The Leeds Teaching Hospitals NHS Trust

Quality Assurance Committee Annual Report

Public Board
26 May 2022

Presented for:	Information and Assurance
Presented by:	Laura Stroud, Non-Executive Director
Author:	Lucy Atkin, Head of Quality Governance

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	

Trust Risks (Type & Category)				
Level 1 Risk	(□)	**Level 2 Risks**	**Risk Appetite Scale**	**Tolerance**
Workforce Risk				
Operational Risk				
Clinical Risk	√	• Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	↔ (same)
Financial Risk				

External Risk	√	• Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	↔ (same)

Key points	
The Quality Assurance Committee annual report provides a summary of the key assurances that have been received during 2021/22, and a summary of changes to the Terms of Reference, membership and work plan, including the work plan for 2022/23.	Assurance
The Quality Assurance Committee annual report was reviewed and approved at QAC on 28 April 2022 in advance of the Audit Committee meeting on 5 May 2022 and will inform the Chief Executive's annual governance statement.	Assurance

1. Purpose

The purpose of this report is to provide assurance to the Audit Committee that the Quality Assurance Committee has discharged its duties in accordance with its Terms of Reference, has completed its work plan for 2021/22 and to propose its work plan for 2022/23.

2. Committee Members and Effectiveness

The Quality Assurance Committee has maintained a core membership of three Non-Executive Directors. In 2021/22 the Quality Assurance Committee has had changes to its core membership due to the end of tenures and new Non-Executive Directors being appointed. In April 2021 Tricia Storey Hart Chaired the Quality Assurance Committee supported by Laura Stroud, Non-Executive Director, and Rachel Woodman, Associate Non-Executive Director. In July 2021 Laura Stroud took position of Chair of the Quality Committee supported by Chris Schofield, Non-Executive Director and Rachel Woodman, Associate Non-Executive Director.

From September 2021 the Quality Assurance Committee core membership was established with Laura Stroud (Chair), Phil Corrigan, Associate Non-Executive Director and Rachel Woodman, Associate Non-Executive Director.

In addition to the non-executive members of the Committee, meetings have routinely been attended by:

- Chief Medical Officer, Phil Wood
- Chief Nurse, Lisa Grant
- Associate Medical Director (Risk and Governance), John Adams
- Company Secretary, Jo Bray
- Director of Quality, Craig Brigg
- Associate Director (Quality), Lorna Johnson (from November 2021)
- Quality Governance Manager, Sarah Johnson (until September 2021)
- Head of Quality Governance, Lucy Atkin (from December 2021)

The Terms of Reference state that any other director or manager may be requested to attend to discuss a particular topic with the members.

The Quality Assurance Committee met on five occasions between April 2021 and March 2022. The Committee reviews its effectiveness following each meeting, this led to the agreement that the Committee would continue to meet bi-monthly (6 times a year) after the frequency of meetings was increased in recognition of the changing environment and assurances required. The Committee convened an extra-ordinary meeting on 10 March 2022 to receive a detailed report into the rising Summary Hospital-level Mortality Indicator (SHMI). 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 scrutiny and challenge to a range of topics impacting on the quality and safety of clinical services at Leeds Teaching Hospitals NHS Trust; reviewing a number of issues that were escalated though routes, including Quality and Safety Assurance Group (QSAG) and related forums, in order to seek further assurance.

The Committee has also considered the continued impact of the coronavirus (Covid-19) pandemic, seeking assurance on the actions that have been taken to mitigate the risks to quality and patient safety that had been identified. The Committee has also considered the impact on the health, safety and wellbeing of staff as they have continued to provide care to patients and their families during this very challenging period.

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 2021/22 the Quality Assurance Committee has discharged its duties in line with the requirements set out in the Terms of Reference.

