Item: 8.2.2

NHS
North East &
North Cumbria

North East and North Cumbria Integrated Care Board

Quality and Safety Committee meeting held on 20 October 2022 from 10.00-11.30am via MS Teams.

Minutes

Present: Professor Eileen Kaner, Independent Non-Executive Member (Chair)

Hannah Bows, Independent Non-Executive Member (Vice Chair)

Siobhan Brown, Director of Transformation, Systemwide for Jacqueline Myers

Ken Bremner, Foundation Trust Partner Member

Professor Sir Liam Donaldson, ICB Chairman

Ann Fox, Director of Nursing

Maureen Grieveson, Director of Nursing

Dr Saira Malik, Primary Medical Services Partner Member

Ewan Maule, Director of Medicines

Rajesh Nadkarni, Foundation Trust Partner Member

Dr Neil O'Brien, Executive Medical Director

David Purdue, Executive Chief Nurse

Dr Mike Smith, Primary Medical Services Partner Member

David Thompson,

In Attendance:

Kirstie Atkinson, Clinical Quality Manager/Interim Head of Quality & Patient Safety (Newcastle/Gateshead)

Neil Hawkins, Head of Governance Newcastle/Gateshead Place

Tony Roberts, Director of NEQOS

South Tees Hospitals NHS Foundation Trust

Jan Thwaites (minutes)

QSC/2022/10/01 Welcome and Introductions

Introductions were given, it was explained that Hannah Bows, Independent Non-Executive Member would be the Vice Chair of the meeting going forward.

It was noted that the ICB was in a year of transition and the membership may change over time, representation from social care needed to be included and any changes to be recommended to the ICB Board.

The meeting today did not require any decision making but there was a lot of information to be processed which was important for the ICB and also the local population. The members were requested to be really mindful of safety and 'do no harm' and think about quality. To ensure the committee had the time and space to ensure public was at its at heart and to drive quality forward.

QSC/2022/10/02 Apologies for absence

Apologies were given by Jeanette Scott, Director of Nursing, Annie Laverty, Executive Chief People Officer, Louise Mason-Lodge, Director of Nursing, Jacqueline Myers, Executive Director of Strategy and System Oversight and Tom Hall, Local Authority Partner Member (Designate)

QSC/2022/10/03 Declarations of Interest

The following interests were declared.

Dr Rajesh Nadkarni, Foundation Trust Partner Member noted that he sat on the GMC advisory panel which looked at Doctors health issues.

Mr Purdue noted that he worked for the CQC as an Executive Assessor and also worked as a health inspector of Wales.

RESOLVED: The interests were accepted.

QSC/2022/10/04 Opening Address

Sir Liam explained that constitutionally he could not attend every meeting but would be happy to hold a seminar at some point to update on both national and international quality issues.

In relation to context the committee needed to decide their positioning on and how strategic they wanted to be.

The position on risk need to be considered to ensure that the correct decisions on risk were made. To also bear in mind that ultimately one day the question could be asked who knew what and when and what was done about it.

Were the committee responsible for the quality in all organisations or just responsible for the quality programme led at a systemic level. If required Sir Liam could assist in a discussion with Trusts over what was or was not the leading edge in relation to quality. It was noted that the Foundation Trusts had been used to working in an autonomous way in the past which included inconsistent reporting of serious incidents, with CCGs not being in the position to have the proper oversight of this area of quality and safety.

Sir Liam gave suggestions on programme areas such as the ICB needed to launch major programmes in quality and safety and had offered to help with a patient safety programme.

There was already an established learning and improvement community programme led by Annie Laverty. The first meeting had been held which needed to continue. The challenge was if the approach would be to skill people in quality improvement and empower them to do place based projects which they considered to be important and priorities or direct and co-ordinate some regional action or a mixture of the two. A special programme on patients and carers was suggested as this was a major part of the quality agenda in all healthcare systems. Working more closely with patients and families was essential.

It was important to work out what the quality and safety synergies would be with other programmes - for instance work on a clinical strategy between the FT and the ICB and how quality would be embedded in that. Do cardiology departments operate to a best practice standard? Or was this not the remit for the ICB, was it just to ensure that the Trusts had good quality programmes.

Questions were put as to workforce - was it up to the ICB to educate and upskill people with the tools for quality assurance and improvement. Did the ICB have any legitimacy in the role of social care of was this for the local authority only?

Assessment, metrics and data were not as strong as they should be in the NHS – were they being measured correctly? Did we need to join any international benchmarking schemes to enable comparisons in performance?

