UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING
HELD ON THURSDAY 28 MARCH 2024 AT 2:00 PM VIRTUAL MEETING VIA MICROSOFT TEAMS

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

In Attendance:
Ms G Belton – Corporate and Committee Services Officer
Ms S Burton – Deputy Chief Nurse
Ms B Cassidy – Director of Corporate and Legal Affairs
Dr P McParland – Consultant Obstetrician (for Minute 33/24/5)
Ms S McLeod – Head of Patient Experience
Ms S Nancarrow – Associate Director of Operations
Ms C Pheasant – Chief AHP
Ms C Rudkin – Head of Patient Safety (for Minutes 20/24/3 and 20/24/4)
Ms C West – ICB Representative
Dr G Xu – Deputy Medical Director

	RESOLVED ITEMS	
28/24	**APOLOGIES**	
	Apologies were received from Dr R Abeyratne, Director of Health Equality and Inclusion, Mr I Browne, Associate Non-Executive Director, Mr R Manton, Head of Risk Assurance, Ms J Smith, Patient Partner and Mr J Worrall, Non-Executive Director.	
29/24	**QUORUM**	
	The meeting was confirmed to be quorate.	
30/24	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
31/24	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 29 February 2024 (papers A1 and A2) be confirmed as a correct record.	
32/24	**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.	
	In respect of action 3 from 28 September 2023 Quality Committee meeting, the Medical Director noted that an item on the Dermatology Never Event was scheduled for discussion at today's meeting. With regards to the planned external review, it was not yet possible to confirm a timeframe for completion as a date for the review had not yet been finalised. It was agreed that the action from 28 September 2023 would be marked as '5' (complete) and a new action would be listed within the matters arising log, as arising from today's meeting, noting that the outcome of the planned external review would be submitted to Quality Committee once available. A verbal update was provided in respect of action 6a from 25 January 2024 and this would feature in the next iteration of the Matters Arising Log.	
	Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	**CCSO**

33/24	**ITEMS FOR DISCUSSION AND ASSURANCE**	
33/24/1	104 + Day Cancer Quality Standard Report – Quarter 1 2023/24	
	The Quality Committee considered the above-referenced report (paper C – as presented by the Associate Director of Operations) 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 one, 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 1, a total of 190 patients waited over 104 days from referral to first definitive treatment. A total of 167 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 23 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 the actions planned to increase capacity and the fact that backlogs had decreased from those reported in the previous quarter's report. Further improvement was expected to be seen in the next quarter's report. Particular note was made that out-patient appointment capacity was an issue and this was reviewed on a regular basis. Members acknowledged the positive progress in respect of waiting times relating to prostate cancer and Mr Farmer, Non-Executive Director, specifically queried the sustainability of the actions that had been adopted in the longer-term, in response to which confirmation was provided of increasing confidence in this being a sustainable service. Assurance was also provided in relation to sustainability from a financial perspective. 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. It was noted that this report would continue to be scheduled on the Quality Committee agenda at quarterly intervals.	
	Resolved – that the contents of paper C be received and noted, and this report continue to be presented to the Quality Committee on a quarterly basis.	**ADoOC**
33/24/2	Dementia Services Quality Account Report 2023/24	
	The Committee received a report (paper D – as presented by the Chief Nurse) which sought to provide assurance of the quality of dementia services provided at the Trust during quarters 1 to 3 of 2023/24. The portfolio of work to support patients living with dementia and their families continued to progress, with an overview provided of the various workstreams linked to aspects of dementia care. Also highlighted were areas of success and the identification of further opportunities for improvement in the coming year's programme of work to ensure the continued delivery of high-quality care to patients with dementia. In discussion on the contents of this report, the Chief Nurse considered some elements of useful information to be missing from the report as currently presented (in discussion these were specifically summarised as (1) the timely assessment of dementia and delirium (2) the environment (3) education and compliance with the programme (4) the involvement of carers and (5) deprivation of liberty / mental capacity elements and the Chief Nurse undertook to seek this additional detail and present it in a shorter follow-up report to the next meeting of the Quality Committee. Also discussed was the need to be able to evidence that patients with dementia experienced the same access to enhanced care irrespective of where within the hospital they were treated and the Chief Nurse undertook to raise this issue with the responsible team. Subject to the additional information referenced above to be provided at the next (April 2024) meeting of the Quality Committee, the Committee approved the Dementia Services Quality Account Report 2023/24.	**CN** **CN**

