Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 26 JANUARY 2023 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Ms V Bailey – Non-Executive Director (QC Chair)
Dr R Abeyratne – Director of Health Equality and Inclusion
Mr A Furlong – Medical Director
Dr A Haynes - Non-Executive Director
Ms J Hogg – Chief Nurse
Mr J Melbourne – Chief Operating Officer
Professor T Robinson – Non-Executive Director
Dr G Sharma – Non-Executive Director
Mr J Worrall - Associate Non-Executive Director (non-voting)

In Attendance:
Ms L Barbrook – Head of Contracts, Estates and Facilities (for Minute 06/23/1)
Ms D Burnett – Director of Midwifery
Ms B Cassidy – Director of Corporate and Legal Affairs
Ms P Jethwa – Performance Manager (Cleaning Services) (for Minute 06/23/1)
Mrs H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Ms R Marsh – Deputy Medical Director (for Minute 06/23/10)
Ms E Meldrum – Deputy Chief Nurse (for Minute 06/23/1)
Ms J Pickard – Macmillan Lead Cancer Nurse (for Minute 06/23/2)
Mr S Pizzey – Head of Strategy and Planning (for Minute 06/23/8 and 06/23/9)
Ms C Rudkin – Head of Patient Safety

	RESOLVED ITEMS	
01/23	**APOLOGIES**	
	Apologies were received from Ms C Trevithick, Ms C West and Ms H Hutchinson, ICB Representatives and Ms J Smith, Patient Partner.	
02/23	**QUORUM**	
	The meeting was confirmed to be quorate.	
03/23	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
04/23	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 24 November 2022 (paper A) be confirmed as a correct record.	
05/23	**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, and the QC Non-Executive Director Chair noted work underway to progress the remaining actions as a matter of urgency.	
	Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	
06/23	**ITEMS FOR DISCUSSION AND ASSURANCE**	

06/23/1	Patient-Led Assessments of the Care Environment (PLACE) Assurance Report	
	The Performance Manager (Cleaning Services) and the Head of Contracts, Estates and Facilities attended the meeting to present paper C, an update following the recent Patient-Led Assessments of the Care Environment (PLACE). It was an external assessment of the non-clinical services within the Trust, organised by Estates & Facilities (E&F) Directorate, and the outcome was a reflection based on the existing state of the facilities and services provided. Following the assessment, improvement plans were being developed and would be shared with the PLACE assessors. Although the scores indicated good performance, members felt that it did not reflect the lived experience in several areas. In response, the Performance Manager (Cleaning Services) acknowledged this and highlighted that the outcome from the assessment was a snapshot and the assessors had only visited certain areas. They recognised that there was still a lot of work to do within the whole estate across the three hospitals. A Task and Finish Group involving colleagues from Infection Prevention Team would be established to undertake further improvements. It was suggested that in future assessments, consideration be given to a 'fresh eyes' approach rather than having assessors who frequently attended the hospital sites. In summary, the Committee could take some assurance but noted that there was still more work to do and noted the need for appropriate focus on this matter. Members noted that PLACE Lite would be undertaken in the Spring of 2023 across all 3 sites to drive further improvements.	
	Resolved – that the contents of the report be received and noted.	
06/23/2	Cancer Harms Quarterly Report - Quarter 2 2022-23	
	The Committee received the quarterly report (paper D refers) on potential harm to patients waiting for cancer treatment and it was noted that three patients had harm recorded in the second quarter of 2022-23, however, two of these were still to be validated. The Macmillan Lead Cancer Nurse presented the report and provided assurance that the longer waiting cancer patients were being monitored effectively and that themes common to longer patient pathways were being explored and acted on. The key remedial reasons for delay in this period were surgical capacity, robotic capacity, and capacity for template biopsies for prostate patients. Outpatient capacity in Urology and Oncology Services, other diagnostics (PET/Bone scans), patient choice, patient complexity and late tertiary referrals were other less frequent reasons for delays to pathways. The Medical Director provided assurance that recovery actions in terms of the non-clinical factors was being taken forward through the Operations and Performance Committee. In response to a comment regarding avoidable non-clinical factors (i.e., high-risk anaesthetic assessments), the Macmillan Lead Cancer Nurse undertook to liaise with the Medical Director outwith the meeting, if any support was required.	
	Resolved – that the contents of the report be received and noted;	
06/23/3	Update on quality concerns and actions taken to identify deteriorating areas	
	The Chief Nurse presented paper E, an update on concerns raised about a clinical area at the Quality Committee meeting in September 2022. A number of changes to the leadership and staffing within that area had been put in place. Although the performance of this area was improving, there was still more work to do. The report also provided an overview of interventions that were undertaken when a clinical area's accreditation moved from 'green' to 'amber or 'red'. In response to a query from the Committee Chair in relation to wider triangulation, it was noted that a heat map/ monthly suite of metrics using the exemplar programme was being reviewed by the Chief Nurse and Medical Director and would focus on the multi-professional team rather than emphasis being only on nursing metrics. The Chief Nurse advised that future updates on the accreditation program would be presented to the Quality Committee via the NMAHPC update.	
	Resolved – that the contents of the report be received and noted.	
06/23/4	Update in respect of monitoring any quality impacts of the Rapid Flow SOP	
	Paper F provided an update on the quality impacts following the implementation of the Rapid Flow SOP. The Chief Nurse briefed members on the 'rapid flow' and 'boarding' processes. This SOP had been put in place at the end of September 2022 following a national mandate to improve	

