NHS
The Leeds Teaching Hospitals
NHS Trust

# Quality Assurance Committee Chair's Report 26 October 2023

## PUBLIC BOARD

### 30 November 2023

| | |
|---|---|
| **Presented for:** | Information |
| **Presented by:** | Phil Corrigan, Non-Executive Director |
| **Author:** | Lucy Atkin, Head of Quality Governance |
| **Previous Committees:** | Summary of Quality Assurance Committee 26 October 2023 |

| **Our Annual Commitments for 2023/24 are:** | |
|---|---|
| Effectively develop and deploy new assets (buildings, equipment, IT) | |
| Reduce healthcare associated infections | ✓ |
| Improve staff retention | |
| Deliver the financial plan | |
| Reduce average length of stay by 0.5 days per patient | |
| Achieve the Access Targets for Patients | |
| Support a culture of research | ✓ |

| **Risk Appetite Framework** | | | | |
|---|---|---|---|---|
| **Level 1 Risk** | (✓) | **Level 2 Risks** | **(Risk Appetite Scale)** | **Impact** |
| 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 | Moving Towards |
| 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 | Moving Towards |

| **Key points** | |
|---|---|
| 1. 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 26 October 2023. | For Information |

## 1. Summary

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, QAC also carries out more detailed reviews of topic areas, as required. The Committee met on 26 October 2023 on MS Teams.

## 2. SIGNIFICANT ISSUES OF INTEREST TO THE BOARD

**Patient Story** – The Committee were introduced to the Patient Story, which provided information to members on the benefits of laser therapy for amputees and the importance of signposting trust services. **https://youtu.be/UFwDaUQp-9g**

Lisa had had an accident on an assault course and developed complex regional pain syndrome (CRPS), which led to an above knee amputation. She had a prosthetic limb fitted and described the skin irritation issues, which were impacting on her quality of life. Through speaking to another amputee, he was able to signpost her to laser therapy, which was delivered through LTHT. She shared the difference this treatment had made to her daily life, including increased self-confidence and being able to wear her prosthetic limb for longer periods of time supporting her independence.

Jackie Murphy advised members of the work undertaken with this team to review the patient journey and to improve signposting and referral criteria for patients who could benefit from this treatment. Members discussed the positive impact of this story of personalised care and reflected on the Leeds Way approach, which displayed how small changes could have a significant impact on a patient journey.

**Leadership Visit Programme –** The Committee received a summary of the Leadership Walkround programme for the period April 2022 to March 2023 and the themes emerging from this.

Members were advised of the context to the Leadership Visit programme and reminded that this had been the final year in continuing the virtual visits that had been introduced during the Covid pandemic. From April 2023 the visits had returned to in person. Key themes raised during these visits were highlighted, which included staff health and wellbeing, ongoing operational pressure/patient safety, staffing, learning and patient experience.

Members discussed the purpose of the visits, which were distributed evenly across CSUs and locations, to enable the Board to have broad oversight, and provide opportunity for all CSUs to engage with the Board through this process, in line with the annual programme. The specific area to visit would continue to be arranged by the member of the corporate nursing/quality team allocated to the visit, taking into account local intelligence and response to patient safety issues, including risks and quality improvements. A programme of assurance visits was in place to respond to specific concerns raised about patient safety

and quality, which was informed by metrics and routes of escalation to Executive Directors, co-ordinated by the corporate nursing team.

The Committee received and noted the report; and it was agreed that a copy of the report would be shared with the Board via the Blue Box for information.

**Maternity Services assurance report** – The Committee received a report to provide assurance regarding risk management, safety and quality in the maternity service.

The Committee received key points of note and learning in regard to incidents and investigations. Members were informed regarding the Maternity Incentive Scheme (MIS) that whilst there remained some challenges, the service remained on track to meet the trajectories and achieve full compliance, noting the further narrative within the report.

