UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 27 JUNE 2024 AT 2:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:
Dr A Haynes – Non-Executive Director (Chair)
Mr I Browne – Associate Non-Executive Director
Ms J Hogg – Chief Nurse
Mr M Farmer – Associate Non-Executive Director
Mr A Furlong – Medical Director
Mr J Melbourne – Chief Operating Officer
Mr J Worrall – Non-Executive Director

In Attendance:
Dr R Abeyratne – Director of Health Equality and Inclusion
Dr R Bell – Clinical Lead for Organ Donation (for Minute 76/24/10)
Mr P Brookes-Baker – Improvement Lead (for Minute 76/24/2-76/24/3)
Mr M Clayton – Head of Safeguarding (for Minute76/24/9)
Ms G Gunn – Macmillan Deputy Lead Cancer Nurse (for Minute 76/24/4)
Ms K Kaur – Assistant Director of Information and Business Intelligence (for Minute 76/24/5)
Ms H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Mr M Rahman – Chief Pharmacist
Dr P Patel – Clinical Director, CSI (for Minute 74/24/6)
Ms C Rudkin – Head of Patient Safety (for Minute 76/24/1)
Ms H Stokes – Head of Corporate Governance (on behalf of Director of Corporate and Legal Affairs)
Mr C Walker – Clinical Audit Manager (for Minute 76/24/2-76/24/3)
Dr L Walker – Clinical Director, ESM (for Minute 76/24/7-76/24/8)
Ms C West – ICB Representative

	RESOLVED ITEMS	
71/24	**APOLOGIES**	
	Apologies were received from Ms B Cassidy, Director of Corporate and Legal Affairs; Ms K Darby, ICB Representative; Ms C Pheasant, Chief AHP, Professor T Robinson, Non-Executive Director; Ms J Smith, Patient Partner and Dr G Xu, Deputy Medical Director.	
72/24	**QUORUM**	
	The meeting was confirmed to be quorate.	
73/24	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
74/24	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 30 May2024 (papers A1 & A2) be confirmed as a correct record.	
75/24	**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.	
	Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	
76/24	**ITEMS FOR DISCUSSION AND ASSURANCE**	
76/24/1	Quality and Safety Performance Report – April 2024	

	The Quality Committee considered the monthly patient safety and complaints performance report for May 2024 (paper C 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, 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. Members were advised that further to discussion, the Patient Safety Committee had approved the recommendation to block close all overdue incidents that were reported before 5 March 2024 with the following criteria: - all prevented patient safety incidents (PSIs), PSIs (no harm and minor harm only) and staff incidents (no harm and minor harm only). CMGs would be reviewing a list of their incidents designated for closure to identify if there were any that they wished to keep open to monitor it. It was noted that this was a one-off unprecedented action and CMGs had been advised to ensure that staff were taking prompt action to manage incidents with managers driving forward improvements from this point. The new PSIRF approach which aimed to provide a more responsive approach to incidents, would also assist in taking this work forward.	**QC Chair**
	Resolved – that (A) the contents of this report be received and noted, and **(B) the recommendation approved by the June 2024 Patient Safety Committee be brought to the attention of the Trust Board (i.e. to block close all overdue incidents that were reported before 5 March 2024 with the following criteria: - all prevented patient safety incidents (PSIs), PSIs (no harm and minor harm only) and staff incidents (no harm and minor harm only). This was a one-off unprecedented action and CMGs had been advised to ensure that staff were taking prompt action to manage incidents with managers driving forward improvements from this point.)**	**QC Chair**
76/24/2	National Clinical Audit (NCA) Update	
	The Committee received paper D, an update on work undertaken to review the national clinical audit reporting process to improve the reporting of NCAs and any improvement work undertaken as a result of potential outlier results. The Clinical Audit Committee and CMG Quality and Safety Boards were overseeing this. A massive quality improvement collaborative activity with clinical audit had been undertaken and there had been numerous benefits from this. It was suggested that there was an opportunity to embed health equality and inclusion, and this be included within the initial workbook which described the project. Following the publication of a national audit report, the Clinical audit team provided an infographic summary of UHL results and action required to be taken – the Quality Committee found this information useful. Members were assured that the Trust had a good process in place around external national audits which linked to the real time dashboard from the National Audit provider.	
	Resolved – that the contents of this report be received and noted, and this update be highlighted to the Trust Board, for information.	**QC Chair**
76/24/3	Audit and Quality Improvement Programme Update	
	The Committee noted that the new UHL Audit and Quality Improvement Programme (AQIP) (formerly the Clinical Audit Programme), continued to be rolled out across the Trust as detailed in paper E. Over 2000 projects had been registered on the AQIP system that had been developed in-house. The Clinical Audit Committee had agreed some actions to prioritise and refine the programme so it could deliver further improvements to patient care. AQIP encouraged clinical teams to prioritise efforts where it could be most effective addressing the biggest concern/risk to patient care via national, trust and speciality projects. The real-time AQIP Qlik reporting tool had been launched, a dynamic system with open access to all UHL colleagues. The Medical Director was assured that the Audit and QI team were in a good place and the AQIP reporting tool was very helpful.	
	Resolved – that the contents of this report be received and noted.	
76/24/4	104 Day + Cancer Quality Standard Report – Quarter 2 2023/24	