	ambulance handover position. Members were assured that the respective teams ensured that there was safe level of staffing and senior oversight out of hours, to support these processes. Despite some of the negative consequences on patient experience, this SOP was having a positive impact on the ambulance handover position. Due to the continued challenges surrounding ambulance handovers, the Trust would need to continue to implement the rapid flow processes. Further to a detailed discussion, it was noted that consideration needed to be given to how the quality impacts would be monitored in future.	
	Resolved – that the contents of the report be received and noted.	
06/23/5	Patient Safety Report – November and December 2022	
	In respect of the November 2022 report (paper G1 refers), the Head of Patient Safety highlighted that 9 SIs had been escalated. This comprised of one never event relating to wrong-site surgery in gynaecology theatres, five in-patient falls and three maternity incidents (which did not meet the HSIB criteria). Triangulating the wards where falls had occurred with safe staffing data indicated that the actual staffing was below the required staffing levels in some of those wards. A patient safety incident relating to outlying patients had been escalated by the Adverse Events Committee. Initial discussions had taken place in respect of medical outliers and the inconsistency in responsibility for reviewing patients from a medical perspective. The Medical Director would be discussing this issue with the Senior Clinical Cabinet and consideration would be given to strengthening the outlying policy in this respect. Members noted that 12 SIs had been escalated in December 2022 (paper G2 refers). There had been an increase in incidents with evidence gaps in Duty of Candour compliance. Responding to a query, the Chief Nurse assured members that there was a robust process in place to manage nurse staffing issues on a day-to-day basis. In terms of compliance with nursing risk assessments, members were advised that a review of nursing documentation was in place to ensure that a streamlined process was available for staff to support provision of safe care. .	
	Resolved – that the contents of these reports be received and noted.	
06/23/6	Bi-Annual Review of Moderate Plus Harm Incidents and Learning from SIs (Q1&Q2 2022-23)	
	The QC noted that the number of harm incidents had decreased in quarters 1&2 of 2022-23 in comparison to 2021-22 (paper H refers). Inpatient falls and Post-Partum Haemorrhage (PPH) were the most common themes from these incidents and workstreams were in place to improve patient safety. Discussions were underway to ensure that specific targeted work was put in place to address the theme in relation to 'clear information to patient for follow up/risks at point of discharge or post outpatient department appointment'. The Director of Midwifery suggested the need for some triangulation and inclusion of some more detail relating to definition of harm, particularly for maternity incidents highlighting that there might be a risk of interpretation without this detail being added to the report. In response to a comment on whether data was available to show a correlation between incidents and the staffing level when that incident took place, the Committee Chair requested the Chief Nurse to give consideration via NMAHPC on how the loop was being closed where there were identified themes/trends (i.e., falls, HAPUs, communication).	**HPS/ DoM** **CN**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Head of Patient Safety and Director of Midwifery to liaise outwith the meeting in respect of inclusion of some more detail in the report relating to definition of harm, particularly for maternity incidents, and** **(C) the Chief Nurse to give consideration via NMAHPC on how the loop was being closed where there were identified themes/trends arising from incidents.**	**HPS/ DoM** **CN**
06/23/7	Complaints Report Q2 2022/23	
	Members noted that the number of formal complaints in quarter 2 had decreased slightly in comparison to quarter 1 of 2022-23 whereas the number of re-opened complaints remained the same in both quarters (paper I refers). Urology and General Surgery were the specialties with the most complaints and concerns and Urology had had the largest rise in the number of complaints	