4. Amendments to Terms of Reference

The Committee's Terms of Reference (ToR) and Workplan for 2022-23 were reviewed to ensure that the Committee was fit for purpose and carried out its duties as delegated by the Board of Directors and approved in February 2022 (following approval of the ToR by the Trust Board at its meeting held 27 January 2022). It was acknowledged that the national changes to redefine the NED Champion Roles (as detailed in the document: NHS England Enhancing Board Oversight; a New Approach to NED Champion Roles) were included and that additional areas that the Committee would be seek assurance on to replace several previous NED Champions Roles is outlined within the Committees Workplan.

The Committee has discharged its duties in line with the ToR; during 2021/22 amendments to the membership of the group were updated to reflect changes to Non-Executive representative and Chair.

5. Assurance of delivery of work plan

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

- Serious Incidents (including Never Events)
- Learning from Deaths report
- Seven Day Service Assurance report
- Nursing and Midwifery Quality and Safety Staffing report
- Maternity Risk
- Infection Prevention and Control Assurance Reports
- Patient harm – falls and pressure ulcers
- End of life care
- Leadership Walkround Programme
- Quality Account
- Minutes from Quality and Safety Assurance Group

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, Inquests and Claims)
- Infection Prevention and Control Annual Report
- Complaints and PALS annual report
- Safeguarding Annual Report
- Annual Clinical Audit Report

The Committee also reviewed the Clinical Strategy 2021/24 that was finalised and approved by the Board in September 2021.

6. Specific Assurance reviewed by the Committee in 2020/21

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

Ockenden report

The Committee received updates from the Women's CSU and maternity leads on the Trusts progress to implement recommendations arising from the Ockenden Report. The first draft of the Ockenden Report was published in December 2020, which described failings in the maternity and neonatal care provided by Shrewsbury and Telford NHS Trust over a number of years. Seven 'Immediate and Essential Actions' were identified for all Maternity care providers, with twelve clinical priorities requiring immediate implementation. An assurance assessment tool was presented to the Committee and submitted to NHSE North East. The Maternity Service has self-assessed as compliant with the recommendations from the Ockenden report. Formal evidence of compliance has been uploaded onto a national portal provided by NHSE.

In April 2021 the Committee received a report providing an update on all quality improvement developments, reporting structures for maternity safety incidents, training compliance and audit activity as well as detail from the engagement meeting held with CQC in February 2021.

Feedback received from NHSE/I on the submission had rated some of the actions previously rated by the Trust as compliant as Amber; this was due to benchmarking criteria that had been implemented after the deadline for submission meaning the Trust had not provided specific evidence in its data return (it was noted that the majority of Trusts were also in this position).

The Committee received a copy of the Trust's response to the CQC as part of a regional review of maternity services, which was shared with the CQC at the Trusts regular engagement meeting, the CQC advised there was one case that was currently being reviewed by the CQC, the Committee were briefed on the details of this case.

The Committee received a further update at its meeting in July 2021 on the progress made to support the Ockenden Immediate and Essential Actions, and of the requirement to submit additional documented evidence to a national digital portal (of previously submitted narrative evidence) to the national and regional maternity teams for additional review and scrutiny. All additional evidence requirements had been submitted by the revised deadline of 30 June 2021; this had included the minimum evidential requirements for all seven areas, alongside extensive additional evidence to show the comprehensive approach taken regarding governance and risk management, the processes and monitoring in place within the CSU, Trust and wider system work.

The Committee were assured of the evidence to support the Declaration Form and recommended sign off by the Chief Executive. The Chair of the Committee has provided specific support as the Trust's maternity champion and has met with the maternity team in this role during the course of the year.

62-day Cancer Standard *(item escalated from Finance and Performance Committee)* The Committee received a report in relation to oversight of patients on planned waiting lists in regard to the 62 Day Cancer Standard; the report was to provide assurance on safety and quality processes adopted to ensure patients on the waiting list were prioritised appropriately and their safety maintained.

