UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE PART INQUORATE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 24 FEBRUARY 2022 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS (INQUORATE ITEMS MARKED * BELOW)

Voting Members Present:
Ms V Bailey – Non-Executive Director QC Chair (up to and including Minute 14/22/5)
Dr A Haynes – Non-Executive Director (Acting Chair for Minutes 14/22/6 to 18/22)
Ms E Meldrum – Acting Chief Nurse
Mr J Melbourne – Chief Operating Officer

In Attendance:
Mr R Bell – Intensive Care and Renal Consultant (for Minute 14/22/7)
Ms H Busby-Earle – Clinical Director, Musculo-Skeletal and Specialist Surgery (for Minute 14/22/5)
Miss M Durbridge – Director of Quality Transformation and Efficiency Improvement
Ms H Hutchinson – CCG Representative
Mr J Jameson – Deputy Medical Director (on behalf of Mr A Furlong, Medical Director)
Ms B O'Brien – Director of Quality Governance
Ms K Rayns – Corporate and Committee Services Officer
Ms P Vaughan – Deputy Chief Operating Officer (for Minute 14/22/4)
Mr J Worrall – Associate Non-Executive Director

RESOLVED ITEMS — **ACTION**

10/22 APOLOGIES AND WELCOME

Ms V Bailey, Non-Executive Director QC Chair welcomed everyone to the meeting, advising that she would have to leave at 3.20pm and that Dr A Haynes would chair the remainder of the meeting from that point. Noting that Mr P Aldwinckle had recently resigned from his role as Patient Partner, the Committee Chair paid tribute to the contribution that Mr Aldwinckle had made to the Committee. She also undertook to liaise with Mr K Mayes, Head of Patient and Community Engagement regarding future Patient Partner representation on the Committee. **QC NED CHAIR**

Apologies were received from Mr A Furlong, Medical Director, Professor T Robinson, Non-Executive Director and Ms G Collins-Punter, Associate Non-Executive Director. Following the meeting, it was also noted that Ms J Smith, Patient Partner had been unable to join the virtual meeting due to technical issues with the MS Teams link.

<u>Resolved</u> – that the Committee Chair be requested to liaise with the Head of Patient and Community Engagement regarding future Patient Partner representation on the Quality Committee. **QC NED CHAIR**

11/22 DECLARATIONS OF INTERESTS

<u>Resolved</u> – that no additional declarations of interests were received.

12/22 MINUTES

<u>Resolved</u> – that the Minutes of the Quality Committee meeting held on 23 December 2021 (paper A refers) be confirmed as a correct record.

13/22 MATTERS ARISING

Paper B provided the Quality Committee matters arising progress report. Particular discussion took place regarding the following entry:-

- item 18 (Minute 35/21/4 of 29 April 2021 refers) – the Director of Quality Governance advised that the Palliative Care Team had been requested to present a report to the next Executive Quality Board in respect of the area of non-compliance with the NICE guidance relating to the education plan for provision of end of life care.

Resolved – that the Matters Arising report and the additional verbal information be noted.

14/22 ITEMS FOR DISCUSSION AND ASSURANCE

14/22/1 Pertinent Safety Issues

The Acting Chief Nurse briefed the Committee on the pertinent safety issue relating to the care of looked after children at UHL, describing in some detail the type of circumstances which led to increasing numbers of such children being presented at the Emergency Department, the decisions taken by their original care homes not to accept them back and the lengthening delays in finding them suitable alternative accommodation. Discussion took place regarding the pressures on social care and mental health services and it was noted that UHL was working with the CCGs, LPT, Social Care providers and the Leicestershire Police in order to provide safe child-centred care. Whilst it was recognised that UHL was providing a safe place for such children, it was sometimes the case that their behaviour deteriorated whilst they were waiting for suitable accommodation to be found and this was having a significant impact upon patients and their families as well as staff. A multi-agency system meeting had been scheduled for 10 March 2022 and it was agreed that the Chief Nurse would escalate UHL's concerns appropriately and seek senior level attendance at that meeting.

The Care Quality Commission (CQC) had been briefed on the situation and proposals were being developed to improve the care pathways for looked after children across the LLR System to ensure that such children were being cared for in the most appropriate setting. These proposals would be presented to the Executive Quality Board for consideration in the first instance. The Chief Operating Officer commended the incredible work of the Chief Nurse and her teams in managing these cases, acknowledging that UHL was not the best place for them to be, but the care provision in the community was backing up and similar pressures were also being experienced nationally. Mr J Worrall, Non-Executive Director briefed the Committee on some work he had undertaken on this subject as part of his previous role with NHS England, noting the need to agree a robust protocol with the out of area providers and local System partners going forwards.