The Committee were advised that the assurance visit led by the West Yorkshire and Harrogate, Local Maternity and Neonatal System was scheduled for 1 November 2023. Progress with the initial 7 Immediate and Essential Actions (IEA's) identified in the interim Ockenden report would be evaluated, however the assurance visit would incorporate the wider quality and safety strategy for perinatal services. The Trust was found to be fully compliant with all the 7 IEA's and this visit was to ensure the actions were being embedded.

Members commended the detail within the comprehensive report, and the detail it provided on the monitoring and managing processes of risk.

The Committee received the report and confirmed the assurance it had received.

**Patient Harm Review –** The Committee received assurance that patients on the waiting lists were being clinically and administratively validated and reviewed on a regular basis and considered the recommendation that changes were made to the process of reviewing P2-coded patients to a standardised four-weekly validation across the specialties and compliance reviewed through the Access and Quality Governance meetings.

Members discussed findings included within the report, and also noted the percentage of patients currently waiting more than the required time for treatment as designated by their P-code and discussed CSU/speciality validation processes.

The Committee agreed that due to the nature of some specialities, patients within their waiting lists were at greater risk of harm. Therefore, a risk-based approach was recommended with attention on pathways where increased delay could lead to greater harm or deterioration.

The Committee received the report and confirmed its support to the changes to the assurance process for CSUs.

**Patients waiting for cancer treatment –** The Committee received an assurance report on the Cancer Waiting Time (CWT) position and the challenges for 2023/24 in improving timeliness of care and treatment. In addition, the report updated on changes to the national CWT Monitoring Dataset Guidance implemented on 1 October 2023 and identified the potential impact on CWT performance as a result of these changes.

The Committee discussed the Trust performance against the CWT in particular achievement against the main CWT standards (linked with 2 week wait GP referrals), which had remained steady or improved until July of this year. This was linked to the impact of Industrial Action, a deterioration in the skin pathway performance and a deterioration in 2 week wait performance in August 2023, which had been due to an increase in the tele-dermatology triage in the skin pathway, which had impacted the 62 day backlog due to patients waiting for a first appointment in the skin service. This position was recovering in September and all other CSU backlogs remained stable.

Members discussed the 104-day position, which had increased, however remained lower than at the start of 2023; on average, circa 25% of patients waiting over 62 and 104 days were from external referrals into the Trust and in many instances were referred late in the 62 day pathway. Action was being taken across the region to address this and improve timely inter-provider transfers. The paper proposed a policy for the review of harm to patients awaiting treatment, which would be discussed at the next Cancer Board meeting.

The Committee agreed it would continue to monitor patient harm as a result of patients awaiting treatment and that the challenges related to waiting times would continue to be reported to Finance and Performance Committee.

**Infection, Prevention and Control Update –** The report provided an update on progress against the 'Reduce Healthcare Associated Infections (HCAI)' annual commitment. The report evaluated the effectiveness of the existing HCAI performance and advised on further actions outside the current HCAI annual programme and IPC Board Assurance Framework (BAF).

The Committee received an overview of performance against mandatory reportable infections and ongoing incidents. The Trust continued to be above trajectory for five of the six mandatory reportable infections for 2023/24.

Members were advised that to support the annual commitment to reduce HCAI's all CSU's had been asked to focus on three key areas: IPC standards, antimicrobial stewardship and, procedure and invasive device management. In October 2023 the 'Essentials of IPC' toolkit was updated to move the campaign to a patient focus with individual guidelines on a page and patient stories.

The Committee were advised of the infection outbreaks that had occurred over the reporting period and mitigating actions taken, noting the further detail within the report; there had been one outbreak of Serratia marcescens within the neonatal unit, four cases of Pseudomonas aeruginosa infection in paediatric oncology at LGI and outbreaks of CPE-KPC Klebsiella oxytoca within the SIM CSU.

The Committee received the report and noted the progress made to date.

**Patient Safety Incidents and Never Events Report –** The Committee received an assurance report on patient safety incident reporting themes and trends and the incidents reported against the Patient Safety Incident Response Framework (PSIRF) between the period 1 August to 30 September 2023.