	<u>Resolved</u> – (A) the Dementia Services Quality Account Report 2023/24 be approved subject to additional detail currently felt to be missing from this report being presented in a shorter follow-up report to the next Quality Committee meeting in April 2024, and **(B) the Chief Nurse be requested to raise with the responsible team the need to be able to evidence that patients with dementia experienced the same access to enhanced care irrespective of where within the hospital they were treated.**	**CN** **CN**
33/24/3	<u>15 Steps Programme</u>	
	The Committee were provided with an overview of the Trust's newly established 15 Steps Programme and the findings of the programme to-date (paper E refers, as presented by the Head of Patient Experience). The purpose of the 15 Steps Programme was to determine how patients and relatives saw the ward and the Patient Experience Review Team used questions and prompt guides in the toolkit to support their observations and then provide structured feedback about their experience, including what was working well and what could be improved upon. The Patient Experience team had completed 92 Fifteen Step visits since September 2023 across all three sites and all Clinical Management Groups. Visits were usually undertaken with a volunteer and or/ Head of Patient Experience and/or Senior Nurse (Patient Experience). Feedback was given immediately to the Ward Leader, Matron, Heads of Nursing and Deputy Heads of Nursing, where possible. The Patient Experience team had revisited any wards with potential concerns and were continuing the programme of 15 Step visits. Particular themes which had arisen as a result of the programme were instances where call bells were not being given to patients and also not all patients having wrist bands. A common finding also was not being greeted upon arrival to the ward, nor being approached and asked why the team was on the ward. As this was a new initiative, there was much work to be undertaken still in improving staff members' understanding that these visits focused specifically on wards from the viewpoint of a patient's experience. In discussion on this item, it was agreed that the outcome from the 15 Steps Programme should be incorporated into future iterations of the quarterly Patient Experience report. Also referenced was the triangulation work undertaken to date with findings from the Friends and Family Test (FFT), PLACE audits etc. In response to specific queries raised, the Head of Patient Experience noted that the input of the volunteers who had taken part in the 15 Steps Programme visits had been very valuable in providing a completely different viewpoint. Issues of concern which had arisen in the Specialty Medicine wards were often as a consequence of throughput. Second visits were undertaken to any wards identified with concerns as a result of the first visit, and to-date, it had been the case that improvements were usually evident. In response to a specific question raised by Mr Farmer, Non-Executive Director, it was not envisaged that the Patient Partners who were currently being recruited would be involved in undertaking the 15 Steps Programme visits and this work would continue to be undertaken by the Patient Experience Team in conjunction with a diverse group of volunteers. The Committee received and noted the contents of this report, noting the value in ascertaining patient perspective in this way, acknowledging that the outcome of future visits would form part of the quarterly Patient Experience report presented to the Committee.	
	<u>Resolved</u> – that (A) the contents of this report be received and noted, and **(B) the outcomes from the 15 Steps Programme** b**e incorporated into future iterations of the quarterly Patient Experience report.**	**CN**
33/24/4	<u>Quality and Safety Performance Report – February 2024</u>	
	The Quality Committee considered the monthly patient safety and complaints performance report for February 2024 (paper F, as presented by the Head of Patient Experience). The report provided a focus on key performance indicators for quality and safety particularly in respect of: - VTE risk assessment in ESM (with figures for ED now included), HAPUs, falls, serious incidents, medicines safety, FFT, complaints, NPSA, mortality and blood traceability. In respect of current quality and	

