Public Trust Board paper H

Meeting title:	Public Trust Board					
Date of the meeting:	10 August 2023					
Title:	**Escalation Report from the Quality Committee (QC): 27 July 2023**					
Report presented by:	Vicky Bailey, QC Non-Executive Director Chair					
Report written by:	Alison Moss, Corporate and Committee Services Officer					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes. BAF risk within the remit of QC is listed below:

BAF Ref	Risk Cause	Risk Event
01-QC	Lack of Quality Governance and Assurance framework	Failure to maintain and improve patient safety, clinical effectiveness, and patient experience

Impact assessment
N/A
Acronyms used: MBRRACE-UK - Mothers and Babies Reducing Risk through Audits and Confidential Enquiries through the UK NICE - National Institute for Health and Care Excellence CQC – Care Quality Commission VTE – Venous Thromboembolism C-diff - Clostridium difficile BAF – Board Assurance Framework HAPU - Hospital Acquired Pressure Ulcers SI – Serious Incidents IP – Infection Prevention UKHSA United Kingdom Health Security Agency CMGs – Clinical Management Groups PRMs – Performance Review Meetings PSIRF - Patient Safety Incident Response Framework ACPs – Advanced Clinical Practitioners

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Quality Committee, and escalate any issues as required.

2. Summary

Quality Committee met on 27 July 2023 and was quorate. It considered the following items, and the discussion is summarised below:

3. Discussion items:

3.1 Perinatal Mortality: MBRRACE Summary Report *(mitigating BAF risk 1)*

The Committee received an update on actions that have taken place since publication of the MBRRACE-UK perinatal mortality report (2021 births) released in May 2023 where it was identified that UHL's perinatal mortality was 5% greater than the average for our peer group. The accompanying report provided details and assurance of the steps that had been taken both internally and externally to understand the data, validate our Perinatal Mortality Review governance processes and use of the Perinatal Mortality Review Tool, review care bundles and to enhance services. Alongside this, work has started with Public Health colleagues to review potential modifiable factors in the wider determinants of health and to better understand factors contributing to inequalities in outcomes.

The Committee noted that whilst the data risk adjusts for congenital abnormalities, the Trust had a more complex case mix linked to its tertiary services, particularly for cardiac conditions that were not fully risk adjusted for by MBRRACE methodology. Whilst this could account for the Trust's position, it was agreed there was still a need for internal and peer review to understand the picture and consider other actions. It was also noted that the Trust served an ethnically diverse population, and that deprivation and ethnicity were key determinants of health. As such, the approach of seeking to learn more and work with Public Health was supported whilst ensuring ongoing quarterly peer review of use of the Perinatal Mortality Review Tool and further internal validation of use of care bundles.

The Committee highlighted the report to the Trust Board for information.

3.2 Compliance to NICE Guidance *(mitigating BAF risk 1)*

The Committee considered the Trust's compliance with NICE guidelines. Of the 181 NICE Guidance documents published or updated in 2022/23, 175 were applicable to UHL. The Trust was compliant with 97% of the Guidelines. The areas of non-compliance were set out in the report. It was noted where NICE Guidance had informed the Clinical Audit Program.

The Committee was assured regarding the good progress, noting that ongoing work would be overseen by the Patient Safety Committee.

3.3 CQC Update *(mitigating BAF risk 1)*

The Committee noted the themes from the draft CQC reports and a high-level action plan. A more detailed workplan with specific timelines underpinned the report. The Committee was assured noting that ongoing work would be overseen by the Patient Safety Committee and escalated as appropriate.

3.4 Quality and Safety Performance Report *(mitigating BAF risk 1)*

The Committee received the monthly update on Quality and Safety issues and noted the following:

- the VTE risk assessment target for May 2023 had been missed in ESM. Further training and improvements to NC dashboards in ESM were planned.
- hospital acquired pressure ulcers had decreased in June 2023
- the number of falls had increased slightly in May and June 2023 and were below the national average.
- ten SIs, detailed in the report, were escalated in June 2023.