It was noted that the reduced capacity across all sites as a direct impact of the Covid-19 pandemic had resulted in an increased number of patients waiting longer for their treatment. The Committee were informed of actions taken to manage the risk of patients facing increased delays in treatment and reference was made to the guidance provided by the Royal College of Surgeons; this provided a framework for the prioritisation of patients on admitted waiting lists. It was noted that the Trust had developed a Surgical Priority Oversight Group, which reported to the Chief Medical Officer following agreement at Clinical Advisory Group to provide a weekly review of critical care referrals and surgical prioritisation. In addition, a weekly Cancer Oversight meeting had been established in February 2021 to review and assess the 62-day backlog levels. There had been significant progress in restoring elective capacity across the Trust during Q4 2020/21, with the Trust having good oversight and capacity modelling in place.

The Committee scrutinised the prioritisation model and noted that 571 patients had not been assigned a priority code; assurance was provided that there was minimal risk for these patients, as patients had been clinically prioritised and that where a category had not been assigned these were non-surgical patients.

The Committee explored the information systems used to capture the data, and assurances were provided that the Trust had sufficient oversight of system data that was securely stored on the Patient Administration System (PAS). It was noted that further exploration of patient harm was needed, including the review of patients beyond the prioritisation groups.

The Committee received the report and confirmed its assurance of the actions taken to mitigate risks of harm as a consequence of reduced elective capacity during the coronavirus pandemic.

Clinical Harm Review (104ww) – The Committee received a report to provide assurance following the Clinical Harm Review of patients waiting over 104 weeks for planned elective surgical treatment. The Committee noted the NHSE/I guidance (Priorities and Operational Planning Guidance: October 2021 to March 2022) and the clear statement that a key priority for the NHS was to reduce the number of patients waiting over 104 weeks for treatment to zero by the end of March 2022; noting that the delivery plan was overseen by the Corporate Operations team, reporting to Finance and Performance Committee. The review of clinical harm, carried out by Medical Directors, was a sample of the waiting list to assess potential harm as a consequence of increased waiting time. The findings of the 106 cases reviewed was that there had been no evidence of harm as a consequence of waiting > 104 weeks, however there was evidence of poor patient experience as a consequence of the waiting time for treatment. The review highlighted both good practice and areas for improvement related to the process in which specialities conducted regular reviews of patients on the waiting list and a number of recommendations were made to take forward identified learning and build this review into routine business with clinicians providing the validation and assurance, with oversight from the Corporate Operations team.

Leeds Vaccination Programme – The Committee received a report on the progress of the Leeds Covid-19 Vaccination Programme, noting that the programme had delivered over 300,000 vaccinations to the population of Leeds within the Thackray Medical Museum and Elland Road sites delivering over 100,000 vaccinations.

It was noted that there had been 16 incidents reported on Datix. In addition, there had been two incidents of thrombosis in patients reported by haematology specialists in March, which had been reported through the ‘yellow card’ system and directly to the MHRA, in line with the appropriate processes.

The Committee received the report and confirmed its assurance of the robust quality assurance mechanisms in place within the programme, noting the feedback received following the CQC visit and from NHSE/I.

Maternity Incentive Scheme Compliance - The Committee received a report providing a summary of the Trusts Compliance with the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme (Maternity Safety Actions) 2020/21.

The Committee were provided with an overview of the progress against the safety actions outlined in the scheme. It was confirmed that oversight was provided by the Director of Midwifery and the Deputy Head of Maternity to review and monitor compliance, as well as outline interventions where required.

The Committee received the report and confirmed its recommendation of the approval to sign off the Board Declaration by the Chief Executive.

Patient Safety Incident Response Framework (PSIRF) – The Committee received an update on progress in the implementation of the NHS Patient Safety Incident Response Framework (PSIRF). The Trust is an early adopter for this Framework, which describes the requirements for investigation, methodology and engagement of patient safety incidents. A Patient Safety Incident Response Plan (PSIRP) for the Trust is in development, which will provide a structured approach to the identification of key priorities, resources and required skills and training. The Serious Incident Investigations & Learning Manager highlighted the proposal to go live on 1 April 2022; from that date the Trust's obligations against the NHS Serious Incident Framework 2015 would cease and incidents would be managed in-line with the PSIRP that would be agreed. The Committee received the report and approved the PSRIP, noting the biannual assurance that would be provided to this Committee through the serious incident report.

