Leeds and York Partnership NHS Foundation Trust

Minutes of the Quality Committee – Part A
Thursday 9 May 2024 at 9.30am
Held via Teams

Present:

Dr Frances Healey, Non-executive Director (Chair of the Committee)
Mrs Zoe Burns-Shore, Non-executive Director
Mrs Joanna Forster Adams, Chief Operating Officer
Dr Chris Hosker, Medical Director
Ms Nichola Sanderson, Director of Nursing and Professions
Mr Darren Skinner, Director of People and Organisational Development

In attendance:

Miss Kerry McMann, Head of Corporate Governance

		Action
	Welcome and Introduction Dr Healey welcomed everyone to the meeting.	
24/110	**Apologies for absence** (agenda item 1) No apologies were received from members of the committee. Apologies were received from Mrs Clare Edwards, Associate Director for Corporate Governance, who is an attendee.	
	The committee was quorate.	
24/111	**Declarations of any conflict of interest in respect of agenda items** (agenda item 2)	
	No one present declared a conflict of interest in respect of agenda items.	
24/112	**Approval of the minutes of the Quality Committee meeting held on the 11 April 2024** (agenda item 3) The committee agreed to remove a sentence from minute 24/091.	
	The minutes of the quality committee meeting held on the 11 April 2024 were **agreed** as a true record, subject to one amendment to minute 24/091.	
24/113	**Approval for the minutes above to be uploaded to the Trust's external website** (agenda item 3.1)	

	The committee **agreed** that the minutes of the quality committee meeting held on the 11 April 2024 were suitable to be uploaded to the Trust's external website, subject to one amendment to minute 24/091.
24/114	**Matters Arising** (agenda item 4)
	The committee **noted** that there were no matters arising that were not either on the agenda or on the action log.
24/115	**Board Assurance Framework: SR1 and SR2 – for information only** (agenda item 5) The committee had sight of strategic risks one and two on the Board Assurance Framework (BAF) so that it could be mindful of its responsibilities to assure that they were being adequately controlled through the course of the meeting. It noted that the BAF was currently under review and would be shared with Board the Board of Directors at its meeting on 30 May 2024.
	The committee **had sight of** strategic risks one and two on the Board Assurance Framework so that it could be mindful of its responsibilities to assure that they were being adequately controlled through the course of the meeting.
24/116	**Hot topics / urgent issues update** (agenda item 6) Dr Hosker informed the committee that the government had launched a call for evidence to inform a programme of work to reform the fit note process. He also informed the committee that the Office for National Statistics had published suicide data which had showed an increase of 6% in suicides in England and Wales between 2022 and 2024. The committee discussed the updates provided.
	The committee **noted** and **discussed** the updates provided.
24/117	**National Staff Survey Recommended Quality Metrics** (agenda item 13) Mr Skinner presented a report which contained a high-level summary of the metrics from the 2023 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care. He noted that the report included results from the surveys for both substantive staff and bank staff, adding that the response rate had been 50.2% for substantive staff and 27% for bank staff. The committee reviewed the information provided. The committee noted that the result for the question *'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'* had increased since the previous survey but was 3.2% lower than

	the sector average. It asked Mr Skinner to provide a breakdown of the results for each service, where possible.	**DS**
	The committee noted that each service received a breakdown of their results and developed an intention plan. Dr Hosker informed committee members that, going forward, services would use the staff survey results as evidence on their self-assessment against the Learning Culture Leadership (LCL) Framework as part of their annual quality reports. The committee next discussed the result on the bank staff survey for the question '*I am able to make improvements happen in my area of work',* acknowledging that bank staff, especially those who had worked across a variety of services, could have a good insight into how improvements could be made. It asked Mr Skinner to liaise with the Improvement and Knowledge Service to ensure bank staff were supported to make improvements happen across the Trust.	**DS**
	The committee thanked Mr Skinner for the report and agreed that the report should be provided on an annual basis.	
	The committee **received** and **discussed** a report which contained a high-level summary of the metrics from the 2023 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care.	
24/118	**Summary of the Acute Service Line's Annual Quality Reports** (agenda item 7)	
	Dr Hosker delivered a presentation which provided the highlights of the Acute Service Line's Annual Quality Report, focusing on how the service had scored itself against the Learning, Culture and Leadership (LCL) Framework and the STEEEP (Safe, Timely, Effective, Efficient, Equitable and Patient Centred) dimensions of quality to enable the conditions for high quality care to flourish. The committee discussed the information provided, noting that the full report had been reviewed by the Quality Information and Knowledge Group.	
	The committee discussed the methodology used for the self-assessments, the scoring system and the validity of the scores. Dr Hosker explained the definitions for the scores were different for each self-assessment and agreed to add additional detail to the slides going forward. He noted that the nuances of the scoring had been described within the full report.	
	The committee discussed the scores provided for timely and equitable in relation to the STEEEP framework. It noted that timely scores were based on the care provided to those who had been able to access the service but did not take into consideration those in the community who were unable to access the service due to capacity issues. It noted that scores for equity were mindful of differences in services provided (e.g. bedroom type, or bed in area versus out of area) and also needed to consider wider inequalities e.g. national findings of disproportionate use of the Mental Health Act for some ethic groups. Dr Hosker explained that the Community and Wellbeing Service Line's report and presentation would contain this detail. The committee welcomed the addition of the final slide in the presentation, which provided an executive insight into the service line's	