- there was increased focus on antimicrobial prescribing practice to avoid broad-spectrum antibiotic use except where necessary.
- work to improve the functionality of the IT system with respect to medicines safety.
- performance for formal complaints had improved
- the Trust's mortality continued to be in line with the national average for both risk-adjusted measures.
- monthly blood traceability data compliance remained excellent, consistently achieving 99.8 to 100%. However, this was reliant on manual processes and there was a need to ensure the IT system was used appropriately.
- work was underway to build into governance and assurance processes to triangulate complaints, incidents and claims using the NHS Resolution scorecards. This would support quality improvement to reduce clinical and non-clinical claims.

The Committee discussed blood traceability and antimicrobial prescribing practice, noting that C-Diff rates at ICB level had deteriorated. The Infection Prevention team will undertake further work to review C-Diff rates. A report on complaints resolution and patient experience of the new process was requested for a future meeting.

3.5 **Thematic review of seven HAPU Category 4 incidents** *(mitigating BAF risk 1)*

The Committee considered a review of seven Category 4 HAPUs reported as SIs between October 2022 and February 2023. There was no single contributory factor and themes, and consequential actions were set out in the report.

The themes reported covered: clinical photography system; pressure relieving equipment; validation process; education and training, and scrutiny and oversight of HAPU validation. A number of associated issues were also considered. The Committee approved a number of recommendations to improve care. The target to reduce HAPUs classed as unstageable was noted and it was agreed to set a Quality Standard to ensure there were no Category 4 HAPUs.

The Committee highlighted the report to the Trust Board for information.

3.6 **Patient Experience – 360 Assurance report update** *(mitigating BAF risk 1)*

The Committee received the report from the Internal Auditors (360 Assurance) 'Patient Experience – Friends and Family Test'. The effectiveness of controls had been examined and a number of corrective actions identified. The Audit Opinion was 'limited assurance'. The action plan was noted.

3.7 **Patient Involvement and Patient Experience Committee Annual Report** *(mitigating BAF risk 1)*

The Committee received assurance that patient feedback was promoted and monitored. The annual report reflected the themes identified. There had been a focus on the following workstreams: carers; outcomes and experience for patients from an ethnic minority background; and patients with long term conditions/physical disability. It was agreed to retain the priorities for 2023/24 and identify actions to support the ambition.

3.8 **Infection Prevention Self-Assessment Framework/BAF** *(mitigating BAF risk 1)*

The Committee noted that NHSE had developed a BAF during the pandemic which focussed on the management of Covid-19. This had been revised and the scope widened with the template issued in April 2023. As The Trust already had a framework in place it had been agreed to incorporate the IP BAF into a combined tool to present the Annual IP Programme and Assurance against the UKHSA requirements. This would provide granular detail and enable readers to drill down to ward level. There would be quarterly reports to the Committee. The Internal Auditors would be reviewing the process for assurance.

This report constitutes a standalone item on the public Trust Board agenda for 10 August 2023.

3.9 **Board Assurance Framework (BAF)**

The Committee reviewed strategic risk 1 'a framework to maintain and improve patient safety, clinical effectiveness and patient experience'. There were no matters of concern from the strategic risk or significant changes proposed to the content this month.

The Trust Board had agreed that the review of the clinical audit programme would fall within the remit of the Committee. It was noted that any delays or issues with respect to national clinical audits was addressed through the monthly CMG PRMs.

4. **Reports from UHL Boards**

The Committee received the following reports

4.1 Patient Safety Committee Report

The following aspects of the report were highlighted: UHL Transfusion Committee report; progress on PSIRF; new approach for Policy and Guidelines; IP BAF.

4.2 Nursing, Midwifery, and Allied Health Professionals Committee Report

No issues had been escalated and the report was noted.

The Chief Nurse reported that the Trust

- would receive an award from NHSE for Pastoral Care of International Recruits
- had joined NHSE Hidden Talent Programme and accepted five refugees from the Lebanon
- had created a central Training Programme for ACPs

The Committee highlighted the report to the Trust Board for information.

4.3 Maternity Assurance Committee (MAC) Highlight Report

The report was noted, as previously submitted to Trust Board in July 2023.

5. **LLR Quality Board**

The Perinatal Mortality: MBRACE Summary Report would be submitted to LLR System Quality Board.

6. Items for Noting

Integrated Performance Report – Month 3 2023-24

7. Any Other Business - None