Item 11.2
Appendix 2

North East and North Cumbria

North East and North Cumbria Integrated Care Board
Quality and Safety Committee (QSC) meeting
held on 31 July 2024 from 9.00-12.00pm
in the Joseph Swan Suite, Pemberton House

Minutes

Present:
Sir Pali Hungin, Independent Non-Executive Member (Chair) – in person
Dr Maria Avantaggiato-Quinn, Director of Allied Health Professionals – in person
Ms Sarah Dronsfield, Director of Quality – in person
Mrs Ann Fox, Deputy Chief Nurse – in person
Mr David Gallagher, Chief Procurement and Contracting Officer - in person
Ms Kate O'Brien, Director of Nursing, Mental Health, Learning Disabilities, Autism and Complex Care – in person
Dr Saira Malik, Primary Medical Services Partner Member – in person
Ms Louise Mason-Lodge, Director of Nursing (safeguarding) – MS Teams
Dr Rajesh Nadkarni, Foundation Trust Partner Member – in person
Mr David Purdue, Chief Nurse, AHP and People Officer – in person
Mrs Claire Riley, Chief Corporate Services Officer – in person
Ms Jeanette Scott, Director of Nursing (South) – MS Teams
Mr Richard Scott, Director of Nursing (North) – in person
John Warrington, Medical Director (deputising for Neil O'Brien) - in person

In Attendance:
Mr Christopher Akers-Belcher, Regional Co-ordinator, Healthwatch – in person
Mr Neil Hawkins, Strategic Head of Corporate Governance – in person
Judith Thompson, Learning Disability & Autism Clinical Network Manager - in person
Nicola Lambert, Northern Cancer Alliance Clinical Lead for Nursing – MS Teams
Ms Jenna Easton, Executive Assistant (minutes) – in person

QSC/2024/07/01 Welcome and Introductions
The Chair welcomed members to the meeting.

QSC/2024/07/02 Apologies for Absence

Apologies were received from Mr Chris Piercy, Director of Nursing, Dr Neil O'Brien, Executive Medical Director and Mr Dan Jackson, Director of Policy, Involvement and Stakeholder Affairs.

QSC/2024/07/03 Declarations of Interest

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

QSC/2024/07/04 Quoracy

The meeting was confirmed as quorate.

QSC/2024/07/05 Minutes of the meeting held on 9 May 2024

The minutes of the meeting were agreed as a true and accurate reflection with the addition of the agreement to a future Quality Safety Committee (QSC) Development session.

RESOLVED: The Committee **AGREED** the minutes from the meeting held on 9 May 2024 which were accepted as a true and accurate record.

QSC/2024/07/06 Matters Arising from the Minutes and Action Log

The action log was discussed and updated accordingly.

Action updates: -

- Discussions took place on the Committee's perception of Quality, and Safety and agreement made to convene a dedicated QSC development session to focus on areas of concern that do not sit with the overall agenda. i.e. access appointments.
- **ACTION:** suggestion to host two development sessions per year and to schedule within the QSC cycle of business.
- QSC/2024/03/10 ICB Quality Report; TR and CP to hold conversation outside the meeting to discuss sepsis work, action noted as outstanding.
- QSC/2024/05/12 Quality Strategy; action confirmed as complete.
- QSC/2024/05/15 Involvement and engagement update; comprehensive report scheduled for discussion today, though additional overarching report specifically for children is required.
- QSC/2024/03/22 Clinical effectiveness; report scheduled today for discussion.
- QSC/2024/03/22 Gender Dysphoria; details shared with Executive Directors and agreement was made to share with Claire Riley for further input.
- Thoughts on perceptions regarding culture within our system; the Committee were updated on the 'Speaking up' progress within the ICB.

QSC/2024/07/07 Board Assurance Framework and Risk Register

The Committee were asked to receive the risk register and Board Assurance Framework, to note the slightly updated content and proposal to amend reporting arrangements to the QSC on a quarterly basis.

