Cover report to the Trust Board meeting to be held on 3 February 2022

	Trust Board paper F3
Report Title:	**Quality Committee – Committee Chair's Report**
Author:	Ms K Rayns – Corporate and Committee Services Officer

Reporting Committee:	**Quality Committee (QC)**
Chaired by:	Dr A Haynes – Adviser to the Trust Board (Acting Committee Chair)
Lead Executive Director(s):	Mr A Furlong – Medical Director Ms E Meldrum – Acting Chief Nurse
Date of meeting:	23 December 2021

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality Committee meeting on 23 December 2021:- *(involving Dr A Haynes, Adviser to the Trust Board [Acting Chair]; Professor T Robinson, Non-Executive Director; Mr M Williams, Non-Executive Director; Ms K Gillatt, Associate Non-Executive Director; Mr I Orrell, Associate Non-Executive Director; Mr A Furlong, Medical Director; Ms E Meldrum, Acting Chief Nurse; Miss M Durbridge, Director of Quality, Transformation and Efficiency Improvement; Ms J Smith, Patient Partner, Mr P Aldwinckle, Patient Partner, and Ms C Trevithick, Leicester City CCG. (Ms B O'Brien, Director of Quality Governance and Dr C Marshall, Deputy Medical Director attended to present their respective items).*

- **Pertinent Safety Issues** – the Medical Director advised that the LLR System and UHL were running very 'hot' from an operational perspective, with the Omicron variant of Covid-19 now being the most dominant strain. A significant increase in community-transmitted infections had not yet translated into a significant rise in admissions. There were currently around 100 to 110 patients being treated for Covid-19, with 9 patients on ITU and 1 on ECMO. Staff sickness levels remained a concern due to the increased transmissibility of the Omicron variant, but any areas of workforce vulnerability were being actively monitored and addressed. The Covid-19 alert level had been increased to Level 4, the Tactical and Strategic Cells had been stood up to meeting 5 times per week and shadow rotas were being created to manage any staffing pressures. Communications regarding preparations for potential redeployment of staff had commenced. A series of actions had been agreed to reduce ambulance handover delays, free-up existing bed capacity, create additional bed capacity, and spot purchase additional care home beds in preparation for an anticipated spike of Omicron cases in January 2022. Discussion took place regarding the virtual Respiratory ward, ongoing plans to create virtual wards for other services (eg heart failure and COPD) and the LLR System Covid Medicines Delivery Unit which was sited at the Glenfield Hospital. The Committee received assurance regarding the joint decision-making processes that were in place between the Trust and the wider LLR System. Within the LLR System there was a Strategic Group, a Tactical Group and a Clinical Executive which included UHL representation. These groups were proactively considering any contingency plans which might be required going forwards and a visible audit trail was being maintained surrounding all decision-making;

- **Integrated Performance Report** – paper C provided the Integrated Performance Report (IPR) for Month 7 of 2021/22. The Acting Chief Nurse provided a summary of the exception reports within the Safe Domain, including Methicillin Sensitive Staphylococcus Aureus (MSSA) and Hospital Acquired Pressure Ulcers (HAPUs). She briefed the Committee on the arrangements to ensure safe staffing levels, noting the potential impact of staffing gaps upon pressure ulcers and patient falls. In respect of the Caring Domain, a slow decline in ED friends and family test scores had been noted which partly correlated to reduced footfall in some areas, but long waiting times and cleanliness issues had also contributed to these results. The Acting QC Chair sought additional information regarding HAPU risk assessments and the Acting Chief Nurse confirmed that harm reviews indicated that the risk assessments were being completed, but some of the required interventions (eg patient turns) were not taking place at the required frequency and this was being triangulated with the staffing data. A discussion also took place regarding the arrangements for supporting staff who had not yet received their Covid-19 vaccinations. It was confirmed that letters had been sent to the affected staff and discussions were being scheduled with their line managers to comply with the end of March 2022 deadline when unvaccinated staff could not be deployed going forwards. The CCG Representative reported on the System-wide approach to supporting NHS staff, care home staff and agency staff with their vaccination programmes, by addressing the broad themes of 'convenience,

complacency and confidence' which encompassed the main barriers to receiving the vaccine. The Medical Director confirmed that the remaining key themes arising from the month 7 IPR had been highlighted under his verbal report on pertinent safety issues (Minute 114/21/1 above refers). Discussion also took place regarding the process for embedding learning from patient safety incidents, the review of patients who had been 'lost to follow-up' and the process for engaging with patients and their relatives within the investigation process;

- **Patient Safety Report** – the Director of Quality Governance introduced paper D, providing the monthly report on Patient Safety at UHL and advising on progress of the Trust's safety ambition to drive down preventable patient harm and Never Events. In setting the context for the increase in Serious Incident (SI) reports, she highlighted recent changes in the reporting criteria for HSIB maternity and patient falls SI reporting. Section 9 of paper D detailed the 8 SIs which had been escalated during November 2021. The broad themes of patient safety incidents related to delays in care and failure to follow-up patients and specific areas of interest included deterioration of patients, hospital acquired infections and nurse staffing incidents. Prevented patient safety incidents had also continued to increase. The National Reporting and Learning System data provided in section 15 of the report advised that UHL was ranked 12th nationally in terms of the reported patient safety incidents, suggesting that there was a good reporting culture at the Trust. The Central Alerting System (CAS) for cascading safety alerts and urgent public health messages continued to function well and a summary of performance was provided in section 16. The Acting QC Chair sought additional information regarding the monitoring arrangements for previous CAS alerts and it was noted (in response) that the Clinical Audit Team reviewed some of the CAS alerts to ensure that any changes in practice were embedded. However, the Director of Quality Transformation and Efficiency Improvement suggested that it would be helpful to request Internal Audit to undertake a deep dive of 2 or 3 CAS alerts each year for assurance purposes.

