UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 27 JULY 2023 AT 2:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey - Non-Executive Director (QC Chair)
Mr A Furlong - Medical Director
Dr A Haynes MBE – Non-Executive Director
Ms J Hogg - Chief Nurse
Mr J Melbourne - Chief Operating Officer
Mr J Worrall- Associate Non-Executive Director

In Attendance:
Dr R Abeyratne - Director of Health Equality and Inclusion,
Ms D Burnett - Director of Midwifery
Ms B Cassidy - Director of Corporate and Legal Affairs
Ms E Collins - Lead Nurse/IP (for Minute 86/23/8)
Dr J Cusack - Clinical Director (Women's and Childrens) (for Minute 86/23/1)
Ms J Kay - Head of Quality Assurance (for Minute 86/23/2)
Ms A Moss - Corporate and Committee Services Officer
Ms C Pheasant - Chief Allied Health Professional
Ms C Rudkin - Head of Patient Safety (for Minutes 86/23/4 and 86/23/5)
Dr N Sanganee - ICB Chief Medical Officer (ICB Representative)

RESOLVED ITEMS

81/23 APOLOGIES

Apologies were received from Professor T Robinson, Non-Executive Director and Ms J Smith, Patient Partner.

82/23 QUORUM

The meeting was confirmed to be quorate.

83/23 DECLARATIONS OF INTERESTS

Resolved – that no additional declarations of interests were received.

84/23 MINUTES

Resolved – that the Minutes of the Quality Committee meeting held on 29 June 2023 (paper A) be confirmed as a correct record.

85/23 MATTERS ARISING

Paper B updated Quality Committee on progress against previous actions. Any updates now provided would be reflected in the next iteration of the log. All '5' rated actions would be removed after this meeting

Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly. **CCSO**

86/23 ITEMS FOR DISCUSSION AND ASSURANCE

86/23/1 Perinatal Mortality: MBRACE Summary Report

The Clinical Director (Women's and Childrens) presented the perinatal mortality report (2021 births) from 'Mothers and Babies Reducing Risk through Audits and Confidential Enquiries through the UK ((MBRRACE-UK). Which identified that UHL's perinatal mortality was 5% greater than the average for our peer group. The accompanying report (paper C refers) provided details and

assurance of the steps that had been taken both internally and externally to understand the data, validate the Perinatal Mortality Review governance processes and use of the Perinatal Mortality Review Tool, review care bundles and to enhance services. Alongside this, work had started with Public Health colleagues to review potential modifiable factors in the wider determinants of health and to better understand factors contributing to inequalities in outcomes.

The Committee noted that whilst the data was risk adjusted for congenital abnormalities, the Trust had a more complex case mix linked to its tertiary services, particularly for cardiac conditions that were not fully risk adjusted for by MBRRACE methodology. Whilst this could account for the Trust's position, it was agreed that there was still a need for internal and peer review to understand the picture and consider other actions. It was also noted that the Trust served an ethnically diverse population, and that deprivation and ethnicity were key determinants of health. As such, the approach of seeking to learn more and work with Public Health was supported whilst ensuring ongoing quarterly peer review of use of the Perinatal Mortality Review Tool and further internal validation of use of care bundles.

The Chief Medical Officer, ICB, asked whether the MBRRACE data could be further segregated to take account of deprivation and ethnicity. This had been discussed with Professor Draper from EMRRACE and it was noted that there would be variation with respect to small numbers which meant the analysis would lack statistical validity.

A further report would be presented in October 2023. The Committee took assurance from the report noting that the actions were in mitigation of BAF Risk 1.

Resolved – that the report be received and noted.

86/23/2 Compliance with National Institute for Health and Care Excellence (NICE) Guidance

The Head of Quality Assurance presented paper D which provided a review of the Trust's compliance with guidelines issued by NICE (paper D) in mitigation of BAF Risk 1.

It was reported the 181 NICE Guidance documents were published or updated in 2022/23, of which 175 were applicable to UHL. The Trust was compliant with 97% of the Guidelines. The areas of non-compliance were set out in the report. The report highlighted where NICE Guidance had informed the UHL Clinical Audit Program.

The Chief Operating Officer questioned whether there needed to be a different approach noting that the Clinical Management Groups spent a lot of time considering potential changes to the guidance. The Medical Director noted that it was often difficult to predict what the guidance would be, and the guidance took a long time to be developed before it was published. It was agreed that the process was fit for purpose and that the Trust had done well to achieve 97% compliance.

