Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 28 APRIL 2022 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey – Non-Executive Director QC Chair
Ms G Collins-Punter – Associate Non-Executive Director (non-voting)
Mr A Furlong – Medical Director
Ms H Hutchinson – CCG Representative (non-voting)
Mr J Melbourne – Chief Operating Officer
Dr G Sharma – Associate Non-Executive Director (non-voting)
Professor T Robinson – Non-Executive Director
Mr J Worrall – Associate Non-Executive Director (non-voting)

In Attendance:
Miss M Durbridge – Director of Quality Transformation and Efficiency Improvement
Ms N Green – Duty Chief Nurse
Ms A Moss – Corporate and Committee Services Officer
Ms C Rudkin – Head of Patient Safety (for Minute 33/22/2 and 33/22/3)
Ms P McParland - Consultant Obstetrician (for Minute 33/22/4)
Ms L Lane - Head of Nursing (for Minute 33/22/4)
Ms C Whiteley - Deputy Service Manager/HTA Designated Lead (for Minute 33/22/5)
Ms J Gilmore - Head of Operations (for Minute 33/22/6)
Ms J Brown - Deputy Lead Cancer Nurse (for Minute 33/22/6)
Mr S Pizzey- Head of Strategy and Planning (for Minute 33/22/7)
Dr S Salta - Haematologist Consultant (for Minute 33/22/8)
Ms C Marshall - Deputy Medical Director (for Minute33/22/9)

RECOMMENDED ITEMS **ACTION**

28/22 CQC STATEMENT OF PURPOSE

The Committee received paper K which set out the services provided by the Trust. The Trust was required to notify the Care Quality Commission (CQC) of any changes to its services or registered locations. The changes with respect to the National Centre for Sports and Exercise Medicine and Renal Care were noted.

Recommended: That the revised CQC Statement of Purpose be approved by the Trust Board.

RESOLVED ITEMS

29/22 APOLOGIES AND WELCOME

Ms V Bailey, Non-Executive Director QC Chair welcomed everyone to the meeting including Dr Gopal Sharma who had been appointed as the System Associate Non-Executive Director. Apologies were received from Ms E Meldrum, Acting Chief Nurse and Ms J Smith, Patient Partner.

30/22 DECLARATIONS OF INTERESTS

Resolved – that no additional declarations of interests were received.

31/22 MINUTES

Resolved – that the Minutes of the Quality Committee meeting held on 31 March 2022 (paper A refers) be confirmed as a correct record.

32/22 MATTERS ARISING

Paper B provided the Quality Committee matters arising progress report. All items were either marked as (5) complete or (4) on track and it was confirmed that the completed items would be removed in the next iteration of the report.

Resolved – that the Matters Arising report be noted.

33/22 ITEMS FOR DISCUSSION AND ASSURANCE

33/22/1 Pertinent Safety Issues

The Deputy Chief Nurse, the Medical Director and the Chief Operating Officer briefed the Committee on the following pertinent safety issues:-

a) Changes to Infection Prevention Controls;
It was noted that the revised national guidance had been received before Easter. The visiting policy would be reviewed by the Infection Prevention Cell the following week. The Trust would continue to test patients attending Emergency Department using the Polymerase Chain Reaction (PCR) Test as moving to lateral flow tests would increase the burden on nursing staff. With this exception, the national guidance would be adopted.

b) Move of services to accommodate the interim reconfiguration of ITU;
The Medical Director reported that there were sequential moves scheduled to accommodate the relocation of the Level 3 Intensive Care Unit from the Leicester General Hospital to the Leicester Royal Infirmary and Glenfield Hospital. This was part of the interim reconfiguration of services. He noted that this involved considerable planning and additional work for numerous departments.