Members received and reviewed the report noting the summary of the lessons learned and improvement actions from the PSIRF completed investigations and the dissemination of

learning across CSU's; the value of the WYAAT Shared Learning Network Meeting and the external source of assurance it provided and commended as good practice.

The Committee received the report and confirmed their assurance of the progress of the PSIRF, and the actions taken to mitigate risks and share learning.

**Learning from Deaths report quarter 1 2023/24 -** The Committee received the quarter 1 report, which sought to provide assurance that the Trust had appropriate processes in place to report on and review patient deaths and ensure that lessons were being learned and improvements identified.

Members discussed the Summary Hospital-level Mortality Indicator (SHMI) published in August 2023 for April 2022 - March 2023 was 1.1268 (decrease from 1.304 in July 2023). The Hospital Standardised Mortality Ratios (HSMR) for June 2022 – May 2023 was 112.5 (an increase from 111.8). Both indices remained above the expected range and would continue to be monitored by the Mortality Improvement Group (MIG).

The Committee received the report and confirmed its assurance on the processes in place to report on and review patient deaths. It was noted that a copy of the report would be provided to the Board via the Blue Box.

**Annual Report on Incidents, Coroners and Claims –** The Committee received the annual report on Incidents, Coroners and Claims.

The Committee received a presentation of key points from the report and noted 35,167 patient safety incidents were reported in 2022/23 representing a 13% increase when compared with 2021/22; pressure ulcers, tissue damage and unwitnessed falls were the most commonly reported patient safety incidents; 76% of reported patient incidents resulted in no harm in 2022/23 compared with 79% in 2021/22. There were notable increases in incidents resulting in moderate harm; severe harm and death. A significant proportion of incidents resulting in harm were linked to falls and healthcare associated infection.

The Trust received one Regulation 28 Prevention of Future Deaths Report following Coroner's Inquests, a reduction of one on 2021/22; there was a 1.3% increase in clinical negligence claims reported to NHS Resolution when compared with 2021/22 (nationally there was a 3.3% rise) and a 4.5% reduction in personal injury claims reported (nationally there was a 2% rise).

Members received a detailed breakdown of incidents reported meeting Duty of Candour (DoC) requirements (3,037) of these 98% received a verbal apology, 82% first DoC letter and 81% second DoC letter. Further detail is provided within Appendix 1.

The Committee received and noted the report; it was confirmed that the Duty of Candour statement would also be reported to the Board via the QAC Chairs report (Appendix 1).

**Industrial Action Report –** The Committee received an assurance report regarding the impact on patient treatment, safety, and experience during periods of industrial action. The report summarised a detailed review of incidents, elective and outpatient cancellations, readmissions and complaints and PALs.

Members were advised that readmission, complaints, and PALs would continue to be routinely monitored to ascertain if any statistically significant deteriorating trends in variation occured in future months. The risk team would continue to review incidents categorised as moderate harm and above at the weekly risk management review meeting, significant patient safety incidents would be escalated and discussed with the Chief Medical Officer and Interim Chief Nurse at the Weekly Quality Review meeting.

The Committee noted the assurance provided within the report and noted the ongoing monitoring via the weekly risk meeting.

**Nursing & Midwifery Quality & Safe Staffing Workforce Report** – The Committee received the Nursing and Midwifery Quality and Safer Staffing report (NMQSSR), which triangulated key quality and staffing information for the period July and August 2023.

The Committee were advised of the process to review wards that fell below 80% with regards to achieving its planned nursing numbers by shift. A number of quality metrics were reviewed to see if patient care and outcomes has been affected due to the planned establishment not being fully met. Where concerns were identified as part of the Ward Health Check programme a ward would enter into an escalation stage and be subject to further support and multidisciplinary discussion and input.

Members discussed key points of the report in particular the action taken to mitigate red shifts and red flags and reviewed the hard truths data. In August 2023 the financial ledger showed that the Trust had a registered nursing, midwifery, and operating department practitioner vacancy of 538 WTE. The current Registered Nursing turnover rate was 6.19%. Recruitment to vacant posts remained a priority.