In respect of other pertinent safety issues, the Chief Operating Officer reported verbally on the impact of delayed discharges on patient flow and the Trust's ability to treat some 110,000 patients on the planned care waiting list. There were currently some 200 patients awaiting discharge from UHL's wards whose episode of acute care had been completed. This was also affecting upon ambulance handovers and, whilst there was a plan in place to address this, he felt that it was important to draw the continued pressures to the attention of the Committee and the Trust Board. The Non-Executive Director QC Chair highlighted the processes in place to manage and mitigate the risk of patient harm arising from extended waiting times for elective care and ambulance handover delays.

Resolved – that (A) the pertinent safety issues highlighted at today's meeting be noted;

(B) the Acting Chief Nurse be requested to:-
(1) escalate UHL's concerns regarding partnership working within the care pathways for looked after children at the LLR System meeting on 10 March 2022 and seek senior level attendance at this meeting, and **ACN**
(2) present proposals to the Executive Quality Board outlining ways of improving the care pathways for looked after children across the LLR System. **ACN**

14/22/2 Integrated Performance Report Month 10 2021/22

Paper C provided the Integrated Performance Report for month 10 (January 2022). The Deputy Medical Director provided an overview of clostridium difficile (cdiff) trajectories, noting that there had been 90 cases in the year to date (compared with the target of no more than 91 cases) and that there were links between the increased incidence and antibiotic prescribing practices. The number of different strains found suggested that the increases were not linked to an outbreak. Antibiotic stewardship was also a key focus for suspected sepsis. The Acting Chief Nurse had discussed this issue with Dr D Jenkins, Deputy Director of Infection Prevention and Control (DIPAC) and they had agreed to hold a discussion with the Medical Director on key areas of

responsibility within the prescribing guidelines. The Acting Chief Nurse also commented that another local NHS Trust had recently experienced a significant reduction in their cdiff rates following a widespread mattress decontamination campaign.

The Acting Chief Nurse reported on a recent increase in the incidence of third and fourth degree perineal tears (4.6% in January 2022 compared with year to date performance of 2.9% and a locally agreed target of 3.5%) and she advised that the Women's and Children's Clinical Management Group had been requested to undertake some additional analysis work to establish the likely causational factors. The Deputy Medical Director observed that a previous fluctuation in perineal tear rates had been linked to a changeover of Registrars in 2020. **ACN**

In discussion on the Integrated Performance Report, Dr A Haynes, Non-Executive Director noted a high cdiff colonisation rate in the community (as reported by the CCGs) and he suggested that some of the reported infections might have been acquired in the community but reported as hospital acquired infections. The Acting Chief Nurse confirmed that this possibility was already being looked into by the Deputy DIPAC.

Resolved – that (A) the contents of the Month 10 Integrated Performance Report be received and noted, and

(B) the Acting Chief Nurse be requested to arrange for some additional analysis work to be undertaken in respect of third and fourth degree perinatal tears and present the outputs to the Quality Committee in March 2022. **ACN**

14/22/3 Patient Safety Report

Ms B O'Brien, Director of Quality Governance introduced paper D, outlining the nine serious incident (SI) reports that had been escalated and five SI investigation reports that had been closed during January 2021. One of the incidents had involved a Trust wide network outage requiring the Trust's major incident plan to be enacted and another involved a maternal death relating to Covid-19. The most common theme for the new and closed serious incidents was inpatient falls resulting in fractured neck of femur and a notable theme was 'failure to follow up'. Moderate and above patient harm incidents in maternity services had reduced in the past few months, and there had been an increase in the number of prevented patient safety incidents across the Trust – 93 of these related to lack of nurse staffing, but all 93 had been graded as no harm incidents. The Central Alert System for cascading national safety alerts continued to be working effectively with all targets being met.

In discussion on the report, the Director of Quality Governance agreed to include a specific focus on the thematic review of 'failure to follow up' incidents in the March 2022 Patient Safety Report. The Director of Safety and Risk commended this focus and sought confirmation that there were no urgent issues to be escalated. The Chief Operating Officer queried whether the increase in patient falls resulting in fractured neck of femur was linked with staffing challenges and the Acting Chief Nurse confirmed that the SI reviews took into account staffing fill rates and the falls risk assessments, noting that one of the mitigation measures was to cohort high risk patients together in the same bay to enhance their supervision. The Deputy Medical Director also observed that hospital visitors were sometimes able to assist by drawing staff's attention to a confused patient before they suffered a fall, but the number of visitors had declined as a result of Covid-19 infection prevention measures. Dr A Haynes, Non-Executive Director provided his view that staffing was almost certainly a contributing factor in the number of patient falls. He also observed that the SI incident report relating to a fatal head injury following an inpatient fall seemed to be taking a long time to finalise, noting in response that the patient inquest had only recently be held and that the lessons learned report would be presented to the Committee in March 2022.