	The Quality Committee considered paper F, 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 2, 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 2, a total of 165 patients waited over 104 days from referral to first definitive treatment. A total of 110 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 55 would be reviewed on return to the Cancer Centre. 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 and oncology capacity. Although template biopsy capacity for prostate cancer patients was still an issue, but the number of patients waiting too long because of this had reduced. Due to patients being brought through their prostate pathways more quickly resulted in radiotherapy capacity issues. Mitigations were being put in place to address this issue which included weekend working and mutual aid. Additional oncology capacity (i.e., mobile treatment centre) had been put in place at the Glenfield hospital site. It was suggested that a demographic understanding of patients who were waiting the longest be obtained, to understand if there were any patterns, and an equity based approach be taken to address any issues that were identified – in response to which confirmation was provided that this information would be included in the next report if it was possible to extract the demographic information from the data held on the system. 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.	**MDLCN**
	<u>Resolved</u> – that (A) the contents of this report be received and noted, and **(B) the following information be included in the next report (if it was possible to extract the demographic information from the data held on the system) - a demographic understanding of patients who were waiting the longest, to understand if there were any patterns, and an equity-based approach be taken to address any issues that were identified.**	**MDLCN**
76/24/5	<u>Data Quality and Clinical Coding Report</u>	
	Paper G provided assurance that the external view of UHL's data quality was good. In addition, the report also provided an update on initiatives that had been implemented to improve clinical coding. The Data Quality Maturity Index, published monthly by NHS England, was used to monitor data quality at the Trust. Remedial actions had been taken to address the quality of UHL's Emergency Care Data Set (ECDS) submission, which had resulted in an improved position in the published data. For data quality, the Trust ranked second in the peer group for the latest data. Many of the key data quality reports previously used for managing outpatient and elective patients through the Trust had been replaced with a Qlik Data Quality dashboard. There had been persistent issues with uncoded HRGs due to data warehouse processing, therefore the IM&T team would be undertaking a root cause analysis and implementing remedial measures. The Clinical Coding risk had a score of 15 on the Trust's risk register. This was mainly due to transitioning from paper case-notes to multiple electronic clinical systems for source documentation. The Trust's Internal Auditors had conducted a coding and activity benchmarking review which consisted of high-level analysis of coding complexities and co-morbidities. They had identified potential opportunities and a joint 6-week pilot with the Trauma and Orthopaedics service had been agreed. Dr Foster's mortality review had highlighted that the Trust's coding had decreased for specialised palliative care, this would be monitored as part of quality improvement for Financial Sustainability Group. Work was underway with the Transformation Team to drive some of the improvements with Clinicians and Junior Doctors in respect of the depth of coding. In discussion, it was also noted that the Trust used a variety of different systems which made the process even more challenging, as it required Clinicians and Coders to input and access, respectively. Members noted that De Montfort University were quite keen for the Trust to work with	**ADI**