c) Pressures on the Emergency Department
The Medical Director reflected the discussion held at the Operations Performance Committee the previous day. The Trust was continuing to experience significant urgent & emergency care pressures. A steering group would meet weekly to oversee the actions that would make the most difference to improve performance; these would include a refresh of Inter-Professional Standards and work with Clinical Management Groups to robustly embed these; and development of a larger Minor Injuries & Minor Illness Unit which patients would be streamed to from the front door of Emergency Department. The Trust also still had high numbers of patients medically optimised for discharge waiting over 24 hours. The problems in discharging patients in a timely manner affected flow in the hospital and meant that patients had to wait for long periods of time in the Emergency Department before being admitted. Ms V Bailey, Non-Executive Director QC Chair, noted the need to understand the impact of these pressures on the quality of care. She expressed concern as the longer the stay in hospital the more likelihood of de-conditioning .

d) CQC visit
The Medical Director reported that the Care Quality Commission had made an unannounced visit before Easter 2022; the focus had been on the Emergency Department. It was thought likely that the commission would undertake a further visit to assess against the 'well-led' standard. Feedback on the CQC visit would be provided to the Trust Board the following week.

Resolved – that the pertinent safety issues highlighted be noted.

33/22/2 Patient Safety Report

The Head of Patient Safety, Ms Claire Rudkin, presented paper C which reported on Trust-wide patient safety data for March 2022. The main theme identified was the 12 Serious Incidents escalated in that month, two of which were Never Events. A summary of the two new Never Events and the main point of learning from the closed Never Event investigation were reported. A total of nine Never Events had been escalated in 2021/22 which was the highest annual number recorded for the Trust. A separate report detailing the Never Event Action Plan was considered later in the meeting.

It was reported that the number of moderate and above harm incidents had increased slightly from February to March 2022. There had been gaps in the evidence for Duty of Candour. The Executive Board had agreed to change the terms of reference for the Adverse Events Committee

to ensure representation of the Clinical Management Groups. It was thought that this would improve ownership, accountability and shared learning.

Dr G Sharma, Associate Non-Executive Director, asked how the Trust ensured patient and public engagement in the patient safety agenda. The Head of Patient Safety noted that patient partners sat on every Serious Investigation Panel and the patient safety strategy set out the arrangements for patient and family engagement in the process.

Dr G Sharma, Associate Non-Executive Director, asked how the gaps in evidence for Duty of Candour had been dealt with. The Head of Patient Safety confirmed that the gaps were followed up. It was often the case that the letter had been sent but just not recorded on DATIX. Action was taken to close the evidence gaps.

Dr G Sharma, Associate Non-Executive Director, asked about the Never Event when the oral liquid methadone had been used instead of the injection form, noting that the medication appeared to be very similar. The Head of Patient Safety noted that the root cause analysis would consider the design of medication containers and packaging. If necessary, the issue would be escalated nationally for consideration.

Dr A Haynes, Non-Executive Director, asked whether staffing levels had contributed to the Serious Incidents involving patient falls and pressure ulcers. The Deputy Chief Nurse described the process for escalating concerns around staffing levels. Nursing staff were moved to different wards to maintain safe staffing levels. As part of the investigation into the Serious Incidents, staff levels at the time of the incident were considered. It was suggested that since hospital visiting had been restricted, there had been an increase in falls as friends and family were unable to assist /support patients. The Medical Director noted that work was in train to fill nursing vacancies.

Ms V Bailey, Non-Executive Director QC Chair, noted that the discussion had provided more assurance regarding patient safety and it would be helpful if future reports could reflect the points made verbally in the meeting . She considered that whilst the focus was on Never Events, the Committee needed to understand the level of patient harm for all incidents. The Deputy Chief Nurse noted that the Committee received reports that were more detailed on falls and pressure ulcers, which triangulated the data including staffing levels. **HoPS**

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

(B) future reports provide greater assurance with regard to patent harm, and **HoPS**

(C) the discussion be highlighted to the Trust Board for information.

33/22/3 <u>External Guidance Quarters 1 -3 NICE Report</u>

The Committee received paper D, presented by the Head of Patient Safety, which described the approach taken to comply with National Institute for Health and Care Excellence (NICE) guidance, and the audit programme to assure the Committee that guidance was followed.