Mr J Worrall, Associate Non-Executive Director, noted that it was unclear who the lead was for the guidance on vaccine uptake in the general population. It was noted that it was often difficult to determine how applicable guidance was to the Trust and in this instance, it was for community-based services.

Dr A Haynes, Non-Executive Director, asked whether there were any risks in being unable to demonstrate compliance with the guidance listed in Appendix 1. The Medical Director considered that there was minimal risk but there was a need to close the actions. He observed that the greatest pressures came from the Technical Appraisals and the occasions when high-cost treatment was proposed without additional funding.

It was noted that in future compliance with NICE guidance would report to the Patient Safety Committee and only escalated to Quality Committee if needed.

Resolved – that the report be received and noted.

86/23/3 CQC Update

The Chief Nurse presented an update on CQC activity in Quarter 1 of 2023/24 (Paper E). Themes from the draft CQC Reports and actions taken were set out in the report and provided mitigation of BAF Risk 1.

Ms V Bailey, Non-Executive Director, Chair, asked about the actions outstanding and the target for completion. The Chief Nurse noted that a more detailed workplan with specific timelines underpinned the report. In addition, the Trust had yet to receive the final inspection report for maternity services and this would be overseen by the Maternity Assurance Committee.

It was noted that in future CQC engagement and progress against actions would report to the Patient Safety Committee and only escalated to Quality Committee if needed.

Resolved – that the report be received and noted.

86/23/4 Quality and Safety Performance Report

The Head of Patient Safety presented the monthly update on Quality and Safety issues (paper F) which provided mitigation of BAF Risk 1.

With respect to VTE risk assessment it was reported that the target for May 2023 had been missed and there was a need for admitting teams to understand the importance of completing the assessment. In addition, work would be undertaken to improve the IT system used to record the data and mandate the assessment. The Medical Director noted that a further report was scheduled for Quality Committee.

It was noted that Hospital Acquired Pressure ulcers had decreased in June 2023; the number of falls had increased slightly in May and June 2023 and were below the national average. Ten Serious Incidents (SIs) detailed in the report were escalated in June 2023. This included a Never Event which related to retained foreign object post procedure (retained guidewire).

With respect to infection prevention, it was noted that there was increased focus on antimicrobial prescribing practice to avoid broad-spectrum antibiotic use except where necessary. Work was being undertaken to improve the functionality of the IT system with respect to medicines safety.

Performance for formal complaints had improved.

The Trust's mortality continued to be in line with the national average for both risk-adjusted measures.

Monthly blood traceability data compliance remained excellent, consistently achieving 99.8 to 100%. However, this was reliant on manual processes and there was a need to ensure the IT system was used appropriately.

It was reported that work was underway to build into governance and assurance processes to triangulate complaints, (serious) incidents and claims using the NHS Resolution scorecards. This would support a targeted quality improvement focus for the reduction of clinical and non-clinical claims.

Dr A Haynes, Non-Executive Director, asked about blood traceability and referenced a previous Never Event. The report noted the BloodTrack IT system was not always used, and some evidence of traceability collected manually after the event. The Medical Director noted that the Chair of UHL Transfusion Committee considered that the risk of reoccurrence was very low and was more assured given the mitigations in place. It was proposed to mandate the prescription of blood on Nervecentre which would further mitigate the risk. The e-Hospital Board would be asked to expediate the development.

Dr N Sanganee, ICB Representative, asked about rates for Clostridium difficile (C-diff) noting that the rates for Leicester, Leicestershire and Rutland were the worst in the country, and whether there was action the System could take collectively. It was noted that the Trust's approach to antimicrobial prescription was overseen by the Trust Infection Prevention Committee and would review C-diff rates. It was difficult to understand what the practice was in the community, and it was thought that the guidance given to dentists was not consistent with that applied in general practice.

Ms V Bailey, Non-Executive Director Chair, requested a report on the complaints process and complainants' experience, in light of the new process aiming to achieve early resolution, to a future meeting. **HPS**

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

(B) a report be present to a future meeting on complaints. **HPS**

86/23/5 Thematic review of Seven Hospital Acquired Pressure Ulcers (HAPU) Category 4 incidents

The Head of Patient Safety presented the review of seven Category 4 HAPUs reported as Serious Incidents between October 2022 and February 2023 (paper G refers). There was no single contributory factor and themes, and consequential actions were set out in the report.