	safety performance in the Women's and Children's Clinical Management Group (CMG), assurance had been provided by the Director of Midwifery of expected improved traction now that staffing levels had improved in the CMG's Quality and Safety team. In response to a query raised by the Quality Committee Chairman, the Medical Director provided assurance that risks were reviewed during the monthly CMG Performance Review Meetings (PRMs), albeit recognised that the reporting cycles could be different to those referenced within reports. Where possible, the Quality Committee Chairman suggested that it would be helpful to add commentary to confirm where risks had been further explored and assurance provided. The Director of Corporate and Legal Affairs noted that the timing of reporting was key and this particular issue was being addressed by the Head of Risk Assurance. The Committee commended this updated version of the report, noting that the format was much clearer than previously. The Chief Nurse advised of her wish to give consideration as to how issues relating to health and safety could be embedded within this report in the future. In concluding discussion on this matter, the Quality Committee Chair recognised the progress evident via this scorecard, noting the need to remain mindful of the efforts it had taken to achieve such.	
	Resolved – the contents of the report be received and noted.	
33/24/5	Perinatal Mortality: MBRRACE Summary Report / Actions	
	The Committee was provided with an update on the UHL Perinatal Mortality rate, in the form of the UHL MBRRACE report for 2022, which had been received in early March 2024 (paper G refers, as presented by Dr McParland, Consultant Obstetrician). An update on the actions being undertaken to review and assess the data was provided, alongside the actions proposed. Of particular note was the higher-than-average neonatal mortality rate at UHL against its peer group for 2022, which was the third consecutive year that the neonatal mortality rate at UHL had been more than 5% above its peer group. In line with MBRRACE-UK processes, this information had been escalated to NHS England. Mortality reviews of all of 2022's cases had been undertaken through the Perinatal Mortality Review Group (PMRG) process with identified learning disseminated and actions taken forward. Work had already been undertaken in early 2023 to scrutinise the 2022 data, with advice sought from external experts. 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. Previous external peer review of UHL's use of the national Perinatal Mortality Review Tool for 2021 deaths did not identify any issues about how the tool was being used and no recurrent underlying care themes were identified. However the potential weaknesses of this process were recognised, and so formation of a wider peer review group comprising Trusts with the most complex case mix was being set up. Data analysis and case review undertaken to date had not identified a single group of babies or single point in the care process contributing to the higher rate of mortality. Therefore a multi-pronged approach to further scrutinise the data and key elements of the service was being developed. This would include working with peer Trusts, Public Health England and a peer review of UHL's fetal medicine service and case mix to support further learning and potential areas for improvement work. In response to a query raised by the QC Chair as to progression of the work referenced in the previous year relating to diabetes, the Chief Nurse provided assurance that there was good oversight of diabetes care, with the Trust having achieved expected compliance, with further work to be undertaken to achieve full compliance. She also reported verbally that the Trust had received funding for glucose monitoring. In response to a query as to the expected timelines for the work referenced, it was noted that the planned work with Public Health England was expected to take three to four months to complete. It was agreed to schedule a further update on progress in six months' time (September 2024) unless available any earlier. In the meantime, it was noted that the quarterly Learning from Deaths report would continue to be submitted to the Quality Committee and this would report on perinatal deaths. The Committee was assured that appropriate work was being undertaken to understand the data, ensure that the care provided to mothers and babies was in accordance with local and national standards and that the risk to patients and staff was minimised.	