Key highlights from within the report were shared and noted: -

- Two new risks identified and included within the register:
    - **NENC/0079** - Patient safety concerns - complex care case management in Tees Valley. As a result of changes in complex case management, there has been inconsistent and variable oversight of the caseload, which has and could result in quality and safety concerns including the exposure and actual risk of harm (safeguarding harms). The residual risk is scored 12 (high).
    - **NENC/0083** – Quality/safety of paediatric audiology services across the North East and North Cumbria. A national review of paediatric audiology is underway following evidence of harm at several organisations in the UK. The ICB has seven Trusts providing these services across the NENC footprint and assessments of those providing auditory brainstem response (ABR) services is underway to determine who if at all may need to enter a formal incident management process. The residual risk is scored 4 (low).
- Two risks were recently closed, both risks were reduced, and assurance allowed closure from the register:
    - **NENC/0003** – The implementation of the Mental Capacity (amended) Act 2019 Liberty Protection Safeguard. Risk reviewed and closed by risk owner. Risk categories are now low and risk can be closed. Residual score was 2 (low).
    - **NENC/0026** - Funding allocation for Local Maternity and Neonatal System (LMNS). Risk reviewed by risk owner and LMNS implementation funding has now been confirmed as recurrent. Risk controlled and no longer applies. Residual score was 9 (medium).
- Additional appendix shared to provide overview of the current Quality and Safety risks at Place.

RESOLVED: The Quality and Safety Committee received and reviewed the risk register and BAF for assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/08 ICB Quality Report

The Committee received the report which provided members with oversight of key themes outlined in the ICB Area Quality reports for the North and South ICB footprint.

The Committee were informed the report comprises of sections that will evolve moving forward and the format will reflect slight changes in future reports.

Several thematic risks and concerns were outlined to the Committee:

- Digital incidents: Two incidents reported by two separate Trusts experiencing significant clinical system issues that resulted in patient correspondence not being dispatched. Close working relations with both Trusts are underway to resolve, mitigate and prevent reoccurrence.
- In relation to improvement, the ICB Executive Chief Digital and Information Officer (CIO) has issued communications to the digital network to raise awareness of the open loop nature of transmitting clinical correspondence from secondary care to GP practice destinations. Also, to highlight the need to create a more proactive method of regular checks of outbound correspondence and documentation processes relating to clinical activities.
- Never Events: Two Never Events reported by two separate Trusts under the category of overdose of insulin due to abbreviations or incorrect device. New medicine safety operations have been incorporated and included within oversight.
- All aged Continuing Healthcare (AACC): The ICB do not hold a comprehensive list of CHC contracts in the ICB, this means we cannot be fully assured that we have only commissioned packages of care with registered providers. Information received so far has identified that there is an actual and potential risk of providers not being registered with CQC or registered correctly for the regulated activity they are delivering. AACC Teams are working with the quality and contract teams and supporting liaison with Local Authorities to gather the facts and scale of risks and issues and will contribute to a separate assurance report.
- Court of Protection. Deprivations of Liberty (CoP DoLs):
  There is concern regarding lapsed CoP DoIs and variation across the region with how CoP DoLs is delivered. To date capacity issues have negatively impacted on the ICBs ability to address this risk.
  Discussions continue with the Mental health, Learning Disabilities and Complex case management team regarding new ways of working within the new structure and utilisation of existing resource within the system.
- In relation to improvement, communications have been released, and additional resource is being sourced.
- Safeguarding: Significant demand is being placed on the health system to meet the requirements of multi-agency risk assessment

conferences (MARAC). Equally the volume of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) across the footprint continues to place further demands on the ICB safeguarding resource.

- Changes to the Safeguarding workforce are underway, prioritisation has commenced to manage resource and ensure compliance and a deep dive exercise is planned to review MARAC.
- Forensics: Currently there is no forensic service available should an adult present with a suspected non-accidental injury, unlike with paediatrics. A forensic awareness raising project in the North-East has been developed by one of the Named GPs and a colleague in Yorkshire. which includes face-to-face training to general practice.
- The forensic project has been delivered at a time-out session to clinicians in Newcastle. A recording has been produced to support a virtual training package for North East and Yorkshire (NEY) audiences, including 'train the team' materials for safeguarding leads to use in their own organisations. The creators have been asked by the national network of named GPs to deliver this training nationally.