	them and use their Media Centre to develop digital solutions to such challenges – the Assistant Director of Information and Business Intelligence undertook to contact them. Members noted that the report showed good progress in some areas. However, due to increasing challenges with the demand, and the impact it had on wider quality metrics, there was a need to maintain focus, given that it was becoming an increasingly competitive area nationally. Quarterly updates were requested to be provided to QC.	**ADI**
	<u>Resolved</u> – that (A) the contents of this report be received and noted, and the Assistant Director of Information be requested to contact De Montfort University who were quite keen for the Trust to work with them and use their Media Centre to develop digital solutions to coding challenges, and **(B) quarterly updates be provided to QC on data quality and clinical coding.**	**ADI** **ADI**
76/24/6	<u>Radio Pharmacy MHRA Inspection Update</u>	
	Further to an update to QC in November 2023, the Clinical Director, CSI advised that all the actions in the action plan following MHRA's inspection of the Radio Pharmacy services in June 2023, had been completed except two, one of which was on-going (paper H refers). Bi-monthly meetings were taking place with the MHRA, and they were largely satisfied with the progress that had been made by the Trust. The only outstanding issue was a long-term requirement/expectation that the Trust replaced the current facility with a new modern facility (provision of an aseptic environment) that complied with current regulations. Space for a Radio Pharmacy facility at the Glenfield hospital site had been identified. The requirement for the new facility had been highlighted to the Capital Monitoring and Investment Committee, although at the current time, funding allocation for the future had not yet been confirmed. Members acknowledged this noting the need for local investment whilst also continuing to engage in regional and national discussions about Radio Pharmacy and Aseptic Pharmacy provision.	
	<u>Resolved</u> – the contents of the report be received and noted, and it be highlighted to the Trust Board, that the short-term and medium-term requirements had been met, but there was one outstanding issue to be met (i.e., the new facility) in the long term (next 3-5 years) to comply with the MHRA requirements.	**QC Chair**
76/24/7	<u>Healthwatch Update</u>	
	Paper I provided an update and assurance on actions taken following recommendations made by Healthwatch further to their visit to the Emergency Department (ED) in September 2023. The visit in September 2023 was to review the improvements made in the ED based on their 16 recommendations from a previous visit in September 2022. They had acknowledged the volume of work undertaken to improve the service delivered to patients and recommended continuing with improvement works with a particular focus on 10 recommendations. The action plan would be monitored, and the plan was to invite Healthwatch again in late 2024/early 2025 for a further review. An update, further to this visit was requested to be provided in the second half of 2025.	**CD. ESM**
	<u>Resolved</u> – that (A) the contents of the report be received and noted, and **(B) it be noted that Healthwatch would be invited again in late 2024/early 2025 for a further review – an update, further to this visit be provided to QC in the second half of 2025.**	**CD. ESM**
76/24/8	<u>VTE Performance in ESM (including ED)</u>	
	The Committee were provided with a detailed background regarding concerns that patients being admitted via the Emergency Department to Specialist Medicine, were not receiving timely assessment and/or subsequent treatment, for VTE Thromboprophylaxis (paper J refers). Since then, there had been several quality initiatives to address this, but concerns had been raised that performance remained below the required standard. On investigation, it came to light that this was in-part due to incorrect representation of the data. Once corrected, this would improve results but not entirely to the required standard. The following two actions would be undertaken to further improve performance: - (i) senior medical input for medical in-reach admissions would be increased and (ii) further reinforcement that the ED team were expected to complete VTE assessments prior to referring a patient for admission to Medicine. The Committee recognised that	

