The Leeds Teaching Hospitals NHS Trust

Annual Report Quality Assurance Committee

Public Board Meeting
20th May 2021

Presented for:	Information and Assurance
Presented by:	Laura Stroud
Author:	Quality Assurance Committee, 4 February 2021

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	
A centre for excellence for research, education and innovation	✓
Seamless integrated care across organisational boundaries	
Financial sustainability	

Key points	
Terms of Reference - The Committee Chair, along with the Committee has reviewed the Terms of Reference to ensure that the Committee is fit for purpose and carries out its duties as delegated by the Board of Directors. The committee has discharged its duties in line with the ToR; during 2020/21 amendments to the membership of the group were updated to reflect changes to Non-Executive representative and the inclusion of the Medical Director (Governance & Risk) and Medical Director (Planned Care)	Assurance
Reporting Requirements - The Terms of reference for Quality Assurance Committee state; The Committee will report annually on the delivery of its work programme. Will report specifically on: (i) patient safety (ii) clinical outcomes; (iii) patient experience/satisfaction; (iv) the effectiveness of quality governance arrangements; (v) the appropriateness of any compliance disclosure made or to be made by the Board.	Assurance

1. Work Plans I. The Board of Directors approved the Committees Work Plan for 2020/21, and reports assurance against items received during the year, (or stating where it cannot provide assurance). II. The Committee sets out its draft Work Plan for the coming year, seeking approval from the Board.	Assurance

1. Purpose

The purpose of this paper is to provide assurance to the Audit Committee that the Quality Assurance Committee has discharged its duties in accordance with its Terms of Reference, completed its work plan for 2020/21 and to propose its draft work plan for 2021/22.

2. Committee Members and Effectiveness

The Quality Assurance Committee has had a core membership of four Non-Executive Directors, Moira Livingston (Chair), Mark Chamberlain, and Tricia Storey Hart. In December 2020 Moira Livingston confirmed she would not be extending her tenure as a Non-Executive Director, therefore from February 2021 Tricia Storey Hart will Chair the Quality Assurance Committee. Laura Stroud joined the membership as a Non-Executive Director alongside Rachel Woodman as an Associate Non-Executive Director.

As well as the non-executive members of the Committee, meetings have routinely been attended by:

- Chief Medical Officer, Phil Wood
- Chief Nurse, Lisa Grant
- Deputy Chief Medical Officer, Medical Director - Operations, David Berridge
- Director of Quality, Craig Brigg
- Quality Governance Manager, Sarah Johnson
- Company Secretary, Jo Bray

Yvette Oade retired from her position as Chief Medical Officer in March 2020.

Any other director or manager may be requested to attend to discuss a particular topic with the members.

The Quality Assurance Committee met on three occasions between April 2020 and March 2021. The meeting in April 2020 was cancelled in line with the Trusts response to the Covid-19 pandemic; assurance reports in relation to the Quality portfolio were received directly by the Trust Board. The draft minutes of the meetings have been received by the Trust Board with a supplementary update provided by the Chair.

The committee has provided an effective forum affording scrutiny and challenge to a range of topics impacting on the quality and safety of clinical services at LTHT; reviewing a number of issues that were escalated though routes such as Quality Management Group (QMG) and related forums, in order to seek further assurance.

The Committee structure has been reviewed and refreshed, as documented in Appendix B; implementation of the revised structure was discussed and approved at the Quality Management Group on 11 February 2021.

3. Delivery Against Terms of Reference

The Committee has reviewed the Terms of Reference to ensure that the Committee is fit for purpose and carries out its duties as delegated by the Board of Directors. Throughout

2020/21 the Quality Assurance Committee has discharged it's duties in line with the requirements outline in the Terms of Reference.

4. Amendments to Terms of Reference

The Committee Chair, along with the Committee has reviewed the Terms of Reference to ensure that the Committee is fit for purpose and carries out its duties as delegated by the Board of Directors.

The committee has discharged its duties in line with the ToR; during 2020/21 amendments to the membership of the group were updated to reflect changes to Non-Executive representative and the inclusion of the Medical Director (Governance & Risk)

5. Assurance of delivery of work plan

The Committee received the following routine reports in line with the Committee's workplan:

- Integrated Performance Report
- Serious Incidents (including Never Events)
- Leadership Walkround Programme
- Minutes from the Quality Management Group
- Quality Account Preparation
- Final Quality Account
- Learning from Deaths report
- Seven Day Service Assurance report
- Nursing and Midwifery Quality and Safety Staffing report
- Maternity Risk

The Quality Assurance Committee has also received the following annual reports;

- Medicines Management and Pharmacy Services (MMPS) Annual Report
- Controlled Drug (CD) Accountable Officer's Report
- Integrated Risk Report (Incidents, Complaints and Claims)

6. Other Issues addressed by the Committee in year

The Committee reviewed a range of topics that were escalated though routes such as Quality Management Group (QMG) and related forums, in order to seek further assurance, these included:

CQC Provider Well Led Assessment - The Committee received an update on the progress related to the provider well- led inspection in September 2018. The Committee acknowledged the areas of good practice and were assured by the actions underway in response to the five elements requiring improvement. The committee discussed the substantial work that had been undertaken in relation to nursing establishment and staff escalation processes and referenced the streamlined Safer Staffing report and Stop the Line / Red Flag escalation processes.