NHS Framework for Involving Patients in Patient Safety - The Committee received an overview of the recently published NHS Framework for involving patients in patient safety, which was included in the National Patient Safety Strategy, and noted the actions required to ensure compliance.

The framework was explained to the Committee, which described how NHS organisations should include patient partners in their own safety processes, with recognition that staff themselves would need to be supported to encourage patients to do so. In addition, the framework outlined the expectations regarding recruitment, training and support for people in the Patient Safety Partner roles. The existing patient partner programme was noted; the framework would be an opportunity to expand on this to meet the new requirements.

The Committee noted the value this would provide and reflected on the importance of triangulation with Equality and Diversity and with training requirements.

Mortality Improvement

The Committee convened an extra-ordinary meeting on 10 March 2022 to receive a detailed report into the rising Summary Hospital-level Mortality Indicator (SHMI). The (SHMI) publication for December 2021 showed an elevated SHMI to 1.1114 for the data period August 2020 to July 2021. This had increased further with the latest publication in February 2022 showing a Trust SHMI of 1.1259, which was in the 'higher than expected' range.

An analysis of the data and coding for the July 2021 reported SHMI was conducted. Data provided by Dr Foster Healthcare Intelligence revealed 'Pneumonia', 'Congestive Cardiac Failure', and 'Viral illness' diagnostic categories were responsible for over 60% of the excess deaths seen in July 2021 and were selected for closer analysis. The chair of the Mortality Improvement Group undertook a case-by case review of all deaths of patients in the three diagnostic categories of concern in July 2021. The review concluded there had not been a material change in clinical practice in July 2021 and showed that good quality care was received overall.

The Mortality Improvement Group will continue to monitor the SHMI and HSMR and develop the Trust's ability to review and respond to future variance in mortality. The

Committee will receive regular assurance through the Learning from Deaths 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

Quality Improvement Programme – The Committee received an update on the Quality Improvement (QI) Programme and on the work of the collaboratives, the steering group, the 2022 Improvement Strategy and the Leeds Improvement Method Value Streams. Additionally, the expansion of the Quality Partner Programme was noted.

The use of the Leeds Improvement Method within operational transformation programmes was explored by the Committee, and insight provided into the discharge pathway linking with community service providers.

The implementation work relating to Reason to Reside (R2R) was summarised, which had expanded onto the next steps of the programme to challenge and change behaviours. Data was being used to support discussions across the system. This work was recognised by the Committee as a core component of the Trust's Quality Improvement Strategy, and an important tool in the Trust's recovery and journey to 'Outstanding' CQC rating.

The Committee received the update and were assured by the on-going developments.

Maintaining Quality During Winter - The Committee were presented with assurance on the actions taken to maintain quality during winter, with a focus on the specific risks related to the ongoing pandemic and the impact on staffing and patient safety. The presentation included winter planning stages, model scenarios, descriptions of CSU initiatives, system actions taken on 'no reason to reside' (no RtR) patients, areas of risk, and additional controls in place to mitigate these risks. The impact of staff sickness was discussed, and assurance was provided on the established escalation processes and contingency planning.

The city-wide commitment to reducing the number of patients with no RtR was noted, and the initiatives in place to support this were outlined. It was noted incremental improvements were being made, however there were still challenges in this area, particularly in relation to workforce, across the system.

It was noted that the regular audit cycle within ED would provide assurance that processes were being followed to maintain patient safety. The Committee were briefed on the patient safety review that had been undertaken relating to patients waiting for long periods in ED for an inpatient bed in October, as a consequence of system pressures, and it was acknowledged that there remained a risk relating to 12 hour waits in the department. The Executive Team had oversight of this, and it was confirmed that all areas of the presentation were underpinned by actions with oversight provided by the Quality and Safety Assurance Group.

