Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

HNY ICB Committee Assurance and Escalation Report

Report to: HNY Integrated Care Board

Report from: Quality Committee

Date of meeting: 21 December 2023

Committee Chair: Mark Chamberlain

Director Sponsor: Teresa Fenech, Executive Director of Nursing & Quality

Author: Kate Bedford, Senior Programme Manager

Key agenda items covered by the meeting
(A bulleted list of the key agenda items discussed at the meeting)

Detailed summary appended at AP1

Governance

- Maternity update
- Patient Safety Update - Summary of Regulation 28s
- Risk Management:
  - Board Assurance Framework (BAF)
  - Risk Operations Model
- ICB Quality Committee Policies:
  - Choice on Discharge Policy
  - Continuous glucose monitoring Policy

Quality

- Healthwatch update to include themes and issues – *appended at AP2*
- Urgent and Emergency Care (UEC)
- Place Quality Meetings 4A report: (by exception)
- Significant Issues: Update: Paediatric Hearing Services
- Agree annual programme of business for Quality Committee

ALERT
(BY EXCEPTION ONLY - key matters and / or risks to alert or escalate to the ICB Board)

- **Patient Safety -** A lead non-executive director (NED) for patient safety is required to meet the patient safety strategy requirements. The Quality Committee asked to escalate this requirement to the board.

The Board is also required to undertake level 1 Patient Safety Syllabus training and it is proposed that this be delivered by a Place Deputy Director of Nursing, at the next available Board development session.

ADVISE AND / OR ASSURE

(BY EXCEPTION ONLY - *Key decisions and any updates to advise the ICB Board on the matters the Committee was able to take assurance on or where additional information was required)*

- **Maternity -** A data deep dive into neonatal deaths seen in North Lincolnshire occurred. Assurance was provided that understanding where aspects of learning have occurred in terms of system wide operational issues is underway. The Patient Safety Committee will bring a focus to these issues in more detail.

  The board is advised that the top three risks noted in December within LMNS were: Provision of Maternal Mental Health Services; CNST achievement (Assurance provided in terms of provider engagement in support of Maternity Incentive standards (MIS) declaration submissions) and Workforce.

- **Patient Safety update**
  - **Patient Safety -** the transition to the Patient Safety Incident Response Framework (PSIRF) is progressing well and to national timescales.
  - **Patient Safety Committee -** development of the Committee is progressing well with the first committee anticipated for April 2024.
  - **National Patient Safety Alert – Valproate –** a specific patient safety alert in relation to Valproate via the Central Alerting System (CAS) was received. Assurance was provided that the sodium valproate issue had been raised at the Regional Quality Group and a deep dive update would be included in a future Quality Committee.
  - **Regulation 28s –** it is noted that Regulation 28 reports and collection of available information is inconsistent. Assurance was provided that additional consideration will be had in terms of Regulation 28s falling under the remit of the Patient Safety Committee.

- **ICB Quality Committee Policies approved:**
  - Discharge Policy
  - Continuous Glucose Monitoring (CGM)

- **Healthwatch (includes themes and issues)** – committee requested that the slides shared from Healthwatch be shared with Board. Attached at AP3.

- **Urgent and Emergency Care (UEC) –** dashboards in support of quality metrics highlighting recent trends in relation to urgent and emergency care performance, with a particular focus on the key quality metrics i.e 12-hour trolley breaches and ambulance handovers; which the data demonstrated had been deteriorating. The biggest risk noted during the update resulted from the UEC position, which included but was not limited to harm.

  Assurance was provided that substantial work had been underway during the Christmas period to ensure a number of adverse events were not repeated, including ensuring robust clinical risk management processes were in place i.e zero tolerance approach in terms of 72 hours and 8 to 10 hour waits for ambulances.

- **Place Quality Meetings 4A report –** the report provides a combined update following all six Place Quality Groups' escalation and assurance processes. This is detailed under the headings of 'Alert, Advise, Assure, Applaud'. Themes included areas of concern, mitigations and support as follows: Impact of system pressures in urgent and emergency care; Workforce; Migrant health; Industrial Action.

- **Significant Issues: Paediatric Hearing Services Improvement Programme System Recommendations -** issues which came to light in 2021, when the Scottish Public Services Ombudsman reported serious concerns about audiology care, were discussed. Key findings were collected from trust questionnaires from all services. The ICB is working with regional teams to look at the findings in order to start developing key lines of enquiry (KLOEs) and to ensure sharing, learning and resultant improvements implemented start to have positive outcomes. Site visits will occur in January 2024 and action plans developed.

- **AOB** - An ongoing dispute between junior doctors and government, the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) announced junior doctors would take strike action during December 2023 and January 2024. Assurance was provided that support is extended to staff working in these difficult situations and that robust mitigation plans were in place.