Agenda item: 10.1

NHS
The Leeds Teaching Hospitals
NHS Trust

PUBLIC BOARD

Quality Assurance Committee Chair's Report 3 February 2022 & Extra-Ordinary meeting 10 March 2022

31 March 2022

Presented for:	Information and assurance
Presented by:	Laura Stroud Non-Executive Director
Author:	Lucy Atkin, Head of Quality Governance
Previous Committees:	Summary of Quality Assurance Committee 3 February 2022 and 10 March 2022

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 and Outcomes	Minimal	↔ (same)
Financial Risk				

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External Risk	√	• Regulation	Averse	↔ (same)

Key Points	
To provide an overview of significant issues of interest to the Board, highlight key risks discussed, key decisions taken, and key actions agreed at Quality Assurance Committee on 3 February 2022.	For Information
To provide an overview of significant issues of interest to the Board, highlight key risks discussed, key decisions taken, and key actions agreed at of the extraordinary Quality Assurance Committee held on 10 March 2022 regarding mortality.	For information

1. INTRODUCTION

The Quality Assurance Committee (QAC) provides assurance to the Board on the effective operation of quality governance in the Trust. It does this principally through scrutiny of, and appropriate challenge to, this work. In addition, the QAC also carries out more detailed reviews of topic areas, as required. The Committee met on 3 February 2022.

2. SIGNIFICANT ISSUES OF INTEREST TO THE BOARD

Patient Story - The Committee were introduced to a patient story that had been chosen to highlight the work of the Trust's Learning Disabilities and Autism Team. The story was told by a patient who described her experience of care received as a person with Autism. The patient had been keen to share their story, recognising that she had not always had the best experience prior to the support and involvement of the Learning Disability and Autism Team.

The Committee noted the examples of personalised care evidenced within the video and recognising the difference this could make to a patient's experience. Following the patient story, the Deputy Chief Nurse updated the Committee that the Trust had been selected as one of eight Trusts to participate in a national review in the form of an Independent Voice product led by the CQC, which would support patients with Learning Disabilities and Autism receiving treatment in the acute sector and this would provide opportunity to further strengthen the Trust's service.

Terms of reference and 2022-23 workplan

The Committee's Terms of Reference (ToR) and Workplan for 2022-23 were presented for information and ratification 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 was outlined within the Committee's revised Workplan.

Nurse staffing - The Committee received a presentation on the biannual process of the Safer Nurse Establishment reviews. The presentation included an overview of the development of the Safer Staffing guidance, which was developed to encompass recommendations within the Hard Truths report (Francis, 2013) and NICE Safer Staffing guidance; a summary of the principles of Safer Staffing was set out which built upon foundations of safe staffing, evidence based tools, outcomes and professional judgement; and details of the internal and external assurance mechanisms and requirements in place were provided.

The outcome of the most recent nursing establishment review was presented, noting the agreement of additional funding in 2022/23 to increase the establishment, approved by the Trust Board in November 2021. The committee confirmed their assurance.

Quality and Safety review programme - The Committee received a summary of the Trust's the Quality and Safety Review Programme (QSRP). The QSRP had been developed with the aim of improving the quality of care for patients. The methodology was based around a standardised toolkit aligned to the five core domains used by the CQC (safe, effective, caring, responsive and well-led) and involved a three-stage process, which included a pre-visit to the area, a physical review of the area and a follow-up visit prior to drafting and validating the report. On completion of the process wards were given a rating of Red, Amber, Green or Perfect Ward. The presentation included a summary of the assessments of the 49 wards who had taken part in the QSRP to date and the process for follow-up reviews of Red and Amber wards. The Committee received the update and confirmed its assurance.

Clinical Harm Review (104ww) – The Committee received an update to provide assurance following the Clinical Harm Review of patients waiting over 104 weeks for planned elective care. 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 the impact of increased waiting times on patient experience was acknowledged by the Committee. The review highlighted the need to improve practice in the way in which some specialities conducted regular reviews of patients waiting for treatment 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.

Infection Prevention and Control - The committee received a report and an update on the Infection Prevention and Control Board Assurance Framework (IPC BAF), IPC Annual Programme and IPC related to seasonal respiratory infections during winter. An update was provided on the actions taken to ensure oversight and assurance.