The report referenced two outstanding responses, which had subsequently been received. With respect to the guidance for end of life care for adults: service delivery, the Medical Director noted that the five key risks identified would be addressed in relevant work streams. He proposed that a report be made to the Executive Quality Board in the next quarter to provide assurance of how the risks were mitigated. **MD/Dir QG**

Ms V Bailey, Non-Executive Director QC Chair, noted that there had been a long-standing action to address compliance with NICE guidance for end of life care. She enquired about the process for closing out actions. The Medical Director offered to provide a summary of the process in the next report. **Dir QC**

The Committee was assured of the Trust's compliance.

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

(B) a further report be made to the Executive Quality Board, and **MD**

(C) the next report summarise the approach for closing out actions. **Dir QC**

33/22/4 Mortuary Procedures (retained products of conception)

The Committee received a report, paper E, presented by Ms P McParland, Consultant Obstetrician and Ms L Lane, Head of Nursing, which provided assurance regarding procedures for dealing with products of conception.

It was reported that an audit, undertaken in summer 2021, found there had been errors in accounting for products of conception. Work had been undertaken to review processes and improve communication between the Pathology Department and Obstetrics and Gynaecology.

Ms V Bailey, Non-Executive Director QC Chair, asked about the communication with patients/parents. The Consultant Obstetrician noted that the incident had come to light as a result of a complaint and that there had been communication with the family. It was noted that the establishment of Bereavement Midwives had increased to 1.6 FTE (with three post holders) which had a positive impact on processes and patient care.

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

33/22/5 Mortuary Security Close Down Report

The Committee received paper F, presented by Ms Caroline Whiteley, Deputy Service Manager /HTA Designated Lead, which provided an update on the actions taken to ensure compliance with a national directive regarding security for the mortuary. The Committee was assured that all the actions, including the outstanding one noted on the report, had been taken and confirmation provided to NHS England..

In response to a question from the Chief Operating Officer, it was noted that reference within the report to PPD referred to the name of the pharmaceutical company that used to own the standalone building at the Leicester General Hospital. There were two mortuaries at the hospital but only one of them was used for patient care.

It was reported that the action relating to access to the mortuary had been completed. There had been connection issues at Glenfield Hospital but these had been resolved. It was noted that a standalone system for determining access was use and that only the Deputy Service Manager and the Clinical Manager had administrative rights. It was reported that the Trust had, prior to the audit, tight restrictions on the access to the mortuary. Only mortuary staff were allowed access to the building alone.

The Deputy Service Manager wished to thank colleagues in Estates and Facilities for their support.

Resolved – that (A) the contents be received and noted, and

(B) the discussion be highlighted to the Trust Board for information.

33/22/6 Cancer Harm Quarter 3 Report

The Committee received paper G, presented by Ms J Gilmore, Head of Operations and Ms J Brown, Deputy Lead Cancer Nurse, provided an update to the Cancer Harm 2022/23 Quarter 3 report. The update provided more information in relation to a case of patient harm referenced in the original report. Whilst there had been a delay in treating the patient, the review found that it would have been very unlikely to have changed the eventual outcome.

The Medical Director requested sight of the investigation report.

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

33/22/7 Outpatient Transformation

The Committee received paper H, presented by Mr S Pizzey, Head of Strategy and Planning, on the transformation of outpatient services. The report focussed on the feedback received from patients.

It was noted that as part of the NHS Long-term Plan that the ambition was to offer more virtual appointments and reduce the number of follow up appointments. The target was to reduce the number of follow-up appointments by 25% from 2019/20 levels which would be a reduction of 153,867 appointments. The Head of Strategy and Planning considered that the target was ambitious. However, further work would be undertaken learning from trusts, which had significantly reduced the number of follow up appointments.

It was noted there had been no deterioration in the scores the Friends and Family Test with the exception of one aspect of the service. When patients were offered a face-to-face appointment, which was subsequently changed to a virtual appointment, the satisfaction score was lower.

