UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 29 AUGUST 2024 AT 2PM (VIRTUAL MEETING VIA MICROSOFT TEAMS)

Members Present:
Professor I Browne – Associate Non-Executive Director (Acting Chair)
Ms J Hogg – Chief Nurse
Mr M Farmer – Associate Non-Executive Director
Mr A Furlong – Medical Director
Ms S Taylor – Deputy Chief Operating Officer (on behalf of Chief Operating Officer)

In Attendance:
Mr C Allsager – Clinical Director, ITAPS (for Minute 104/24/1)
Ms B Cassidy – Director of Corporate and Legal Affairs
Ms L Cowan – Head of Operations. MSS (for Minute 104/24/1)
Mr M Clayton – Head of Safeguarding (for Minute 105/24/2)
Ms J Kay – Head of Quality Assurance (for Minute 104/24/4)
Ms M Kelly – Children's Safeguarding Matron (observing) (for Minute 105/24/2)
Ms H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Ms S McLeod – Head of Patient Experience (for Minute 104/24/7)
Mr M Rahman – Chief Pharmacist
Dr P McParland – Consultant Obstetrician (for Minute 97/24)
Dr P Patel – Clinical Director, CSI (for Minute 104/24/2)
Ms C Rudkin – Head of Patient Safety (for Minutes 104/24/5 and 104/24/6)
Ms C West – ICB Representative
Dr G Xu – Deputy Medical Director

	RECOMMENDED ITEMS	
97/24	Mortality and Learning from Deaths (LfD) Quarterly Report	
	The Committee received paper C, 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 Trust's Summary Hospital-Level Mortality Indicator (SHMI) stood at 99 and the risk adjusted Hospital Standardised Mortality Ratio (HSMR) was 100, both within the expected range. The crude mortality rate for 2024-25 was 0.88%, which was the lowest it had been since reporting of this metric had commenced. Dr Foster's quarterly report on UHL's risk adjusted mortality had been reviewed in detail to understand the reasons for UHL's "expected mortality rate" seeming to be lower than other Trusts and the drop in the comorbidity index score. This work had identified the need for coding improvement and work was underway, however, challenges and risks remained. The Medical Director highlighted that the changes to risk adjustment and UHL's current coding practice might cause changes to UHL's adjusted mortality indicators. Further to an action from Trust Board in June 2024, a review of all deaths between 2019 and 2024, which were considered to be more likely than not due to issues in care, had identified 'delays to or missed diagnosis', 'medications management' and 'escalation' as the most common themes. The Medical Director assured the Committee that appropriate actions were being taken and where possible, being incorporated into on-going quality improvement workstreams. These themes formed the core priorities within the PSIRF strategy and the e-hospital programme, which aimed to use digital technology to reduce risk associated with miscommunication. It was requested that the themes/trends be included in the next quarterly report in addition to the actions being taken to address those issues. In respect of the learning from deaths programme, the number of primary care referrals to the Medical Examiner office had continued to increase. The statutory requirements of the Medical Examiner process being implemented across LLR including national changes to the process of death certification would commence from 9 September 2024. The outcome of Structured Judgement Reviews was being followed-up. Two deaths (one to be confirmed) during quarter 1 of 2024-25 had been considered more likely than not due to issues in care, the actions being taken following a review of these cases had been included in the report.	**MD**