achievements and challenges. It agreed that this slide would be tabled at each meeting and circulated after the meeting.

Overall, the committee was assured that the service had good systems in place for understanding its quality issues and to drive improvements, and good knowledge of its strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the service's strengths, weaknesses, challenges and blind spots and how issues were being managed.

The committee **reviewed** a presentation which provided the highlights of the Acute Service Line's Annual Quality Reports, focusing on how the service had scored itself against the LCL Framework and the STEEEP dimensions. It was **assured** by the information provided.

24/119 **Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report (Q4)** (agenda item 8)

Ms Sanderson presented the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report which contained data from quarter four (Q4). She noted that there had been an increase in PALS activity and complaints and went on to reassure the committee that the data had been analysed and no trends had been identified.

The committee reviewed the chart which showed the subject matters of PALS contact for Q4 of 2023/24 compared to Q4 of 2022/23, acknowledging that the most common subject matters for both years was communication. Dr Healey queried whether the category options for complaints were helpful for understanding the issues, as almost all fell under 'communication' which was a broad term, and none fell under access which might be expected to be a concern. Ms Sanderson explained that some complaints had been raised with the wrong Trust but noted that she would review the category options.

The committee reviewed the data on self-harm, acknowledging that many of the self-harm incidents reported could be attributed to a smaller number of service users. It asked what support was being provided to the services that cared for individuals with high levels of self-harm. Ms Sanderson reassured the committee that robust support systems were in place, which included additional support from the Professional Practice Lead for Reducing Restrictive Practice and the Prevention Management of Violence and Aggression Team. She added that she had oversight of every incident within the Trust that had been categorised as level three or above, in both inpatient and community services.

The committee next discussed the number of patient safety incidents that had been recorded as patient safety events and reported to the Learning From Patient Safety Events Service. Dr Healey asked for reassurance that staff understood the reporting criteria and that the 834 patient safety incidents that hadn't been recorded as patient safety events had been recorded correctly. Ms Sanderson explained that this had also been discussed by the Trustwide Clinical Governance Group which had commissioned work to look into this. She agreed to provide an update on this work as it progressed. **NS**

The committee made suggestions for improvements to the report, which included:

- the addition of target data to the charts
- the addition of an executive summary to the report
- the inclusion of information on the additional support provided to services who care for individuals with high levels of self-harm
- the inclusion of the details of the carried over or closed CAS alerts from previous quarters within the table, not as narrative
- the inclusion of further information on the duty of candour in relation to medication incidents (to reconcile data suggesting very few medication incidents of moderate or greater harm with duty of candour numbers)
- continuing the shift to more content on actions taken in response

The committee thanked Ms Sanderson for the report and agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them.

The committee **received** and **discussed** a report which provided data from Q4 for PALS activity, the concerns and complaints handling process, compliments, claims, central alert system, incidents, serious incidents and inquests.

24/120 **Update on timeline for moving to non-stratified risk assessment formats** (agenda item 9)

Ms Sanderson presented a report which provided an update on the work being undertaken to review the Trust's approach to clinical risk assessment, and the expected timelines for approval and implementation. She noted that staff were engaging well with this work. The committee discussed the update provided, noting that this had been logged as a significant risk on the Trust's risk register. Ms Sanderson agreed to provide a further progress update at a future meeting. **NS**

The Committee **received** an update on the work being undertaken to review the Trust's approach to clinical risk assessment, and the expected timelines for approval and implementation.