In regard to patient experience data, how much do the ICB use these patient reported outcome measures to look at qualitative survey data and what would he FTs say if gathering these data on their organisations.

In regard to culture were there ways to have surveillance to spot in advance and issues for example the recent reporting from CQC.

The Chair thanked Sir Liam for his opening address and noted that his comments set out a wide canvas following on from this transition phase. The agenda would

reflect lived perspectives and the membership would look to include both young and older public representatives and also representatives from voluntary organisations. To also put patients at the heart of all that the ICB undertook.

QSC/2022/10/05 Terms of Reference Review

The terms of reference for the committee were discussed.

It was explained that at a recent Audit Committee meeting it had been suggested that the Chair of the Quality and Safety Committee would be invited to be the Vice Chair of that meeting. It was noted that due to this committees Terms of Reference this was not possible.

The membership currently lacked representation of social care; this issue would be taken back to the ICB board for a recommendation to be included for future meetings.

In relation to page 6 reference to patient group directions being reviewed to ensure appropriate governance was in place. This also fell under the remit of the ICB Medicines Committee which it was felt to be a more appropriate place for them to be reviewed. Any future issues would be highlighted in the medicines overview report.

Action: It was agreed to remove the patient group directions section from this committee's terms of reference.

It was suggested that all 4 area Directors of Nursing should be in attendance and for clarity to ensure titles are aligned and representative of each area. Also to make it explicit around having patient safety partners from provider organisations.

Action: To invite all Directors of Nursing to the meetings.

It was explained that the System Quality Group (SQG) had been the NHS England (NHSE) and CCG approach to quality and had been previously called the Quality Surveillance Group which will be co-chaired by Mr Purdue and Jane Robinson.

Any issues from the SQG would be reported to the Regional Quality Group to ensure no duplication.

Action: An organogram to be produced to distinguish the quality structure.

A comment was made that the terms of reference could not be confirmed until there was a clear idea of what the focus of the committee was. There was a need to revisit them earlier than the noted yearly review. The Foundation Trusts would be looking for a degree of transparency on who was doing what which had not at this point been confirmed. It was suggested that the committee give a view on what was expected of it i.e. effective robust processes and take learning from other areas and use collectively then test this with the ICB board after being discussed by Sir Liam and Mr Purdue.

Action: The Chair to formulate a response for her report to the ICB board for discussion on the terms of reference and the confirmation on what was expected from the Foundation Trusts.

Action: To ensure space at next meeting to discuss the terms of reference.

There were some important areas to look at with challenge but need the guidance of some terms of reference going forward.

It was noted that the NHSE Operating Framework clarified some of the areas that ICBs and NHSE were responsible for. A group to be arranged to look at the terms of reference.

Action: A group to be arranged to look at the terms of reference – this should include Mr Bremner, a representative from mental health, primary care, social care, the Chair and the Head of Governance.

RESOLVED: The terms of reference were received.

QSC/2022/10/06 Cycle of business

The cycle of business for the committee was discussed.

This had been drafted at a point in time and was a work in progress. It had been built on previous activity from the CCGs as a starting point but did not touch on areas such as strategic views, forward looking and deep dive elements.

There were regular items such as the clinical quality exception reports and annual reports for complaints, safeguarding, LeDeR and serious incidents along with items for assurance.

It was noted that the draft document was helpful but there was a need to be proactive and not reactive, to monitor items on a more regular basis and change or prevent where remit allows. To continue to add into the cycle of business on a regular basis and to include a social care element.

The following to be included:

- Patient experience to be added to each meeting for instance a patient story (both positive and negative)
- A regular complaints report

It was agreed to make amendments to the cycle of business and pick up regular themes. An edited version to be brought to the meeting in December. It was important to think about not only health but wider care.

Action: An edited version of the cycle of business to the December meeting.

RESOLVED: The cycle of business was received.

QSC/2022/10/07 Overview of Agenda

Key issues and clinical quality exceptions were highlighted in this presentation, these included the following areas:

Healthcare Acquired Infections (HCAI)

MRSA 4 cases since April with 3 hospital-onset and 1 community-onset

C.difficile 278 cases across the region since April 2022 with 4 Foundations Trusts (FTs) exceeding their year to date thresholds.

The biggest issues were C.difficile and MRSA.