	In relation to perinatal mortality, in 2023, there was a fall the stillbirth rate with a further rise in the number of neonatal deaths. The perinatal mortality reviews for 2023 had been completed and the data would be summarised and analysed to identify themes/trends. Although the rise in neonatal mortality rate was concerning, it was felt that all measures had been exhausted internally to make any further improvements and it was likely to do with UHL's case mix and some of the wider health inequalities. During the first half of 2024, the Trust's still birth rate was higher than 2023, however, no immediate causes of concern had been identified. The Trust's neonatal mortality rate seemed to have plateaued. Members were advised that the external review of UHL's fetal medicine services was constructive and initial feedback and draft report had been received and the final report was awaited. The perinatal mortality trends at UHL seemed to reflect many of the trends and themes identified nationally. In summary, the Committee was assured with this update, noting that several 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: • statutory requirements in respect of the Medical Examiner process being implemented across LLR from 9 September 2024; • HM Senior Coroner's request to refer all deaths which may be due to problems in care; • external reporting of child deaths to the Child Death Overview Panel (CDOP) & neonatal deaths and stillbirths to the Mothers and Babies – Reducing Risk through Audit and Confidential Enquiries (MBRRACE), and • Safety Action 1 of the Year 5 Maternity Incentive Scheme (MIS)/Clinical Negligence Scheme for Trusts (CNST).	
	<u>Recommended</u> – that (A) in respect of the review of deaths which were considered to be more likely than not due to issues in care, the themes/trends be included in the next quarterly report in addition to the actions being taken to address those issues, and **(B) the Mortality and Learning from Deaths report be endorsed and recommended for Trust Board approval.**	**MD** **MD**
98/24	<u>QC Terms of Reference – Review</u>	
	The Director of Corporate and Legal Affairs presented paper K and advised that some elements in terms of the duties of the Quality Committee were now reported via the subgroups of the Committee. Therefore, instead of removing these references from the terms of reference, she suggested that these remained, in order that there was clear oversight, noting that those reports might not be presented as standalone items but via the subgroup reports. The terms of reference also listed the subgroups which reported directly into the Quality Committee. She undertook to add 'PSIRF reporting.' The Chief Pharmacist advised that assurance reports re. oversight of appropriate medicines management/pharmacy would be provided to the Quality Committee from October 2024 onwards. An organogram of the reporting structures was requested to be developed.	**DCLA** **DCLA**
	<u>Recommended</u> – that (A) the Director of Corporate and Legal Affairs be requested to update the QC terms of reference as per discussion at the meeting and the updated terms of reference be endorsed and recommended for Trust Board approval, and **(B) an organogram of the reporting structures be developed.**	**DCLA** **DCLA**
	<u>RESOLVED ITEMS</u>	
99/24	**APOLOGIES**	
	Apologies were received from Ms R Abeyratne, Director of Health Equality and Inclusion; Dr A Haynes, Non-Executive Director and QC Chair; Mr J Melbourne, Chief Operating Officer; Ms C Pheasant, Chief AHP; Professor T Robinson, Non-Executive Director and Mr J Worrall, Non-Executive Director.	
100/24	**QUORUM**	

	The meeting was confirmed to be quorate.	
101/24	**DECLARATIONS OF INTERESTS**	
	<u>Resolved</u> – that no declarations of interests were received in the items being discussed.	
102/24	**MINUTES**	
	<u>Resolved</u> – that the Minutes of the Quality Committee meeting held on 25 July 2024 (papers A1 and A2) be confirmed as a correct record.	
103/24	**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.	
	<u>Resolved</u> – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	
104/24	**ITEMS FOR DISCUSSION AND ASSURANCE**	
104/24/1	<u>Fractured Neck of Femur Update</u>	
	Paper D provided an update on the performance of the #NOF service over that last 6 months including the number of #NOF admissions per month, theatre productivity metrics and performance against the 36-hour admission to operation KPI. In 2023-24, the compliance rate was 51% against a target of 72% for this KPI. The reasons for this were multifactorial, including, insufficient theatre capacity, inability to respond to surge of #NOF patients, challenges in accommodating other trauma subspecialities lines of work, insufficient imaging support within theatres, extended waiting times in ED prior to admission and insufficient workforce to undertake some of the improvement work required to streamline the service. The Medical Director requested the 'lack of radiology cover over the lunchtime period' be resolved outwith the meeting as it seemed a 'quick fix' and offered support if there were any issues. Whilst a number of transformations had been in place across the #NOF pathway, there was efficiency work still to be done, noting that the constrained capacity at LRI was the fundamental issue. The Medical Director highlighted that the team had taken all steps to use the facilities as efficiently as possible. An update was also provided on the joint working undertaken between MSS and ITAPS CMGs. The following actions were planned (a) to continue to maximise throughput in LRI trauma theatres; (b) to reduce wait times in ED; (c) to revisit #NOF admissions unit plan, particularly in relation to an uplift in ortho-geriatrician provision, and (d) further development of the ambulatory trauma hub at LGH scheme. At the request of the Patient Safety Committee in August 2024, the team would be developing a smaller, more focused business case at pace to ensure additional resources were put in place for the coming winter, to resolve the need for additional capacity and reduction in waiting times.	**CD, ITAPS/ HoO, MSS**
	<u>Resolved</u> – that the 'lack of radiology cover over the lunchtime period' be resolved outwith the meeting as it seemed a 'quick fix' and support from the Medical Director be sought if there were any issues.	**CD, ITAPS/ HoO, MSS**
104/24/2	<u>Report from the Clinical Director, CSI</u>	
	<u>Resolved</u> – that this Minute be classed as confidential and taken in private accordingly.	
104/24/3	<u>Dementia Services Annual Report 2023-24</u>	
	The Quality Committee noted the update of the dementia and delirium services provided across UHL and were assured by the progress to date and priorities for the coming year (paper F refers). It was suggested that data about patient/carer experience was included in future reports.	**CN**