The committee were informed that a self-assessment had commenced against the Key Lines if Enquiry (KLOE) which detailed the specific requirements for an outstanding rating and what actions were required for attainment. In addition, it was noted that the trust was working in collaboration with trusts nationally who had an outstanding rating in order to share learning. The next steps were discussed, and it was noted that an external review would be undertaken and arrangements for this were being explored.

Quality and Safety Visits - The Committee received a paper outlining the introduction of a Quality and Safety Visit programme which sought endorsement and support for implementation. It was noted that the programme was designed on a peer review model and focused on the Safe, Effective and Caring elements of the CQC KLOE framework. The

practicalities and requirements for triangulation of data were explored and discussions were noted in relation to the need for the framework to be flexible and incorporate emerging priorities e.g. issues identified through the staff survey.

The Committee reflected on the assurance the introduction of the process would provide; it was confirmed that the Quality Management Group would provide ongoing oversight of the programme.

Workforce Committee: Integrated working with Quality Assurance Committee -
The Committee noted that the reasoning for this item was to discuss and outline the escalation process for the workforce committee and QAC to ensure that items related the Quality and Safety of services from a workforce perspective were escalated as appropriate.

Complaints Review Process – The Committee received a report, which provided an overview of the findings following the external review of the complaints process which was commissioned in October 2019. The Committee scrutinised the findings of the report and noted that 22 recommendations had been identified, and an action plan was being drafted. It was noted that the responsiveness to patient concerns would be included in the Clinical Quality Strategy and would be reviewed with each CSU. It was confirmed that the Trust Board would continue to receive oversight of the key complaints metrics outlined in the IQPR. In addition, once the action plan had been finalised this would be shared and updates on progress would be included in reports to the Trust Board workshop.

Mortality Update - The Committee received a presentation providing an overview of the mortality measures in place for the management and monitoring of mortality indicators across the Trust. An overview of the current national datasets was provided, noting that the Summary of Mortality Indicator (SHMI) was within the 'expected' range however the Hospital Standardised Mortality Ratios (HSMR) was 'higher than expected'; the differing reporting criteria was outlined. The Committee scrutinised the coding processes, noting key elements of work that had been undertaken in relation to coding practices and data quality processes.

An overview of the findings from the independent CHKS review was provided, outlining key findings and concluding that the Trust was focusing on the right topics and actively addressing the areas for improvement. The committee explored the actions taken to date, providing challenge to the different recording processes for assessment areas and the need for internal clinical review alongside external peer review. The committee were assured by the clinical approach: the oversight, the alignment of the Get it Right First Time (GIRFT) programme, and the bespoke external peer reviews when required.

The Committee were assured by the measures in place but noted that further work was still required, therefore it was agreed that the Committee would continue to provide scrutiny on behalf of the Board with regular oversight of the mortality work programme.

In addition, The Committee reviewed and noted compliance and improvements achieved in line with the Mortality Review Policy which was introduced in June 2017. The committee was assured that improvements had been made relating to the screening of all deaths within the Trust; in addition, the Committee was provided with assurance regarding potentially avoidable deaths, with feedback and learning from subsequent investigations being detailed in the report. The quarterly updates were provided to the Public Board via the QAC Committee Chair's Report; the full assurance reports were received in the Blue Box

Maternity Quality & Safety Update - The Committee received a presentation in relation to Quality and Safety within Maternity Services. An overview of the local and national datasets was provided detailing areas of improved performance and areas in need of improvement; it was noted that finding appropriate peers to benchmark against was an issue for this service due to the complexity of care required by some babies. However, the committee were assured

that best efforts had been made to get the right benchmarking in place and so was a valuable way of understanding our performance.

The impact of Covid-19 was explored by the committee and it was acknowledge that this had had a significant impact on patient experience which had resulted in an increase in the number of PALs and Complaints received; this was predominately associated with the changes to the Trusts visitor policy.

Feedback from the Healthcare Safety Investigation Branch (HSIB) was discussed, with the Committee seeking further clarification on the process of embedding and sharing learning from these cases, assurance was provided through the introduction of the Clinical Service Unit (CSU)'s Integrated Learning website which was now live.

The Committee were assured by the update and complimented the team on their work and their approach.