The Committee received the report, noted the quality and staffing information for July and August 2023 and confirmed its assurance of the daily processes to monitor and manage nurse staffing levels at ward level through the SafeCare system and Red Flag escalation process.

**Maintaining Quality during Winter –** The Committee received a report, which described the controls and processes in place for monitoring quality and safety during the winter period. Members discussed the winter planning stages, modelled scenarios and potential risks for this winter. The current ward configuration, Trust modelling and mitigation was also described.

The Committee received the update and confirmed it had received sufficient assurance on the controls in place for monitoring quality during the winter and noting the additional updates that had also been provided to the Finance and Performance Committee and Trust Board.

**Quality Improvement Programme Update -** The Committee were presented with a high-level overview of activity related to the Trust Quality Improvement strategy.

An overview of the seven goals and ambitions within the Trusts Quality Improvement Strategy to continually improve quality of care and services was provided followed by a deep dive into each goal to share the in-year progress and ambitions for next steps. Within the update the triangulation of the seven goals against creating a supportive culture were noted and to provide focus on the areas that made the greatest difference.

The Committee received and noted the update.

**Routine Reports -** The Committee also received routine reports, including the Essential Metrics.

**Annual reports** – The Committee received annual reports for assurance, including the Clinical Audit Annual Review, Leadership Visit Programme and Annual Report on Incidents, Coroners and Claims.

## 3. Financial Implications

There are no financial implications detailed within this report.

## 4. Risk

The Quality Assurance Committee provides assurance oversight of the Trust's Patient Safety and Outcomes risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

## 5. Communication and Involvement

This report will be available to members of the public, patients and staff through publication of the Board papers.

## 6. Equality Analysis

Not applicable

## 7. Publication Under Freedom of Information Act

This report has been made available under the Freedom of Information Act 2000

## 8. 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 26 October 2023 that have been summarised in this report.

## 9. Supporting Information

The following papers make up this report:

- Appendix 1 Duty of Candour extract from the Annual Integrated Incidents, Inquests and Claims Report
- 12.1 (ii) Learning from Deaths report quarter 1 2023/24
- 12.1 (iii) Leadership Walkrounds Annual Report 2022/23

**Phil Corrigan**
**Non-Executive Director and Chair of Quality Assurance Committee**
**October 2023**

**Appendix 1 Duty of Candour extract from the Annual Integrated Incidents, Inquests and Claims Report**

## 1.13 Duty of Candour

This section provides information on the application of the Duty of Candour Regulations into incident management processes at Leeds Teaching Hospitals NHS Trust (LTHT) and CSU compliance with these for 2022/23.

## 1.14 Procedural Framework at LTHT

The statutory Duty of Candour requirements are described in the LTHT *Being Open (Duty of Candour) Procedure 2020*. There are also references to the Duty of Candour requirements in the following LTHT Risk Management procedures:

- *LTHT Patient Safety Incident response Plan (PSIRP) 2022*
- *Incident Reporting Procedure 2023*
- *Investigation of Incidents and Complaints Procedure 2023*

## 1.15 Reporting

Patient safety incidents are reported on the Trust's incident reporting system (Datix). If the reporter selects a harm level where the regulatory Duty of Candour applies (moderate harm, severe harm, or death), the system prompts the reporter with a message to follow the Duty of Candour process. The reporter is also provided with a field to document that an apology has been provided to the patient and/or family and a field to record the acceptable exceptions where these may apply in-line with the regulations.

Once the incident has been submitted it is sent to a senior member of the specialty team/CSU to review. The reviewer of the incident is responsible for ensuring that Duty of Candour regulations have been applied where appropriate. In response to CSU user requests further updates have been made in-year to the Duty of Candour fields in Datix to provide CSUs with more detailed data on incidents that meet the threshold for the regulatory Duty of Candour.