Mr Skinner left the meeting.

24/121 **Final Quality Account 2023/24 and discussion around CQUINs** (agenda item 10)

Ms Sanderson presented the Quality Account 2023/24, confirming that the feedback provided by the committee in March and April had been incorporated into the document. The committee supported the improvements that had been made to the level of content within the document. It agreed that the document showcased a lot of good practice for service users, members of the public, regulators and commissioners to read. It acknowledged the efforts that had gone into the production of the Quality Account and thanked those involved.

	The committee noted that the sections on learning from deaths and the CQUIN scheme were incomplete and discussed these sections. The committee reviewed the list of mandatory inclusions for the Quality Account and asked Ms Sanderson to double check that all had been included. It suggested that this list should be added to the cover sheet for the Quality Account when it is presented to the Board of Directors on 20 June 2024. The committee next explored any further improvements that could be made to the report, suggesting that the section on falls and pressure ulcer management could include more about the improvement work that had been carried out in these areas. It also suggested that a statement could be added to explain why staff-related information, such as the staff survey results and Guardian of Safe Working Hours, had been included (noting that the committee understood why these had an impact on quality of care, but that the Quality Account needed to explain that to public readers). The committee agreed to approve the Quality Account, however it was noted that the incomplete sections would be approved by the Board of Directors on 20 June 2024. The committee noted that a report would be made to the Audit Committee on 18 June 2024 to provide assurance on the process undertaken to develop the Quality Report, with the Board of Directors having final sign off in June 2024. It agreed that it would be helpful to have a discussion on the process for developing the content of the 2024/25 Quality Account in July 2024.	**QC**
	The committee **reviewed** and **approved** the Quality Account. It **noted** that the sections on learning from deaths and the CQUIN scheme were incomplete and would be approved by the Board of Directors on 20 June 2024.	
24/122	**Response to action 24/094 – list of mandatory inclusions in the Quality Account** (agenda item 14.1)	
	The committee **discussed** the response provided for this action under minute number 24/121.	
24/123	**Out of Area Placement Quality Indicators Reporting to Quality Committee Briefing Paper** (agenda item 11) Mrs Forster Adams presented a paper which outlined the current arrangements established to ensure the quality of out of area (OOA) placements and a proposal to move to arrangements where key quality surveillance metrics for out of area placements are reported as a matter of routine through the Trust's clinical governance arrangements. The committee discussed the current quality assurance arrangements, which included the OOA Specialist Practitioner routinely attending multi-disciplinary team reviews for service users placed in out of area placements. It suggested that any issues that arise in these meetings that are equivalent to the exceptional issues escalated for patients within the trust's bed-base should be escalated to the Quality Committee in its private meetings. The committee noted there was currently no systematised data recovery or data surveillance system in place and supported the proposal for key quality	

	surveillance metrics for out of area placements to be reported as a matter of routine through the Trust's clinical governance arrangements, including to Quality Committee where that is the case for in-trust patients. It recognised that this would be more challenging to achieve for single patient placements than for units where we may have several out-of-area patients at the same time. Mrs Forster Adams confirmed that a timeline for the full implementation of this would be shared with the committee in July 2024.	**JFA**
	The committee **discussed** the current arrangements established to ensure the quality of OOA placements and **supported** a proposal to move to arrangements where key quality surveillance metrics for out of area placements are reported as a matter of routine through the Trust's clinical governance arrangements.	
24/124	**Patient and Carer Experience and Involvement Progress Report** (agenda item 12) The committee received an update progress made against the priorities and aims identified in the Patient and Carer Experience and Involvement Strategy. Ms Sanderson informed the committee that work was underway to co-produce a new strategy with service users, carers and staff members. She highlighted the Service User Network and its development. The committee praised the progress that had been made in embedding the Have Your Say feedback measure and acting on feedback, suggesting that this good practice could be shared beyond the Trust. The committee discussed the results from the Community Mental Health Services Survey for 2023. It noted the scores for questions 32d and 32c, which related to services users receiving financial advice from the Trust, and suggested that staff could receive training to support them in providing this. The committee noted that two questions scored in the bottom 20% of organisations surveyed and asked for further details on these questions. The committee thanked Ms Sanderson for the report and thanked the Patient and Carer Experience Team for its work. It agreed that it was assured on the systems and processes in place to involve, and collect feedback from, the Trust's service users and carers.	**NS**
	The committee **received** an update on the priorities and aims identified in the Patient and Carer Experience and Involvement Strategy.	
24/125	**Cumulative action log** (agenda item 11) The committee reviewed the action log and agreed to close the actions that had been completed. Dr Healey thanked committee members for their efforts to ensure actions had been completed. Ms Sanderson provided an update for action 24/096d, noting that any investigations that had not been completed within 30 days would be notified to the committee. She added that information would be added to the Combined PALS, Complaints, Compliments, Claims, CAS, Incidents, Serious Incidents and Inquests Report. The committee agreed to close this action.	