The Committee noted the updated national Infection Control Guidance that had been published by the UK Health Security Agency (formerly Public Health England) and included all seasonal respiratory illness including Covid (SARS-CoV-2). The Deputy Director of Infection Prevention Control advised that the guidance was published the

same week that Omicron cases had emerged and highlighted the significant changes within the guidelines, which included the opportunity to divide services differently, however the Trust had opted to keep its current structure to keep staff and patients safe. This decision had been supported by the Clinical Advisory Group and IPC Tactical Command structure. However, now the pressures from Omicron were showing signs of stabilisation the Trust was able to review the new guidelines in detail to understand how they would support the Trust in its operational reset and roll-out.

The Committee were also advised that the national IPC BAF had been updated and new risk assessment documentation published, noting the further description within the report. All clinical areas had completed the revised risk assessment, which will be used to provide assurance to the Committee.

Patient Safety Incident Response Framework (PSIRF) – The Committee received an update on progress on the implementation of the NHS Patient Safety Incident Response Framework (PSIRF). The Trust was an early adopter for this Framework, which described the requirements for investigation, methodology and engagement of patient safety incidents. A Patient Safety Incident Response Plan for the Trust was in development, which would 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 will be managed in-line with the LTHT Patient Safety Incident Response Framework Plan (PSIRP). The Committee received the report and approved the PSRIF, noting the biannual assurance that would be provided to this Committee through the serious incident report

Serious Incidents and Never Events report - The Committee received a summary of Serious Incident reporting themes and trends during Q3 2021/22. It was noted that two Never Events has been reported in this period, both of which had been discussed at the WYAAT shared learning group. The Committee reflected on the human factors impact on Never Events, recognising that there had been recurring incidents where staff had deviated from defined checklists. The Trust has recognised the significant impact human factors could cause and reflected on the fatigue of staff from the ongoing operational pressures, therefore a Human Factors lead has been appointed within the Trust who would be reviewing priority areas for action.

Mortality Improvement - In addition to the Q2 Learning from Deaths Report, the Committee received a detailed overview of the SHMI publication for December 2021, which showed an elevated SHMI to 1.1114. This data covered the period of 12 months as a rolling average to end of July 2021. Following initial investigations, it was anticipated the SHMI would increase further. The January 2022 SHMI had been published and had increased to 1.1227. This was a 12-month rolling average up to the end of August 2021.

In response to this increase a coding and individual patient case record review was underway with July 2021 being a key point of focus (due to the 12-month rolling average and impact of the coronavirus pandemic). The Committee convened an Extra-Ordinary QAC meeting on 10 March 2022 where the results of this review would be reported in full.

Routine Reports - The Committee also received routine reports, including the Essential Metrics, Learning from Deaths Report Q2 2021/22, Serious Incident Report Q2 (2021/22), and Infection, Prevention & Control, .

Extraordinary Mortality Focused Quality Assurance Committee – 10 March 2022

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 'spike' 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 therefore chosen for closer analysis. The chair of the Mortality Improvement Group (Associate Medical Director) undertook a case-by case review of all deaths of patients in the three diagnostic categories of concern in July 2021. The review suggested no 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 continue to receive regular assurance through the Learning from Deaths report.

3. KEY RISKS DISCUSSED

The Committee discussed the risks associated with the number of patients waiting more than 104 weeks for planned (elective) treatment. The actions taken to mitigate risks regarding harm for those patients who had been waiting for treatment were discussed and current challenges and mitigations were being shared with the CQC engagement lead.

The Committee discussed the potential risk associated with the rising SHMI data. Assurance was provided through the Learning from Deaths report and by the Chair of the Mortality Improvement Group at the Extra-ordinary meeting 10 March 2022. There had been no change in clinical practice and that quality of care was good overall. The Committee will continue to receive regular assurance through the Learning from Deaths report.

4. AGREED KEY ACTIONS

It was agreed that the Committee would continue to seek assurance on the impact of waiting for planned surgery/elective care on patient safety. The next assurance report will be received in July 2022.

It was agreed that an update on the national review in the form of an Independent Voice product led by the CQC, which would support patients with Learning Disabilities and Autism receiving treatment in the acute sector would be provided at the meeting in April 2022.

It was agreed that item 5.3 Infection Prevention and Control Annual Programme and Board Assurance Framework and item 5.8 Q2 Learning from Deaths report will accompany this report as Blue Box items.

Commented [LA1]: To include

5. FUTURE BUSINESS

The next meeting of the Quality Assurance Committee will be 28 April 2022.

6. RECOMMENDATION

Trust Board is asked to note the Quality Assurance Committee Chair's report and receive assurance on the items discussed at the Committee on 3 February 2022 and Extra-Ordinary meeting 10 March 2022 that have been summarised in this report.

Laura Stroud

Non-Executive Director and Chair of Quality Assurance Committee

March 2022