## 1.16 Monitoring

The CSUs are responsible for ensuring that all relevant notifiable patient safety incidents have had the regulatory Duty of Candour correctly applied. Duty of Candour is included in the CSU Quality Assurance guidance and is also included in the standard agenda (template) for CSU and specialty governance meetings. To support CSUs in monitoring compliance, a Duty of Candour dashboard is included in Datix for each CSU to access and monitor all their relevant incidents to ensure compliance with the regulatory requirements. The Patient Safety and Quality Managers attend CSU governance forums to provide support and advice, including compliance with the Duty of Candour process. Additional support and advice is provided by the Trust Risk Management team.

## 1.17 Assurance (Internal)

The Duty of Candour dashboard on Datix is used to support CSU quality framework (performance) meetings, providing senior corporate oversight of compliance with the Duty of Candour process. All new Duty of Candour applicable incidents (categorised as moderate harm, or above) are reviewed weekly as a standing agenda item at the Risk

Management team meeting, led by the Medical Director (Governance and Risk) and Director of Quality, providing advice to CSUs to ensure Duty of Candour has been considered and applied correctly.

Duty of Candour compliance is included in the Quality Framework Review dataset, focusing on a review of the governance processes, including recording first and second Duty of Candour letters on Datix, for assurance.

Updates have been made this year to the CSU Duty of Candour Datix dashboards to provide CSUs with more detailed data on incidents that meet the threshold for the regulatory Duty of Candour and support exemption validation of data for the Quality Framework Review process.

### 1.18 Assurance (External)

Duty of Candour is subject to external scrutiny from Internal Audit, External Audit and the Care Quality Commission (CQC). The last Internal Audit of the Trust's Duty of Candour process reported in Quarter 4 2020/21. Recommendations were made relating to the training and learning materials available for staff regarding discharging Duty of Candour in accordance with regulations. Duty of Candour was not on the LTHT audit plan for 2022/23

The internal audit team (PWC) have introduced CSU compliance audits to the annual audit cycle, which includes a review of Duty of Candour compliance through a sample of incident investigation reports.

External Audit select a sample of Duty of Candour applicable incidents as part of their review of the incident data supplied for the Trust's Quality Account. The Trust is required to provide evidence that the Duty of Candour process has been completed for this sample of incidents.

As part of the CQC regulatory inspection process a sample of Duty of Candour applicable incidents is provided to demonstrate compliance with the Duty of Candour requirements. Information is also provided to the CQC relationship manager in response to enquiries that are received by the CQC, and monitored through the monthly engagement meeting, for assurance.

### 1.19 Training and Communication

Duty of Candour training is not currently a mandatory or priority training topic for the organisation. The LTHT Duty of Candour learning tool has been refreshed and is available for staff to refer to on the intranet, which includes relevant clinical examples of when to apply the Duty of Candour.

Duty of Candour is referenced in the induction training for all new members of staff joining the organisation. It is also covered during the Incident Investigation Skills training programme and ad-hoc Datix training provided to individuals or groups. The Risk Management intranet site has a range of resources dedicated to Duty of Candour, including template letters to support clinical teams and a learning tool with clinical examples to guide staff in practice. Advice is provided to clinical teams by Risk Management, including from Associate Medical Directors, to support staff in the implementation of the Regulations. A Duty of Candour masterclass was provided for senior leaders by the Medical Director (Governance and Risk) and Director of Quality, they have

also attended specialty governance meetings by invitation to discuss applying this in practice.

