NHS
North East and
North Cumbria

Item: 9.2.2

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD 28 NOVEMBER 2023	
Report Title:	Approved minutes from the Quality and Safety Committee – meetings held on 20 July and 14 September 2023.

Purpose of report

To provide the Board with an overview of the discussions at the meeting of the Quality and Safety Committees held in July and September 2023, including the approved minutes for assurance.

Key points

The confirmed minutes from the meetings of the Quality and Safety Committee held on the 20 July and 14 September 2023 are attached at Appendix 1 and 2.

20 July 2023
At the meeting the Committee considered several issues and supporting papers including:

Area quality exception reports/key risks, issues and assurances Cumbria, North, Central and Tees
The report outlined the current risks and issues within each of the four geographical areas within the ICB. Updates included performance of local foundation trusts and incidents reported; SEND inspections; Care Quality Commission visits/inspections and safeguarding.

Maternity update
The Committee received an overview of key areas of ongoing workstreams within maternity which provided updates on key areas of risk. The Committee noted the process for monitoring and assuring Clinical Negligence Scheme for Trusts (CNST) Year 5 compliance.

Infection, prevention and control update
The report provided an update of the current infection prevention and control position of local trusts against nationally set thresholds. The outcome of a deep dive event into the Clostridium Difficile infection rates across the ICB was also discussed, with a progress report to come back to a future meeting.

LeDeR Annual Report
The Learning from Lives and Deaths (LeDeR) of people with a learning disability and autistic people annual report is a statutory requirement that provides assurance on delivery of LeDeR including numbers of reviews, causes of death and learning/improvement action undertaken across the North East and North Cumbria (NENC).

This was the first ICB LeDeR report, the national report was expected in September 2023. The Committee noted that the report gave the position of completed reviews and not the number of deaths.

Patient involvement and experience
The report provided an update on how the ICB was involving people in conversations around health services at community, place, area and ICB-wide levels. The report provided a high-level summary of key activities currently taking place across the NENC region to actively support the implementation of the ICB's strategy and provide assurance on the ICB's commitment to listening to patient experience and voice.

The Committee was also provided with an update on the formation of the Patient Voice Subcommittee.

Maternity Patient Voices
The report provided an overview of the current processes to engage maternity patient voices in co-production across the ICB's Local Maternity and Neonatal System (LMNS) and Maternity Clinical Network.

NICE guidelines, ICB test beds for implementation
The Committee was informed that the last audit of the technology appraisals showed the ICB as non-compliant in 26 out of 46 areas of the published guidance. This would be re-audited once more detailed work had been completed and the outcome brought back to a future meeting.

North East Quality Observatory Service (NEQOS) Hospital Monitoring Report
The Committee received a presentation of the latest quarterly mortality information based on the NEQOS quarterly mortality report. The NEQOS quarterly mortality report provided further detail and interpretation alongside supporting text and key mortality updates which gave greater insight into mortality both for individual trusts and across the wider system.

Special Education Needs and Disability (SEND) Assurance Sub Committee
The paper proposed the development of a Special Education Needs and Disability (SEND) Assurance Sub Committee to support quality improvements across the SEND agenda and deliver assurance regarding compliance with statutory duties. Permission was sought to establishment of this sub-committee to which the Committee agreed.

Clinical Effectiveness Subcommittee proposal
The report outlined a proposal to strengthen governance in relation to the ICB clinical effectiveness agenda. This would ensure links with existing forums and stakeholders and maximising opportunities to seek assurance, using data to understand and improve practice and review compliance with national quality standards.

The proposal was for a clinical effectiveness advisory group that would report into the Committee, providing a summary report of current data and information. The functions of the Group would be NICE compliance; assessing impact and outcomes of proposed changes to commissioned pathways; developing a system wide audit plan and overseeing its delivery and using data insight to provide assurance to Committee. The Committee agreed to the development of a Clinical Effectiveness Advisory Group and noted terms of reference would be developed.

All Ages Continuing Healthcare (CHC) and Transformation Plan
A transformation programme for all age continuing care was to be developed including adult NHS continuing healthcare, NHS-funded nursing care, children and young people's continuing care and S117 mental health and learning disabilities care packages to deliver compliance with statutory duties without unwarranted variation.