Maintaining Quality during Winter – The Committee were provided with an update in relation to the Trusts winter planning process, with a focus on patient safety and quality which outlined three key themes; CSU initiated and owned winter plans (61 schemes had been identified and were in place), additional bed capacity and citywide system working.

An overview of the staffing models and associated escalation plans were explored, with challenge being given to the inclusion of sickness absence. The team confirmed that the model did account for sickness absence and that the outlined additional footprint was an extension of the existing wards which was more manageable by the workforce. Clarification was also provided regarding the integration of the Covid-19 surge plan for the medical cover and outlined that learning from phase 1 had been incorporated. The measure in place to monitor quality and safety were discussed and there was a further focused discussion on same day discharge.

The Committee sought additional assurance regarding the impact of the Covid-19 staff testing, and track and trace, with a focus on staffing levels and the wider workforce; the team confirmed that this a key element to the planning and the measures for monitoring and supporting staff were highlighted. It was noted that the NHS Nightingale Hospital Yorkshire & The Humber was not included in the additional capacity plans, but clarity was provided regarding the 'state of readiness' tests being undertaken to ensure the facility could be stood up at pace.

From the discussion, there was further scrutiny regarding staff health and wellbeing and measures in place to safeguard not only the physical health of staff but also their mental wellbeing. The Committee were provided with an overview of the services available to staff if additional support, advice or guidance was required. The Committee were assured by the actions taken and thanked the team for the comprehensive update.

Duty of Candour (DoC) - The Committee received a report outlining the procedure and governance processes in place across the Trust to ensure compliance with the Duty of Candour regulations. Key assurance measures were discussed, and attention was drawn to the compliance summary detailed in the report; improved technical solutions to Trust systems were discussed in order to provide greater compliance and assurance. It was agreed that Duty of Candour would be included in the quarterly Serious Incidents and Never Events report for on-going assurance regarding compliance for serious incidents. The committee provided challenge regarding the variation of compliance across CSUs and requested further clarity on the actions outlined to address this; it was confirmed that improvements had been outlined to address this issue, with a focus on educational materials to support CSUs.

Pressure Ulcers External Review – The Committee received a report providing an overview of the findings and recommendations following the external peer review of pressure ulcer management within the Trust. The report identified a number of areas of good practice

alongside 30 recommendations to be considered as areas of improvement, the Trust had reviewed the recommendations and outlined an action plan. In addition, the report also explored the impact of the Covid-19 pandemic and provided assurance that the Trust was not an outlier in terms of increased incidences during this period, and that figures had reduced in line with the baseline trajectories.

Non-Invasive Ventilation (NIV) Death *(Item escalated from Quality Management Group)* This item was escalated from Quality Management Group (QMG) to provide assurance on the on-going implementation of actions identified in the serious incident investigation; it was noted that all actions were due for completion by December 2020. The report provided an overview of the actions implemented to date and outlined that monitoring processes had been introduced to ensure that improvements were sustained, and compliance continued.

In response to the Covid-19 pandemic the Committee received a number of assurance reports, these included;

NHS Nightingale Yorkshire and the Humber: Phase 2 – The Committee received a report outlining the repurposed function of the NHS Nightingale Hospital Yorkshire and the Humber (NHYH). It was noted that the NHYH would be used as an ambulatory outpatient imaging department to enable local Trusts to offer CT scans to patients to support the phase 2 recovery plan. The Committee discussed the functionality and associated accountability of the facility and noted that this would be utilised on a rotational basis between LTHT and Harrogate District Foundation Trust. The Committee scrutinised the governance and accountability to the Trust Board in detail, alongside the regulatory registration requirements and communications with the CQC. The Committee agreed that it had received assurance however due to the complexity and ongoing review it was agreed that this would be further discussed with Executive Directors and at Trust Board in July 2020.

Infection and Prevention Control (IPC) Board Assurance Framework - The Committee were presented with the IPC Board Assurance Framework, which provided assurance in relation to guidance published by NHSE/I on 4 May 2020; the framework provided a self-assessment against Public Health England and other Covid-19 related IPC guidance. The Committee acknowledged that the assessment was still a work in progress, with CSU's further exploring the framework at a local level; it was confirmed that regular oversight would be provided by the IPC Committee. In addition, it was noted that the IPC Board Assurance Framework would be discussed with the CQC at an engagement meeting on 16 July 2020 and would be included on the agenda at July Board, to be received for assurance/information (blue box item). The Committee were assured by the report.

Phase 2 Recovery Plan – The Committee were provided with an overview of the Quality Impact Assessment (QIA) process adopted for the review of the current service provision and to outline the impact of service changes in response to the Covid-19 pandemic. A significant number of QIA's had been completed by CSU and these had been reviewed and validated; 21 specialities, out of 136 had recorded the impact of change as high risk, these had been escalated to the Deputy Director of Operations and Director of Quality for further review and discussion with the Executive team.

