University Hospitals of Leicester NHS
NHS Trust

Public Trust Board paper K2

Meeting title:	Trust Board
Date of the meeting:	10 October 2024
Title:	**Escalation Report from the Quality Committee (QC): 26 September 2024**
Report presented by:	Dr Andy Haynes, Quality Committee Non-Executive Director Chair
Report written by:	Hina Majeed, Corporate and Committee Services Officer

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
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:
QC – Quality Committee; ED – Emergency Department; CMGs – Clinical Management Groups; FFT – Friends and Family Test; KPI – Key Performance Indicator; HAPU – Hospital Acquired Pressure Ulcers; VTE – Venous thromboembolism; NPSA – National Patient Safety Alerts; PSC – Patient Safety Committee; PALS – Patient Advice and Liaison Service; PSIRF – Patient Safety Incident Reporting Framework

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 Quality Committee met on 26 September 2024 and was quorate. It considered the following items, and the discussion is summarised below:

3. Discussion Items

3.1 104 Day + Cancer Quality Standard Report – Quarter 3 2023/24

The Quality Committee considered the above-referenced report which outlined the process currently in place for the reporting of cancer harm as monitored by the Cancer Centre. The 104+ day process reported actual physical harm to a patient from the date of receipt of their two-week wait referral to their first definitive cancer treatment. The report illustrated the Trust position for quarter 3, along with individual tumour site data including key themes and actions identified to improve waiting times and detailed the number of outstanding clinical harm reviews for this time. In quarter 3, a total of 150 patients waited over 104 days from referral to first definitive treatment. A total of 109 completed clinical harm review forms had been received to date and the outcome of these was noted, including one potential harm recorded, with a root cause analysis now being undertaken to further investigate this. The remaining 41 would be reviewed on return to the Cancer Centre.

At the Quality Committee in June 2024, it was suggested that a demographic understanding of patients who were waiting the longest be obtained, to understand if there were any patterns, so that an equity-based approach could be taken to address any issues that were identified. Therefore, the Associate Director of Cancer tabled a presentation providing the ethnicity of patients who were waiting the longest in quarter 2 of 2023-24. Although there was not much variation in those longer waiters by reported ethnicity and there did not appear to be any particular significant trends, there seemed to be a high proportion of patients where the ethnicity was either 'not

known' or 'not reported'. In further discussion on this matter and the need for a deep dive of ethnicity in the context of harms, the Committee Chair requested the Deputy Medical Director and the Director of Health Equality and Inclusion to consider the scope of this work and provide an update to Quality Committee, as appropriate.

The Quality Committee received and noted this update on long waiting cancer patients in the Trust, specifically noting that whilst prostate cancer patients continued to make up the largest proportion of longest waiters the numbers of them waiting had continued to reduce. The key themes contributing to the delay in this period were urology, oncology and theatre capacity, complex pathways, and diagnostic waits. Although template biopsy capacity for prostate cancer patients was still an issue, the number of patients waiting too long because of this had reduced. Urology and Oncology teams were working towards joint clinics for prostate cancer patients who require multispecialty involvement.

In response to queries, the Associate Director of Cancer: -

- provided an update on the actions being taken to resolve the delays relating to skin analytics and joint clinic capacity with the plastics team;
- advised that assessing the psychological harm of patients on a cancer pathway was regarded as very difficult and for that reason was advised nationally to be kept out of the 104+ day process. However, in the recent months UHL and LLR now had initiatives like Prehab, which provided more psychological support for patients who were on a cancer pathway or undergoing cancer treatment. The onward funding for these initiatives needed to be considered.

The Committee was assured that the monitoring and investigation processes for these long waiters was robust, with the reported numbers stable and improvements being observed and continued to endorse the wait time monitoring processes in place for cancer patients at UHL. The Committee passed on their thanks to the team for their efforts in making the improvements.

3.2 Perinatal Mortality: MBRRACE Summary Report/Actions

Further to a report presented to Quality Committee in March 2024 re. UHL MBRRACE report for 2022, the Clinical Director, Women's and Children's attended to provide an update on progress of the agreed actions. An external review of UHL's fetal medicine services had been undertaken and a group was being established to take forward the changes suggested by the review. A peer review visit to Leeds Teaching Hospitals NHS Trust took place in May 2024 with no concerns highlighted in relation to the Perinatal Mortality Review processes. Further to a deep dive of neonatal deaths and work to address necrotizing enterocolitis, appropriate changes had been put in place. UHL have been working closely with public health experts as part of a broader analysis of the wider determinants of health. This work continues and initial learning correlates with the national findings that cases of neonatal mortality at UHL were from more deprived backgrounds. Prevention will be a crucial factor in developing the next steps and UHL will be working with system partners on developing a response and actions. A consortium had been developed with a number of large perinatal centres with associated cardiac and surgical services, to share practice. The Committee were briefed on the number of neonatal deaths in 2023 which was higher than that observed in 2022, however, this had fallen in the first half of 2024. Data analysis was underway, however, it appeared likely that this reflected a high number of 'in utero' transfers of women who were transferred to UHL for Level 3 neonatal services and the East Midlands Congenital Heart Centre. The publication of the latest MBRRACE report for 2023 was expected in November 2024 which would allow national benchmarking. Local data analysis identified that the complexity of the UHL case mix, with non-standard referral pathways, resulted in a very high-risk population that might not be adequately reflected in the MBRRACE data analysis when comparing Trust's within the peer group. The Committee was assured of the robust process in place, noting that even though UHL was an outlier, there was a more comprehensive understanding of the data and the collective system actions required.