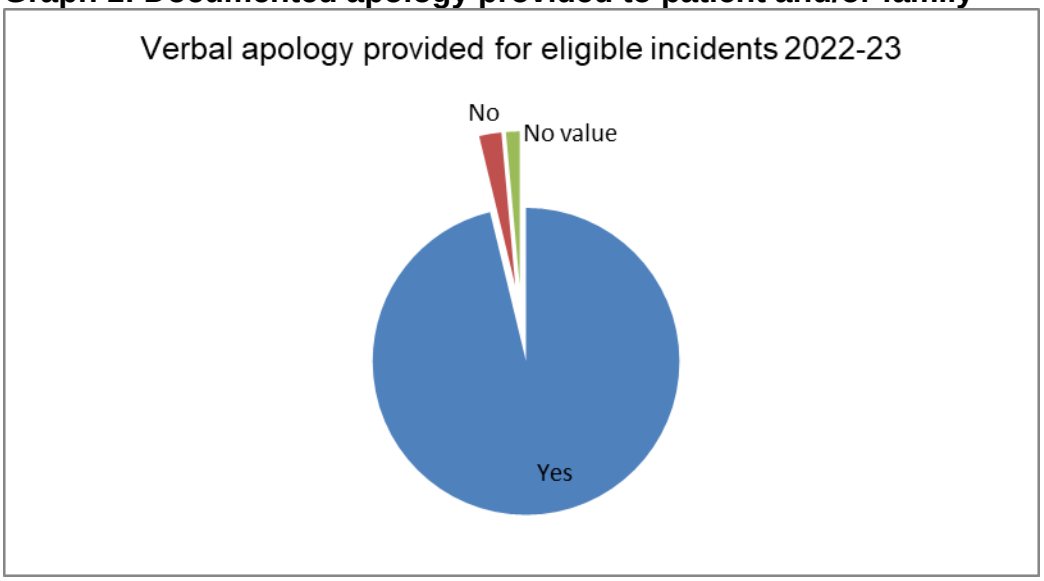
A Quality & Safety Matters Bulletin focusing on the requirements of the Duty of Candour Regulations has been circulated to all staff via the Chief Nurse e-mail on five separate occasions to summarise the requirements and highlight the actions staff are required to take. A further circulation is timetabled for 2023/34. A monthly forum with CSU governance leads is in place to support them in implementing the quality governance and assurance framework, including providing advice regarding Duty of Candour and sharing good practice to support improvements in compliance.

### 1.20 Compliance

Patient Safety Incident reporting continues to increase each quarter. 35,167 patient safety incidents were reported via the LTHT Datix incident reporting system in 2022/23. **3,047** (8.6%) of the incidents reported met the requirement for Duty of Candour due to a recorded severity of moderate harm, or above. This is 1,727 more incidents than the previous year that met the threshold for Duty of Candour regulations

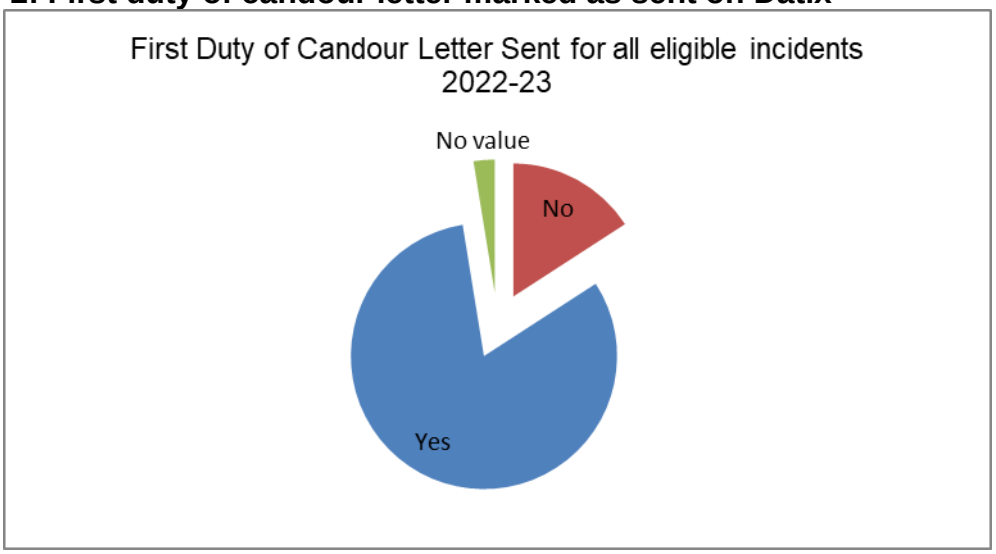
Graph 1 demonstrates that 98% of eligible records had a verbal apology recorded. 71 records (2%) were recorded as “no apology”. These figures a similar to last year. Of the 71 incident records, 57 included a documented rationale for why it had not been possible to provide a verbal apology. This is a 29.5% increase from the previous year. 44 records did not contain data. This is a recognised issue in Datix and occurs when the severity is increased by the reviewer after the incident has been entered with a no harm or low harm severity level.