The committee reviewed action 23/110a and noted that a meeting had taken place on 7 May 2024 to discuss the quality data that could be provided while the quality dashboard was being developed. Dr Healey noted that a number of actions had been agreed at the meeting which would be considered at an Executive Management Team meeting.

The committee next discussed action 23/128, agreeing that it could be closed because it had been superseded by the action that had been agreed under minute 24/119. The committee also agreed to close action 24/067, noting that Dr Hosker had tabled the additional slide at the meeting. It went on to discuss and agree deadlines for a number of actions on the log.

The committee was **assured** with the progress made on the actions within the cumulative action log and **agreed** on which actions should be closed.

24/126 **Combined Quality and Workforce Performance Report** (agenda item 15)

The committee reviewed the Combined Quality and Workforce Performance Report (CQWPR). It noted that workforce data continued to be discussed at Workforce Committee and at Board. Dr Healey thanked committee members for the developments that had been made to the report. The committee discussed the new trendline showing the different reasons for restraint and suggested that chart may also be of useful for the Mental Health Legislation Committee.

The committee acknowledged that the Trust was no longer required to report the number of inpatients diagnosed with Covid-19 and therefore this would be removed from the report from March 2024.

The committee **received** the Combined Quality and Workforce Performance Report and **discussed** its content.

24/127 **Assurance and escalation reporting: Trustwide Safeguarding Committee** (agenda item 16.1)

Ms Sanderson noted that the Trustwide Safeguarding Committee had met on 16 April 2024 and agreed to provide a written summary of the discussions outside of the meeting. She informed the committee of a discussion that had taken place on the number of Domestic Homicide Reviews the Safeguarding Team was being asked to support, noting that this had been raised at a governance meeting within the ICS. **NS**

The committee **noted** the update provided.

24/128	**Assurance and escalation reporting: Trustwide Clinical Governance Group, including investigations delayed to a point of concern / any significant findings from investigations** (agenda item 16.2) Dr Hosker provided an update from the Trustwide Clinical Governance Group meeting on 2 May 2024. He noted that the group had received the Information Governance (IG) Group Annual Report which had highlighted an increased number of IG breaches. He reassured the committee that the breaches had been reviewed and no themes had been identified.
	The committee **noted** the update provided.
24/129	**Update/escalation of infection control issues** (agenda item 16.3)
	Ms Sanderson **confirmed** that there had been no outbreaks across the Trust since the last meeting.
24/130	**Assurance and escalation reporting: Update on industrial action** (agenda item 16.4) Mrs Forster Adams reminded the committee that the SAS doctors and the junior doctors had agreed a mandate for further industrial action, but noted that the Trust had not yet been notified of any future strike dates. She reassured the committee that the Industrial Action Planning Group continued to meet on a regular basis.
	The committee **noted** the updates provided.
24/131	**Assurance and escalation reporting: Professions and Nursing Council** (agenda item 16.5) Ms Sanderson noted that the Professions and Nursing Council had met on 23 April 2024 and had discussions on: • the work that had been undertaken in response to the findings from the Independent Review of Greater Manchester Mental Health NHS Foundation Trust • the vacancy management plan • risk registers • fit notes • the role of the Multi-professional Approved Clinician • the newly developed Advanced Clinical Practitioner policy.
	The committee **noted** the updates provided.