The Committee scrutinised the impact Covid-19 had on quality aspects such as complaints and litigation, it was noted that this had been considered as a secondary harm as a result of Covid-19 and had been outlined on the corporate risk register. It was confirmed that oversight of these risks were discussed at the Risk Management Committee, in addition Quality Management Group provided monthly oversight.

Process for Care Home Discharges - The Committee received a report outlining the process followed by the Trust regarding the transfer of Medically Optimised for Discharge (MOFD) patients to an appropriate/ safe place of care, to provide capacity for the expected influx of

COVID-19 positive patients. It was noted that the Trust followed the national guidance provided and a timeline of actions and key issues were highlighted to the Committee. The substantial work undertaken was scrutinised by the Committee and the improved relationships with the care homes were noted. The Committee were assured by the report.

Quality Assurance Objectives 2020/21

The Committee structure has been reviewed and refreshed, as documented in Appendix C. The Quality Assurance Committee, Quality and Safety Assurance Group, and its streamlined supporting structure have been revised, reducing duplication and allowing more detailed management discussions when required.

A priority in 2021 is to continue to build on the assurance provided by Quality Assurance and Safety Group and the associated Sub Groups, ensuring that the refreshed Quality Meeting structure continues to provide a consistent and concise means of assurance regarding the quality and safety of clinical care at LTHT.

In 2020/21 the Quality Assurance Committee had a key focus on the following objectives;

- Complete the programme of scrutiny of assurances set out in the work plan for the quality portfolio, adopting the 5 key lines of enquiry framework – safe, effective, caring, responsive and well-led
- Receive and scrutinise the reporting activity against regulatory requirements, including CQC and NHSE/I, overseeing the plan relating to core services and provider well-led to achieve an outstanding rating at the next inspection.
- Oversee the production of the annual Quality Account, focusing on measures of achievement in 2020/21 and approve the goals for improvement relating to patient safety, experience and clinical effectiveness in 2021/22.
- Prepare and deliver annual assurance report to the Audit Committee, confirming the effectiveness of the Committee and fulfilment of its objectives.
- Oversee the development of a Trust Clinical Quality Strategy, integrating the existing Quality Improvement Strategy 2017-20.
- Work in partnership with workforce and finance and performance committees to integrate quality, performance and finance, focusing on the impact of delivering constitutional standards and waste reduction programme on quality and safety

Due to changes in the meeting Chair, the objectives above will be extended into 2021/22 and will be reviewed with the new Chair for Quality Assurance Committee in June 2021.

7. Risk Management

Since May 2015, assurance has been provided to the Quality Assurance Committee by the Quality Management Group directly, and through its Sub-Groups. This process is now embedded, with the assurance provided being increasingly robust and key risks escalated. The Committee has received assurance and assessed risks associated with national reports relating to the recently published Ockenden review and Cumberledge; focusing on benchmarking od standards and the outlining the improvements required. The committee were assured by the action taken to date and will continue to scrutinise the position and associated risks throughout 2021/22.

8. Proposed 2021/22 Work Plan

The proposed work plan is outlined in Appendix B.

9. Publication Under Freedom of Information Act

This paper is exempt from publication under Section 29/36/38/40/41/43 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

10. Recommendation

The Quality Assurance Committee has delivered the agreed delegated activities by the Board as set out in its Work Plan, and gained assurance as defined by the Committee Terms of Reference, and these are current and valid. The Audit Committee (and subsequent Trust Board) is asked to note this report, and the assurance provided.

Sarah Johnson
Quality Governance Manager
April 2021

THE LEEDS TEACHING HOSPITALS NHS TRUST

QUALITY ASSURANCE COMMITTEE WORK PLAN 2020/21

The Quality Assurance Committee will provide oversight and seek assurance in line with the Constitutional and Fundamental Standards, the Trust's Quality Priorities and Regulatory Standards. In order to achieve this objective, the Committee will follow the outlined work programme below; where further assurance is required, or specific risks identified these will be included in the work programme as topic reports throughout the year.

