University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 7 June 2022

	Trust Board paper H
Report Title:	**Quality Committee – Committee Chair's Report**
Author:	Ms A Moss – Corporate and Committee Services Officer

Reporting Committee:	**Quality Committee (QC)**
Chaired by:	Ms V Bailey – Non-Executive Director
Lead Executive Director(s):	Mr A Furlong – Medical Director Ms J Hogg – Chief Nurse Mr J Melbourne – Chief Operating Officer
Date of meeting:	26 May 2022

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 26 May 2022 *(involving Ms V Bailey, Quality Committee Non-Executive Director Chair; Professor T Robinson, Non-Executive Director; Mr J Worrall, Associate Non-Executive Director; Dr A Haynes, Non-Executive Director, Mr A Furlong, Medical Director; Ms J Hogg, Chief Nurse; Ms J Smith, Patient Partner and Ms H Hutchinson, Leicester City CCG. (Ms B O'Brien, Deputy Director of Quality Governance; Ms E Broughton, Head of Midwifery; Mr I Scudamore; Clinical Director, Womens and Children's; Dr P McParland, Consultant Obstetrician; Mr John Jameson, Deputy Medical Director, Ms P Vaughan, Deputy Chief Operating Officer, Mr M Clayton, Head of Safeguarding, Miss M Durbridge, Director of Quality Transformation and Efficiency Improvement and Ms B Cassidy, Director of Corporate and legal Affairs, attended to present their respective items).*

Recommended for Approval

- **Mortality and Learning from Deaths Quarterly Report**
  The Committee received the quarterly report on mortality rates, progress against the learning from deaths programme, perinatal mortality, and the medical examiner process. The latest rolling 12-month risk adjusted Hospital Standardised Mortality Ratio (HSMR) had been below 100 for the past three reporting periods (which was within the expected range), and the latest Summary Hospital-Level Mortality Indicator (SHMI) stood at 104 (also within the expected range). The role of the Medical Examiner was being extended to primary care and would become a statutory duty in 2023.

  The Committee considered perinatal mortality and the interim findings of an internal review. It was noted that 2021 had seen a higher rate of stillbirths. All the cases had been reviewed using the Perinatal Mortality Review Tool with external participation and themes identified. Further work was being undertaken to understand the contributory causes. The Committee took assurance from the report (pending the final report), noted improvements in processes, and held a discussion regarding a partnership with Leeds Teaching Hospital NHS Trust to provide an external review for any shared learning.

  The Learning from Deaths report (excluding appendices) was recommended to the Trust Board for approval and would be presented as a stand-alone report at its meeting on 7 June 2022.

Resolved items

- **Pertinent Safety Issues**
  The Medical Director and the Chief Nurse briefed the Committee on the following pertinent safety issues: Monkeypox – it was noted that three cases had been suspected in LLR with one confirmed. A Standard Operating Procedure would be approved imminently, and the Trust had been asked to plan for the Infectious Diseases Unit to operate at Level Three. Additional funding for the uplift in nurse staffing had been agreed. CQC Findings - it was noted that, following the recent inspection of Urgent and Emergency Care, the draft CQC report would be received the following week. The Trust would be allowed to make representations regarding factual accuracy. There was a plan in place to address the findings and the enhanced medical presence in the Emergency Department had been achieved. It was anticipated that there would be an inspection provisionally August 2022, to assess against the 'well-led' standard with further visits to core services.

Nurse staffing – it was noted that an establishment review of all wards would be undertaken supported by an external expert in safe staffing.

- **Patient Safety Report**
  The Committee considered the monthly Patient Safety Report noting that five Serious Incidents had been escalated in April 2022 and that investigations had been concluded for nine Serious Incidents. The lack of nurse staffing was identified has the highest reported Patient Safety Incident. The report considered a review of the specific locations reported and whether there was a correlation with patient harm. The Committee noted the induction and support for bank and agency staff. The need to progress the gaps in the evidence for Duty of Candour was noted.

- **Maternity Safety Report (Q4)**
  The Committee received a new draft report in development on the progress of the maternity safety agenda, including Healthcare Safety Investigation Branch reports (HSIB), Serious Incidents and 72-hour reports for Q4 2022. The revised template for the report used the perinatal surveillance tool template combined with the relevant data in a refined dashboard. The simplified report was to enable assurance for the Board. Comments included the need for further detail when compliance was low and for greater specificity around the actions to be taken and timescales. The report would be presented as a stand-alone report at the Trust Board in line with the Ockenden review requirements.