In relation to the new addition of forensics, further clarity was requested based on the reasoning to incorporate into Primary Care. It was stated, due to historical issues with adults presenting at Primary Care, this matter then escalated to the Safeguarding Network with the proposal for further GP awareness, recognition, and a viewpoint of a forensic eye with further visibility. Acknowledgement and assurance was made by members of the Committee.

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/09 Patient Safety Incident Framework (PSIRF)

A high-level presentation was shared with the Committee to provide oversight of the PSIRF framework.

Members recognised the importance of developing the necessary culture, system, and behaviours to respond to patient safety incidents to support learning and areas for improvement.

The Committee were assured the ICB are working collaboratively with Trusts and the wider system to establish continuous improvement in relation to PSIRF.

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/10 Involvement and engagement update

The Committee were provided with an update on the ICB's involvement and engagement activity across the North East and North Cumbria.

Reflections focused on access and the positive work underway to alleviate pressure from services via Pharmacy First scheme etc. Perceived public feedback has significantly improved over the years, although further communication and education activities are required.

A comment was made referring to the exceptions and experience defined within the report, to further accompany this it was suggested to make links with complaints to identify common themes.

In relation to Primary Care access, there are evident issues with public perceptions and the continuous issues with telephony systems.

ACTION - Primary care access to be considered as an area of focus for proposed QSC development session (Chief procurement and contracting officer to advise on content).

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC /2024/07/11 Complaints Report

Two complaints reports were shared with the Committee to update on progress achieved to date and map the current common themes/issues.

Consistent themes were identified primarily in relation to access to NHS dental care and CHC (Continuing Healthcare).

The Committee noted assurances that the ICB has fulfilled its statutory responsibilities regarding complaints management, the process for primary care complaints is in recovery and the backlog is in progress with real expectation to clear the backlog over the coming months.

ACTION: Agreement was made to update on the primary care complaints recovery plan at the next meeting scheduled in September 2024.

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/12 Clinical Effectiveness and governance subcommittee terms of reference

The report outlined the proposed terms of reference (ToR) for the newly established clinical effectiveness and governance subcommittee which will report into the Executive Committee and Quality and Safety Committee. This subcommittee will bring together and merge the functions of the existing medicines subcommittee and clinical effectiveness subcommittee and associated governance structures.

The purpose of the subcommittee is to provide assurance and oversight of the delivery of effective care and treatment in the North East and North Cumbria ICS (system wide).

Members discussed the proposed reporting arrangements and agreed further discussions are required concerning where the subcommittee best sits within the governance structure and reporting arrangements.

ACTION: Executive Directors to give further thought about the reporting arrangements of the clinical effectiveness and governance subcommittee, to review the proposed arrangements, and agree the reporting/parent committee arrangements.

RESOLVED: The Committee received the Terms of Reference and agreed to receive regular standard reports for information purposes.

QSC/2024/07/13 Learning and Disability and Autism Network update

A presentation of the network's current work plan was provided to the committee to provide assurance it is in line with national and ICB strategic plans in relation to people with learning disability and autistic people.

The presentation shared the breadth and range of work underway across health and social care in the North East and North Cumbria, to tackle health inequalities faced by people with learning disability and workforce transformation.

Key highlights and a clear overview of progress in working areas were shared with members.

Comments were shared by members of the Committee and the following observations were made: -

- The Committee were encouraged to further support the Learning and Disability and Autism Network by continuing to share information frequently across the ICB and partner organisations.
- Members acknowledged the Committee's responsibility of oversight to the Learning and Disability and Autism Network, and agreement was made to review key progress yearly via the cycle of business.

The Chair expressed sincere thanks for the robust presentation shared and the inclusive achievements made to date.

RESOLVED: The Committee accepted the work programme of the Learning Disability Network.