Agenda Item	Frequency	Apr	Jul	Oct	Feb
Quality Improvement					
Quality Goals (as part of Quality Account)	Annual update			✓	
Quality Improvement Programme (including Safety Improvement Plan)	Six-monthly summary report			✓	
Quality Governance					
CQC Registration Annual Assurance (and ad hoc reports from in-year Inspections, and oversight of action plans)	Annually			✓	
Quality Account	Annually			✓	
External Audit Assurance on Quality Account	Annually		✓		
Annual Report (incl Work Plan for next Calendar year)	Annually for Board				✓
Essential Metrics	Six-Monthly		✓		✓
Clinical Service Presentations	Quarterly		✓	✓	✓
Reports from QMG	Minutes from QMG		✓	✓	✓
Leadership Walkround Programme	Annually				✓
Quality Impact Assessments	Annually				✓
Patient Safety					
Mortality Review (Learning From Deaths)	Quarterly		✓	✓	✓
Maintaining Quality during Winter	Six Monthly			✓	
HCAI Action Plan	Annually				✓
Safety Thermometer	Six-Monthly		✓		✓
Annual Report on Incidents, Coroners and Claims	Annual		✓		

Agenda Item	Frequency	Apr	Jul	Oct	Feb
Serious Incidents (including Never Events six-monthly)	Quarterly		✓	✓	✓
Review of Major External Inquiries	As required				
Performance update	Quarterly		✓	✓	✓
Digital and Informatics Update	Six-Monthly			✓	
Seven Day Services	Annually				✓
Annual Reports:					
Safeguarding Annual Report	Annually		✓		
MMPS Annual Report	Annually			✓	
CD Accountable Officer's Report	Annually			✓	
Medical Devices Accountable Officer's Report	Annually			✓	
Maternity service NHS Resolution scheme	Annually		✓		
Clinical Effectiveness & Outcomes					
Annual Clinical Audit Programme - for approval	Annually				
Implementing Best Practice Guidance (including NICE)	As required for approval of non-compliance				
Clinical Audit Annual Report: Including findings from Trust-wide Audits	Annually			✓	
Annual Public Health Report (unless it is going direct to Board)	Annually			✓	
Findings from National Audits	Annually			✓	
External Assurers Report	Six-monthly		✓		✓
Patient Experience					
Equality and Diversity (unless it goes straight to Board)	Annually				
Annual Report on Complaints and PALS	Annually		✓		
Committee Governance					
Review of Committee ToR and Work Plan	Annually				✓
Topics for further investigation from QMG or SOSG	Quarterly		✓	✓	✓

NB: Papers are for assurance purposes, not for detailed review
*April meeting cancelled due to Covid-19 pandemic.

THE LEEDS TEACHING HOSPITALS NHS TRUST

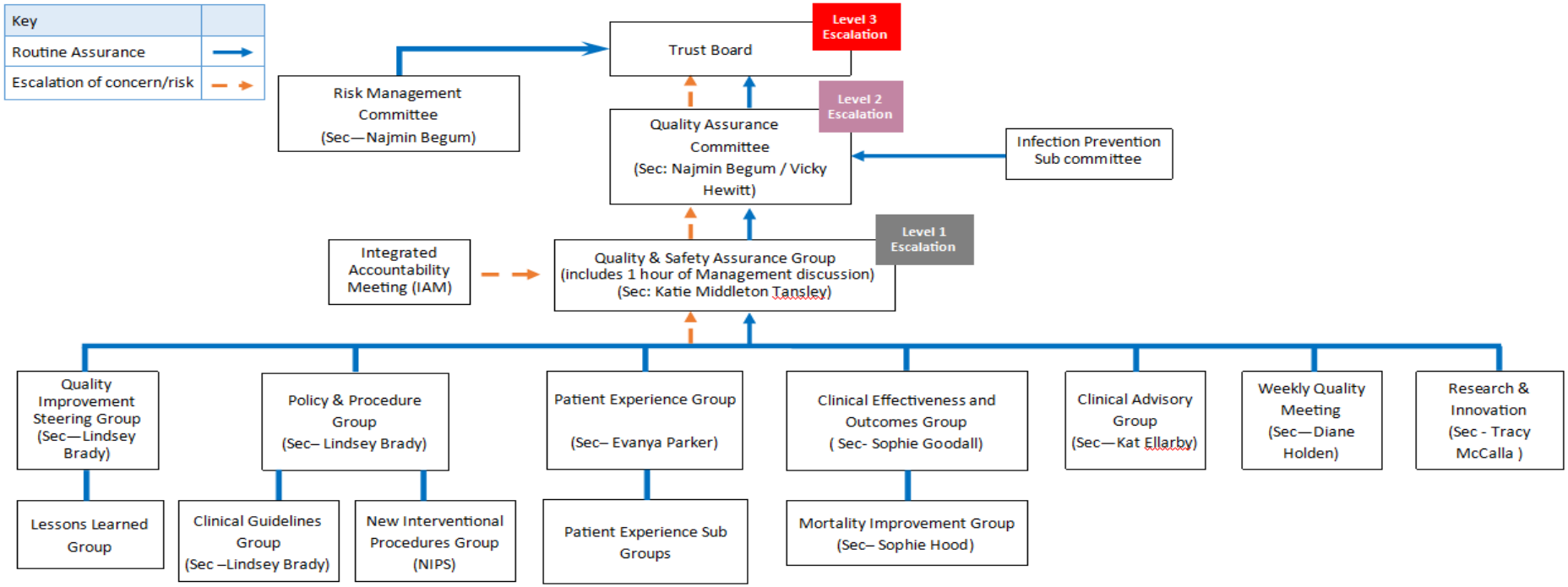
QUALITY ASSURANCE COMMITTEE WORK PLAN 2021/22