Quality Assurance Committee Objectives 2021/22

The Quality Assurance Committee, Quality and Safety Assurance Group, and its supporting structure was revised in 2021/2022 to reduce duplication and allow for more detailed management discussions when required. This proved successful in

2021/22 it will remain a priority to continue to build on the assurance provided by Quality Assurance and Safety Group and the associated Sub Groups, ensuring that the quality meeting structure continues to provide a consistent and concise means of assurance regarding the quality and safety of clinical care at Leeds Teaching Hospitals NHS Trust.

In 2021/22 the Quality Assurance Committee had a key focus on the following objectives:

- the level of risk to which patients are exposed;
- the extent to which clinical outcomes set out in corporate strategy are being met;
- the extent to which patient and user satisfaction set out in corporate strategy is being met;
- the extent to which the Trust can demonstrate learning and improvement;
- the level of compliance with Fundamental Standards of Care.

The Quality Assurance Committee have reviewed and updated the Committee's objectives for 2022/23:

- To support delivery of the Trust's clinical services strategy, focusing on implementing and embedding the Patient Safety Incident Response Framework (PSIRF), to support learning and improvement.
- To deliver the national Patient Safety Strategy, focusing on involving patient partners in quality improvement to support patient-centred care.
- To focus on compliance with Fundamental Standards of Care, seeking assurance on preparations for CQC inspection, to support the Trust to achieve an outstanding rating at the next inspection.
- To support the maternity team to implement the recommendations and improvement plan related to the Ockenden report and seek assurance that this is on track
- To seek assurance from the Emergency Care team and support them to deliver quality and safety improvements.
- To support the Trust's Covid-recovery plan, including working with partners, focusing on the impact on patient safety and health inequalities.
- To test the Trust's risk appetite statements against the assurances received.

Well Led Developmental Review

AQUA concluded the well led review of Committees of the Board in 2021/22. The report noted the following regarding the Quality Assurance Committee:

- Committee members were respectful, well prepared and patient-centred, a patient story was told. The focus was on assuring the Board of progress on key clinical quality topics; there was evidence of a well-embedded understand-learn-improve cycle underpinned by The Leeds Way and Leeds Improvement Method.
- Quality of care metrics were triangulated with workforce wellbeing and resilience and patient feedback through the CSU accreditation framework.

- Relevant examples of cross-referencing with other Board committees were seen, eg the referral from Finance and Performance Committee of patients waiting 104 weeks for elective care.
- There was evidence of external advice and peer learning being sought to address quality issues such as the increased incidence of pressure ulcers; topics were internally escalated, eg complaints about lost property led to involvement of the Professional Standards Team, and inclusion of patient property in the Trust audit programme 2021/22.

The review noted an area for improvement relating to the construction of the agenda, length of papers and that clarity was required on what the Committee was being asked to address. The Chair and Committee facilitators have reflected on the report and amended the agenda to include time for constructive challenge and ensured that focused summaries/papers are presented describing the action the Committee is required to take.

7. 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.

8. Recommendation

Audit Committee are asked to receive the annual report of Quality Assurance Committee and the assurance provided, to inform the Chief Executive's annual governance statement.

9. Appendices

Appendix A Quality Assurance Committee Work Plan 2021/23

Appendix B Quality Assurance Committee Work Plan 2022/23

Appendix C Quality Assurance Committee Reporting Framework

Appendix D Quality Assurance Committee Terms of Reference V21

Laura Stroud
Non-Executive Director and Chair of Quality Assurance Committee April 2022

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	Sept	Nov	Jan	Mar
1. Quality Improvement							
Quality Goals (as part of Quality Account)	Annual update	✓					
Quality Improvement Programme (including Safety Improvement Plan)	Six-monthly summary report			✓			
2. 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	Bi-monthly		✓		✓		✓
Leadership Walkround Programme	Annually				✓		
Quality Impact Assessments	Annually	✓					
2.1 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				✓		
Serious Incidents (including Never Events six-monthly)	Quarterly		✓	✓	✓		✓
Review of Major External Inquiries	As required						
Seven Day Services	Annually					✓	
End of life care	Annually				✓		
Annual Reports:							
Safeguarding Annual Report	Annually		✓				