	and concerns. The top themes were medical care, staff attitude and nursing care. In relation to medical care, the main sub theme was related to 'decision making' and 'questions about treatment'. In respect of 'waiting times', the main theme related to waiting for appointments and waiting for surgery/admission. The number of Transferring Care Safely (GP) concerns had increased slightly in quarter 2. In discussion on this matter, the Medical Director advised that consideration was being given to setting up an electronic solution to automate fit notes to be issued by a health care professional. One new PHSO enquiry had been received, and one had been closed in this period. In response to a suggestion from the Committee Chair, the Director of Midwifery was requested to review the complaints received by the Gynaecology Service in quarter 2 to understand if there were any issues/themes that needed to be resolved.	**DoM**
	<u>Resolved</u> – that (A) the contents of the report be received and noted, and **(B) the Director of Midwifery to review the complaints received by the Gynaecology Service in quarter 2 to understand if there were any issues/themes that needed to be resolved.**	**DoM**
06/23/8	<u>Accessible Information Standard (AIS)</u>	
	Paper J presented by the Director of Health Equality and Inclusion and Head of Strategy and Planning provided an update on the Trust's approach to increasing its compliance with the legal duties outlined in the 2016 AIS. The AIS was a legal requirement for all providers of public services to make reasonable adjustments to ensure individuals (and their families/carers) from the deaf, blind, learning disabled and/or autistic communities could access healthcare materials and provision in a format that suited their needs. A multidisciplinary working group had been established to understand the requirements, further to which several interventions in the elective care pathway had been put in place. However, resourcing of these interventions was a challenge to sustainability and progress of existing work. It was noted that a short-term business case around the broader health equality resource had been put forward in the 2023-24 planning round. Meetings had been scheduled to discuss and agree the governance structure for this workstream and identify a permanent lead for the delivery of the AIS. A further update would be provided to QC in 3 months' time (i.e., April 2023).	**DHE&I/ HSP**
	<u>Resolved</u> – that (A) the contents of the report be received and noted, and **(B) the Director of Health Equality and Inclusion/ Head of Strategy and Planning be requested to provide an update on progress with the Accessible Information Standard workstream to QC in 3 months' time (i.e., April 2023).**	**DHE&I/ HSP**
06/23/9	<u>Health Equality at UHL – Update</u>	
	Paper K provided an overview of the work undertaken around health equality and inclusion since May 2022. A number of projects had been put in place which were at different stages of development, however, the consistent theme was around deprivation and ethnicity. Some simple interventions had had a significant impact in terms of reducing non-attendance rates. Members noted the huge amount of progress and the positive work being undertaken. The Committee were advised that discussion regarding future work and governance structure would be taking place as there was a real challenge in terms of prioritising the work and then delivering sustainable change.	
	<u>Resolved</u> – that the contents of the report be received and noted.	
06/23/10	<u>Patients on Ambulances and ED long waits harm review</u>	
	The Committee received an update (paper L refers) on the harm reviews undertaken of patients waiting for long periods of time in ambulances. The review indicated low level of significant harm directly related to care on the ambulance and there had not been an increase in readmissions or HAPUs. However, there had been an increase in 30-day mortality related to the length of time patients were in an ambulance and the delays in ED. The Medical Director advised that the rise in 30-day mortality had been discussed at the Mortality Review Committee. He also advised that discussion had taken place with colleagues in the Dr Foster Intelligence (DFI) Team, however, they were not able to provide the relative mortality risk by diagnosis for this group of patients. They also did not currently collect data to enable UHL to benchmark against other Trusts. An audit had	