The Quality Assurance Committee will provide oversight and seek assurance in line with the Constitutional and Fundamental Standards, the Trust's Quality Priorities and Regulatory Standards. In order to achieve this objective, the Committee will follow the outlined work programme below; where further assurance is required, or specific risks identified these will be included in the work programme as topic reports throughout the year.

Agenda Item	Frequency	Apr	Jul	Oct	Feb
Quality Improvement					
Quality Goals (as part of Quality Account)	Annual update	✓			
Quality Improvement Programme (including Safety Improvement Plan)	Six-monthly summary report			✓	
Quality Governance					
CQC Registration Annual Assurance (and ad hoc reports from in-year Inspections, and oversight of action plans)	Annually			✓	
Quality Account	Annually	✓			
External Audit Assurance on Quality Account	Annually		✓		
Annual Report (incl Work Plan for next Calendar year)	Annually for Board				✓
Essential Metrics	Six-Monthly		✓		✓
Reports from QMG	Minutes from QMG	✓	✓	✓	✓
Leadership Walkround Programme	Annually				✓
Quality Impact Assessments	Annually	✓			
Patient Safety					
Mortality Review (Learning From Deaths)	Quarterly	✓	✓	✓	✓
Maintaining Quality during Winter	Six Monthly	✓		✓	
HCAI Action Plan	Annually				✓
Annual Report on Incidents, Coroners and Claims	Annual		✓		

Agenda Item	Frequency	Apr	Jul	Oct	Feb
Serious Incidents (including Never Events six-monthly)	Quarterly	✓	✓	✓	✓
Review of Major External Inquiries	As required				
Seven Day Services	Annually				✓
Annual Reports:					
Safeguarding Annual Report	Annually		✓		
MMPS Annual Report	Annually			✓	
CD Accountable Officer's Report	Annually			✓	
Medical Devices Accountable Officer's Report	Annually	✓			
Maternity service NHS Resolution scheme	Annually		✓		
Clinical Effectiveness & Outcomes					
Annual Clinical Audit Programme - for approval	Annually	✓			
Clinical Audit Annual Report: Including findings from Trust-wide Audits	Annually			✓	
Annual Public Health Report (unless it is going direct to Board)	Annually			✓	
Findings from National Audits	Annually			✓	
External Assurers Report	Six-monthly		✓		✓
Patient Experience					
Equality and Diversity (unless it goes straight to Board)	Annually	✓			
Annual Report on Complaints and PALS	Annually		✓		
Committee Governance					
Review of Committee ToR and Work Plan	Annually				✓
Topics for further investigation from QMG or SOSG	Quarterly	✓	✓	✓	✓

NB: Papers are for assurance purposes, not for detailed review



Group / Reports that report into Quality & Safety Assurance Group:

- CSU Presentations (2 per Group)
- Perfect ward report
- Quality & safety visits report
- Quality dashboard
- Maternity Risk
- Nutritional care
- Medicine Management
- Safeguarding (inc training performance)
- MCA & Mental Health legislation
- Medical Devices

Group / Reports that report into Quality Improvement Group

- Trust Priorities (Falls, Sepsis, PU's, discharge, de -escalation)
- KPO Projects
- Trends / themes requiring QI support (e.g. from incidents, complaints, audits etc) .

Group / Reports that report into Clinical Effectiveness & Outcomes Group:

- Clinical Audit
- National Audits
- Best Practice Guidance
- External Agency visits inc GIRFT
- Blood Transfusion
- Clinical Outcomes / Assessment (VTE, NELA etc)
- Cancer Board
- Mortality
- Organ Donation
- Resuscitation & Deterioration
- End of Life

Group / Reports that report into Policy & Procedure Group

- New Policies / Procedures for consideration
- Review of policies prior to Executive Approval
- Oversight of outstanding policies/ procedures
- Oversight of policy standards
- Oversight of clinical guidelines and NIPs

APPENDIX D - Terms of Reference - Quality Assurance Committee

1. Main Authority / Limitations

1.1 The Board has resolved to establish a Committee of the Board to be known as the Quality Assurance Committee ("the Committee"). The Committee is comprised of Non-Executive Directors, accounts to the Board and shall have Non-Executive responsibilities, powers, authorities and discretion as set out in these terms of reference. The purpose of the Committee is to lead on behalf of the Board of Directors the acquisition and scrutiny of assurances concerning (i) patient safety, clinical effectiveness and patient experience; (ii) the effectiveness of the quality governance framework including compliance with Fundamental Standards of Care; and (iii) learning and quality improvement.