	<u>Resolved</u> – that (A) the contents of this report be received and noted, **(B) a further update on progress be scheduled for receipt at the Quality Committee in six months' time (September 2024) unless available any earlier.**	**MD/CCSO**
33/24/6	<u>Learning from Dermatology Never Events</u>	
	The Committee received an update on actions implemented following a wrong site surgery Never Event in Dermatology (paper H refers, as presented by Dr Xu, Deputy Medical Director). Following a Never Event in wrong site surgery, the UHL Safer Surgery and Interventional Procedures (SSIP) Board had actively engaged with the Dermatology department to understand the factors that had led to this NE (including a very busy service with a high volume of patients, the majority of whom had multiple skin lesions) and to help deliver system-based changes including a visit to the department on 16 November 2023. The Dermatology team now had a clear action plan in place, including: (1) deployment of a paper-free / lite patient pathway in dermatology. The target date for live deployment was April 2024 (2) a Safe Surgery training day to be carried out at St Peters Health Centre (the base for the department) in April 2024 with a focus on National Safe Standards for Invasive Procedures principles and (3) development of a new dermatology specific learning package aimed at all health care professionals in the department. In response to questions raised during discussion, the Deputy Medical Director advised that whilst the actions being implemented would not necessarily provide a 100% guarantee that such a Never Event would never recur, the team were all engaged, in conjunction with the Safer Surgery Board, in taking all possible action to prevent such a recurrence and would retain a continued focus on this issue. Particular discussion took place as to the viability or otherwise of a role for the patient in the processes discussed and of the importance of a follow-up visit to ensure the new processes had been well-embedded, the outcome of which the Quality Committee would wish to be informed about. Also recognised during discussion was the need to think about processes, in terms of whether these could be refined rather than just transferred wholesale, when changing service locations. The Committee were assured by the ongoing work in the department and UHL to introduce system wide changes to improve patient safety and looked forward to receiving a follow-up report on progress when available.	
	<u>Resolved</u> – that the contents of this report be received and noted.	
33/24/7	<u>BAF Report</u>	
	The Committee 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 (paper I refers as presented by the Director of Corporate and Legal Affairs). The Committee noted the updates in the month. 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.	
	<u>Resolved</u> – that the contents of this report be received and noted.	
34/24	**REPORTS FROM UHL BOARDS**	
34/24/1	<u>Patient Safety Committee (PSC) (19.3.24) Report</u>	
	The Medical Director highlighted, in particular, the following updates received by the Patient Safety Committee at its meeting on 19 March 2024 (paper J refers):- • NHS Patient Safety Strategy and PSRIF Report. • Breast Screening SQAS Review – an update on progress would be provided to the Patient Safety Committee in six months' time and would be escalated to the Quality Committee via the usual escalation process thereafter if required. • Congenital Heart Disease Audit Database. • Sub Committee reports from W&C, CSI and MSS. In discussion on this item, the Quality Committee Chair noted the value in the external reviews and outcomes being flagged, in response to which the Medical Director provided assurance that all such	

	external reviews and their outcomes would be reported to the Patient Safety Group and thereafter through to Quality Committee. In response to a query raised by the Quality Committee Chair as to the progression of work being undertaken in relation to fractured neck of femur, the Medical Director confirmed that improvement work remained on-going in this respect given the continued variability in performance due to issues with capacity. The Medical Director undertook to liaise with MSS with a view to an update report being submitted to the Quality Committee meeting in June 2024 (provisionally).	**MD/CCSO**
	<u>Resolved</u> – that (A) the contents of the report be received and noted, and **(B) the Medical Director be requested to liaise with MSS with a view to a report on the progression of the improvement work being undertaken in relation to fractured neck of femur care being submitted to the Quality Committee meeting in June 2024 (provisionally).**	**MD/CCSO**
34/24/2	<u>Maternity Assurance Committee (MAC) Chairs Summary Report including January 2024 Perinatal Scorecard</u>	
	The MAC Chairs Summary report (including January 2024 perinatal scorecard) – paper K refers - had already been submitted to the Trust Board at its meeting on 14 March 2024 and members received and noted its contents and the additional verbal updates provided by the Chief Nurse as follows: the Empowering Voices work had been placed on hold temporarily to facilitate focus elsewhere at the current time; Quality Committee members would have access to the perinatal insight dashboard as it continued to be developed and the Trust had not yet received the formal written report following the CQC Maternity Visit in January 2024. Particular discussion took place regarding understanding of the technical requirements of the evidence required in relation to aspects of the Saving Babies Lives bundle relating to smoking. The Quality Committee Chair commended this report and the significant progress being made.	
	<u>Resolved</u> – that the contents of the report be received and noted.	
34/24/3	<u>Nursing, Midwifery and AHP Committee Escalation Report</u>	
	Paper L, as presented by the Chief Nurse, summarised the discussions and decisions taken at both the February and March 2024 NMAHPC meetings and focused on the Nursing, Midwifery and AHP priorities: strengthening the voice of the patient, reducing avoidable hospital acquired harm, leading the digital agenda, and making UHL the employer of choice. Particular areas of progress included strengthening of cardiac arrest trolley checks, agreeing the Terms of Reference for the Roster Review and Reflect Group and the Pathway to Excellence. In response to a query raised, the Chief Nurse undertook to consider how best to align the workstreams described with those reported through the quarterly Patient Experience report and also how best to report through to the relevant Committees on how the introduction of new technology was improving patient experience.	
	<u>Resolved</u> – that (A) the contents of this report be received and noted, and **(B) the Chief Nurse be requested to consider how best to align the workstreams described with those reported through the quarterly Patient Experience report and also how best to report through to the relevant Committees on how the introduction of new technology was improving patient experience.**	**CN**
35/24	**LLR QUALITY BOARD**	
35/24/1	<u>Feedback from and escalation to LLR System Quality Board</u>	
	The ICB representative acknowledged the considerable work being undertaken, noting that peer review represented an important part of assurance.	
	<u>Resolved</u> – that this verbal information be noted.	