QSC/2024/07/14 Cancer Alliance update

A high-level presentation was shared with the Committee to highlight the Northern Cancer Alliance workplan for 2024/25, and to share achievements to date.

The Chair expressed appreciation for the contributions shared with the Committee and acknowledged the achievements made to date.

RESOLVED: The Committee received the presentation for information and assurance.

QSC/2024/07/15 Closedown of Serious Incident panels

The Committee were provided with a report concerning the progress made in closing down the ICB Serious Incident Panels.

The ICB inherited a significant volume of open serious incident cases from clinical commissioning groups. This number is now at a minimum with the anticipation that the remaining caseloads will be concluded by 31st July 2024.

Patient Safety Incident Framework (PSIRF) was published in August 2023 and replaces the NHS Serious Incident Framework (2015) and promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

All patient safety incidents requiring investigation are now managed through each organisations own internal safety/learning processes with sign off now being the responsibility of the providers own Board governance arrangements, not of the commissioner. To support good practice arrangements are in place for ICB quality representatives to routinely attend Trust patient safety and learning panels or quality committees where executive sign off takes place.

RESOLVED: The Quality and Safety Committee received the report for information, noted the assurances, mitigating actions and the work being undertaken by the ICB.

QSC/2024/07/16 Fuller Report

The Committee noted the purpose of the report, to update on the Fuller inquiry phase 1 and 2.

Phase 1 of the inquiry published in November 2023 and focussed on matters relating to David Fuller's conduct whilst an employee at Maidstone and Tunbridge Wells NHS trust.

This included looking at: -

- the recruitment and employment,
- mortuary access and offences
- evidence of unlawful/ inappropriate acts or complaints
- management of the mortuary
- Arrangements for post-mortem examinations.

There were seventeen recommendations specifically for the trust in relation to the findings and oversight of the mortuary.

Phase 2 of the inquiry is looking at the broader national picture and is considering if procedures and practices in other hospitals and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

Specifically: -

- Whether procedures and practices in hospital settings, including the private sector where bodies of the deceased are kept, safeguard the security and dignity of the deceased, and would prevent reoccurrence of matters raised by David Fuller's case.
- Whether procedures and practices in non- hospital settings, including local authority mortuaries, funeral directors, ambulance services, medical schools, and hospices where bodies of the deceased are kept, safeguard the security and dignity of the deceased, and would prevent reoccurrence of matters raised by David Fuller's case.
- The role of regulators and their use of regulatory measures in assuring that mortuary practices safeguard the security and dignity of the deceased.

Assurance was given to the Committee and members were specifically asked to note all providers successfully completed the seventeen recommendations and are fully compliant.

Further assurance from the report outlined the ICB are working collaboratively with trusts and the wider system to review and implement the findings and learning from the Fuller inquiry. All trusts have undertaken a self-assessment against the recommendations from phase 1.

One issue highlighted related to the access to buildings that have been delivered using the Private Finance Initiative (PFI) scheme. Access requirements were challenging in these scenarios when access had been required to install required CCTV/cameras. Agreement was made for the Chief Nurse, AHP and People Officer to share with the Chief Executive for intelligence and if necessary, further escalation.

ACTION: Fuller recommendations - Chief Nurse, AHP and People Officer to raise with the ICB Chief Executive the issue of access to buildings delivered through Private Finance Initiative (PFI) funding hindering progress to install required CCTV/cameras (in some instances) to ensure compliance with the Fuller recommendations.

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/17 Maternity and Neonatal Services

All ICBs and Provider Trusts received a letter from Dame Ruth May, Chief Nursing Officer, Professor Steve Powis, National Medical Director and Dr Emily Lawson DBE, Chief Operating Officer on 15 May 2024 regarding maternity and neonatal services – listening to women and families. The purpose of the report presented to the committee was to provide a position statement on the points raised within that letter.

The letter focuses on the importance of listening to women, and taking appropriate action in response, and this has again been brought into sharp focus with the recent publication of the report by the All-Party Parliamentary Group (APPG) on Birth Trauma.