Infection Prevention and Control (IPC) had increased due to Covid19, all providers had signed up to a set of principles in terms of the management of Covid IPC. These were being reviewed regionally although this may differ at place. One of the main issues at the moment with Covid was the lack of testing which made it difficult for the provider organisations to manage this.

The community and care home IPC provision would be reviewed and support would be provided.

In terms of C.difficile rates South Tees had been the biggest outlier, throughout the pandemic a lot of organisations had cancelled their deep clean programmes. South Tees had recommenced their deep clean programme in each patient area.

An antimicrobial system wide approach had been taken, this was being managed.

In regard to never events 14 had been reported year to date with South Tees being an outlier. There were opportunities to share practice across the system by looking at local procedures.

In terms of serious incident reporting it was explained that high reporting was a positive as it showed that organisations were willing to share information.

It was noted that Newcastle Hospitals had a high number of pressure ulcer incidents for which they had reported each and everyone. There was a need for all organisations to increase their reporting of incidents.

In relation to falls there had been a dramatic increase during the pandemic due in part to a lack of staffing and lack of visiting. The highest reporter of falls had been Gateshead FT due in part to the setup of the wards having all individual rooms which made observations of patients more difficult.

In terms of self-harm the highest reporters were Tees, Esk and Wear Valley (TEWV) and Cumbria, Northumberland, Tyne and Wear FT (CNTW). A lot of support work was being put into TEWV.

In regard to maternity a lot of focussed work would be undertaken in this area.

The 60-day timeframe was no longer a requirement under the NHSE SI Framework/PSIRF. The timeframe was suspended during COVID and has since been permanently removed. Trusts provided regular updates on their open cases and reasons for delays via Quality Review Group & NENC ICB SI panels.

A piece of work had been undertaken to look at the overdue incidents.

In terms of quality PSIRF and what that means would be in place by September 2023.

Four sub ICP quality groups had been set up to look at the sharing and learning from incidents and never events. There was social care representation at these meetings looking at thematic reviews and how the system was being affected.

One of the key pieces of work to focus on would be harm reviews across the system to understand the areas of most risk. These included the following:

- Waiting for an emergency response
- Waiting in an ambulance
- Overcrowding in ED
- Waiting for discharge
- Being discharged to the wrong place

It was explained that anyone waiting over 3 days for discharge should be classed as a serious incident.

A joint outcomes framework with the Local Authority would be agreed.

In terms of workforce risk issues there had been 1 care home that would be changing over from nursing to residential as cannot engage any staff. The 21 residents were having to be found alternative provision. The Directors of Nursing were asked to look at quality in care homes and assessments of quality but need to look at staffing provision also. Once this piece of work had been undertaken the resulting report would be brought to this committee.

In regard to the North East Ambulance Service (NEAS) independent enquiry, a chair had been appointed and staff interviews were underway. The timescale for completion was the end of this year. Support continued to be offered to NEAS from the QRG/ ICB system.

Good progress had been made against the 7 Ockenden essential actions with 3 organisations being rated green and the other areas were around informed consent and around how we get patient views of services. There was a strong maternity voices partnership across the ICB.

Following a CQC inspection North Tees had been invited to join the national maternity support programme and STSFT had been invited to join the national workforce programme.

The East Kent report had been published with 4 key areas highlighted – these included poor performance units to be identified, giving care with compassion and kindness, team working with a common purpose and responding to challenge.

A review had been undertaken of the Local Maternity Neonatal Services (LMNS) and how this worked.

The number of falls were increasing this was down to deconditioning where patients lost confidence after lockdown in homes and in hospitals. There were excellent programmes looking at this. It was noted that those falls which were serious incidents were falls that resulted in harm.

In relation to care homes some were not wishing to continue with care home nursing beds due to the difficulties in workforce recruitment. Focus was on the Covid capacity tracker which looked at the number of beds across the system, the information not shown was the staffed beds. A question was raised on this gap in the system and what could be done to refine this tracker. In response it was noted that the Local Authorities had a better system where they had daily calls to care homes to collate staff levels, how many staffed beds there were.

The Chair noted that if the Local Authority were doing something well should they be invited to this meeting.

Action: Mr Purdue to have a conversation with NECS as they support the tracker information.

One of main aims as an ICB was to reduce inequalities in outcomes access and experience and improve outcomes - this lens needed to run through our quality and safety reporting too.

In regard to SI reporting primary care had their own central reporting system and only report on the central reporting system when there was a cross system issue. There may be a need for a piece of work in primary care to make more robust. In response it was noted that PSIRF would be looked at to introduce across the whole system.