1.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. The Committee may invite any Director, Executive, external or internal auditor, or other person to attend and meeting(s) of the Committee as it may from time to time consider desirable to assist the Committee in the attainment of its objective. The Committee may appoint, employ or retain such professional or legal advisors the Committee consider appropriate. Any such appointment shall be made through the Company Secretary, who shall be responsible for the contractual arrangements and payment of fees by the Trust on behalf of the Committee. All Board Members shall be entitled, should they wish to do so, to see the advice received from the Committee's advisors.

1.3 The Committee will report annually on its work in support of the Annual Governance Statement and Quality Account. Reports will specifically comment on: (i) patient safety (ii) clinical outcomes; (iii) patient experience/satisfaction; (iv) the effectiveness of quality governance arrangements; and (v) the appropriateness of any compliance disclosure made or to be made by the Board.

1.4 Approved minutes of the Committee are circulated to the Board for information at the first formal meeting of the Board after approval. The minutes are also circulated to those regularly in attendance. The Committee Chair provides the Board with a brief summary of the Committee's work at the first available Board meeting opportunity after each Committee meeting. The Chair of the Committee will escalate matters to the Board as deemed appropriate.

1.5 Trust Standing Orders and Standing Financial Instructions apply to the operation of this Committee.

2. Objective

2.1 The Committee shall be accountable to the Board and shall examine assurances in the following areas: (i) the level of risk to which patients are exposed; (ii) the extent to which clinical outcomes required by corporate strategy are being met; (iii) the extent to which patient and user satisfaction matches that required by corporate strategy; (iv) the extent to which the Trust can demonstrate learning and improvement; and (vi) the level of compliance with Fundamental Standards of Care.

3. Primary Duties and Responsibilities

3.1 The Committee will take assurance using three key lines of enquiry; relevant overarching governance structures, the effectiveness of processes in place, and outcomes achieved. The Committee shall:

Governance Structures

3.2 Consider and approve the Trust's Quality Improvement Strategy, and periodically review the adequacy of resources and organisational capability to deliver the Trust's Quality Improvement Strategy.

3.3 To be satisfied that the breadth and depth of the Trust's patient safety, clinical effectiveness and patient experience control framework (i,e, policies and procedures) is well designed, effective and embedded in clinical practice.

3.4 Consider the scope of the Quality Improvement Plan and be satisfied that the breadth and depth of the planned work is sufficient to meet the Board's assurance needs, and that there is sufficient resource, capacity and capability to deliver the plan.

3.5 Be satisfied that there is appropriate co-ordination between clinical, internal and external audit programmes where appropriate (such as in respect of Quality Account indicators).

Processes

3.6 Explore, explain and justify the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with *Fundamental Standards of Care*[1], and learning effectiveness. Providing to the Board such assurances as it may reasonably require regarding compliance.

3.7 Be satisfied that processes are in place and sufficiently rigorous for assessing the impact of proposed cost improvement schemes on patient safety, clinical effectiveness and patient experience. Where assessment or a review of a scheme suggests a potential or actual adverse impact, which cannot be mitigated in line with the Board's risk appetite, advise the Board accordingly.

3.8 To consider and review the Trust's compliance with the statutory Duty of Candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting patients and their relatives who have been involved in a notifiable patient safety incident.

Outcomes

3.9 To provide advice to the Board on whether the Quality Account, taken as a whole, is fair, balanced and understandable and provides the information necessary stakeholders need to assess the Trust's performance.

3.10 To consider any findings of major investigations or reviews (internal or external to the Trust) relevant to patient safety, clinical effectiveness or patient experience, as delegated by the Board or on the Committee's initiative and consider management's response.

3.11 To consider and review, where required by the Board or Audit Committee, the treatment of specific matters concerning patient safety, clinical effectiveness or patient experience, raised in accordance with the Public Interest Disclosure Act

(commonly known as "Whistleblowing"), and evaluate the appropriateness and effectiveness of the management response.

3.12 To consider and review reports and information relevant to clinical quality, including quality measures, incident reports, mortality data and audit results, and evaluate and consider management's response.

Other Duties

3.13 The Committee shall ensure that material issues arising from its work which relate to matters that fall within the purview of the Finance & Performance or Audit Committees, shall be communicated to such Committees and considered within their agendas. The Quality Assurance Committee shall require feedback from these Committees on their review of such referred work.

3.14 To provide an annual letter of assurance to the Chair of Audit Committee confirming the effectiveness of the Committee and fulfilment of its objective, and to the effect that the Committee has disclosed to the Audit Chair all significant deficiencies and material weaknesses in the design or operation of internal controls, of which the Committee is aware, which could adversely affect the Trust's ability to provide safe, high quality and satisfactory care for patients.

