University Hospitals of Leicester NHS
NHS Trust

Public Trust Board paper K2

Meeting title:	Trust Board
Date of the meeting:	12 September 2024
Title:	**Escalation Report from the Quality Committee (QC): 29 August 2024**
Report presented by:	Professor Ivan Browne, Associate Non-Executive Director (Acting Chair on behalf of 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 29 August 2024 and was quorate. It considered the following items, and the discussion is summarised below:

3. Public items recommended to the Trust Board:

3.1 Mortality and Learning from Deaths (LfD) Quarterly Report

The Committee received 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.

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).

The Mortality and Learning from Deaths report be endorsed and recommended for Trust Board approval. A stand-alone report on this item is included on the September 2024 Trust Board agenda accordingly.

3.2 QC Terms of Reference – Review

The Director of Corporate and Legal Affairs 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.

The updated QC terms of reference (appended to this report) be endorsed and recommended for Trust Board approval.

4. Discussion Items

4.1 Fractured Neck of Femur (#NOF) Update

The report 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.

4.2 Dementia Services Annual Report 2023-24

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. It was suggested that data about patient/carer experience was included in future reports.

4.3 2024/25 CQUIN Schemes Quarter 1 Performance Update

The Committee received 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.

4.4 Quality and Safety performance dashboard – July 2024

The Quality Committee considered the monthly patient safety and complaints performance report for July 2024. 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. 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.

4.5 Patient Safety Report – Quarter 1 2024-25 (including PSIRF)

The Committee received the first quarterly report since the Trust went live with PSIRF on 1 April 2024. 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.

4.6 Patient Experience Annual Report 2023-24

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**.** 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.
A stand-alone report on this item is included on the September 2024 Trust Board agenda.

4.7 Infection Prevention Annual Report 2023-24

The Chief Nurse presented the report 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.

4.8 Board Assurance Framework (BAF)

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 both the content and the current risk score of 20, which were unchanged from previous considerations.

4.9 Reports from Quality Committee sub-groups:

Quality Committee noted detailed updates from:

- **Infection Prevention (IP) Committee Quarter 1 2024/25 Report** – the Chief Nurse 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.
- **Safeguarding Assurance Committee (SAC) Report** – the Head of Safeguarding 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.
- **Patient Safety Committee (PSC)** – with regard to the issues covered at the 20 August 2024 PSC, the Medical Director particularly highlighted discussion on: -
    - the 12 top clinical risks approved as the highest Trust-wide clinical risks, and
    - 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.

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

4.11 Items for Noting

- Integrated Performance Report 2024/25 – Month 4;
- Perinatal Surveillance Scorecard, and
  Regulation 28: Report to Prevent Future Deaths.

Date of next meeting – 26 September 2024

Quality Committee
Terms of Reference

1. Constitution

The University Hospitals of Leicester NHS Trust hereby resolves to establish a Committee of the Board of Directors (hereafter referred to as "the Board") to be known as the Quality Committee (hereafter referred to as "the Committee").

The committee shall have terms of reference conferring delegated authority from the Board and will be subject to conditions such as reporting its activities of the Board, as the Board shall decide and act in accordance with any legislation, regulation or direction issued by regulators or statutory bodies.

2. Purpose

The purpose of the Committee is to seek and receive assurance on the appropriateness and effectiveness of the Trusts overall quality governance arrangements. This committee has delegated authority from the Board to gain assurance on the robustness of quality governance across the Trust to ensure safe care to patients.

3. Membership

The Committee shall comprise:

Core Members

- 3 x Non-Executive Directors (not including the chair of the Audit Committee or the Trust Chair) one of whom will chair the committee
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Director of Health, Equality and Inclusion

Additional Attendance

- Colleagues will be asked to attend to present and discuss relevant topics as is appropriate

A standing invitation to attend the Quality Committee will be extended to the following:

- Chief Executive
- Trust Chair

- Other Non-Executive Directors
- Representatives of Internal and External Audit
- ICB representative
- Director of Corporate and Legal Affairs
- Head of Risk and Assurance
- Chief Pharmacist
- 1 x Patient Partner

The secretary and administrative support to the committee shall be provided through the Corporate and Committee Services Team.

A deputy shall be nominated to attend a meeting of the Committee when the absence of one of the members (detailed above) would prevent an item of business being addressed. The deputy attending shall count towards meeting quorum, but not to the attendance record of the Committee member him / herself.

Deputies and heads of professional services are invite to observe the meeting where appropriate.

All members shall attend a minimum of 75% of meetings of the Committee on a rolling 12 month basis.

4. Quorum

Quorum shall be 4 members to include 2 Non-Executive Directors (one of which will chair if the chair is unable to attend) and 2 Executive Directors.