	been undertaken and the Trust was meeting the minimum standards for this group of patients receiving timely review and triage. A review of 30-day mortality and readmissions for 6 weeks of data for those patients rapid flowed and boarded to the wards would be undertaken and presented to EQB in 3 months' time (i.e., April 2023) and subsequently to QC, where a discussion would need to be held on how this would fit into normal reporting processes. The Committee was assured on the work being undertaken noting that quality and safety of patients through the emergency care pathway was being regularly reviewed.	**DMD**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Deputy Medical Director to present an update to EQB in 3 months' time (i.e., April 2023) and subsequently to QC, following the review of 30-day mortality and readmissions for 6 weeks of data for those patients rapid flowed and boarded to the wards.**	**DMD**
06/23/11	CQC Update	
	Members received paper M which provided an update on (a) actions being undertaken following the unannounced inspection of Urgent and Emergency Services and Medicine at LRI (b) actions being developed following the unannounced inspection of Surgery at the Glenfield Hospital, and (c) changes to the CQC regulation and monitoring processes from 2023.	
	Resolved – that the contents of the report be received and noted.	
06/23/12	Tissue Viability Improvement Plan 2023 - Following External Review	
	Due to the increased incidence of HAPUs in quarter 1 and 2 of 2022-23, the Trust had commissioned an external review in September 2022 and the report (paper N refers) provided the improvement plan further to the recommendations from the review. There had been a further peak between October-December 2022. A number of immediate actions had been put in place and the Chief Nurse had commissioned a clinically led thematic review of all the HAPUs validated for the month of December 2022. Responding to a query, the Chief Nurse advised that the effects of new equipment (i.e., mattresses) introduced at LRI and LGH and staff training on the use of the mattresses would be monitored to track potential impact on HAPU incident numbers. The Committee was assured by the actions taken and noted that the outcome of the thematic review would be available in due course.	**CN**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Chief Nurse to present the outcome of the clinically led thematic review of all HAPUs validated for the month of December 2022, in due course.**	**CN**
06/23/13	Board Assurance Framework (BAF)	
	The Head of Risk Assurance presented the report (paper O refers) advising that the report was reviewed by the Medical Director and Chief Nurse on a monthly basis. The Committee reviewed Strategic risk 1 on the BAF around 'failure to maintain and improve patient safety, clinical effectiveness and patient experience' which was aligned to its remit. 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 and the progress with internal control around transactional services. 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.	
	Resolved – that that the contents of the report be received and noted.	
07/23	**REPORTS FROM UHL BOARDS**	
07/23/1	Maternity Safety Report - Quarter 3 2022-23	
	The Committee received the Maternity Safety Quarter 3 2022-23 report (paper P refers) which provided an update on the Healthcare Safety Investigation Branch (HSIB) investigations in	