3.15 To undertake or consider on behalf of the Chairman or the Board such other related task or topics as the Chairman or Board may from time to time entrust to the Committee.

3.16 The Committee shall review annually the Committee's terms of reference and its own effectiveness and recommend to the Board any necessary changes arising therefrom.

3.17 To report to the Board on the matters set out in these terms of reference and how the Committee has discharged its responsibilities.

3.18 Where there is a perceived overlap of assurance responsibilities or gap between the Trust's Audit, Quality Assurance Committee, Finance & Performance Committee, Digital and Informatics Committee, Workforce Committee or the Building Development Committee the respective Committee Chairman shall have the discretion to agree the most appropriate Committee to fulfil any obligation. An obligation under the terms of reference of the relevant Committee, will be deemed by the Board of Leeds Teaching Hospitals NHS Trust to have been fulfilled providing it is dealt with by a Committee of the Board.

3.19 Where the Committee's monitoring and review activities reveal cause for concern or scope for improvement, it shall make recommendations to the Board on action needed to address the issue or to make improvements.

4. Duties and Etiquette

4.1 The duties of the Chairman of the Committee shall be to:

- keep the Board informed regularly of any material matters which have come to the Committee's attention;
- ensure that minutes of the Committee are an accurate reflection of discussion;

- review and approve the proposed wording of the Quality Account Report;
- attend or designate another member of the Committee to attend public meetings of the Trust to answer any questions related to the work of the Committee;
- prepare and present an annual report on the work of the Committee to the Board; and
- ensure that all significant risks are discussed and where necessary escalated in line with LTHT's Risk Management Policy.

4.2 The duties of members and attendees shall be to:

- attend and contribute;
- have read the papers and materials in advance and be ready to work with them;
- actively participate in discussions pertaining to Committee business ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact Trust-wide;
- disseminate the learning and actions from the meetings;
- to attend at least 75% of meetings of the Committee.

5. Constitution

5.1 The Committee shall meet with such frequency and at such times as it may determine. It is expected that the Committee shall meet at least four times each year.

5.2 The quorum for meetings shall be two Non-Executive Directors, one of whom should be the Committee Chairman, unless he or she is unable to attend due to exceptional circumstances. In the absence of the Committee Chair a decision will be taken in advance of the meeting as to which independent Non-Executive Director who is a member of the Committee shall chair that particular meeting.

6. Membership and Attendance

6.1 The Membership and attendance shall be disclosed in the Annual Report and shall be two independent Non-Executive Directors of the Board. Any member of the Committee who is able to speak and be heard by each of the other members shall be deemed to be present in person and shall count towards the quorum. The Members shall be:

- ~~Tricia Storey-Hart (Chair~~)
- Laura Stroud (Chair)
- Rachel Woodman

6.2 The Chief Nurse, Chief Medical Officer, Medical Director (Planned Care), Medical Director (Governance and Risk), Director of Quality, Chief Digital & Information Officer, Quality Governance Manager and Company Secretary shall be in attendance at all meetings except in relation to reserved business. They may send deputies to represent them in their absence or invite specific colleagues to address the Committee where appropriate.

6.3 The following persons shall be invited to attend at the discretion of the Committee, either for a particular item or for the whole meeting:

- Executive Directors; and
- others at the invitation of the Committee.

6.4 In order for decisions taken by the Committee to be valid, the meeting must be quorate. This will consist of two members of the Committee being present at the point when any business is transacted. [See 6.1 above].

6.5 The Committee is serviced by Board Secretariat which organises meetings. Papers shall be available at least five clear days before each meeting. Papers shall not be tabled unless it is essential and only with the Committee Chair's prior agreement.

6.6 Terms of reference are reviewed annually or in light of changes in practice or national/local guidance. The Committee will review annually its own performance, including the extent to which it has operated in satisfaction of its terms of reference, and in particular compliance with reporting arrangements to the Board.

7. Version Control

Version Control	Date	Comments
V13	31 Jan 2019	Update to Cttee membership approved at Public Board
V14	28 Nov 2019	Update to Cttee membership approved at Public Board
V15	30 Jan 2020	Update to cross ref to est new Cttees
V16	30 July 2020	Update to membership
V17	26 Nov 2020	Update to NED membership
V18	25 March 2021	Updated to reflect membership by Medical Director (Planned Care)

Document Owner

The Company Secretary is the owner of this document and of any Board minute authorising amendment.

[1]The patient safety record, clinical outcomes, patient experience ratings and compliance with *Fundamental Standards of Care* involve a wide range of metrics, which may change from time to time. These metrics reflect the Board's quality ambition as well