University Hospitals of Leicester NHS
NHS Trust

Public Trust Board paper L

Meeting title:	Trust Board
Date of the meeting:	14 September 2023
Title:	**Escalation Report from the Quality Committee (QC): 31 August 2023**
Report presented by:	Vicky Bailey, QC Non-Executive Director Chair
Report written by:	Hina Majeed, Corporate and Committee Services Officer

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Yes. BAF risk within the remit of QC is listed below:

BAF Ref	Risk Cause	Risk Event
01-QC	Lack of Quality Governance and Assurance framework	Failure to maintain and improve patient safety, clinical effectiveness, and patient experience

Impact assessment

N/A

Acronyms used:
DFI – Doctor Foster Intelligence
QC – Quality Committee
ESM – Emergency and Specialist Medicine
CMG – Clinical Management Group
LLR – Leicester, Leicestershire, and Rutland
M&M – Morbidity and Mortality
MRC – Mortality Review Committee
PRMs – Performance Review Meetings
RCN – Royal College of Nursing
TLT – Trust Leadership Team
PHSO – Parliamentary and Health Service Ombudsman
ED – Emergency Department
ICB – Integrated Care Board
NMAHPC – Nursing, Midwifery and Allied Health Professionals Committee
OD – Organ Donation

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee, and escalate any issues as required.

2. Summary

The QC met on 31 August 2023 and was quorate. It considered the following items, and the discussion is summarised below:

3. Recommended items:

3.1 Mortality and Learning from Deaths (LfD) Quarterly Report

The Committee received the quarterly report on mortality rates and progress against the learning from deaths framework which provided assurance in respect of both the national risk adjusted mortality measure (SHMI) and delivery of Death Certification, Medical Examiner (ME) Scrutiny and Case Record Review as per national statutory requirements. The following points were highlighted in particular:

i. the Summary Hospital Mortality Indicator (SHMI) had fallen to 104, and Hospital Standardised Mortality Ratio (HSMR) remained within the expected range at 98.4. Appropriate actions were being taken to monitor UHL's crude and risk adjusted mortality rates. Detailed review was being undertaken of any patient or diagnostic groups which were 'above expected' or appeared to have increased over time;
ii. 'Septicaemia (except in Labour) was one diagnosis group with a higher SHMI value than expected in the latest SHMI data. More detailed analysis was presented by the DFI Consultant at relevant Committees, and the respective Leads would correlate this information with internal monitoring data. Following national changes, a relaunch of the sepsis care pathway was planned and ongoing improvement work on sepsis pathways was proposed as a priority for the Year 1 Patient Safety Incident Response Framework (PSIRF) work programme;
iii. learning themes from Medical Examiner screening, bereaved relatives' feedback and specialty reviews had been collated for consideration as part of UHL's Year 1 PSIRF work programme. The themes included septicaemia, anticoagulation, and ward round reviews;
iv. the national plans for rolling out the Medical Examiner process to cover all deaths in primary care had been postponed to April 2024, however, in the interim, UHL continued to engage with GP Practices. LOROS and LPT;
v. during quarter 1 of 2023-24, reports were received from the Perinatal Mortality Review Group with details of analysis and improvement actions undertaken following the most recent MBRRACE publication which showed UHL's neonatal mortality rate to be >5% higher than its peer group. The Committee noted the cases reviewed including the identified learning and agreed actions. Although external reviews had not identified any recurrent themes, the Trust continued to undertake individual and cluster reviews internally and would develop an on-going process for external input into the review process, and
vi. three adult deaths during quarter 1 of 2023-24 had been more likely than not due to issues in care – the learning and actions being taken were noted by the Committee.

The Chief Nurse and Medical Director provided assurance that the Trust had reviewed the recent NHSE guidance following the verdict of the Lucy Letby Trial. This included current arrangements for freedom to speak up and listening to the concerns of patients, families, and staff. A report on this matter was scheduled to be presented to the Trust Board in September 2023.

In summary, the Committee was assured with this update, noting that a number of actions were underway, and the Trust's learning from deaths programme was supporting identification of learning to improve the outcomes of future patients and plans were in place to meet:

- anticipated statutory requirements in respect of the Medical Examiner process being implemented across LLR;
- HM Senior Coroner's request to refer all deaths which may be due to problems in care;
- external reporting of neonatal deaths and stillbirths to the Mothers and Babies – Reducing Risk through Audit and Confidential Enquiries (MBRRACE), and
- Safety Action 1 of the Maternity Incentive Scheme (MIS)/Clinical Negligence Scheme for Trusts (CNST).