In relation to infection control and respiratory infections and how they could overwhelm the primary care system – was this to be monitored as would be a massive issue particularly the impact on workforce. In response this could be monitored from a ICB perspective and coded to look at infection rates.

A comment was made to be clear on the data presented to this committee with the need to understand the implications and the need for data to be more robust and consistent. There was a need to share where there were exceptions.

<u>Patent Safety Incident Responses Framework (PSIRF)</u>

PSIRF had been published in August 2022 to replace the Serious Incident Framework and was a major component of patient safety strategy. This was a mandatory and contractual requirement under the NHS Standard Contract for all organisations.

The framework focussed on the learning from patient safety incidents not on compliance. This was not mandatory for primary care but may be of real interest. There was a 12 month implementation plan which commenced in August.

The implementation plan was highlighted noting that the 1st 3 months looked at the system and associated requirements and documentation. Organisations were required to complete a patient safety profile

There were 4 components of the framework:

- compassionate engagement and involvement
- application of a range of system based approaches
- considered and proportionate responses
- supportive oversight focussed on strengthening response system

There were a lot of supporting documentation with the output of a patient safety incident policy and plan.

There was a system based approach to learning with the framework based on System Engineering Initiative for Patient Safety (SEIPS) methodology.

It was important to move away from a blame culture and look more to system thinking with the learning not focussing on root cause analysis.

The ICB should appoint a lead to collaborate with providers, oversee and support the effectiveness and support the co-ordination of cross-system learning responses. It was important to look at who was asking for assurance from provider organisations as it was not the wish for them to be inundated for assurance, this needed to be a system approach.

It was confirmed that the ICB lead would be Maureen Grieveson.

It was explained that Maureen would make contact with the Directors of Nursing in provider organisations. It was hoped that in working in this way the question would only be asked once and then cascaded through regional and NHSE contacts – to bring national speakers to learning events to share learning across the patch.

A comment was made on the fundamental shift re reporting and learning – there was a need to know if there was a particular organisation which may not meet the timescale of transition and what could be done to support them. It was noted that preventative work would come from learning across the system rather than individuals.

A question was raised as to what extent under this agenda the committee relied on the views for assurance of external bodies for example the CQC. Would this be used as one of main areas of assurance and don't replicate. There may be an opportunity to focus on systems rather than organisations to align them and use their work rather than replication. It was confirmed that the CQC were moving to system inspection and not individual organisations.

RESOLVED: The overview was received.

QSC/2022/10/08 Risk Register

The purpose of the report was to provide the Quality and Safety Committee with some suggested risks facing the ICB which aligned to the quality and safety portfolio.

The main risks had been assessed, there was a need to add on workforce as the biggest issue across the system for patient safety and to also encompass social care.

A process was being worked through to amalgamate legacy risks and to capture the new organisations risks, looking at different tiers of risk not just at a corporate level and ensure assurance was in place.

New risks had been included which would be presented at the next meeting which included maternity workforce pressures and the funding element of maternity services.

In regard to risk 0006 access to mental health following on from the learning and improvement event where it was acknowledged that children's mental health response was the biggest priority – should this be separated out from adult services. Some were issues rather than risks and how the ICB should articulate and show this.

The residual risk around ambulance delays should be more clearly defined and were too low – the risk had not been mitigate down, think of how to illustrate this.

Action: The children and adults risks should be separated out and the residual risk to be altered also to include the residual risk in relation to ambulance delays. Maternity workforce should be a standalone item on the risk register.

In relation to the risk 0011 prescribing, the committee should concentrate this on the quality aspect and the financial aspect should be reviewed elsewhere.

RESOLVED: The Risk Register was received.

QSC/2022/10/09 Clinical Quality Exception Report

The report provided an overview on a range of quality measures relating to providers across the North East and North Cumbria Integrated Care System (NENC ICS) and assurance that actions were taken, where appropriate.

RESOLVED: The Clinical Quality Exception Report was received.

QSC/2022/10/10 National Cancer Patient Experience Survey 2021

The report provided an overview of the key findings from the National Cancer Patient Experience Survey (2021) for NENC ICS and Acute Trust Providers which had been published in July 2022. The report had been presented to the ICB and the acute trusts across the region. The response rate for the ICB for 6 of the trusts were either at or above the national response rate.

The report showed the scoring for the ICS for each of the trusts, overall the ICS had 50 questions where they were a positive outlier.

Question 59 showed the overall position where patients had a positive experience.

