UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 29 JULY 2021 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Voting Members Present:
Ms V Bailey - Non-Executive Director (Chair)
Professor P Baker - Non-Executive Director (Deputy Chair)
Ms C Fox - Chief Nurse
Mr A Furlong – Medical Director
Mr M Williams – Non-Executive Director

In Attendance:
Mr P Aldwinckle – Patient Partner
Ms G Belton – Corporate and Committee Services Officer
Dr H Brooks – Cancer Centre Lead Clinician (for Minute 66/21/3)
Miss M Durbridge – Director of Quality Transformation and Efficiency Improvement
Ms K Gillatt – Associate Non-Executive Director
Dr A Haynes – Adviser to the Trust Board
Ms K Kingsley – Assistant Director of Operations (for Minute 66/21/3)
Mr M Mannix – Deputy Director of Estates and Facilities (for Minutes 60/21 and 61/21)
Ms B O'Brien – Director of Quality Governance
Mr I Orrell – Associate Non-Executive Director
Ms J Taylor – Deloitte (observing)
Ms C West – CCG Representative

RECOMMENDED ITEMS

60/21 PREMISES ASSURANCE MODEL

The NHS Premises Assurance Model (PAM) enabled NHS Trusts to utilise an evaluation model that produced a range of nationally recognised performance metrics across Estates and Facilities services. The current UHL PAM assessment was configured to be populated across a two-year period, thus making the current 2020/21 data set year one of two. The NHS PAM was a tool allowing the Trust to better understand the efficiency, effectiveness and level of safety applicable to its estate and how that linked to patient experience. It also enabled the Trust to assure patients, commissioners and regulators that robust systems were in place to demonstrate that its premises and associated services were safe. The 20/21 PAM results, as presented by Mr M Mannix, Deputy Director of Estates and Facilities (paper D refers), were broadly comparable with those reported 12 months ago. Financial, resource pressures and Covid-19 had been a barrier to further progress. There was a risk across four of the five domains (Safety, Patient Experience, Efficiency, Effectiveness, Organisation Governance) that they could drop from 'minimum improvement required' to 'moderate improvement required' if workforce gaps and building, infrastructure and equipment attrition was not funded to drive improvement. The contents of this report were received and noted.

In discussion on this item, the Quality Committee Chair noted her intention to discuss the Estates Profile with the Trust Chairman in terms of determining the correct committee reporting route for the future (in terms of both the Premises Assurance Model report and also the Annual Fire Report referenced in the Minute immediately below). Whilst the Committee considered that this report served its purpose in terms of governance validation, it did not provide particular clarity in terms of actions that needed to be taken and it was therefore considered important that a cover sheet accompanied this report to the Trust Board which confirmed that this report related to self-assessment of processes only. The Committee did not gain a sense from the report's contents as to how strong the Trust was relative to comparative Trusts and the responsibilities that existed in terms of future improvements. The report also did not offer a sense of timescale, priorities and risk, nor was there an associated improvement plan. In concluding discussion on this item, the Committee recommended the report onto the Trust Board for formal approval, albeit recognising

the limitations of the report as described above.

<u>Recommended</u> – that (A) this report be supported for onward submission to the Trust Board for formal approval, albeit with multiple limitations (as described above) and subject to the inclusion of a cover sheet as referenced in recommendation (B) below, **DEF/CCSO**

(B) the Deputy Director of Estates and Facilities be requested to write a cover sheet to accompany this report for submission to the meeting of the Trust Board on 2 September 2021 confirming that this report related to the self-assessment of processes only, and **DDEF**

(C) the Quality Committee Chair be requested to discuss the Estates Profile with the Trust Chairman in terms of determining the correct Committee reporting route for the future (in terms of both the Premises Assurance Model report and the Annual Fire Report referenced in Minute 61/21 below). **QC Chair**

61/21 ANNUAL FIRE REPORT

Mr M Mannix, Deputy Director of Estates and Facilities, presented the Annual Fire Report 2020/21 (paper E refers), the purpose of which was to detail the current level of Fire Safety provisions across the Trust portfolio, highlight where improvements had been made and indicate where further Fire Safety related improvements and investments were necessary. Covid had impacted the Fire Safety "normal" working processes; consequently the figures provided in relation to the Fire Risk Assessment Review process had seen a reduction from the previous reporting year from 220 to 155 primarily due to constraints on access to clinical areas. The Fire Safety Team had been unable to provide 'Face to Face' Annual Fire Safety, however the Fire Safety Training compliance remained high and at the end of the reporting year was at 86%; this represented a small reduction on last year's figures. Where requested, specific evacuation training had been provided due to configuration alteration within the clinical spaces. There were a number of areas of focused attention to continue to drive improvements across the Trust such as: a) developing further operational fire protocols to support the new Fire Policy; b) improved recording (classification) and reporting of all Fire Signals by Switchboard; c) reduction of Unwanted Fire Signals across all sites and the assessment of the implementation of the new procedure at the Glenfield Hospital; d) responding to the "new normal" following changes brought about via Covid-19; e) re-introduction of Fire Evacuation Procedure Training; f) re-introduction of Face to Face training via the Clinical Education Centre; g) the provision of Fire Evacuation Drills to all stand-alone buildings and Clinical Education Centres and h) the provision of advice and assistance to the Capital Team on all Capital Schemes taking place and also those in the planning stage.