The NHS Priorities and Operational Planning Guidance 2024/25 makes clear that the implementation of the Three-Year Delivery Plan for Maternity and Neonatal Services continues to be a key priority for ICBs, Trusts and primary care. The vast majority of women, babies and families receive safe care, and the plan commits the NHS to making maternity and neonatal care safer, more personalised, and more equitable, and prioritise listening to women and families to achieve this.

Trust boards and ICBs have a duty to ensure regular, robust oversight of maternity and neonatal services in line with the perinatal quality surveillance model. Boards are asked to review the commissioning and implementation of existing commitments for which they received funding for implementation in 2023/24 and which will help address recommendations in the All-Party Parliamentary Group (APPG) on Birth Trauma report:

- Perinatal pelvic health services, in line with the national service specification
- Maternal mental health services, in line with national guidance
- Availability of bereavement services 7 days a week
- LMNS equity and equality action plans, working across organisational boundaries.

Since 2020 there has been a contractual requirement to offer women a maternal postnatal consultation with a GP, and in December 2023, NHS England issued 'what good looks like' guidance in support of this. ICBs are therefore asked to review local delivery of this standard.

The letter also announced additional funding for maternity and neonatal voice partnerships (MNVPs) in 2025/26 and 2026/27, with a part-year effect of £76,923 for the NENC Local Maternity and Neonatal System (LMNS). ICBs should already be providing appropriate levels of funding and resourcing to MVNPs, and therefore the additional funding recognises the central role MNVPs play in helping to improve care as outlined in the Maternity and neonatal voices partnership guidance, and the need to strengthen the neonatal parental voice component.

The Committee acknowledged the complaint status and accepted the position statement.

RESOLVED: The Quality and Safety Committee received the report for information, discussion and assurance and confirmed the report provided good assurance on the issues outlined.

QSC/2024/07/18 Items escalated from sub committees.

Safeguarding sub committee - no items escalated this reporting period.
HCAI sub committee - no items escalated this reporting period.
SEND sub committee - no items escalated this reporting period.
Clinical Effectiveness sub committee - no items escalated this reporting period.

Medicines sub committee - no items escalated this reporting period.
North sub committee - no items escalated this reporting period.
South sub committee - no items escalated this reporting period.

QSC/2024/07/19 Integrated quality, performance and finance report

The NENC Integrated Delivery Report (IDR) provides an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions.

The report uses published performance and quality data covering April 2024 for most metrics and May 2024 for others, unless otherwise specified. Finance data is for May 24 (Month 2).

RESOLVED: Committee members received the report for information and assurance.

QSC/2024/07/20 Area Quality and Safety Subcommittee Minutes

The following minutes were received:

- North Cumbria minutes of the meeting held on 18 December 2023 and 12 February 2024
- North minutes of the meeting held on 20 February and 16 April 2024.
- South minutes of the meeting held on 09 April 24
- Central minutes of the meeting held on 19 Dec 23 and 16 April 24
- Tees Valley minutes of the meeting held on 9 April 2024

RESOLVED:
The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/21 System Quality Group minutes of 1 May 2024

No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/22 Health Care Acquired Infection subcommittee minutes of 3 April 2024

No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/23 Medicines Subcommittee Minutes of 8 April 2024

No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/24 Patient Voice minutes of 15 February 2024
No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/25 Safeguarding Health Executive minutes of 20 March 2024
No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

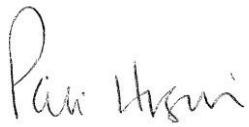
QSC/2024/05/26 SEND Assurance Subcommittee Minutes from 24 April 2024
No comments raised.

RESOLVED: The Committee **RECEIVED** the minutes for assurance.

QSC/2024/07/27 Any Other Business and items for escalation.
No further items of business raised.

QSC/2024/07/28 Date and Time of Next Meeting
Thursday 12 September 2024, 09.00-12.00pm in the Joseph Swan Suite, Pemberton House.

The meeting closed at 11.46am

Signed: 

Position: Chair

Date: 31 July 2024