The areas which had less positive comments where on diagnoses not explained to patients, positive long term effects not being explained, family not fully informed on care needs at home – these were not negative responses but collectively information to patients was not as robust as it should be. What was being done about this.

It was explained that each survey had been discussed in detail at quality improvement group meetings and any actions taken forward.

It was agreed that these were important areas, assurance was given that the trusts do give detailed responses to the surveys and were picked up in the Quality Review Groups at a local level where they were looked at in detail but it was also agreed that these issues should be brought back to this committee.

RESOLVED: The National Cancer Patient Experience Survey 2021 was received

.

QSC/2022/10/11 GP Patient Survey 2021

The report provided an overview of the headline findings and results from the National GP Patient Experience Survey (2022) for NENC ICS.

The survey had been conducted between January and April this year after a rise in Covid cases which may have impacted on patients overall experience. The response rate for the ICB was 34% which was above the national average of 29.1%.

The results were available at an individual GP practice level and also an ICS level. The report covered the key headlines from the ICS report.

RESOLVED: The GP Patient Survey 2021 was received.

QSC/2022/10/12 Quality and Safety of inpatient services

A letter had been received from Claire Murdoch, National Director, Mental Health in regard to the quality and safety of mental health, learning disability and autism in patient services.

The letter came out following the BBC Panorama programmes. The Executive Chief Nurse had written to both Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to gain assurance and received good assurance in return. All individual private providers had also been asked to provide assurance. The NHSE Nurse for Direct Commissioning had been asked for a report that could be shared with the team and providers. The work was ongoing around closed cultures.

RESOLVED: The Quality and Safety of inpatient services was received.

Item: 8.2.2

QSC/2022/10/13 NEQOS Regional Mortality

The report provided surveillance of hospital mortality using mortality metrics (like the Summary Hospital-level Mortality Indicator), the use of mortality case note reviews, currently within hospitals but with the aim of extending along care pathways and the scrutiny provided by Medical Examiner Services.

There were 3 types of assurance around mortality

- statistical approaches
- case note review of deaths
- medical examiners or referral to coroners

On the statistical side there was an issue in that the way that SHMI was calculated was likely to change to exclude hospices which would change the outlier status. The system had not been designed to work through a pandemic therefore the assurance was less than normal.

In regard to case note reviews all hospitals undertook this but would like to do this along the pathway of care. There was a role for the ICB to assist with this process.

In relation to Medical Examiners development of these services was going ahead and there was a need to report how foundation trusts were getting on delivering this service.

Mortality was discussed at the System Quality Group (SQG), the Regional Mortality Oversight Group and at this committee. Guidance was requested on what and where the committee thought this information should be presented. It was confirmed that the wider strategic elements and oversight should be presented to this meeting especially around the medical examiner but the data should also be shared at the SQG.

Action: To hold a discussion around what reporting was to be presented at both this meeting and the SQG.

RESOLVED: The NEQOS Regional Mortality report was received.

QSC/2022/10/14 Medicines Overview

The report informed the committee of the current priorities relating to medicines, the emerging governance structures and proposals for strong links between the medicines and quality and safety agendas.

There was a significant overlap between Quality and Safety and Medicines, the paper proposed methods by which close links remained between the two committees. This was a starting point and would evolve.

Action: It was proposed that the minutes from the Medicines Safety Committee and an annual report be brought to this committee.

Item: 8.2.2

A question was raised in relation to the place based delivery groups - does that include any reporting into area ICP quality groups. It was confirmed that the place based delivery groups were primarily about delivering against prescribing objectives and would feed into existing place based quality routes.

Concerns had been raised in general practice around the supply of medicines, and the risk of patients not receiving their medication.

The risk on the risk register it was noted was too vague and needed to reflect these issues. A summary was being prepared on these issues and would be brought back to a future meeting.

The committee discussed the content of the interim report and provide guidance on how links between the medicines committee and quality and safety may be established

RESOLVED: Medicines Overview report was received.

QSC/2022/10/15 Any other business

Public representation for this committee would be discussed on the agenda for the December meeting.

To embed the meetings in patient experience

A question was raised in relation to the terms of reference that the meeting would meet in private – could the reports be shared outside of the meeting.

Action: The Executive Chief Nurse would look at the constitution of the ICB and report back to the meeting.

QSC/2022/10/16 Date and time of next meeting

Thursday 15 December 2022, 10.00-12.00.

Signed: 

Date: 15.12.22