Mr M Williams, Non-Executive Director, made reference to the use of the word 'mostly' in section 7.2 of the report ('despite the design of a number of these projects already being agreed; many of them are under constant review / change and the Fire Safety Team are mostly kept in the loop regarding these changes), noting that this should presumably be always (kept in the loop) rather than 'mostly'. The Deputy Director of Estates and Facilities was requested to speak to the author of the report to determine the experiences giving rise to this statement in order that appropriate learning could be ascertained and addressed. The Deputy Director of Estates and Facilities was also requested to consult with Leicestershire Fire Service to determine if it would be helpful to them to receive a copy of this report and, if so, to issue this accordingly. In response to a query raised by Mr Aldwinckle, Patient Partner, regarding the number of attendances by Leicestershire Fire Service to false alarms, the Deputy Director of Estates and Facilities advised that the Trust had introduced different arrangements than previously in place to help reduce attendances at false alarms. The Quality Committee received and noted the contents of this report and recommended it onto the Trust Board for formal approval accordingly.

<u>Recommended</u> – that (A) this report be supported for onward submission to the Trust Board for formal approval, **DEF / CCSO**

(B) in relation to the wording used in section 7.2 of the report, the Deputy Director of Estates and Facilities be requested to ask the author of the report why this particular wording was used and to ascertain the learning from this, and **DDEF**

(C) the Deputy Director of Estates and Facilities be requested to ascertain if Leicestershire **DDEF**

Fire Service would find it helpful to receive a copy of this report and, if so, to issue it accordingly.

RESOLVED ITEMS

62/21 APOLOGIES AND WELCOME

Apologies for absence were received from Ms J Smith, Patient Partner.

Ms V Bailey, Quality Committee Chairman, welcomed everyone to the meeting, noting that the title of the Committee was now the Quality Committee (and no longer the Quality Outcomes Committee).

63/21 DECLARATIONS OF INTERESTS

Ms K Gillatt, Associate Non-Executive Director, declared her interests as Non-Executive Director of Trust Group Holdings Ltd and Non-Executive Director of the NHS Business Services Authority. With the agreement of the Quality Committee, Ms Gillatt remained present.

64/21 MINUTES

Resolved – that the public Minutes of the Quality Outcomes Committee (QOC) meeting held on 24 June 2021 (paper A1 refers) and the QOC Summary from the same meeting (paper A2 refers) as submitted to the Trust Board on 1 July 2021 be confirmed as a correct record.

65/21 MATTERS ARISING

The contents of the Quality Committee Matters Arising Log (paper B refers) be received and noted.

Resolved – that the Matters Arising Log (paper B refers) be received and noted.

66/21 ITEMS FOR DISCUSSION AND ASSURANCE

66/21/1 Covid-19 Position

The Chief Nurse and Medical Director reported verbally and briefed the Committee on key issues in relation to the COVID-19 pandemic, highlighting the following matters in particular: (a) the increasing number of Covid-19 patients being treated currently within the Trust; with the majority of those acutely unwell being unvaccinated. There had also been a national rise observed in terms of pregnant patients requiring hospitalisation for Covid-19 treatment (b) a vaccination update; with over 90% of UHL staff now vaccinated and (c) the fact that work was on-going in relation to the impact of the increase in Covid-19 cases (plus urgent and emergency care pressures combined with an increasing number of isolating staff) upon surgical activity and elective care. Note was also made of ICS work which was being progressed in relation to Covid-19. The contents of this verbal report were noted. The Chief Nurse was requested to provide a response to a query raised by Dr Haynes, Advisor to the Trust Board, in relation to whether the figure reported regarding the percentage of vaccinated staff included non-substantive staff or substantive staff only.