5. Meetings

The Committee shall meet monthly. Additional ad hoc meetings may be convened as and when required.

6. Duties

Quality and Effectiveness

6.1 Agree the Trust Quality Priorities and receive assurance for the performance against those priorities agreed

6.2 To receive CQC updates in a timely manner and monitor ongoing compliance with CQC fundamental standards and oversight of the implementation of agreed action plans

6.3 To monitor the Trust's compliance with CQC registration requirements and where there are changes

6.4 Receive assurance the Trust has appropriate staffing establishments which are reviewed in a timely manner via the Nursing, Midwifery and AHP committee.

6.5 To receive, review and approve the annual Quality Report prior to formal approval at the Board

6.6 To monitor the impact on the Trust's quality of care of cost improvement programmes
6.7 Receive assurance the Trust's approach to Quality Improvement is robust and embedded across the organisation. Receive updates on the outcomes of Quality Improvement initiatives
6.8 To receive and approve the clinical audit plan, receive assurance on the progress against the plan and approve the annual report
6.9 Receive all limited assurance internal audit reports pertinent to the remit of this committee seeking assurance on the actions being taken to address the risks identified
6.10 To escalate appropriate concerns to the System Clinical Quality Executive Group

Safety

To gain assurance via quarterly reports on patient safety, particularly focussing on:

6.11 Harms as a result of Cancer performance
6.12 Mortality and Learning from Deaths
6.13 Maternity safety and CNST (via MAC)
6.14 Learning from Claims and Inquests
6.15 Patient Safety Incident Response Framework (PSIRF), Complaints and Serious Incidents
6.16 Deteriorating patient, Resuscitation and End of Life and Palliative Care (via Patient Safety Committee)
6.17 Falls (via Patient Safety Committee)
6.18 Pressure Ulcers (via Patient Safety Committee)
6.19 Safeguarding
6.20 IPC
6.21 Receive themes, trends and learning from serious incidents across the Trust, including application of the Duty of Candour
6.22 Receive assurance on the Trust's oversight of appropriate medicines management, prescribing, administration and safety and medication errors
6.23 Oversee the implementation of the mental health strategy (via Patient Safety Committee)
6.24 Receive the IPC Board Assurance Framework before being presented to the Board

Core responsibilities and sub group reporting

6.25 To review and support the Trust's core strategies associated within the committee's remit
6.26 To monitor, review and assess the level of assurance received on the quality risks, controls and governance processes identified in the Board Assurance Framework delegated to the committee by the Board, providing reports to the Board of Directors and/or Audit Committee when requested
6.27 To review the reporting subcommittee structure to ensure both efficiency and effectiveness of reporting, including any addition of new sub groups or working groups as required
6.28 To escalate issues of concern requiring Board attention
6.29 To develop and maintain an annual work programme to reflect and enable assurance in relation to the above duties
6.30 Annually review the committee terms of reference to ensure they remain fit for purpose and align with annual work programme

6.31 The committee will produce an annual report incorporating its effectiveness to adhere to the duties placed upon it

6.32 To receive and approve a biannual report re: organ donation

6.33 To receive and approve annual reports from:

- Complaints
- Safeguarding
- Learning disability, autistic people and mental health
- Infection Prevention Control
- Serious incidents
- Patient involvement and experience
- Clinical audit
- Dementia

7. Reporting and Governance Procedures

The Committee shall produce minutes of its meetings which will be formally ratified at the following meeting. A written summary of each meeting shall be submitted to the next scheduled meeting of the Board. The summary will focus on items of escalations, items which have been approved and specific items connected to strategic risks and strategic direction. The Chair of the Committee will present this report.

The Committee will also provide a highlight report to the system Clinical Quality Executive Group which will be presented by the Committee Chair.

An annual report will be produced setting out the Committee's compliance with its terms of reference, performance of its duties and strategic priorities for the next 12 months. This will be informed by an annual self-assessment conducted by the committee, ensuring its work and responsibilities are reflective of the changing environment within which the committee functions. The Board will receive and approve the annual report.

The reporting subgroups to Quality Committee are:

- Patient Safety Committee
- Nursing Midwifery and AHP Committee
- Maternity Assurance Committee
- Safeguarding Assurance Committee
- Trust Infection Prevention Assurance Committee
- Medicines Optimisation Committee
- New Interventional Procedures Group
- Clinical Policy and Guideline Committee

8. Review

The committee will continually review the effectiveness, and where appropriate, revise the committee membership and terms of reference at least annually. Ratification will be by the Board.

9. Ratification:

Updated and reviewed by: Quality Committee
Date: 29 August 2024

Ratified by: Trust Board
Date: (12 September 2024)