	progress had been made, however, felt that it had taken longer than it should have and noted the need for achieving the national target of 95% through the course of the year.	
	Resolved – the contents of the report be received and noted, and a further update on this matter be provided to QC, in due course.	**CD. ESM**
76/24/9	Learning Disability, Autistic People and Mental Health (LDAP and MH) Annual Report	
	Paper K provided a summary of the work being undertaken across the Trust to support autistic people and those with mental health or learning disability, from April 2023- March 2024. The following key achievements were highlighted in particular:- (a) formation of the UHL LDAP and MH Steering Group; (b) launch of mental health training and awareness, together with the roll-out of Oliver McGowan training for learning disability and autism, (iii) launch of the UHL Mental Health strategy; (iii) rollout of learning disability resource files to clinical areas and care bags, and (iv) completion of an autism scoping project. In respect of the increase in referrals in terms of Mental Health Act Detention, it was noted that work was underway with LPT to explore this in more detail. The Chief Operating Officer undertook to liaise with the Mental Health team in respect of any escalations following discussion with LPT colleagues. In response to a suggestion, the Head of Safeguarding noted that there were significant health inequalities in this patient cohort and confirmed that focus would be given to health outcomes for people with mental health and neurodiversity, by appropriately linking with mental health and learning disability collaboratives. Mr I Browne, Associate Non-Executive Director offered support for a brief case study/ review of data to disaggregate numbers by ethnicity, deprivation, and age, noting that that at a recent Leicester City Health and Well-Being board, a report was presented on the disparities particularly faced by the Black community in Leicester. It was also suggested that it would be helpful to breakdown the data by specialities these patients were most commonly accessing (i.e., oncology service). The ICB representative undertook to feedback to the Head of Safeguarding, further to discussion with her colleagues in respect of system modelling over the next 10 years for this patient cohort. The Committee commended the work that had been undertaken noting the significant developments, with work focussed on creating robust governance and reporting structures.	
	Resolved – (A) the contents of the report be received and noted, and this update be highlighted to the Trust Board, for information – in particular, the discussion re. Mental Health Act Detention and the good work happening around reasonable adjustments.	**QC Chair**
	(B) the Chief Operating Officer to liaise with the Mental Health team in respect of any escalations following discussion with LPT colleagues regarding the increase in referrals in terms of Mental Health Act Detention;	**COO**
	(C) Mr I Browne, Associate Non-Executive Director be requested to support the Head of Safeguarding in respect of undertaking a brief case study/ review of data to disaggregate numbers by ethnicity, deprivation, and age in order that there was appropriate focus on health outcomes for people with mental health and neurodiversity;	**ANED(IB)**
	(D) the Head of Safeguarding to consider including a breakdown of data by specialities, the LDAP and MH patient cohort were most commonly accessing (i.e., oncology service), and	**HoS**
	(E) the ICB Representative to feedback to the Head of Safeguarding, further to discussion with colleagues in respect of system modelling over the next 10 years for this patient cohort.	**ICB Rep**
76/24/ 10	Organ Donation – Bi-Annual Report	
	UHL was a Level 1 organ donation Trust having consistently facilitated more than 12 donations per year. However, from April 2023-24, only 6 donations had been facilitated, all of which were Donation after Brainstem Death (DBD) donors (paper L refers). Overall potential donor numbers had declined from the previous year, which reflected the national picture. Although the national figures for 2023-24 had not yet been published, there was an indication that there had been a decline in DBD donors, whereas in Leicester this was not the case. Ongoing publicity, support and training for Intensive Care Unit and Emergency Department teams was required to improve the donor database. Nationally there seems to be a reduction in willingness to engage with organ donation, which reflected in a national decline in consent rates. The Clinical Lead for Organ Donation was offered support from the Director of Health Equality and Inclusion and Mr I Browne,	