Resolved – that (A) the contents of this verbal update be noted, and

(B) in response to a query raised by Dr Hayes, Adviser to the Trust Board, the Chief Nurse be requested to clarify, outside the meeting, whether the figure reported verbally re the percentage of vaccinated staff included non-substantive staff or substantive staff only. **CN**

66/21/2 Discussion on the Future Shape and Content of the Quality Committee

As part of the work underway in relation to the Trust's Committee structure, members provided their initial thoughts on the future shape and content of the Quality Committee going forward. General matters raised were the importance of the Committee reviewing incidents, complaints, claims and inquests in order to identify lessons to be learned, the benefit of keeping the membership to a core group with others attending for specific items only, the consideration of

other key strands which impacted upon quality (i.e. the quality impact of matters relating to performance, finances and risk), the role of the Patient Partner, the undertaking of deep dives where beneficial rather than simply assurance seeking, the potential summarisation / escalation of issues considered by EQB to Quality Committee, the development of a clear work plan, the benefit in ensuring adequate representation in terms of the skill-set of the Quality Committee's membership, a focus on the quality output delivered to patients, the need for adequate time for consideration and discussion (albeit there was not an appetite to increase the length of the meetings) and ensuring alignment to the new ICS governance. In conclusion of discussion on this item, it was agreed that the Quality Committee Chair would receive feedback from Deloitte and would also hold further discussions with (1) the Chief Nurse and Medical Director and (2) the Patient Partners to discuss these matters further.

Resolved – that (A) the contents of this verbal discussion be noted,

(B) the Quality Committee Chair be requested to receive feedback from Deloitte and also to hold discussions with (1) the Chief Nurse and Medical Director and (2) the Patient Partners to discuss the future shape and content of the Quality Committee. **QC Chair**

66/21/3 Cancer Performance Recovery

Ms K Kingsley, Assistant Director of Operations, attended to present paper C, which outlined recent cancer quality achievements and updates over the last month, the contents of which were received and noted. It also provided performance for the most recent uploaded and validated dataset (May 2021) as well as giving performance for the month being validated (June 2021). Performance data ran one month behind (e.g. June data was validated in July and uploaded at the end of July) and data was likely to change as patients completed their cancer pathways.

Key achievements highlighted during presentation of the report were as follows: (1) an on-line Health and Wellbeing Event was being delivered on 18 August 2021 in LLR for people living with cancer (2) the Macmillan Information and Support Centre was offering virtual consultations for patients and their families and (3) the recognition of work being undertaken by particular individuals and teams. The Trust had achieved 6 of the national cancer targets in May 2021 (relating to 2WW Breast, 31 day drugs, 31 day radiotherapy, 28 Day FDS 2WW, 28 Day FDS Breast 2WW and 28 Day FDS Screening). Some challenges were being experienced in relation to staff sickness and vacancies. Specific work was being undertaken to support patient safety in relation to the 104 day backlog numbers. A clinical harm review was undertaken for any patient waiting over 104 days to receive their first definitive treatment following a 2 week wait referral and the details of this were documented on page 8 of the report.

Specific note was made that the Trust was now starting to see patients with a late presentation of cancer due to Covid-19. Particular discussion took place regarding possible reasons why patients may wait over 104 days for their first definitive treatment including complex cases with many comorbidities, referral from other Centres, patients choosing not to come into hospital during the pandemic etc. The Committee emphasised the need for the number of patients waiting 104 days or over to be as low as it could possibly be. The Cancer Centre Lead Clinician made reference to a focus on whether any delays in the cancer pathway had led to patient harm (with note made by the Committee that the Trust could only assess the level of physical harm and not any psychological harm caused). Data was being collected covering the time period of pandemic and it was agreed that it would be helpful for this report to be submitted to both the Quality Committee and the System-wide Group and, in respect of the latter, Ms West, CCG Representative, was requested to schedule this report on the agenda for the System-Wide Group, once available.

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

(B) the Cancer Centre Clinical Lead be requested to provide the data referenced which was being collated relating to time period of the pandemic to both the Quality Committee and System-Wide Group, once available, and **CCCL**

(C) Ms West, CCG Representative, be requested to schedule an item on the data referenced under resolution (B) above on the System-Wide Group agenda, once available. **CCG Rep**

66/21/4 Report from the Director of Estates and Facilities

Resolved – that this Minute be classed as confidential and taken in private accordingly.

66/21/5 Quality and Performance Report – Month 3 2021/22

The Medical Director presented the Month 3 Quality and Performance report for 2021/22 (paper F refers), particularly highlighting the seven Never Events that had occurred within the Trust in the past twelve months. Whilst this number correlated to the level of Trust activity, the Trust wished to further reduce the potential for Never Events in the future. A particular theme from the Never Events which had arisen was in relation to checking processes and work was currently underway to look at further action which could be taken to address this finding. Unfortunately, due to the Covid-19 pandemic, it had not been possible to hold training days and a refresh of work relating to Never Events was now required. Whilst there had been no serious patient harm arising from these Never Events, this theme required particular focus going forward to further improve the position. The Medical Director also highlighted recent poor performance in terms of fractured neck of femur treatment, which was to be the subject of a report to the next Executive Quality Board meeting and was also being addressed with the relevant Clinical Management Groups (ITAPS and MSS) through the Performance Review Meetings (PRMs), as was performance in relation to staff appraisals and statutory and mandatory training. The Quality Committee Chair noted that it would be valuable to consider data, and subsequent learning, in relation to both Never Events and Serious Incidents and the Medical Director confirmed that this data would be presented on a quarterly basis to the Committee.