The Head of Strategy and Planning referenced a project to improve attendance rates for patients from ethnic minority or deprived backgrounds. They would be contacted a few days before the appointment to offer support about any anxieties and possibly subsidised transport. The Committee agreed that addressing health inequalities was very important. Ms V Bailey, Non-Executive Director QC Chair, asked whether there was a Quality Impact Assessment and an Equality Impact Assessment. She thought it was important to track the learning and build the relationship with primary care for shared decision making.

Prof T Robinson, Non-Executive Director referencing the in-depth qualitative interviews, questioned whether the sample size was sufficient as those who were not comfortable with technology were unlikely to have taken part. The Head of Strategy and Planning acknowledged the sample was likely to be self-selecting but that further feedback would be sought. He surmised that the high scores might be down to the reticence of patients to attend outpatients in person during a pandemic. A project to offer technological support at GP surgeries would be piloted in Rutland.

Prof T Robinson, Non-Executive Director and Dr G Sharma, Associate Non-Executive Director, expressed concern about the impact of virtual appointments on the quality of training. Dr Sharma had been told that trainees were only able to hear one side of the conversation. The Head of Strategy and Planning noted the feedback, and that he would instigate further discussions.

Prof T Robinson, Non-Executive Director, asked about the respective rates for non-attendance for virtual and face-to-face appointments. The Head of Strategy and Planning reported the rates were lower for virtual appointments. However, there was a need to ensure clinicians called at the allotted time. He surmised that the rates might be lower as it was more convenient for those patients who would find it difficult to take time off work or had caring responsibilities.

The Chief Operating Officer noted that the Trust had done well to increase the number of virtual appointments. However, he thought it important to note that the efficacy would differ across specialities and that an unintended consequence could be an increase in the average number of appointments. The average number of requests for diagnostic tests was higher for virtual appointments. There was a need, he considered, to change the clinic template. In addition, increasing the provision of ‘Advice and Guidance’ to primary care would reduce the number of appointments but there were costs to the service which needed to quantified.

Dr G Sharma, Associate Non-Executive Director, noted that the use of PRISM system had standardised referrals from GPs but questioned whether they were too simple and the quality diminished. He added that in many instances the virtual appointments had led to an increase in requests for GPs to undertake diagnostic tests.

Dr A Haynes, Non-Executive Director, agreed that it would not be possible to reduce follow up appointment across all the specialties, as there were be different considerations in relation to medical examinations. He noted that performance for cancelled appointments should be addressed as the numbers were increasing and it was inefficient . The Head of Strategy and Planning agreed that a 25% reduction was not possible for some specialities and agreed with the

need for a nuanced approach.

Ms V Bailey, Non-Executive Director QC Chair, concluded the discussion and requested a further report in six months' time. **HoSP**

Resolved – that (A) the contents of the report be received and noted.

(B) a further report be presented in 6 months' time. **HoSP**

33/22/8 Thrombosis Committee Report

The Committee received paper I, presented by Dr Stella Salta, Haematologist Consultant, which reported on Venous thromboembolism (VTE) prevention and treatment strategy and governance. The positive performance in Q1-3 2021/22 against the Quality Schedule for VTE was noted.

There had been a sustained positive performance for VTE assessment and investigation of Hospital Associated Thrombosis against the Quality Schedule which was above the agreed thresholds (>95%) for the reporting period Q1-Q3 2021/22. It was noted that work was being undertaken with respect to data quality and that the introduction of e-Meds module on the Nerve Centre would improve performance.

The dashboard for the administration of anti-coagulants was presented. It was noted that the largest cause of non-administered doses (when appropriate reasons have been excluded) was patient refusal. There would be an audit of why this occurred and a strategy to improve compliance.

It was reported that the majority of patients (60.4%) had appropriate thromboprophylaxis prescribed within 14 hours of admission (national average 67%). The standard procedure was to administer the medication at the 6pm drug round. However, that meant that it was not possible to meet the target and the practice was being reviewed.

