work was progressing on the Year 2 of the Deteriorating Patient CQUIN, with a focus on escalation. The End-of-Life Committee work focussed on additional clinical focus on ReSPECT pathways led by senior clinicians. The Resuscitation Committee report highlighted that the Trust had received the LP15 defibrillator to replace the aging fleet of defibrillators across the ED and emergency floor. The Committee noted the report and the recommendations.	
	Resolved – that the contents of the report be received and noted.	
60/23/8	Combined Elective Care Audits Update	
	Paper L provided an update on progress against 48 actions resulting from five internal audits relating to elective care, dating from 2020/21 to 2022/23. Members were advised that whilst the Trust was on-track to complete the actions, risks remained until all actions were completed and	

	embedded as business as usual. Members noted that the management of waiting lists was reliant on a largely manual process and aging electronic system. The Chief Operating Officer assured the QC that his team were doing all that they could to streamline and change processes and reduce the likelihood of issues/human factor errors prior to the electronic patient record being in place.	
	Resolved – that the contents of the report be received and noted.	
61/23	**REPORTS FROM UHL BOARDS**	
61/23/1	Maternity Assurance Committee (MAC) Escalation Report	
	Members were advised that MAC was a new Committee, and the inaugural meeting took place in April 2023 where the terms of reference and work plan had been agreed. QC noted paper O, the new governance and infrastructure arrangements in place and the intention of the Women's & Children's CMG to set up an Operational Assurance Group as part of improving oversight. Members noted the publication of the three-year plan for Maternity & Neonatal Services.	
	Resolved – that the contents of the report be received and noted.	
61/23/2	Safeguarding Assurance Committee Escalation report	
	Paper P provided a summary of the current position of safeguarding practice within UHL, together with key developments that informed future safeguarding practice. The 2022 Safeguarding Children and Adults annual report was also included which highlighted the following achievements in particular: - • positive feedback on the effectiveness of the Trust's safeguarding systems by the CQC; • introduction of electronic safeguarding notifications using System 1 for midwifery services; • awarded NHS England Safeguarding Star, and • completed a patient experience survey for adult patients where a safeguarding enquiry had been undertaken which was presented to the LLR Adult Safeguarding Board as an example of best practice. Members were advised that there were national delays in the publication of the Liberty Protection Safeguard, however, this had now been deferred. There were also national delays in the publication of domestic homicide review reports. QC noted the reintroduction of Hospital Independent Domestic Violence Advocate provision (HIDVA) and the new requirements for the ICB under the serious violence duty.	
	Resolved – that the contents of the report be received and noted.	
61/23/3	NMAHPC Escalation Report	
	Paper Q provided a summary of the NMAHPC meeting held in May 2023 in relation to strengthening the voice of the patient, the digital health agenda, reducing avoidable hospital acquired harm, and making UHL the employer of choice for NMAHPs.	
	Resolved – that the contents of the report be received and noted.	
61/23/4	Infection Prevention and Assurance Committee Escalation Report	
	Paper R covered the infection prevention activity outcomes during quarter 4 of 2022-23 and was noted by the QC.	
	Resolved – that the contents of the report be received and noted.	
62/23	**LLR QUALITY BOARD**	
62/23/1	Feedback from and escalation to LLR System Quality Board	
	No reports for escalation from this meeting.	
63/23	**ITEMS FOR NOTING**	

	The following items were received and noted. • Quality Improvement and Assurance Programme (paper S); • Cost Improvement Programme Quality Impact Assessments: 2022/23 Quarter 4 review (paper T), and • Integrated Performance Report – Month 1 2023/24 (paper U)	
	Resolved – that the contents of papers S-U be received and noted.	
64/23	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
65/23	**IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**	
	Resolved – that the following updates be brought to the attention of the Trust Board: - • **the achievements and work of the Safeguarding Assurance Committee (Minute 61/23/2 above refers).**	**QC Chair**
66/23	**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: • Organ Donation Report (deferred to June 2023).	
67/23	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 29 June 2023 from 3pm 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)	*2*	*2*	*100*
R Abeyratne (from December 2022)	*2*	*2*	*100*
A Furlong	*2*	*1*	*50*
A Haynes	*2*	*1*	*50*
J Hogg (from May 2022)	*2*	*1*	*50*
J Melbourne (from December 2022)	*2*	*2*	*100*
G Sharma (from December 2022) **	*1*	*0*	*0*
T Robinson	*2*	*1*	*50*
J Worrall (from December 2022) **	*2*	*2*	*100*

** Changed from attendee to member

In attendance

Name	*Possible*	*Actual*	*% Attendance*
B Cassidy (from December 2022)	*2*	*1*	*50*
G Collins-Punter (until May 2022 and from December 2022)	*2*	*0*	*0*

S Harris (from December 2022)	*2*	*0*	*0*
J McDonald (from December 2022)	*2*	*0*	*0*
R Manton (from December 2022)	*2*	*2*	*100*
R Mitchell (from December 2022)	*2*	*0*	*0*
B Patel (from December 2022)	*2*	*0*	*0*
C Rudkin (from December 2022)	*2*	*2*	*100*
J Smith (PP)	*2*	*1*	*50*
M Williams (from December 2022)	*2*	*0*	*0*
ICB Representative	*2*	*2*	*100*