This update and the discussion with public health, in particular, is highlighted to the Trust Board, for information.

3.3 New Interventional Procedure Authorisation Group (NIPAG) Annual Report 2023-24

The Committee received an update on the background on the establishment of NIPAG at UHL highlighting NIPAG's primary role was to oversee the governance arrangements for the introduction of new procedures and oversee compliance to NICE Interventional Procedure Guidelines at the Trust. UHL had the earliest version of this Committee which commenced in 2004, when it was an Advisory Group, however, it was now an Authorising Group. NIPAG had approved approximately 180 procedures so far which included 6 in 2023-24. Since Covid-19, NIPAG were now starting to see an improvement of activity in both new notifications and the re-start of NIPAG authorised procedures. Determining the safety and efficacy of some procedures may require

long term monitoring, NIPAG would require satisfactory evidence that measures were in place to satisfy such requirements. Recommendations may vary depending on the intervention, but once the procedure was authorised, NIPAG would usually require a report on the first 20 patients treated. NIPAG would be moving to trial a new electronic database which would assist in monitoring the processes more efficiently. The Committee was assured by the process in place, and it was suggested that future annual reports should include any procedures that were rejected and whether any approved procedures had now been incorporated into clinical practice.

3.4 Quality and Safety performance dashboard – August 2024

The Quality Committee considered the monthly patient safety and complaints performance report for August 2024. The report provided a focus on the following key performance indicators for quality and safety. The number of hospital acquired pressure ulcers (HAPUs) had decreased and the August 2024 number was the lowest in the last 2 years. The falls per 1000 bed days continued to remain low and remained below the national average and UHL mean. The report further advised that the overall moderate and above harm incidents reported were less than last month. There had been an improvement in the number of overdue serious incident actions and Transferring Care Safely concerns. There had been a slight increase in the number of overdue serious incident actions and Duty of Candour evidence gaps. Risk management performance indicated a decrease to 22% of open risks currently flagged with elapsed review dates, with W&C, RRCV, CSI CMGs and Corporate Directorates being those that were well above the 10% target threshold. Infection prevention measures were being further strengthened with focused actions on CDI and MSSA data. The Trust was also making advances in medicines safety, an improvement seen in the timely administration of Parkinson's drugs but a decline in the missed dose of anticonvulsants. Compliance with mandatory training had remained at 93% with BLS training showing least compliance. The Friends and Family Test (FFT) scores for inpatient, outpatient and ED were above target but Maternity was just below target. Less formal complaints and less reopened complaints received and there had been a reduction in the number of overdue complaints. The Trust's crude mortality remained at lowest at 0.88% year to date. Blood transfusion traceability compliance was just under 100% and Bloodtrack device compliance remained above 90% for the fifth consecutive month. Health and safety incidents had seen a notable reduction in the number of staff-related incidents and RIDDOR reportable incidents, however, an increase in ligature incidents. Appropriate actions were being taken to ensure staff safety, following reports of violence and aggression against staff. The Trust will be using the new NHSR scorecard to pilot a claims scorecard dashboard tool to extract key data to support learning. A safety report would be developed to support triangulation of safety learning themes to enable identification of hotspots for further scrutiny and review.

Responding to a query, it was noted that Patient Safety Partners had been recently recruited and consideration would be given to inviting them to Quality Committee meetings to provide updates on their work. In discussion, the Quality Committee Chair requested that an update on UHL's position be provided to Quality Committee prior to the go-live, in respect of the changes in the Hospital Standardised Mortality Ratio (HSMR) methodology in terms of how the data was going to be benchmarked. The Committee Chair flagged to the PCC Chair, the discussion around violence and aggression against staff, and requested that work around this be taken forward through PCC.

The Committee were assured with the update provided by the Head of Patient Safety noting the good progress in several areas. ***The sustained improvement in HAPUs and falls is highlighted to the Trust Board, for information.***

3.5 Clinical Correspondence Risk Update

Further to an initial report on this matter being provided to the OPC in April 2024, the OPC had requested that a report on progress and performance against the standard for timeliness be provided to Quality Committee. The Chief Information Officer (on behalf of the Chief Medical Information Officer) attended the meeting to present the Trust's position on risks around clinical and administrative correspondence and the mitigating actions. The risk was relating to the fragmentation of systems and processes around delivery of letters to primary care, in particular. This risk was captured on the risk register and was scoring at 12 for inpatient letters and 9 for outpatient letters as of July 2024. UHL would be using both electronic and paper delivery for inpatient discharge letters to primary care until confidently eliminating the need for paper copies. There was currently variation in processes both across CMGs and wards/clinical teams, but it was highlighted that there was visibility of this, and work was underway to standardise the process. The work in respect of completion of inpatient TTOs was being monitored by the clinical teams. There was a high degree of confidence in relation to creation and delivery of outpatient letters. Patients receiving digital access to letters would be included in the next phase of the project.