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

(B) the Medical Director be requested to present data and subsequent learning in relation to Never Events and Serious Incidents at the Quality Committee. **MD**

66/21/6 Patient Safety

66/21/6.1 Patient Safety Highlight Report

The Director of Quality Governance presented the Patient Safety Highlight Report (paper G refers) which particularly highlighted information on the following this month: (1) the key points from the National Patient Syllabus 2.0 (this was a multi-professional syllabus intended to cover all the patient safety training and educational needs of people currently working in the NHS or in training to work in the NHS, including both clinical and non-clinical staff and covering the voluntary sector and social care. It was planned that level one and two learning materials would be available on the E Learning for Health platform for staff to access and complete from August and September 2021. The Director of Quality Governance and Head of Patient Safety would be developing a plan for how this training would be integrated into UHL training requirements for all staff) and (2) the proposal for change in practice following the CQC updating its Duty of Candour guidance (with a proposal that UHL brought all moderate and above harm incidents relating to a recognised complication in line with the full requirements of the Duty of Candour). This report also detailed the Patient Safety Data and Complaints Data for June 2021. In presenting this report, the Director of Quality Governance advised that the Trust had received the highest ever number of GP concerns during June 2021 in relation to national pressures being experienced in the community which would previously have been addressed within a patient's out-patient appointment. The Medical Director confirmed that a System Task and Finish Group were currently looking into this matter and an interim solution had been implemented. The contents of this report were received and noted.

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

66/21/6.2 Report from the Director of Quality Governance

Resolved – that this Minute be classed as confidential and taken in private accordingly.

67/21 ITEMS FOR NOTING

67/21/1 Derogations from PHE Social Distancing Guidelines for Ophthalmology, ENT and Dermatology (papers H1 – H3 refer)

Resolved – that the contents of these reports be received and noted.

67/21/2 Learning from Claims and Inquests (paper I)

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

67/21/3 EQB Action Notes – 8 June 2021 (paper J)

Resolved – that the action notes from the EQB meeting held on 8 June 2021 (paper J) be received and noted.

67/21/4 Covid-19 Isolation for Staff (paper K)

This document related to members of staff 'pinged' or contacted through Track and Trace. A Standard Operating Procedure (SOP) had been developed incorporating a risk assessment to manage such incidents. Ms Smith, Patient Partner, who was not in attendance at today's meeting, had raised a number of questions in relation to this report, to which the Chief Nurse was requested to respond outside of the meeting, in addition to including any further helpful information in relation to this topic matter on the Trust's website.

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

(B) the Chief Nurse be requested to respond, outwith the meeting, to the questions submitted by Ms J Smith, Patient Partner, in respect of covid isolation for UHL staff and, where appropriate, to include relevant information for patients on the UHL website. **CN**

68/21 ANY OTHER BUSINESS

Departure of Professor P Baker

It was noted that this was the last Quality Committee meeting to be attended by Professor P Baker as he was now leaving his role as Non-Executive Director of the Trust. The Quality Committee Chair expressed thanks on behalf of the Committee to Professor Baker for his valuable contributions over the years, noting that he would be missed.

Resolved – that this information be noted.

69/21 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) the following items be recommended onto the 2 September 2021 public Trust Board for formal approval:

(1) Premises Assurance Model, and
(2) Annual Fire Report

QOC Chair

(B) the following items be highlighted to the 2 September 2021 public Trust Board via the summary of this Committee meeting for information:

(1) Discussion on the Future Shape and Content of the Quality Committee

70/21 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Committee be held on Thursday 26 August 2021 from 2pm via Microsoft Teams.

The meeting closed at 3.58pm

Gill Belton - **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2021-22 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	4	4	100	A Furlong	4	4	100
P Baker (until 29.7.21)	4	4	100	B Patel (until 24.6.21)	3	3	100
C Fox	4	4	100	M Williams (from 29.7.21)	1	1	100

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	4	3	75	I Orrell	4	4	100
M Durbridge (from 29.7.21)	1	1	100	J Smith	4	2	50
K Gillatt (from 29.7.21)	1	1	100	C Trevithick/C West/ H Hutchinson (CCG Representative)	4	4	100
A Haynes (from 27.5.21)	3	3	100				