	<u>Resolved</u> – that the patient/carer experience be included in future such reports.	**CN**
104/24/4	<u>2024/25 CQUIN Schemes Quarter 1 Performance Update</u>	
	The Committee received paper G, an update on performance of the non-mandatory CQUINs schemes in quarter 1 of 2024-25. The total CQUIN funding in 2024-25 will be received and no financial penalties will be applied. The Trust had agreed 7 CQUINs to deliver improvements to services and benefit patients. The Committee were assured that 4 schemes were on track, 2 schemes had a clear plan to deliver and 1 scheme did not require reporting until quarter 2.	
	The Acting Committee Chair queried the plans in place for the on-going audit of intravenous to oral antibiotic switch noting that DMU 3rd year pharmacy students were currently undertaking this during clinical placements. In response, the Chief Pharmacist undertook to liaise with the eMeds team regarding this matter.	**CP**
	<u>Resolved</u> – that the Chief Pharmacist be requested to liaise with the eMeds team regarding the plan in place for the on-going audit of intravenous to oral antibiotic switch, noting that DMU 3rd year pharmacy students were currently undertaking this during clinical placements.	**CP**
104/24/5	<u>Quality and Safety Performance Report – July 2024</u>	
	The Quality Committee considered the monthly patient safety and complaints performance report for July 2024 (paper H refers). The report provided a focus on key performance indicators for quality and safety particularly in respect of: - VTE risk assessment, HAPUs, falls, patient safety incidents, risk register performance, medicines safety, FFT, complaints, NPSA, mortality, the administration of Parkinson medications, blood traceability and health & safety incidents.	
	In respect of the VTE Risk Assessment compliance in ESM, members noted that continued to have a positive impact on overall Trust compliance. The number of hospital acquired pressure ulcers (HAPUs) had decreased in comparison to the previous month. The falls per 1000 bed days and total number of falls had continued to remain low and remained below the national average and UHL mean. The report further advised that there had been an improvement in the number of overdue serious incident actions and Transferring Care Safely concerns. The Trust was also making advances in medicines safety, aiming to reduce missed doses of anticonvulsants and enhance anticoagulant safety. Compliance with mandatory training has remained at 93% with BLS training showing least compliance. Overall risk register performance indicated that 15% of open risks had an elapsed review date and/or actions passed their due date for the reporting period against a target of 10%. In response to a query relating to risk appetite, the Head of Risk Assurance undertook to meet with Professor I Browne outwith the meeting to discuss this matter in detail. There had been a decline in Outpatient FFT score but an improvement in Inpatient and ED FFT score, which was also above the national average. There had been less formal and reopened complaints in July 2024. Blood transfusion traceability compliance remained at 100% and Bloodtrack device compliance remained above 90% for the fourth consecutive month. The Committee were assured with the update provided by the Head of Patient Safety noting the good progress in several areas and the clarity of the report.	
	<u>Resolved</u> – that the contents of this report be received and noted.	
104/24/6	<u>Patient Safety Report – Quarter 1 2024-25 (including PSIRF)</u>	
	The Committee received the first quarterly report since the Trust went live with PSIRF on 1 April 2024 (paper I refers). This report provided an update following a thematic review which allowed focused speciality or wider organisational actions to be developed and implemented to improve quality and safety. The Head of Patient Safety advised that the increase in the moderate and above harm incidents in maternity was discussed at PSC and posed a query in relation to the health inequalities data and the same demographics for this patient cohort in quarters 1 and 2 would be obtained with the view of understanding any themes. In respect of the themes arising	