- **Complaints Report** – the Director of Quality Governance, presented paper E providing the quarterly report on complaints activity and performance data for the period 1 July 2021 to 30 September 2021 (quarter 2). During the quarter the number of formal complaints had increased to 1,002 (from 956 in quarter 1), with ED receiving the most complaints overall and Urology seeing the largest rise in complaints. The top themes related to medical care, waiting times and staff attitude. Complaints response performance had deteriorated partly due to the backlog of complaints, increased activity and staffing pressures within the Corporate Patient Safety Team. A detailed discussion took place regarding the following aspects of the complaints report:-
  - any correlation between the increase in complaints and the increase in SIs;
  - the established processes for investigating and responding to all formal complaints;
  - exploration of available learning from other Trusts (eg Sherwood Forest and Imperial) in relation to their complaints handling processes and the recent award of a research bid looking at ways of streamlining UHL's complaints process, and
  - availability of customer service training and the formal processes used to manage any recurrent complaints about individual member of staffs' attitude (eg Managing High Professional Standards for Doctors). However, it was noted that in some cases, there was no easy way of holding difficult conversations and some patients and their relatives might not be willing to accept the information that they were being given;

- **Safe Surgery and Never Event Action Plan** – Dr C Marshall, Deputy Medical Director, attended the meeting to introduce paper F, briefing the Committee on the development of a new Never Event action plan to respond to the increase in Never Events over recent months. The table provided in section 1.4 of the report provided a summary of the Never Events reported in the calendar years of 2020 and 2021 (to date). It was noted that the new Never Event action plan built upon the solid foundations of the existing actions and aimed to accelerate progress with the Safe Surgery Programme. The most significant components of the work were set out in section 1.8 of the report (focusing upon the Five Steps to Safer Surgery; WHO Checklists; the findings of an Internal Audit review in 2019; Standard Operating Procedures (LocSSIPs), and a Quality Assurance Programme to monitor and support the embedding of NatSSIPs). The 10-point action plan was provided at appendix 1. During the discussion on this report, it was noted that the Quality Improvement lead vacancy had now been recruited to and the improvement work would be linked to the UHL Assessment and Accreditation Programme with regular self-assessments and unannounced safety visits. In theatre areas, a practice facilitator role had been implemented which would empower theatre practitioners to challenge any perceived areas of poor practice. The Medical Director confirmed that the Never Event action plan had been discussed with LLR System partners and with patient safety partners, providing his view that the action plan was robust and fit for purpose. He also cautioned that any decision to review or re-set the action plan might adversely affect the timescale for delivery. Quality Committee members also considered opportunities to 'design-out' human error (eg epidural anaesthetic connectors), the impact of staff fragility during periods of intense operational pressures, and the importance of robust staff communications and training procedures;

- **Mitigating the Harms from the Covid-19 pandemic** – Dr C Marshall, Deputy Medical Director highlighted the variety of unintended consequences of the Covid-19 pandemic which had put an unprecedented strain on the NHS causing reductions in elective care capacity and increasing the level of demand upon the emergency care system.

The Medical Director added that a detailed harms review of delayed ambulance handovers had been undertaken and no incidence of significant patient harm had been detected. Consequently it was proposed that the Trust would stop undertaking these reviews and focus instead on the longest patient waits in ED. He also commented that not all patient harms arising from the pandemic could be easily detected (eg reduced mobility leading to patient deconditioning and increased contracture of muscles). The CCG Representative confirmed her view that ceasing the harm reviews for patients waiting on ambulances seemed sensible, although it remained a priority to transfer patients as quickly as possible in order to release ambulances to attend other patients. She also requested some information on first cancer presentations in UHL's ED so that she could feed this back to the LLR System Clinical Executive. A discussion also took place regarding the absolute priority to reduce the number of patients waiting 104 weeks for elective care to zero by the end of March 2022.

- **Covid-19 Reporting, Reviewing and Investigating Hospital-Onset Cases and Deaths** – the Director of Quality Governance introduced paper I, detailing the arrangements for managing both the retrospective and the prospective processes for reporting, reviewing and investigating hospital onset Covid-19 cases and deaths, as per the guidance document published by NHSE/I in July 2021. In terms of the retrospective cases, all patients had been reported into the Datix system; a single combined StEIS report was being submitted, and Duty of Candour letters were being sent to the relevant families. Where the families had already submitted a concern, complaint or claim a phone call would be made to these families in advance of the letter being sent. The prospective process had been agreed with effect from 1 June 2021, and any nosocomial Covid-19 infections resulting in a patient death would be reported onto Datix, have an Infection Prevention (IP) investigation completed and be reported onto StEIS either as an individual case or as an outbreak. The Committee considered the valuable IP guidance surrounding social distancing, mask wearing, hand washing, ventilation, use of single room accommodation, point of care testing and patient flows (including the lessons learned which were being built into the design work for the New Hospital Programme), and

- **Any Other Business** – there were no items of additional business.

The following reports were noted: -

- **Cancer Harms Report**
- **Clinical Audit Quarterly Report**
- **Data Quality and Clinical Coding Quarterly Report**
- **Patients on Ambulances**
- **Maternity Ultrasound updated Action Plan**
- **Nursing and Midwifery Safe Staffing**
- **Winter 2021 Preparedness Assurance Framework**
- **EQB action notes 9 November 2021.**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- none.

Items highlighted to the Trust Board for information:

- IPR Report
- Patient Safety Report
- Report on Mitigating Harms from the Covid-19 Pandemic

Matters deferred or referred to other Committees: none.

Date of next QC meeting:	Thursday 27 January 2022

Dr A Haynes – Adviser to the Trust Board and Acting Quality Committee Chair