UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 23 DECEMBER 2021 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Voting Members Present:
Dr A Haynes – Adviser to the Trust Board (Acting QC Chair)
Mr A Furlong – Medical Director
Ms E Meldrum – Acting Chief Nurse
Professor T Robinson – Non-Executive Director
Mr M Williams – Non-Executive Director

In Attendance:
Mr P Aldwinckle – Patient Partner
Miss M Durbridge – Director of Quality Transformation and Efficiency Improvement
Ms K Gillatt – Associate Non-Executive Director (from part of Minute 114/21)
Ms B O'Brien – Director of Quality Governance
Mr I Orrell – Associate Non-Executive Director
Ms K Rayns – Corporate and Committee Services Officer
Ms J Smith – Patient Partner
Ms C Trevithick – CCG Representative

RESOLVED ITEMS

110/21 APOLOGIES AND WELCOME

Dr A Haynes, Adviser to the Trust Board and Acting QC Chair welcomed everyone to the meeting, thanking them for their efforts, and noting that this was now the third winter where the NHS was experiencing extreme operational pressures associated with the Covid-19 pandemic. Apologies for absence were received from Ms V Bailey, Non-Executive Director QC Chair, and Ms C West, CCG Representative.

111/21 DECLARATIONS OF INTERESTS

Resolved – that no additional declarations of interests were received.

112/21 MINUTES

Resolved – that the Minutes of the Quality Committee meeting held on 25 November 2021 (paper A refers) be confirmed as a correct record.

113/21 MATTERS ARISING

The contents of the Quality Committee matters arising progress report (paper B refers) were received and noted. In respect of Minutes 75/21/1 and 75/21/2 of 26 August 2021, the Medical Director advised that the expected update reports relating to the Cardiology Service and Ophthalmology long term follow up issues would now be presented to the Committee in February 2022 due to the operational pressures currently facing the Trust.

Resolved – that the Matters Arising report (paper B) and the additional verbal information provided above be noted.

114/21 ITEMS FOR DISCUSSION AND ASSURANCE

114/21/1 Pertinent Safety Issues

The Acting Chair invited the Executive Leads to report on the pertinent safety issues facing the Trust. Reporting verbally, 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.

Resolved – that the position be noted.

114/21/2 Integrated Performance Report Month 7 2021/22

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).

Resolved – that the contents of this report be received and noted.

114/21/3 Patient Safety Report

Ms B O'Brien, 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. **DCQ/ ICFO**

Noting that 58 SIs had been reported for the 2021/22 year to date (compared to 14 for the equivalent period of 2020/21), Mr M Williams, Non-Executive Director sought additional information about any emerging themes, noting in response that the majority of these incidents related to delays in treatment, failure to follow up and changes in reporting processes. The Acting QC Chair noted that a number of other Trusts had noted increased numbers of patient falls arising from deconditioning as part of extended hospital stays. The Medical Director advised that the Deteriorating Patient Board had been asked to undertake a thematic review of incidents involving unexpected patient deterioration and the outputs would be included in their next regular report to the Committee.

Ms K Gillatt, Associate Non-Executive Director sought additional information regarding the lessons learned process arising from patient safety incidents. In response, the Director of Quality Governance detailed the overarching lessons learned bulletins and the CMG-specific reporting processes. As discussed at a recent Executive Quality Board, it was noted that multiple approaches were required to raise and embed staff awareness of the lessons learned from each incident. The CCG Representative suggested that the internal patient falls data be re-checked to sense-check the actual scale of any increases (excluding the impact of the mid-year change in reporting criteria). She also sought and received assurance that the Trust was triangulating its HAPU data with the staffing data to determine any direct correlation between these two sets of data.

The Acting QC Chair commented upon the issue of patients being 'lost to follow-up' and sought additional assurance regarding the processes and checks in place to prevent this. He queried whether the newly formed Operations and Performance Committee would be undertaking a detailed review of this subject. The Medical Director responded by briefing the Committee on the significant number of workarounds currently in place to mitigate the risks surrounding the old Patient Administration System (PAS), the reliance upon human factors in checking and validating the data, and the overall aim to replace the PAS as part of the NerveCentre development. The Medical Director advised that an update on 'lost to follow-ups' was scheduled to be presented to the Quality Committee in February 2022 and he suggested that this report be expanded to include the wider monitoring arrangements and risk mitigation processes surrounding patient follow-up appointments. **DCOO**

Finally, the Acting QC Chair sought and received additional information regarding the arrangements for involving patients and their relatives in SI investigations, noting that under the Duty of Candour, a discussion was usually held whilst the patient was still on the ward and this was followed up by a letter inviting the patient and/or their relatives to attend a meeting. Feedback from this meeting was built into the terms of reference for the investigation and a copy of the investigation report was subsequently provided to the patient.