	Associate Non-Executive Director in respect of taking forward conversations with communities to build relationship/trust and encourage consent for organ donation.	**DHE&I/A NED/ CL, OD**
	Resolved – Mr I Browne, Associate Non-Executive Director and the Director of Health Equality and Inclusion be requested to support the Clinical Lead for Organ Donation in respect of taking forward conversations with communities to build relationship/trust and encourage consent for organ donation.	**DHE&I/A NED/ CL, OD**
76/24/ 11	BAF Report	
	The QC reviewed strategic risk 1 on the BAF around a framework to maintain and improve patient safety, clinical effectiveness and patient experience which was aligned to the committee and its work plan. The Committee noted the updates in the month (paper M refers). There were no changes proposed to risk scores this month: current rating is 20 (likelihood of almost certain x impact of major), target rating is 6 and tolerable rating is 12.	
	Resolved – that the contents of this report be received and noted.	
77/24	**REPORTS FROM UHL BOARDS**	
77/24/1	Patient Safety Committee (PSC) (18.6.24) Report	
	The Medical Director highlighted the following updates received by the Patient Safety Committee at its meeting on 18 June 2024 (paper N refers): - Assurance around the process for renal transplantation was provided further to outcomes published by the NHS Blood and Transplant Services, noting the need for staffing/funding in transplant services to maintain and expand transplant services further; National Patient Safety Alert re. risk of death from entrapment or falls – new paediatric cots had been purchased and the aged bed fleet issue would be addressed through the tendering process. Quality & Safety Board report W&C CMG – UHL was the first Trust to introduce electronic prescribing in the Children's service. The local Operational Delivery Network had visited the Neonatal Services to review the neonatal nurse staffing numbers and a letter from them was expected imminently, and Quality & Safety Board report MSS CMG – ongoing discussions with Northampton General Hospital to formalise the creation of the South Midlands Head & Neck institute. Installation of a new paediatric audiology IT system was underway.	
	Resolved – that the contents of this report be received and noted.	
78/24	**LLR QUALITY BOARD**	
78/24/1	Feedback from and escalation to LLR System Quality Board	
	None	
79/24	**ITEMS FOR NOTING**	
79/24/1	Integrated Performance Report – Month 2 2024-25	
	Resolved – the contents of paper O be received and noted.	
79/24/2	Perinatal Surveillance Scorecard	
	Resolved – the contents of paper P be received and noted.	
80/24	**ANY OTHER BUSINESS**	

80/24/1	Glenfield Hospital was designated as a Pathway to Excellence ® site on 14th June 2024 by the American Nurses Credentialing Centre (ANCC) **– a briefing report on this matter is scheduled to be presented to the Trust Board on 11 July 2024.**	
	Resolved – that the verbal update be noted.	
81/24	**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: - • Quality and Safety Performance Report – May 2024; • National Clinical Audit (NCA) Update; • Radio Pharmacy MHRA Inspection Update, and • Learning Disability, Autistic People and Mental Health (LDAP and MH) Annual Report.	
82/24	**ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH** • Review any UHL core strategies within QC's remit (Bi-annual review of clinical strategy) – being drafted. Quality Strategy scheduled for QC in September 2024 and Clinical Strategy scheduled for QC in December 2024, and • Review QC terms of reference and work plan – deferred to July 2024.	
83/24	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 25 July 2024 from 2pm via Microsoft Teams.	

The meeting closed at 4.02pm Hina Majeed – Corporate and Committee Services Officer

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

Present

Name	*Possible*	*Actual*	*% Attendance*
A Haynes (Chair)	*3*	*3*	*100*
R Abeyratne	*3*	*2*	*67*
I Browne	*3*	*3*	*100*
M Farmer	*3*	*3*	*100*
A Furlong	*3*	*3*	*100*
J Hogg	*3*	*3*	*100*
J Melbourne	*3*	*3*	*100*
T Robinson	*3*	*1*	*33*
J Worrall	*3*	*2*	*67*

In attendance

Name	*Possible*	*Actual*	*% Attendance*
D Burnett	*3*	*1*	*33*
S Burton	*3*	*1*	*33*
B Cassidy	*3*	*2*	*67*
R Manton	*3*	*2*	*67*
C Pheasant	*3*	*1*	*33*
M Rahman	*3*	*3*	*100*
J Smith (PP)	*3*	*1*	*33*
Gang Xu	*3*	*0*	*0*
ICB Representative	*3*	*3*	*100*