North East Ambulance Service (NEAS) Independent enquiry
The Committee received a copy of the Department of Health and Social Care's commissioned report into NEAS which looked at four specific cases, along with a review of governance and HR processes within the organisation. The ICB had been asked to provide an assurance statement which had been delivered.

14 September 2023
The Committee considered several issues and supporting papers including:

Patient Story
The Committee welcomed a storyteller to the meeting who had agreed to discuss their own journey through the health system and the difficulties they had faced when receiving treatment for their mental

health conditions. The patient story detailed the journey from first presentation of symptoms to treatment throughout the entire health system.

Area quality exception reports/key risks, issues and assurances
The report outlined overarching themes structured as per the strategic aims of the National Patient Safety Strategy, i.e., by insight, involvement and improvement. Pressures were noted in continuing healthcare due to staff vacancies and sickness/absence. Support had been offered from across the system to assist with these issues.

Safeguarding continued to carry vacancies and work was ongoing to arrange cover between various geographies within the ICB to fill any gaps as effectively as possible. The teams were also looking at a more robust approach to recruitment.

Learning from Lives and Deaths (LeDeR) reviews continued to be an area of pressure within the ICB with an increasing number of reviews being required. A new workforce model was being developed to improve timeliness of reviews and to share the learning across the ICB area.

Maternity Report
The report provided a triangulation of quality data, information from trusts' self-declared position, and information following assurance visits by the Local Maternity and Neonatal System (LMNS) quality leads. A themes and risks overview was highlighted, noting where trusts were compliant. One trust was highlighted an outlier in relation to postpartum haemorrhage. This was being audited by the LMNS quality group to further explore the issues identified.

Immediate actions from Lucy Letby
The Committee received an overview of the immediate actions implemented following the Lucy Letby verdict. A letter had been sent to all providers from the key leaders in the NHS in response to the Lucy Letby verdict and findings. In response the ICB had carried out a detailed review of the data from all eight neonatal units within the region.

Medicines Optimisation Annual Report
The first medicines optimisation quality and safety annual report was presented to the Committee. There was a new medicines governance structure in place, with a single process for prescribing and formulary, which would make a significant improvement to access.

Excess Mortality report
The Committee received an overview of excess mortality in the population and the various measures currently in use in the UK, along with possible causes. The report would be produced on a quarterly basis going forward and based on summary hospital led mortality indicator (SHIMI) data from NHS England. It was noted that excess mortality had returned to near normal.

County Durham and Darlington Foundation Trust (CDDFT) was noted as an outlier from the SHIMI data as it was fractionally above the upper control limit. Northumbria Healthcare NHS Foundation Trust (NHFT) was inside the lower control limit and Gateshead Hospitals NHS Foundation Trust (GHFT) was below it.

Pharmacy, Optometry and Dental (POD) update
The report provided an update on ICB delegated responsibility from NHS England for the commissioning of pharmacy, optometry, and dentistry services as of 1 July 2023. An established system was in place to manage the quality of these services, along with identifying any risks associated with this.

Risks and issues

The Committee continues to receive and review the corporate risks aligned to the quality and safety portfolio to provide assurance to the Board that the quality and safety risks contained within the corporate risk register reflect the current environment.
The risk report received at the 20 July meeting noted that three risks had reduced in score relating to risks concerning patient and public involvement; respiratory infections; and ambulance handover delays.
The risk report received at the 14 September identified three new risks in the reporting period:

- Learning from Lives and Deaths (LeDeR) reviews
- British Pregnancy Advisory Service (BPAS) termination of pregnancy pathways
- Primary care quality reporting

Assurances
The clinical quality exception report and other supporting reports provide the Committee with a range of data and assurance sources.

Recommendation/action required
The Board is asked to receive the approved minutes from the Quality and Safety Committee meetings held on the 20 July and 14 September 2023 for assurance.

Acronyms and abbreviations explained
As described in the minutes.

Sponsor/approving executive director	Eileen Kaner, Chair of the Quality and Safety Committee and Non-Exec Director Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Date approved by executive director	16 November 2023
Report author	Neil Hawkins, Head of Corporate Affairs

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None at this stage.
Has there been/does there need to be appropriate clinical involvement?	Appropriate clinical representation within the membership of the Committee. Terms of reference to include representation from Nursing Directors and Medical Directors.
Has there been/does there need to be any patient and public involvement?	N/A.
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A.