The themes reported covered: clinical photography system; pressure relieving equipment; validation process; education and training, and scrutiny and oversight of HAPU validation. A number of associated issues were also considered.

The Committee approved the following recommendations:

- to continue the work in line with the trust wide Tissue Viability improvement plan.
- to consider how the organisation assured itself of the appropriate clinical and executive nurse oversight of the procurement, implementation and evaluation processes of all pressure relieving equipment being purchased across the organisation.
- to consider improved collaborative working with the Allied Health Professionals (AHP) teams on how to include them in the training and requirements to document repositioning as AHP staff are currently underutilised in reducing the risk of pressure ulcers and are involved with repositioning patients.
- to consider undertaking a piece for collaborative work with the spinal team to reduce the risk of pressure ulcer development in patients that are under spinal team care that are not on a spinal ward.
- to consider linking with other organisations that use Stellisept wash in the same way for all patients as this may be beneficial to identify if they have increased incidences of hospital acquired skin damage.
- to give more emphasis on not moving or outlying patients (unless clinically required) with a Category 3 or 4 HAPU as this should be identified as a complex need.
- to revise the Outlying Adult Patients Policy to make patients with Category 3 or 4 HAPU a high risk.

The Chief Nurse proposed a further recommendation to learn from other organisations with respect to HAPU prevention in Cardiac Intensive Care Units. This was approved and it was agreed to set a Quality Standard to ensure there were no Category 4 HAPUs.

The Committee took assurance from the review and associated actions in mitigation of BAF Risk no.1.

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

(B) the recommendations set out above, be agreed.

86/23/6 Patient Experience – 360 Assurance report update

The Chief Nurse presented the report from the Internal Auditors (360 Assurance) 'Patient Experience – Friends and Family Test' (paper H refers). The effectiveness of controls had been examined and the Audit Opinion was 'limited assurance.'

The report set out an action in relation to the governance structure. The audit finding reflected that the governance arrangements were at that time under review and the Patient Involvement and Patient Experience Assurance Committee (PIPEAC) meetings had been stood down due Industrial Action.

The Chief Nurse noted that ensuring the feedback mechanism was accessible was more than just the language used and this needed further consideration. She anticipated the newly appointed Head of Patient Experience would improve the processes.

The action plan was noted mitigation of BAF Risk no.1.

Resolved – that the report be received and noted.

86/23/7 Patient Involvement and Patient Experience Assurance Committee (PIPEAC) Annual Report

The Chief Nurse presented the Annual Report from PIPEAC (paper I) which provided assurance that patient feedback was promoted and monitored. The annual report reflected the themes identified.

It was noted the satisfaction rates for the Friends and Family Test had remained relatively stable, although there had been an understandable dip for patients in the Emergency Department.

There had been a focus on the following workstreams: carers; outcomes and experience for patients from an ethnic minority background; and patients with long term conditions/physical disability.

Ms V Bailey, Non-Executive Director, Chair, queried the data on page 6 of the report which separated out results for Indian patients specifically. She asked for it to be removed as it needed to be alongside all protected characteristic data. The Chief Nurse noted that the data existed. However, it would be a significant piece of work and there was a need to invest in a new platform.

The Chair questioned whether the Test captured feedback with respect to short episodic visits and not the management of long-term health conditions.

The Chief Nurse acknowledged that there was more work to do with respect to patient feedback and that the newly appointed Head of Patient Experience would drive improvement. It was agreed to retain the existing priorities for 2023/24 and identify actions to support the ambition.

The report was noted in mitigation of BAF Risk no.1.

Resolved – that the report be received and noted.

86/23/8 Infection Prevention (IP) Self-Assessment Framework/BAF

The Lead Nurse/IP Lead presents the Infection Prevention Board Assurance Framework (BAF) (paper J).

NHSE had developed a BAF during the pandemic which focussed on the management of Covid-19. This had been revised and the scope widened with the template issued in April 2023. As the Trust already had a framework in place it had been agreed to incorporate the IP BAF into a combined tool to present the Annual IP Programme and Assurance against the UK Health Security Agency requirements. This would provide granular detail and enable readers to drill down to ward level.

The Internal Auditors would be reviewing the process for assurance.

The Chief Nurse cautioned of the need to focus on the actions that were RAG rated amber as well as red to ensure on-going compliance.

There would be quarterly reports to the Committee in mitigation of BAF Risk no.1.