- **Deteriorating Patient, Resuscitation and End of Life and Palliative Care Quarterly Update Report**
  The Committee received the quarterly report detailing the work of the Deteriorating Patient Board, Resuscitation Committee and End of Life Steering Group. The Committee highlighted several issues for discussion. These included the replacement of defibrillators since the manufacturer had confirmed that the model, recently purchased by the Trust, would no longer be supported, however there was a plan in place. The reference to the bleeps not activating in response to cardiac arrest alerts was discussed, and assurance was received that this was in response to tests rather than actual calls, and that back-up arrangements were in place and that the issue was being addressed. The need to provide 24-hour palliative care across all sites, which was a requirement of the National Institute for Health and Care Excellence (NICE), and work to close the gap was noted. The assessment for Sepsis in the Emergency Department and the importance of measuring those metrics that determined health outcomes was discussed.

- **Outpatients Potentially Lost to Follow up**
  The Committee received a report setting out the progress made, since the last report in February 2022, regarding patients potentially lost to follow up. As a result of two serious incidents in 2021, data quality issues had been identified dating back to 2016. This necessitated a validation process for c28,000 patients who could have been lost to follow up. The aim had been to complete the process by the end of March 2022. However, there had been some delay and approximately 6,000 records still needed to be validated. The revised target date was the end of June 2022. Whilst no further incident indicating patient harm had been identified, the risk to patient safety was the growing waiting list. The Committee was advised of the outpatient transformation plan to mitigate the risk. The report was noted.

- **Operations Cancelled on the Day of Procedure**
  The Committee considered a report addressing the on-the-day cancelled rate for elective operations. It was noted that the rate referenced in the Integrated Performance Report referred to a wider cohort of patients, including those attending for outpatients and clinical trials. Whilst the on-the-day cancelled rate for elective operations was down to 10% it had been as high as 14% in mid-winter. This led to a poor patient experience and poor theatre utilisation. The internal audit undertaken identified the main reasons for cancellation were patients being medically unfit and the availability of beds. With respect to the first reason, it was noted that considerable work was being undertaken to standardise the preoperative assessment process. This would ensure that patients listed were medically fit. With regard to the second reason, ring fencing of beds was being considered. The Elective Recovery Fund would be used to trial ring fencing eight beds in a surgical ward to improve postoperative capacity. The Committee took limited assurance from the report, expressed concern about the 10% cancellation rate, and requested a further report in six months' time.

- **Quality Account 2021/22**
  The Committee received the draft Quality Account 2021/22, the annual report from providers of healthcare about the quality of services delivered. The final report was due to be submitted at the end of June 2022. The Committee provided comments on the content and asked that consideration be given to how the report could be used for public and patient engagement.

- **Never Event Reports**
  The Committee received a report summarising three Never Events escalated in May 2022. The Committee noted the theme of patient identification and were informed of the action taken to address the issue and ensure best practice. The Committee requested to see a tracker of Never Events to understand progress.

- **Safeguarding and Learning Disability Annual Reports**
  The Committee received the Annual Reports which provided an update on work undertaken to improve services to vulnerable people and future work priorities. The Committee considered the improvements made for people with learning disabilities as a result of the register and improved collaboration with Leicestershire Partnership NHS Trust.

- **Cost Improvement Programme - Quality Impact Assessments**
  This item was deferred until the next meeting of the Quality Committee.

- **Any Other Business**
  Freedom 2 Speak Up
  The Committee received a verbal briefing on the Annual Report of the Freedom to Speak Up Guardian. It was noted that 231 concerns had been raised in 2021/22 and the themes were: communication; staff attitudes/behaviours; and staffing numbers. The report had been circulated separately and comments invited prior to submission to the Trust Board on 7 June 2022.

The following reports were noted: -

- Integrated Performance Report Month 1 2022/23
- Clinical Audit Committee Report

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- Mortality and Learning from Deaths Quarterly Report

Items highlighted to the Trust Board for information:

- That the Trust remained within the expected range for deaths.

Matters deferred or referred to other Committees:

- None

Date of next QC meeting:	Thursday 30 June 2022

Ms V Bailey – Non-Executive Director and Quality Committee Chair