The Mortality and Learning from Deaths report be endorsed and recommended for Trust Board approval. A stand-alone report on that item is included on the September 2023 Trust Board agenda accordingly.

4. Discussion Items

4.1 Retrospective Reporting to the HM Coroner of Deaths considered to be more likely than not due to Problems in Care

Members were advised that there had been recent discussions with the HM Senior Coroner about reporting to her office where medical examiner screening identified potential care issues which may have affected patient outcome. It was also agreed that there should be a retrospective referral to the HM Coroner for 16 cases where death was considered to be more likely than not due to problems in care (following Specialty M&M reviews and MRC discussion) but there had not been a referral made to the Coroner as part of the Medical Examiner process. The 16 cases spanned a 5-year period (the earliest being in 2018). Once the reviews were completed, an update be presented to the Quality Committee as part of the quarterly LfD report if there was nothing significant to highlight from the findings.

4.2 Quality and Safety Performance Report – July 2023

The QC considered the monthly patient safety and complaints performance report for July 2023, noting the slight improvement in position in respect of VTE compliance in ED and actions being taken due to the increase in number of Hospital Acquired Pressure Ulcers (HAPUs) in that month. The falls per 1000 bed days had decreased in July 2023 making it a three consecutive month reduction. 6 Serious Incidents (SI) had been escalated and there had been a decrease in overdue SI actions. The report further advised that there had been an increase in the duty of candour evidence gaps. Overall risk register performance indicated that 20% of open risks had an elapsed review date and/or actions passed their due date for the reporting period against a target of 10%. The medicines management team continued to collaborate with teams to drive improvement in medicines safety indicators. There was continued focus on better understanding missed dose data particularly differentiating between medicines refused by patients (and the reasons for this) and other reasons for medicines being missed. Outpatient FFT had reduced slightly to 93.9% in May 2023 but had increased slightly to 94.7% in June 2023. From a complaints' perspective, formal complaints performance had improved and percentage of open complaints past due date had decreased again for the third consecutive month. In discussion on the NHS Resolution (NHSR) Claims scorecard, it was noted that work was underway to triangulate complaints, serious incidents and claims using the scorecard to consider areas for a targeted quality improvement focus for the reduction of clinical and non-clinical claims

4.3 Complaints Review – Briefing Report

An external review of the complaints process had been undertaken to improve the position in terms of complaints performance and to support the PILS team and complaint process for the Trust. The Head of Patient Safety advised that the recommendations from this review had been considered and six areas for further action had been developed as a result of this.

This update is highlighted to the Trust Board for information.

4.4 Board Assurance Framework (BAF)

The QC reviewed strategic risk 1 on the BAF around a framework to maintain and improve patient safety, clinical effectiveness and patient experience which was aligned to the committee and its work plan. The Committee noted the updates in the month in red text, including reference to the CQC inspection of Maternity Services and the key next steps to improve policy and procedure management. There are no matters of concern from the strategic risk to be escalated or significant changes proposed to the content or risk scores. Current rating is 20 (likelihood of almost certain x impact of major), target rating is 6 and tolerable rating is 12.

5. Reports from UHL Boards

The Committee received the following reports

5.1 Patient Safety Committee Report

The following aspects of the report were highlighted: NHS Patient Safety Strategy /PSIRF update report and reports from Quality and Safety Boards from CHUGGS and ITAPS CMGs.

5.2 Safeguarding Assurance Committee

The Head of Safeguarding provided an update on key safeguarding activity and developments highlighting the areas where further assurance work was required in maternity and safeguarding training compliance. The areas of high service demand and how risks were being managed and reduced was noted.

5.3 Infection Prevention and Assurance Committee

The Committee noted the infection prevention key performance indicators report for quarter 1 of 2023/24. A deep-dive of carbapenem-resistant organisms (CRO) was due to be undertaken and would be included in this report in future. Internal Audit would be undertaking a review of the 2023 Infection Prevention Board Assurance Framework.

6. Feedback from and escalation to LLR System Quality Board

UHL had presented a report following a deep dive of maternity services. For the next 4 months, an update from UHL on each theme following the East Kent maternity and neonatal services report would be provided to the LLR System Quality Board.

7. Items for Noting

- Integrated Performance Report – Month 4 2023-24
- NIPAG Annual Report 2022-23

8. Any Other Business

None

Date of next meeting – 28 September 2023