Agenda Item	Frequency	Apr	Jul	Sept	Nov	Jan	Mar
MMPS Annual Report	Annually				✓		
CD Accountable Officer's Report	Annually				✓		
Medical Devices Accountable Officer's Report	Annually	✓					
Maternity service NHS Resolution scheme	Annually		✓				
2.2 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		✓			✓	
2.3 Patient Experience							
Equality and Diversity (unless it goes straight to Board)	Annually	✓					
Annual Report on Complaints and PALS	Annually		✓				
2.4 Committee Governance							
Review of Committee ToR and Work Plan	Annually						✓
Topics for further investigation from QSAG or CEOG	Bi-monthly	✓	✓	✓	✓	✓	✓

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

THE LEEDS TEACHING HOSPITALS NHS TRUST
QUALITY ASSURANCE COMMITTEE WORK PLAN 2022/23

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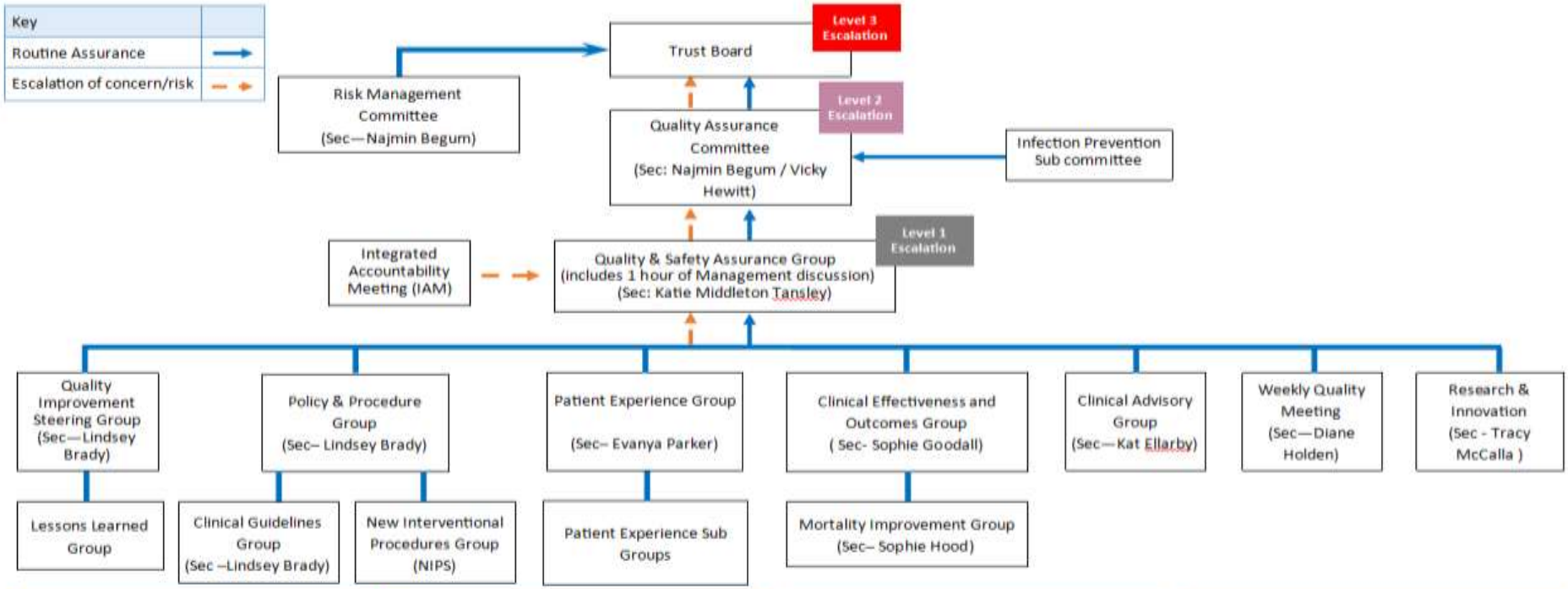
Agenda Item	Frequency	Apr	Jun	Aug	Oct	Dec	Feb
1. Quality Improvement							
Quality Goals (as part of Quality Account)	Annual update	✓					
Quality Improvement Programme (including Safety Improvement Plan)	Annually			✓			
2. Quality Governance							
CQC Registration Annual Assurance (and ad hoc reports from in-year inspections, and oversight of action plans)	Annually			✓			
Quality Account	Annually	✓					
External Audit Assurance on Quality Account	Annually		✓				
QAC Annual Report (including review of ToR, objectives, Work Plan for next Calendar year)	Annually for Board						✓
Essential Metrics	Bi-monthly	✓	✓	✓	✓	✓	✓
Leadership Walkround Programme	Annually				✓		
Quality Impact Assessments (waste reduction programme)	Annually	✓					
2.1 Patient Safety							
Mortality Review (Learning from Deaths) Report to Public Board Blue Box item	Quarterly		✓ **Q4**	✓ **Q1**	✓ **Q2**		✓ **Q3**
Maintaining Quality during Winter	Six Monthly	✓			✓		
HCAI Action Plan	Annually					✓	
Annual Report on Incidents, Coroners and Claims	Annual				✓		
Serious Incidents, including Never Events and Patient Safety Incident Response Framework (PSIRF)	Quarterly		✓ **Q4**	✓ **Q1**	✓ **Q2**		✓ **Q3**
Review of Major External Inquiries	As required						