Resolved – that the report be received and noted.

86/23/9 Board Assurance Framework (BAF)

The Committee reviewed strategic risk 1 ‘a framework to maintain and improve patient safety, clinical effectiveness and patient experience’. There were no matters of concern from the strategic risk or significant changes proposed to the content this month. The Committee noted the updates made in the month in red text in the BAF. There were no changes proposed to the scores of this risk: Current rating is 20 (likelihood of almost certain x impact of major), target rating is 6 and tolerable rating 12.

The Trust Board had been agreed that the review of the clinical audit programme would fall within the remit of Quality Committee. It was noted that any delays or issues with respect to national clinical audits was addressed through the monthly Clinical Management Groups Performance Management Reviews.

Resolved – that the report be received and noted.

87/23 REPORTS FROM UHL BOARDS

87/23/1 Patient Safety Committee Report

The Medical Director noting the Escalation Report from the Patient Safety Committee (paper L refers) drew the Committee's attention to the following issues in the report: UHL Transfusion Committee report; progress on Patient Safety Incident Response Framework; new approach for Policy and Guidelines; IP BAF.

Resolved – that the report be received and noted.

87/23/2 Nursing, Midwifery, and Allied Health Professionals (NMAHP) Committee Report

The Chief Nurse, noting the NMAHP Committee report (paper K) advised there were no issues which had been escalated.

The Chief Nurse reported that the Trust
- would receive an award from NHSE for Pastoral Care of International Recruits
- had joined NHSE Hidden Talent Programme and accepted five refugees from the Lebanon
- had created a central Training Programme for ACPs

Resolved – that the report be received and noted.

87/23/1 Maternity Assurance Committee (MAC) Highlight Report

It was noted that the report had been received at the previous meeting and presented to the Trust Board in August 2023.

88/23 LLR QUALITY BOARD

88/23/1 Feedback from and escalation to LLR System Quality Board

No issues were reported.

89/23 ITEMS FOR NOTING

The following item was received and noted.
- Integrated Performance Report – Month 3 2023-24 (paper O)

Resolved – that report be received and noted.

90/23 ANY OTHER BUSINESS

There were no items of any other business.

91/23 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following update be brought to the attention of the Trust Board: -
- Perinatal Mortality: MBBRACE Summary Report (Minute 86/23/1) **QC Chair**
- Thematic review of Seven Hospital Acquired Pressure Ulcers (HAPU) Category 4 incidents (Minute 86/23/5), and
- Nursing, Midwifery, and Allied Health Professionals (NMAHP) Committee Report (Minute 87/23/2).

79/23 ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH

It was noted that the following reports would be covered in the Patient Safety Committee report unless a specific escalation to QC was required.

- Transfusion Committee Update
- Medicines Optimisation Committee Update
- Safer Surgery Board Update
- NHS Patient Safety Strategy and PSIRF Update
- Learning from SIs/Harms – Quarterly Report

The report re. 'Improvement Collaborative/QI' would now be taken through Reconfiguration, Transformation & Digital Committee' and not 'Quality Committee.'

80/23 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Committee be held on Thursday 31 August 2023 from 2 pm via Microsoft Teams.

The meeting closed at 3.41 pm Alison Moss – Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2023-24 to date).

Present

Name	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	*4*	*4*	*100*
R Abeyratne	*4*	*3*	*75*
A Furlong	*4*	*3*	*75*
A Haynes	*4*	*3*	*75*
J Hogg	*4*	*2*	*50*
J Melbourne	*4*	*4*	*100*
G Sharma (until 30.4.23)	*1*	*0*	*0*
T Robinson	*4*	*1*	*25*
J Worrall	*4*	*4*	*100*

In attendance

Name	*Possible*	*Actual*	*% Attendance*
S Burton (from July 2023)	*1*	*0*	*0*
B Cassidy	*4*	*2*	*50*
G Collins-Punter	*4*	*0*	*0*
C Ellwood (from July 2023)	*1*	*0*	*0*
S Harris	*4*	*0*	*0*
J McDonald	*4*	*0*	*0*
R Manton	*4*	*4*	*100*
R Mitchell	*4*	*0*	*0*
B Patel	*4*	*0*	*0*
C Rudkin	*4*	*4*	*100*
J Smith (PP)	*4*	*1*	*25*
M Williams	*4*	*0*	*0*
Gang Xu (from July 2023)	*1*	*0*	*0*