36/24	**ITEMS FOR NOTING**	
36/24/1	Integrated Performance Report – Month 11 2023-24	
	Resolved – the contents of paper M be received and noted.	
36/24/2	Reporting Non-RTT Overdue Follow-Ups	
	Resolved – the contents of paper N be received and noted.	
36/24/3	Regulation 28 Report and Response	
	Resolved – the contents of paper Q be received and noted.	
37/24	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
38/24	**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: - • **Perinatal Mortality: MBRRACE Summary Report / Actions, and** • **Learning from Dermatology Never Events**	
39/24	**ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH** • Mental Health Annual Report – deferred from the February 2024 meeting and confirmation now received that this needs to be scheduled for July 2024.	
40/24	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 25 April 2024 from 2pm via Microsoft Teams.	

The meeting closed at 3.30pm Gill Belton – Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2023-24 to date).

Present

Name	*Possible*	*Actual*	*% Attendance*
V Bailey (Chair and Member until December 2023)	*9*	*7*	*78*
R Abeyratne	*12*	*9*	*75*
I Browne (from January 2024)	*3*	*2*	*67*
M Farmer (from January 2024)	*3*	*3*	*100*
A Furlong	*12*	*11*	*92*
A Haynes (Member until December 2023, Chair from January 2024)	*12*	*9*	*75*
J Hogg	*12*	*9*	*75*
J Melbourne	*12*	*11*	*92*
G Sharma (until 30.4.23)	*1*	*0*	*0*
T Robinson	*12*	*6*	*50*
J Worrall	*12*	*9*	*75*

In attendance

Name	*Possible*	*Actual*	*% Attendance*

D Burnett	*12*	*7*	*58*
S Burton (from May 2023)	*11*	*9*	*82*
B Cassidy	*12*	*8*	*67*
G Collins-Punter	*9*	*0*	*0*
C Ellwood (from May 2023- November 2023)	*7*	*4*	*57*
D MacDonald (from December 2023)	*4*	*3*	*75*
S Harris	*12*	*0*	*0*
J McDonald	*12*	*0*	*0*
R Manton	*12*	*11*	*92*
R Mitchell	*12*	*0*	*0*
B Patel	*12*	*0*	*0*
C Pheasant (from July 2023)	*9*	*7*	*78*
C Rudkin	*12*	*10*	*83*
J Smith (PP)	*12*	*7*	*58*
M Williams (until 29.2.24)	*11*	*0*	*0*
Gang Xu (from May 2023)	*11*	*6*	*55*
ICB Representative	*12*	*11*	*92*