Agenda Item	Frequency	Apr	Jun	Aug	Oct	Dec	Feb
Seven Day Services	Annually					✓	
Palliative Care and End of life	Annually				✓		
Children and Young People's report	Annually					✓	
Resuscitation report	Annually			✓			
Falls, including hip fractures	Annually	✓					
Dementia	Annually			✓			
Patient harm review (patients waiting for treatment)	Six monthly			✓			✓
Patients waiting for treatment for cancer	Six monthly		✓			✓	
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 Sign off at July Board meeting	Annually		✓				
2.2 Clinical Effectiveness & Outcomes							
Annual Clinical Audit Programme - for approval	Annually	✓					
Clinical Audit Annual Report: Including findings from Trust-wide Audits	Annually			✓			
Findings from National Audits	Annually			✓			
External Assurers Report	Six-monthly		✓			✓	
2.3 Patient Experience							
Equality and Diversity	Annually	✓					
Complaints and PALS: annual report	Annually		✓				
2.4 Committee Governance							
Review of Committee ToR and Work Plan	Annually						✓
Topics for further investigation from QSAG or CEOG	Bi-monthly	✓	✓	✓	✓	✓	✓

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



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

- C5U 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.

In response to the publication to redefine the NED Champion roles NHS England » Enhancing board oversight: a new approach to non-executive director champion roles the Committee will consider and review on behalf of the Board the following;

- *Hip fracture, falls and dementia, Learning from Deaths (noting the duty for the report be in the public domain)*
- Palliative Care & End of Life
- Safeguarding (reporting to Board)
- *Resuscitation (requiring policy sign off by QAC on behalf of the Board)*
- *Children & Young People (Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for CYP, noting oversight – likely to be Chair of QAC)*
- *Health & Safety (aspects include patient safety, employee safety and system leadership)*
- *Safety & Risk (should be integral to all Committees – demonstrating Well-led)*

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 Care1*, 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 report 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:

- Laura Stroud (Chair)
- Rachel Woodman
- Phil Corrigan

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.

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7. Version Control

Version Control	Date	Comments
V19	20 May 2021	NED membership - update
V20	30 Sept 2021	Updated NED membership
V21	27 Jan 2022	Addition to reflect scope of Cttee in response to changes in lead NED roles – at section 3.3

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

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