Public Trust Board paper I

Meeting title:	Trust Board
Date of the meeting:	9 March 2023
Title:	**Escalation Report from the Quality Committee (QC): 23 February 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: QC – Quality Committee

1. Purpose of the Report

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

2. Recommendations

3.1.1 There is one item from Quality Committee to be referred to the Trust Board for assurance. The following is presented as a stand-alone report on the Trust Board agenda for 9 March 2023.

- Mortality and Learning from Deaths Quarterly Report

3. Summary

The QC met on 23 February 2023 and was quorate. It considered the following items, and the discussion is summarised below:

3.1 Recommended Items

3.1.2 Mortality and Learning from Deaths Quarterly Report

The Committee received the quarterly report on mortality rates and progress against the learning from deaths programme. The Medical Director reported that the Trust's Summary Hospital Mortality Indicator (SHMI) was at 104 and the latest Hospital Standardised Mortality Ratio (HSMR) was 100 which were within the expected range.

The progress in extending the Medical Examiner service, and recruitment of additional bereavement nurses was noted. The backlog of Structured Judgment Reviews for 2021/22 had been cleared and the reviews for 2022/23 triaged and high-risk reviews escalated.

The Committee discussed the increase in the number of stillbirths and neonatal deaths in 2021. A thematic review of neonatal deaths had been considered by the Mortality Review Committee. This had not identified the underlying reasons why the Trust had a higher rate than its peers. The Committee noted the further work to be undertaken to gain a better understanding.

The Committee took overall assurance from the report, noting the learning from deaths methodology and the process to review neonatal deaths. A further report would be received in May 2023.

The Mortality and Learning from Deaths Quarterly Report is recommended for Trust Board approval. A standalone report is included on the 9.3.23 Trust Board agenda accordingly.

3.2 <u>Discussion items</u>:

3.2.1 Safeguarding Update Report

The Committee received a report summarising the current position of safeguarding practice. It noted that a joint inspection from Care Quality Commission, Ofsted and the Ministry of Justice for Leicester City safeguarding was expected before April 2023. There was a delay in undertaking multi-agency reviews of domestic homicide cases, with some taking up to three years. Funding had been allocated for additional child residential care. This would assist in supporting children abandoned in the Emergency Department.

The Committee took assurance from the report.

3.2.2 Patient Safety Report – January 2023

The Committee received the monthly report on patient safety. Six serious Incidents had been escalated in January 2023; one of these was identified as a Never Event relating to a misplaced nastro-gastric tube. The number of moderate and above harm incidents had increased in December and January 2023. There had been a decrease in the rate of reported Patient Safety Incidents. Nurse staffing incidents were 50% lower than last month and a third of the number for the same month last year. The actions taken to address the evidence gaps for Duty of Candour were noted.

The Committee considered how Serious Investigation reviews were prioritised and how patient safety data was triangulated and reviewed by the Clinical Management Groups.

The Committee took assurance that the reporting format was being revised to provide a dashboard. It noted that a revised staffing structure for the Patient Safety Team would address some workload issues and give greater focus to the patient safety. The description of the risk-based approach to investigations provided further assurance.

3.2.3 Actions to Improve the Management of Complaints In UHL

The Committee took assurance from an update on the actions being taken to improve the management of complaints.

3.2.4 Establishment of a Trust Infection Prevention Operational Group

The Committee endorsed the establishment of a Trust Infection Prevention Operational Group to maintain a continued agile response to infection concerns. This will replace the IP cell developed in response to Covid-19.

3.2.5 Board Assurance Framework Report

The Committee considered the risks pertaining to its remit strategic risk 1 on the BAF around 'failure to maintain and improve patient safety, clinical effectiveness and patient experience' which was aligned to its remit. There were no matters of concern from the strategic risk or significant changes proposed to the content this month. There were no changes to strategic risks, controls and risk assurance ratings.

3.2.6 Update from the Trust Infection Prevention Committee

The Committee noted infection prevention activity outcomes for Quarter 3 2022/23 and the Healthcare Associated Infection data with the mandated trajectories. The Chief Nurse confirmed that there was nothing of concern to escalate.

3.2.7 Feedback from and escalation to LLR System Quality Board

It was agreed to share the Mortality and Learning from Deaths report, as submitted to the Trust Board, with the LLR System Quality Board following presentation at the Local Maternity System.

4. **Items for Noting**

- CIP QIAs 2022-23 Quarter 3 Review (Paper J)
- Clinical Audit Programme Quarterly Report: End of Quarter 3 2022-23 (Paper K)
- 2022-23 CQUIN Schemes Quarter 2 Report (Paper L
- 2023-24 CQUIN Schemes & Quality Schedule (Paper M)
- Learning Disability and Autism Services - Service provision (Paper N)
- Integrated Performance Report – Month 10 2022/23 (Paper O)

5. Any Other Business

None.

6. Identification of any key issues for the attention of the Trust Board

The Mortality and Learning from Deaths Quarterly Report was recommended to the Board.

Date of next meeting – 23 March 2023