Dr A Haynes, Non-Executive Director, asked whether the long waits in the Emergency Department could lead to patient harm, as the administration of an appropriate thromboprophylaxis might be delayed. The Medical Director reported that an audit had been undertaken which had not identified any increased incidence of hospital acquired thrombosis. This had been reported back to the CQC, which had raised the issue. He added that the Inter-Professional Standards had been clarified and created greater accountability for the oversight of patients in the Emergency Department by the respective specialities. He considered that the introduction of the E-Meds module at the end of June would also support significant improvements.

Prof T Robinson, Non-Executive Director, asked what decision had been made with respect to repeating the VTE risk assessment, undertaken as part of the pre-assessment, on admission. The Medical Director noted that it was still under consideration and at the current time there was not an outpatient module on Nerve Centre, which would assist.

Lead Consultant

The report highlighted key work streams to support the strategic direction. The Medical Director reflected that the performance and reporting for Thrombosis was much improved. He asked for reports to be made every six months and that the next report provide more detail on the planned actions. He suggested that the next report could be delayed if the roll out of the e-Meds module was put back.

Resolved – that (A) the contents of the report be received and noted, and

(B) the next report provide more detail on the planned actions. **Lead Consultant**

33/22/9 Safe Surgery and Never Event Action Plan

The Committee received paper J, presented by Ms Colette Marshall, Deputy Medical Director which provided an update on the Safe Surgery work-stream in UHL's Quality Strategy. It incorporated an update of the Never Event Action Plan and updates from the Consent and Patient Information Committees.

Positive progress was noted specifically in relation to improved reporting; launch of the theatre practitioner competency and leadership programme; and trust-wide roll-out of Trauma Risk Management Methodology (TRiM) training. It was reported that the Local Safety Standards for Invasive Procedure (LocSSIP) accreditation and assurance programme would be restarted.

The Deputy Medical Director reported that the digital e-consent project was being piloted. However, there were risks to the project which related to dependencies on legacy IT systems for patient information.

The Trust had recorded the highest number of Never Events, as there had been nine in 2021/22. Common themes related to the difficulties with communication during the pandemic.
The Trust would be joining a Never Event Collaborative with Imperial College Healthcare, Barts Health, and Royal United Hospitals Bath trusts to share best practice.

Resolved – that the report be received and noted.

33/22/10 Covid-19 Position

The Medical Director had provided an overview of Covid-19 activity, at the beginning of the meeting under Pertinent Patient Safety Issues. He noted that the numbers of patients with Covid-19 were declining slowly. That week there were approximately 150 patients in hospital with Covid-19.

Resolved – that the position be noted.

34/22 ITEMS FOR NOTING

34/22/1 Integrated Performance Report Month 12 2021/22

Paper L provided the detailed Integrated Performance Report for March 2022. The Medical Director advised that he had no specific items of concern to draw to the Committee's attention.

Resolved – that the contents be received and noted.

35/22 ANY OTHER BUSINESS

No items of additional business were discussed.

36/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Recommended – That the following issues be highlighted to, the 5 May 2022 public Trust Board via the summary of the Committee meeting, for information:

- **Patient Safety Report (Never Events)**
- **NICE Quarter 1-3 Report**
- **Mortuary Security**

37/22 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Committee be held on Thursday 26 May 2022 from 2pm via Microsoft Teams.

The meeting closed at 3.55pm

Alison Moss – Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2022-23 to date).

Voting Members

Name	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	1	1	100
J Melbourne	1	1	100
A Furlong	1	1	100
A Haynes	1	1	100
E Meldrum	0	0	0
T Robinson	1	1	100

Non-voting members

Name	*Possible*	*Actual*	*% attendance*
J Smith (PP)	1	0	0
M Durbridge	1	1	100
G Collins-Punter	1	1	100
G Sharma	1	1	100
J Worrall	1	1	100
C Trevithick/C West/ H Hutchinson (CCG Representative)	1	1	100