24/132	**Assurance and escalation reporting: CQC Steering Group** (agenda item 16.5) Ms Sanderson confirmed that the CQC Steering Group had met on 17 April 2024. She noted that discussions had taken place on: • the action plans from peer reviews within the Forensics service (Westerdale Ward) and the Older People's Service (Wards 1 and 4 at the Mount) • the self-assessment tool that had been developed • the Trust's readiness under the CQC Well-led framework • plans to undertake a peer review within the National Inpatient Centre for Psychological Medicine • sharing good practice with the South West Yorkshire NHS Foundation Trust • the preparation of data for the provider information return Dr Healey recalled a discussion at the Council of Governors' meeting on 30 April 2024 and noted that the Specialised Supporting Living Service (SSLS) was separately registered as a Social Care Service with the CQC. Ms Sanderson outlined that although the SSLS was inspected under a different framework, the Trust supported the service in preparing for inspection and undertook peer reviews.
	The committee **noted** the updates provided.
24/133	**Assurance and escalation reporting: Any other groups** (agenda item 16.7)
	No updates were provided.
24/134	**Any other business** (agenda item 17)
	The committee did not discuss any other areas of business.
24/135	**Trust specific NCISH feedback** (agenda item 17.1) Dr Hosker informed the committee that the Trust had received benchmarking data from the National Confidential Inquiry Into Suicide and Safety in Mental Health (NCISH). He outlined that this had been discussed at a meeting of the Trust Incident Review Group and noted that the Trust scored above the median of mental health organisations. Dr Hosker agreed to share this data with the committee going forward.
	The committee **noted** the update provided.

24/136	**Key messages to be shared with the Board of Directors** (agenda item 18.1)

The committee **agreed** that the following areas of discussion should be shared with the Board of Directors:

Issues to which the Board needs to be alerted:

- No issues to which the Board needs to be alerted.

Things on which the Board is to be assured:

- The committee had sight of strategic risks one and two on the Board Assurance Framework so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled through the course of the meeting.

- The committee reviewed a presentation which provided the highlights of the Acute Service Line's Annual Quality Reports, focusing on how the service had defined and scored itself against the Learning, Culture and Leadership Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. It was assured that the service had good systems in place for understanding its quality issues and to drive improvements, the service had good knowledge of its strengths and weaknesses in relation to learning, culture and leadership and the Executive Team had a clear understanding of the service's strengths, weaknesses, challenges and blind spots and how issues were being managed.

- The committee received a report which provided data from Q4 for PALS activity, the concerns and complaints handling process, compliments, claims, central alert system, incidents, serious incidents and inquests. It agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them and discussed further potential improvements to the report.

- The Committee received an update on the work being undertaken to review the Trust's approach to clinical risk assessment, and the expected timelines in relation to approval and implementation. A further progress update will be provided at a future meeting.

- The committee reviewed and approved the Quality Account. It noted that the sections on learning from deaths and the CQUIN scheme were incomplete and would be approved by the Board of Directors on 20 June 2024.

- The committee discussed the current arrangements established to ensure the quality of out of area placements and supported a proposal to move to arrangements where key quality surveillance metrics for out of area placements are reported as a matter of routine through the Trust's clinical governance arrangements, including to Quality Committee where that is the case for in-trust patients.

- The committee received a paper which provided an update on the progress made against the priorities and aims identified in the Patient and Carer

	Experience and Involvement Strategy. It was assured on the systems and processes in place to involve, and collect feedback from, the Trust's service users and carers. • The committee received and discussed a report which contained a high-level summary of the metrics from the 2023 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care. **Issues to advise the Board on:** • No issues to advise the Board on.
24/137	**Items to be referred to other Board sub-committees** (agenda item 18.2)
	The committee did not refer any items to other Board sub-committees.
24/138	**Suggestions for future internal audits** (agenda item 18.3)
	The committee **noted** that there had been no suggestions for future internal audits.
24/139	**Any actions agreed today that ameliorate the strategic risks for which the committee is assurance lead** (agenda item 18.4)
	The committee **noted** that the following action ameliorated the strategic risks for which it is assurance lead: • The discussion around improvements to the quality data received by the committee. • The discussion around the need for key quality surveillance metrics for out of area placements.

The next meeting of the Quality Committee will be held on Thursday 13 June 2024 at 9.30am via Teams