<u>Resolved</u> – that (A) the contents of this report be received and noted, and

(B) the expected update on 'lost to follow-ups' for the February 2022 QC meeting be expanded to include the wider risk mitigation and monitoring processes surrounding follow-up appointments, and **DCOO**

(C) consideration be given to including 2 or 3 deep dives of the Centralised Alert System within UHL's Internal Audit plan each year. **DCQ/ ICFO**

114/21/4 <u>Complaints Report</u>

Ms B O'Brien, 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:-

(a) any correlation between the increase in complaints and the increase in SIs;
(b) the established processes for investigating and responding to all formal complaints;
(c) 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
(d) 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.

Resolved – that the quarterly update on complaints be received and noted as paper E.

114/21/5 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.

Resolved – that (A) the Safe Surgery and Never Event Action Plan be received and noted as paper F, and

(B) the Deputy Medical Director be requested to present a further progress report on the Never Event action plan to the Quality Committee in April 2022. **CM, DMD**

114/21/6 Mitigating the Harms from the Covid-19 pandemic

Paper G provided an overview of the arrangements for mitigating the risk of patient harm arising from the Covid-19 pandemic. In presenting this report, 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 and agreeing a backstop of 52 weeks going forwards.

Resolved – that (A) the contents of paper G be received and noted;

(B) the proposals to cease the patient harms review for delayed ambulance handovers and re-focus on the audit outcomes for patients waiting an excessive amount of time in ED be approved, and **CM, DMD**

(C) information on the numbers of first cancer presentations arriving at UHL's ED be provided to the CCG Representative (outside the meeting) for reporting to the LLR Clinical Executive. **CM, DMD**

114/21/7 Cancer Quarterly Harm report

Resolved – that the contents of this report (paper H refers) be received and noted.

114/21/8 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).

Resolved – that the contents of this report (paper I refers) be received and noted.

114/21/9 Covid-19 Position

The Medical Director confirmed that an overview of the position in relation to the Covid-19 position had been provided earlier in the meeting (Minute 114/21/1 above refers).

Resolved – that the position be noted.

115/21 **ITEMS FOR NOTING**

115/21/1 Clinical Audit Quarterly Report

The Director of Quality Transformation and Efficiency Improvement commented upon the number of National Clinical Audits that were rated as red and amber within appendix 2 of paper J, suggesting that the report appeared to raise more questions than answers at this stage. It was hoped that an improved position would be reported in the next iteration of this report.

Resolved – that the contents of this report (paper J refers) be received and noted.

115/21/2 Data Quality and Clinical Coding Quarterly Report

Resolved – that the contents of this report (paper K refers) be received and noted.

115/21/3 Patients on Ambulances

Resolved – that the contents of this report (paper L refers) be received and noted.

115/21/4 Maternity Ultrasound – Updated Action Plan

Resolved – that the contents of this report (paper M refers) be received and noted.

115/21/5 Nursing and Midwifery Safe Staffing

Resolved – that the contents of this report (paper N refers) be received and noted.

115/21/6 Winter 2021 Preparedness Assurance Framework: Nursing and Midwifery Safer Staffing

Resolved – that the contents of this report (paper O refers) be received and noted.

115/21/7 EQB action notes – 9 November 2021

Resolved – that the action notes from the EQB meeting held on 9 November 2021 (paper P) be received and noted.

116/21 **ANY OTHER BUSINESS**

117/21 **IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**

Resolved – that the following items be highlighted to the 3 February 2022 public Trust Board via the summary of this Committee meeting for information:

- **Integrated Performance Report and the discussion surrounding Covid-19 activity, safe staffing levels and staff vaccinations (Minute 114/21/2 refers);**
- **Patient Safety Report and the increase in Serious Incident rates which would be monitored closely via the Quality Committee (Minute 114/21/3 refers), and**
- **Mitigating the Harms from the Covid-9 Pandemic and the proposed protocol for patients on ambulances which was discussed and approved (Minute 114/21/6 refers).**

118/21 **DATE OF THE NEXT MEETING**

Resolved – that the next meeting of the Quality Committee be held on Thursday 27 January 2022 from 2pm via Microsoft Teams.

The meeting closed at 3.54pm

Kate Rayns - **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2021-22 to date): to be updated with respect to October 2021

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	8	7	88	E Meldrum (from Jan 22)	1	1	100
P Baker (until 29.7.21)	5	5	100	B Patel (until 24.6.21)	4	3	75
C Fox (until Dec 2021)	7	6	86	T Robinson (from Sep 21)	3	3	100

A Furlong	8	6	75	M Williams (from 29.7.21)	5	4	80

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	8	7	88	I Orrell	8	8	100
M Durbridge (from 29.7.21)	5	5	100	J Smith	8	5	63
K Gillatt (from 29.7.21)	5	5	100	C Trevithick/C West/ H Hutchinson (CCG Representative)	8	7	88
A Haynes (from 27.5.21)	6	6	100				