	from Transferring Care Safely concerns, discussion was underway, and actions would be taken, as appropriate. The data relating to 'no harm and minor harm incidents' was being reviewed as skin damage was the most common incident reported. The Committee were pleased with the format of this report and noted the themes highlighted and the work ongoing to improve patient safety in relation to the most notable themes.	
	Resolved – that the contents of this report be received and noted.	
104/24/7	<u>Patient Experience Annual Report 2023-24</u>	
	The Committee were advised that in 2023-24 there had been a reduction of formal complaints and improvement in response performance, in comparison to 2022-23 (paper J refers). The goal was to respond to at least 95% of all formal complaints within the timeframe agreed with those who had made the complaint, and in 2023-24, this target was at 50%. The top themes related to questions about treatment and nursing care. It was anticipated that the ongoing early resolution work by the PALS team would in-turn reduce the formal complaint numbers even further. Members noted some examples of improvements made in response to complaints & concerns and the priorities for complaints and PALS in 2024-25. The Committee noted the significant work being undertaken to triangulate different workstreams and the focus being given to resolving issues before it became a formal complaint. In response to a comment on the frequency of reports to the Trust Board re. complaints and compliments, it was noted that the QC had oversight of this via monthly quality and safety reports and quarterly thematic reports, any issues were reported to Trust Board via the QC escalation report. In discussion, the Chief Nurse suggested that some of the patient stories at the Trust Board should focus on thematic complaints and compliments which would help to bring the voice of the patient in a different way and undertook to liaise with the Director of Communication and Engagement regarding this. Mr M Farmer, Associate Non-Executive Director re-iterated the need for regular updates on patient experience and patient safety to be provided to the Trust Board. In response, the Director of Corporate and Legal Affairs with support from the Chief Nurse and Head of Patient Experience undertook to liaise with the Chief Executive and Trust Chairman regarding the way forward. It was also highlighted that there had been an overarching improvement in patient experience following the roll-out of the 15 Steps programme.	**DCLA**
	<u>Resolved</u> – that the Director of Corporate and Legal Affairs be requested to liaise with the Chief Executive and Trust Chairman regarding the request for regular updates on patient experience and patient safety to be provided to the Trust Board.	**DCLA**
104/24/8	<u>Infection Prevention Annual Report 2023-24</u>	
	The Chief Nurse presented paper L, the infection prevention annual report 2023-24 on behalf of the Head of Infection Prevention. She highlighted that the report demonstrated a huge amount of work from the multi-professional team that drives into the Trust's duties in terms of infection prevention and control. Although the Trust did not stay within the thresholds, the benchmarking data showed that UHL was in a good position in respect of hospital acquired infections. The age of the estate/standard of the physical environment was the biggest concern in terms of infection prevention at UHL and collaborative work was underway between both the teams. The efforts of the teams across the Trust, areas of focus and trajectories for 2024-25 were noted. The Infection Prevention BAF would be presented to QC in September 2024.	**CN**
	<u>Resolved</u> – that the Chief Nurse be requested to present the Infection Prevention BAF to QC in September 2024.	**CN**
104/24/9	<u>BAF Report</u>	
	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 (paper M refers). The Committee acknowledged the decrease in the current score from 20 to 16 regarding the threat related to patients and carers not being involved or heard following an incident/complaint. The highest current score for the Quality Governance risk remains at 20.	
	<u>Resolved</u> – that the contents of this report be received and noted.	
105/24	**REPORTS FROM QUALITY COMMITTEE SUBCOMMITTEES**	