A short discussion also took place regarding the current capacity of the Patient Safety Team in managing the backlog of SI reviews, particularly now that the short term additional resources would be ceased at the end of March 2022. The Director of Clinical Governance agreed to escalate the Committee's concerns in this respect to the Executive Team. The Non-Executive Director QC Chair requested that bi-annual reports on patient safety trends be presented to future QC meetings (to include a progress update on the implementation of the lessons learned from previous patient safety incidents) and a report on the systematic learning arising from analysis reviews of (a) patient falls resulting in harm, and (b) hospital acquired pressure ulcers – to include

the arrangements for embedding such learning.

Resolved – that (A) the contents of the patient safety report be received and noted as paper D;

(B) the Director of Quality Governance be requested to:-
(1) include a specific focus on the thematic review of 'failure to follow up' within the SI section of the Patient Safety report in March 2022; **DQG**
(2) escalate the Committee's concerns regarding capacity constraints in the Patient Safety Team to the Executive Team; **DQG**
(3) present bi-annual reports on patient safety trends to future QC meetings, and **DQG**
(4) present a report to the June 2022 QC on the systematic learning arising from root cause analysis reviews of patient falls and hospital acquired pressure ulcers. **DQG**

14/22/4 Outpatients Potentially Lost to Follow Up – Interim Report

Further to Trust Board Minute 291/21/1 of 4 November 2021, Ms P Vaughan, Deputy Chief Operating Officer attended the meeting to introduced paper E, providing an update on the historic changes to data quality reporting and process that had contributed to a significant number of patients (circa 28,000) potentially being lost to follow up since 2016. As at the end of January 2022, retrospective validation had been completed for 62% of patients who were awaiting reports and 71% of patients who were awaiting a further appointment. The validation process was expected to be completed on target by the end of April 2022, at which point a final report would be presented to the Quality Committee. Two serious untoward incidents had originally been identified as potentially relating to this issue, but no further patients had been identified as coming to harm during the validation process to date. **COO/ DCOO**

A series of deep-dive reviews were being undertaken at Clinical Management Group (CMG) level for each of the affected specialties. This included a review of the capacity and skill set of the administration teams and (if necessary) a short term bid for additional funding would be submitted to the Emergency Recovery Fund for any additional resources required to mitigate the risk of human error within the patient pathways. The medium-term solution would be to implement a purpose-built Patient Administration System (PAS) and the timeline for this project was due to be considered at the Executive IM&T Board in March 2022. The Chief Operating Officer expressed his confidence that everything possible was being done to mitigate the risk, but the Trust would continue to hold significant risk in this area until the new PAS system was implemented and the risk of human error within the process had been eliminated. For assurance purposes, he suggested that it would be helpful to programme a series of annual audits within the affected specialties for them to cross-check sample of new 'follow up required' outcomes with an appropriate booking or waiting list entry. Discussion took place regarding the impact on patients and staff, the nature of the Covid-19 pandemic which had changed people's perceptions of 'normal' waiting times, and health inequality considerations which meant that some patients from particular demographic backgrounds were less-likely to raise a concern if they felt that they had been waiting for an inordinate length of time. **COO/ DCOO**

Resolved – that (A) the interim update on patients potentially lost to follow up be received and noted as paper E;

(B) the Chief Operating Officer and the Deputy Chief Operating Officer be requested to:-
(1) liaise with the CMGs to establish a programme of specialty level annual audits for new 'follow ups', and **COO/ DCOO**
(2) present a final report on patients lost to follow up to the April 2022 or May 2022 Quality Committee upon completion of the validation work (to include the indicative timescale for implementation of the new PAS). **COO/ DCOO**

14/22/5 Breast Two Week Wait Update

Ms H Busby-Earle, Clinical Director Musculo-Skeletal and Specialist Surgery attended the meeting to present paper F, providing an update on symptomatic breast cancer clinic capacity and the impact of increasing referrals upon performance against the two week wait standard. All symptomatic referrals were automatically placed on the two week wait pathway. Prior to the Covid-19 pandemic, the service had maintained performance through 178 available clinic

appointments each week, but between August 2021 and January 2022, the referral rate had increased to between 194 and 268 per week. The issue had been compounded by changes to the Waiting List Initiative (WLI) payment scheme for non-medical staff, resulting in a significant deterioration in performance. Assurance was provided that all patients were being reviewed by a GP prior to referral, appropriate arrangements were in place for communicating with patients and that the service had not noted any increase in the conversion rates between diagnostic referrals and cancer pathways. A vigilant approach was being taken to detecting any patient harm arising from a short delay in diagnosis and if any clinician felt that a patient had suffered potential harm, then this would be escalated via the MDT discussion and reported accordingly. The recovery action plan included the introduction of a fourth ultrasound room, super weekend clinics, recruitment of an Associate Specialist for the Breast service, increasing the footprint of the clinic and extending the use of the insourced independent sector provision.