Currently, the letters not being sent were due to out-of-date information. The replacement PAS go-live in February 2025, would allow connectivity to the national patient demographics service (PDS) which would allow access to the most up-to-date address information of the patient and the most up-to-date GP registration information. There was a brief discussion on the coverage of the NHS app and engagement with the NHS app in LLR including digital exclusion, the wider kind of inclusion aspects around language of letters and the timeliness of the receipt of letters.

A further update/ snapshot of the position was requested to be provided in January 2025 (i.e., before the PAS 'go live') including a narrative on the understanding of the current variation between Services and whether there was a legitimate reason for this, or it needed to be reviewed further.

This update is highlighted to the Trust Board, for information.

3.6 Infection Prevention BAF

The Chief Nurse presented the report, the purpose of which was to ensure that the Committee was sighted to the revised Board Assurance Framework excel workbook document. The report provided assurance that a process for its use has been developed within UHL and quarterly reports will be presented to the Infection Prevention Assurance Committee and Quality Committee. The overall compliance at quarter 1 of 2024-25 with the 10 criterion was listed in the report, however, the Chief Nurse undertook to double-check the percentage of partial compliance just to ensure it was correct. Although most of the criterion had been rated 'amber', this was because the Team were ensuring that it had been appropriately implemented rather than being satisfied with just an action plan being in place. The criterion that had been rated 'red' were as follows: - (a) the One Together toolkit had not been embedded across all theatres where surgical site surveillance had been undertaken, and (b) training compliance remained static. The Committee were assured that the Trust was working towards compliance in most areas and where the Trust was currently non-compliant, there were plans to address these.

This report constitutes a standalone agenda item on the public Trust Board agenda for 10 October 2024.

3.7 Board Assurance Framework (BAF)

The Quality Committee reviewed the BAF risks within its remit (strategic risk 1 failure to maintain and improve patient safety, clinical effectiveness, and patient experience) and endorsed the content and the current risk score of 20, despite the following reductions. The Quality Committee noted revised risk ratings for several threats under the Quality risk category, namely patients and carers not involved or listened to – the current risk score has decreased from 20 to 16; conflicting priorities – the current risk score has reduced from 20 to 12, which is the tolerable level; lack of a systematic approach to quality improvement – the current risk score has lowered from 20 to 12, meeting the tolerable level; patient involvement in a research study – the current risk score has been reduced to 6, which aligns with the target rating.

3.8 Reports from Quality Committee sub-groups:

The Quality Committee noted detailed updates from:

- **Nursing, Midwifery and AHP Committee Summary Report** – the Chief Nurse highlighted the following points in particular:- (a) implementation of Martha's Rule would go-live in the Children's Hospital in October 2024; (b) Leicester Excellence Accreditation Framework – good work had been undertaken, however, there were some issues with collating data into the frameworks but work was underway to address the issues, and (c) Children's hospital staffing – summit had been planned to review the plans for winter.

- **Patient Safety Committee (PSC)** – with regard to the issues covered at the 17 September 2024 PSC, the Deputy Medical Director particularly highlighted discussion on: -
    - **Annual Inpatient Survey 2023** – the key areas identified within the survey for improvement included Listening to patient/carer concern – adoption of Martha's rule/Call 4 concern', noise at night, and patient information leaflets;
    - **Deteriorating Patient and Safe Surgery and Invasive Procedures Board** – continued to focus on sepsis, acute kidney injury and diabetes care as objective markers for recognising the deteriorating patient. A new sepsis tool had been introduced in the Emergency Department (ED) which would ensure senior ED leads were made aware early of any potential patients with sepsis. Plans were in place to implement the new NICE compliant NerveCentre sepsis tool. In response to a query, it was noted that a business continuity plan would be developed to alert cardiac arrest

bleeps if UHL suffered a major Wi-Fi outage, due to changes in UHL telecoms setup. This was a new risk and would be included on the risk register.

- **The Review of Patient Results in Electronic Systems by Non-Medical Staff** – work was underway to sign-off the clinical process and ensure there was assurance that appropriate training, governance, and processes were in place to ensure safe practice.

Responding to a query in relation to concerns from the ICB re. vaccination rates for Pertussis, it was noted that this was due to staff shortages to run the clinics, however, this had now been resolved.

3.9 Feedback from and escalation to LLR System Quality Board (SQB): no items to escalate to Trust Board

3.10 Items for Noting

- Integrated Performance Report 2024/25 – Month 5, and
- Perinatal Surveillance Scorecard,

Date of next meeting – 31 October 2024