105/24/1	Infection Prevention Committee (IPC) Quarter 1 2024/25 Report	
	The Chief Nurse presented paper N and advised that the trajectories for 2024-25 were now available and the Trust was within those thresholds for all the hospital acquired infections except bloodstream infections. The IP team were continuing to address the areas of non-compliance following audits relating to hand hygiene and Peripheral Vascular Access Devices (PVAD) insertion and management. The progress being made with FFP3 Mask Fit Testing, which was now business as usual, was noted. The Infection Prevention BAF would be presented to QC in September 2024.	
	Resolved – that the update from IPC be received and noted.	
105/24/2	Safeguarding Assurance Committee (SAC) Report	
	The Head of Safeguarding presented paper O and advised that following the receipt of the NHSE pressure ulcer safeguarding guidance, a working party had been established led by the Deputy Chief Nurse LLR ICB to consider a local implementation approach. The LLR Adult Safeguarding Board had been satisfied that the Trust followed the correct process for managing Deprivation of Liberty Safeguarding applications. Further to a recommendation from an Internal Audit review, the SAC now received direct feedback from CMGs on safeguarding practice which has in-turn provided the Committee with improved oversight of the safeguarding issues that affected the delivery of services. Work was underway to improve compliance in relation to adult level 3 training, changes had been made to training delivery approaches by increasing the number of interactive online training sessions, and CMGs were required to validate training requirements using newly introduced safeguarding training decision tools.	
	Resolved – that the update from SAC be received and noted.	
105/24/3	Patient Safety Committee (PSC) – August 2024	
	With regard to the issues covered at the 20 August 2024 PSC (paper P refers), the Medical Director particularly highlighted discussion on: - o the 12 top clinical risks approved as the highest Trust-wide clinical risks, and o the themes from the review of claims received in quarter 1 and the plan for a repeat thematic review of claims received in quarter 2.	
	Resolved – that the update from PSC be received and noted.	
106/24	**LLR QUALITY BOARD**	
106/24/1	Feedback from and escalation to LLR System Quality Board	
	No items to highlight.	
107/24	**ITEMS FOR NOTING**	
	Resolved – that the following items be received and noted: **(1) Integrated Performance Report 2024/25 – Month 4;** **(2) Perinatal Surveillance Scorecard, and** **(3) Regulation 28: Report to Prevent Future Deaths.**	
108/24	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
109/24	**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: - **(1) The Mortality and Learning from Deaths Report, and** **(2) The Updated QC Terms of Reference.**	
110/24	**ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH**	

	• NIPAG Annual Report 2023-24 (for noting) – deferred to QC in September 2024.	
111/24	**DATE OF THE NEXT MEETING**	
	<u>Resolved</u> – that the next meeting of the Quality Committee be held on Thursday 26 September 2024 from 2pm via Microsoft Teams.	

<u>The meeting closed at 4.03pm</u> Hina Majeed – **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2024-25 to date).

Present

Name	*Possible*	*Actual*	*% Attendance*
A Haynes (Chair)	*5*	*4*	*80*
R Abeyratne	*5*	*3*	*60*
I Browne	*5*	*4*	*80*
M Farmer	*5*	*5*	*100*
A Furlong	*5*	*5*	*100*
J Hogg	*5*	*5*	*100*
J Melbourne	*5*	*4*	*80*
T Robinson	*5*	*2*	*40*
J Worrall	*5*	*3*	*60*

In attendance

Name	*Possible*	*Actual*	*% Attendance*
D Burnett	*5*	*1*	*20*
S Burton	*5*	*1*	*20*
B Cassidy	*5*	*4*	*80*
R Manton	*5*	*4*	*80*
C Pheasant	*5*	*1*	*20*
M Rahman	*5*	*5*	*100*
J Smith (PP)	*5*	*2*	*40*
Gang Xu	*5*	*2*	*40*
ICB Representative	*5*	*5*	*100*