In discussion on the report, Quality Committee members noted that patients identified through the national breast screening programme were seen on a different pathway, the current backlog of patients was expected to be cleared by the end of March 2022, appropriate scrutiny was being conducted via the MDT meetings and that this would detect any patient harm arising from delays in being seen in clinic. Mr J Worrall, Non-Executive Director commented upon the cost of the additional recovery actions compared to the original savings achieved through changes to the WLI payments. The Chief Operating Officer commended the progress that was being achieved through the recovery actions, but he suggested that it was not sustainable in the longer term to rely on the goodwill of the workforce to deliver additional clinic capacity in this way. On behalf of the Trust, the Committee Chair expressed her thanks to all of the staff involved in turning around the position in such a short space of time. She invited the Chief Operating Officer to consider whether the future arrangements for achieving sustainable performance against the symptomatic two week wait breast cancer standard should be monitored through the Quality Committee or the Operations and Performance Committee. **COO**

<u>Resolved</u> – that (A) the on two week wait breast cancer performance be received and noted as paper F, and

(B) the Chief Operating Officer be requested to consider whether the arrangements for achieving sustainable two week wait breast cancer performance should best be monitored via the Quality Committee or the Operations and Performance Committee going forwards. **COO**

*14/22/6 <u>Learning from Deaths</u>

The Deputy Medical Director presented paper G, providing the quarterly update on mortality rates, progress against the learning from deaths programme, perinatal mortality, and the medical examiner process. The latest rolling 12 month risk adjusted HMSR mortality indicator stood at 102 (which was within the expected range) and the latest SHMI stood at 104 (also within the expected range). He also provided an overview of the perinatal mortality review process, noting that the annual reports provided by MBRRACE-UK were almost two years out of date. Consequently, the Perinatal Mortality Overview Group (PMOG) aimed to analyse perinatal mortality data prospectively in order to identify any concerning trends or themes. The maternity incentive scheme (which was suspended during December 2021 due to the Covid-19 pandemic) was now coming back on-line and a schedule had been developed to deliver this programme by the end of June 2022.

Responding to a query raised by Dr A Haynes, Non-Executive Director and Acting Quality Committee Chair, the Deputy Medical Director advised that feedback from the 17 Safety Incident reviews in quarter 3 would be analysed by the Medical Examiners and the information would be triangulated to ensure that any emerging themes were escalated if necessary.

<u>Recommended</u> – that the Learning from Deaths report be received and noted as paper G.

*14/22/7 <u>Bi-Annual Organ Donation Report</u>

Mr R Bell, Intensive Care and Renal Consultant attended the virtual meeting to present paper H, providing an overview of organ donation and transplantation arising from a local audit. The national data for the financial year 2021/22 had not yet been published. For the period April 2021 to January 2022, the Trust had so far had 13 deceased solid organ donors, resulting in 31 patients

receiving a transplant. This level of activity signalled an encouraging return to pre-pandemic levels. The Deputy Medical Director acknowledged the good work of the organ donation team and the Acting Committee Chair queried whether there was anything the Trust could do differently to support the efforts of the service. In response, Mr Bell commented upon the value of publicity and education, as well as Corporate oversight and he queried the scope to reconvene the UHL Organ Donation Committee, which was previously chaired by Mr B Patel, Non-Executive Director.

Recommended – that (A) the Bi-Annual Organ Donation report be received and noted (as paper H), and

(B) the Quality Committee Chair and the Acting Quality Committee Chair be requested to explore the opportunity to re-convene regular meetings of the UHL Organ Donation Committee. **QC CHAIR/ AQC CHAIR**

*14/22/8 Quality Transformation/Quality Improvement Plans – Quarterly Update

The Director of Quality Transformation and Efficiency Improvement introduced paper J providing the quarterly update on the work of the Improvement Collaborative. The wave 1 activities had been completed in the Vascular and Endoscopy services and wave 2 workstreams were underway in Haematology, fractured neck of femur, and Cardiology. Sections 3 and 4 of the report provided a reflection on the benefits of the approach and areas for future improvement/development. A refined Quality Improvement Strategy was also being developed which would incorporate the lessons learned and support a wider ambition of continuous improvement across the organisation using benchmarking data and recognised improvement methodology. Several of the CMG teams had been very complimentary about the methodology being used and the valuable support that had been provided by the Transformation team.