**Graph 1: Documented apology provided to patient and/or family**




Graph 2 demonstrates that 2,486 records (82%) had evidence on the Datix record that the first Duty of Candour letter had been sent. 483 (16%) records stated that the letter had not been sent. 477 of these had an approved rationale provided. There were 78 records (3%) where the record had not been completed to demonstrate the first duty of candour letter had been sent. These figures are similar to last year but noting the increase in Patient Safety Incidents meeting the threshold for Duty of Candour this year.

**Graph 2: First duty of candour letter marked as sent on Datix**

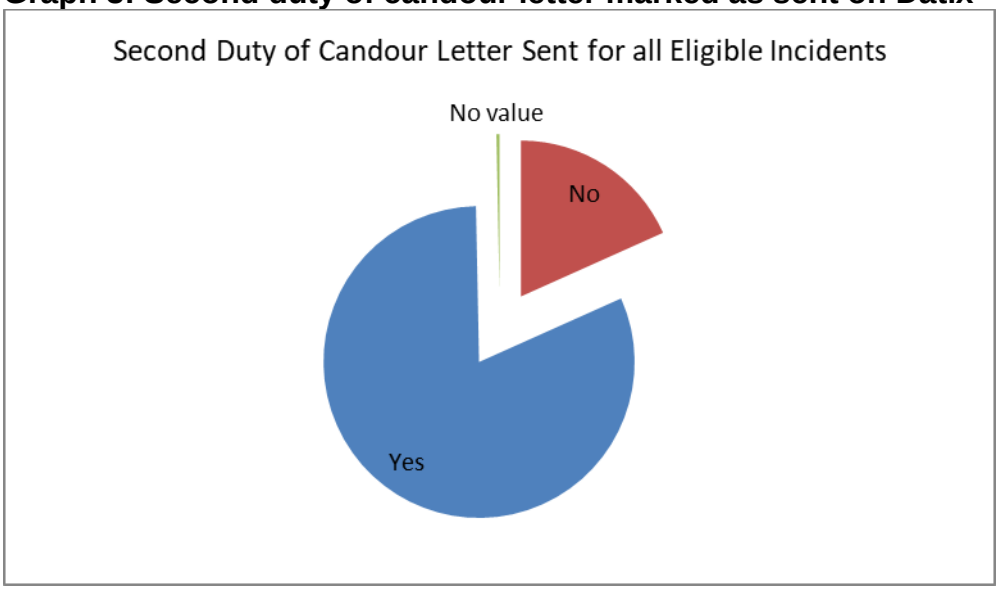



2,851 records where Duty of Candour applies have been marked as closed following completion of the patient safety review. At this stage the second Duty of Candour letter should be sent explaining to the patient or family the findings of the review and offering a further apology for the harm caused.

Graph 3 demonstrates that 2,320 records (81%) reflect that the patient/family has been sent a second Duty of Candour letter following completion of the Patient Safety Review. Of the 522 records marked to state that a second duty of candour letter had not been sent, 518 had a documented rationale.

There were 9 records where the field demonstrating the second letter had been sent was left blank.

**Graph 3: Second duty of candour letter marked as sent on Datix**




**1.21 Action to Improve Evidence of Compliance**

Additional fields have been added to the Datix record to allow the recording of how the initial verbal apology has been delivered, ie by telephone or in person, coding for why apology not provided and also dates that the letters have been sent.

Renewed Duty of Candour dashboards are in place and being used by the Quality Framework Review process to validate any exemptions entered for incidents that meet the threshold for Duty of Candour.