	addition to Serious Incident notifications. The report provided assurance of the actions being taken by the Maternity Service following serious incidents and incidents which required external reporting. The report also indicated the actions initiated to review safety actions within Maternity to ensure alignment and triangulation of safety information and intelligence to inform improvements. A Task and Finish Group had been established to take forward the actions following the midwifery safe staffing summit held in December 2022. The Director of Midwifery highlighted that a number of initiatives were already in place to address the lessons learned from the incidents, however, noted the need for streamlining quality improvement and ensuring that the actions being taken were having an impact.	
	Resolved – that that the contents of the report be received and noted.	
07/23/2	Update from the Trust Infection Prevention Committee	
	Resolved – that the contents of paper Q be received and noted.	
07/23/3	Nursing, Midwifery and AHP Committee (NMAHPC) Report	
	Resolved – that the contents of paper R be received and noted.	
08/23	**LLR QUALITY BOARD**	
	Resolved – that the work being undertaken in respect of HAPUs (Minute 06/23/12 above refers) be escalated to the LLR Quality Board from this QC meeting.	
09/23	**ITEMS FOR NOTING**	
	The following items were received and noted with no discussion, following assurance from the Medical Director that these reports had been presented to the Executive Quality Board. It was agreed that any future updates from EQB should be brought to QC only for escalation and if there were any impacts on quality. • Volunteers At Life's End (VALE) Co-ordinator Roles – Project Update (paper S) • Update on GIRFT Neonatology Visit (paper T) • UHL Transfusion Committee – 6 Monthly Report (paper U) • Quality Improvement & Clinical Audit Team activity updates (paper V) • Compliance with Self Assessments from recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Reports (paper W) • Integrated Performance Report – Month 9 2022/23 (paper X) • Medicines Optimisation Committee Quarterly Report (paper Y) • Cardiology Services (Acute and Elective) (paper Z) • Maxillofacial Workforce Update (paper AA)	
	Resolved – that the contents of papers S-AA be received and noted.	
10/23	**ANY OTHER BUSINESS**	
10/23/1	NPSA Alert Epidural Infusion Bags	
	The Medical Director advised that a NPSA alert was received on 23 January 2023 which related to product shortage of licensed and unlicensed epidural infusion bags, specifically those which contained fentanyl. There were a series of actions that the Trust was required to undertake in respect of reviewing products and current stock levels. This had been undertaken and an action plan had been developed to temporarily use alternative products. The guidelines had been reviewed and it had been agreed that the Trust would stop using epidural infusion bags in all areas except obstetrics. A risk assessment had been completed. The Committee was assured by the work undertaken.	
	Resolved – that the verbal update be received and noted.	

11/23	**IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**	
	Resolved – that the following updates be brought to the attention of the Trust Board: - • **Accessible Information Standard (Minute 06/23/8 refers)** • **Patients on Ambulances and ED long waits harm review (Minute 06/23/10 refers)** • **Tissue Viability Improvement Plan 2023 - Following External Review (Minute 06/23/12 refers)**	
12/23	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 23 February 2023 from 2pm via Microsoft Teams.	

The meeting closed at 4.00pm Hina Majeed – Corporate and Committee Services Officer

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

Voting Members

Name	*Possible*	*Actual*	*% Attendance*
V Bailey (Chair)	9	9	100
R Abeyratne (voting member from December 2022)	1	1	100
A Furlong	9	8	89
A Haynes	9	8	89
J Hogg (from May 2022)	8	6	75
J Melbourne (voting member from December 2022)	1	1	100
E Meldrum (until May 2022)	1	0	0
T Robinson	9	5	56
G Sharma (voting member from December 2022)	1	1	100
J Worrall (voting member from December 2022)	1	1	100

Non-voting members

Name	*Possible*	*Actual*	*% Attendance*
B Cassidy (from December 2022) *	1	1	100
C Rudkin (from December 2022) *	1	1	100
J Smith (PP)	9	5	55.5
C Trevithick/C West/ H Hutchinson/S Bailey (ICB Representative)	9	7	78
B O'Brien (until December 2022)	8	6	75
M Durbridge (until December 2022)	8	8	100
G Collins-Punter (until May 2022)	2	1	50
G Sharma (non-voting until December 2022)	8	6	75
J Worrall (non-voting until December 2022)	8	8	100

- *December 2022 meeting was cancelled due to operational pressures.*