The Acting Committee Chair particularly highlighted the value of organisational learning using the 'early wins' as a teaching/coaching tool to transfer skills within UHL's workforce. He also commented upon the capacity of the finite team and the need to embed continuous improvement into the leadership and culture of the Trust going forwards.

Recommended – that the quarterly update on the work of the Improvement Collaborative be received and noted as paper J.

*14/22/9 Cost Improvement Plan: Quality Impact Assessments 2021/22 – Quarter 3 review

Paper K provided an overview of the third quarterly review of the Quality Impact Assessments (QIA) for the 2021/22 Cost Improvement Programme, advising that 361 CIP schemes were registered on the tracker as requiring a QIA and that 272 assessments had been submitted. To date, the Chief Nurse and the Medical Director had rejected 3 of these assessments (which related to staffing) and returned 2 to the CMGs for additional information. The programme was overseen by Ms H Harrison, Transformation Programme Manager and it was aimed to ensure that the Project Initiation Document (PID) and QIA processes were as meaningful and 'light touch' as possible. Since the report had been written the number of outstanding QIAs had reduced from 60 to 40, but further schemes were being added to the tracker.

The QIA process was a key focus of UHL's plans for exiting the Recovery Support Programme, as it was important to evidence that the efficiency savings planned would not affect upon patient quality and safety. Internal Audit had recently carried out a review of the QIA Process and the findings of their report were due to be presented to the next Audit Committee meeting. Dr A Rashid, the LLR System's Medical Director had also reviewed the process and provided a favourable report. The Acting Committee Chair highlighted the unintended potential consequences of changes to the WLI payment process upon the symptomatic breast cancer two week wait performance and he advocated that the Director of Quality Transformation and Efficiency Improvement considered a further review of this scheme. Responding to this point, the Director of Quality Transformation and Efficiency Improvement confirmed that a dynamic review of the lessons learned from each scheme would be undertaken in quarter 4.

Recommended – that the position be noted.

*14/22/10 Covid-19 Position

Reporting verbally, the Deputy Medical Director and the Chief Operating Officer provided a short overview of the Covid-19 activity, confirming that the numbers were continuing to reduce. Many of the positive cases being detected were being picked up through incidental screening, rather than because the patients were displaying Covid symptoms. Changes in the pre-operative assessment process were due to be implemented, which would involve using lateral flow testing instead of PCR testing.

Recommended – that the position be noted.

*15/22 **ITEMS FOR NOTING**

*15/22/1 Safeguarding Assurance Report

Paper I provided the quarter 3 summary of safeguarding activity across the Trust in adult, maternity and children's safeguarding services. The report was received and noted without any discussion.

Recommended – that Safeguarding Assurance report be received and noted as paper I.

*15/22/2 Quality Account 2021/22

Paper L provided the project plan for the development of the 2021/22 Quality Account, which was a legal requirement for all NHS providers. There was no separate discussion on this item.

Recommended – that project plan for producing the 2021/22 Quality Account be received and noted as paper L.

*16/22 **ANY OTHER BUSINESS**

Recommended – that no items of additional business were discussed.

*17/22 **IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**

Recommended – that the following items be highlighted to the 7 April 2022 public Trust Board via the summary of this Committee meeting for information:-

- **Pertinent safety issues relating to the care of 'looked after' children in an acute setting (Minute 14/22/1 refers), and**
- **the recent positive trend in respect of organ donation activity at the Trust (Minute 14/22/7 refers).**

*18/22 **DATE OF THE NEXT MEETING**

Recommended – that the next meeting of the Quality Committee be held on Thursday 31 March 2022 from 2pm via Microsoft Teams.

The meeting closed at 3.39pm 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)	10	9	90	E Meldrum (from Jan 22)	3	3	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)	5	4	80

A Furlong	10	7	70	M Williams (from 29.7.21 until 27.1.22)	6	5	83
A Haynes (NED from 1.2.22)	1	1	100				

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	9	8	89	I Orrell (until 31.12.21)	8	8	100
M Durbridge (from 29.7.21)	7	7	100	J Smith (PP)	10	6	60
K Gillatt (from 29.7.21 until 27.1.22)	6	5	83	C Trevithick/C West/ H Hutchinson (CCG Representative)	10	9	90
A Haynes (adviser from 27.5.21 to 27.1.22)	7	7	100				