CHAIR'S KEY ISSUES

ISSUES FOR REFERRING / ESCALATING TO BOARD / COMMITTEE / TASK & FINISH GROUP

ORIGINATING BOARD / COMMITTEE / TASK & FINISH GROUP:	Quality and Patient Safety Committee, 20 December 2022
CHAIR:	Hussein Khatib, Non-Executive Director
LEAD EXECUTIVE DIRECTOR:	Giles Thorpe, Chief Nurse; Angela Tillett, Chief Medical Officer

Agenda Item	Details of Issue	Approval Escalation Alert Assurance Information
Section 2 – Executive Group Reports	Reports were received from three groups: • Clinical Effectiveness Group – the Committee questioned whether clinical effectiveness is at the level required. GIRFT (Getting It Right First Time) is key and through Time Matters Board this is being taken forward in several services. Improvements could be made by planning clinical audits more effectively, completing them, and embedding best practice, which will be a focus for the year ahead. • Patient Experience Group, with one alert regarding loss of property. A deep dive is to be undertaken by the patient experience team for the wards and departments, and the complexity of this issue was detailed. Assessing the experience of patients waiting for surgery was questioned. The Chief Nurse would take the comments forward to ensure this is discussed at the Elective Care Board. Patients are seen based on clinical need and there is a balance between undertaking harm reviews and seeing patients. • Infection Control Committee. One alert related to the deteriorating antimicrobial audit position due to the significant vacancies within pharmacy. The Trust-wide audit has been suspended as a result with resource being used in a more targeted way on Care of the Elderly wards. The Director of Infection Prevention and Control now has responsibility for antimicrobial stewardship and an update will be provided to a future meeting. The Committee questioned management of flu, COVID-19 and other infections, and access to medication, and were assured that processes were in place to manage infection closely.	Assurance

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3.1 Chief Nurse/Chief Medical Officer Urgent Issues	Paediatrics activity and Group A Strep have led to significant challenges in identifying appropriate high level care. The next two months will be difficult from an infection prevention perspective, whilst 200 air purification units have been purchased for deployment as part of the infection control strategy to reduce transmission of COVID-19/flu. An update was provided on the plans in place to protect staff from increased exposure to nitrous oxide in the delivery unit at Ipswich Hospital. Patients are being cared for in corridors and this remains a significant risk due to operational pressures. A question regarding Discharge to Assess would be raised at the Performance Assurance Committee.	Alert
3.2 Integrated Patient Safety and Experience Report	The patient safety investigation following a paediatric patient taking her own life has been completed and work with their family continues. A robust mattress audit is being undertaken and a significant number will require replacement. There has been positive feedback from the 15 Steps programme pilot visits, with the agenda being set for the coming year. This will become part of the Care Accreditation Programme. The Committee highlighted community services, and their performance on Duty of Candour requiring follow up, and nursing vacancies in paediatrics in Ipswich. A question was also asked about suicide prevention, and it was confirmed that two practitioners are in place on each site with additional expertise, working closely with teams and undertaking risk assessments. Psychiatric liaison is available for adult patients. Whilst this was positive, concern remained at the lack of support for patients with mental health needs. Assurance was provided that the acute hospital is no longer viewed as a place of safety and system working to support children was described and is much improved. The Committee recognised this whilst the need for a system/ regional/national solution was questioned. Falls, pressure ulcers and medication remain the top three concerns requiring continued monitoring, although levels of harm were low. The Chief Nurse advised that this is not expected to change in the coming weeks due to the current operational challenges and short-term staff sickness, despite the improvement work in place. All Committee members were uncomfortable with this position, whilst appreciating the candour and realistic perspective. The Chief Nurse advised that ongoing work would continue to mitigate patient risk of harm. A close eye is being kept on perinatal mortality and the Committee questioned the issues and timescales for this, which were provided, particularly regarding reduced foetal movements. There had been very good input from the Learning Disabilities nurse at the Learning from Deaths Group. The Committee questioned HSMR, the differences by site and the message to staff about protecting our most vulnerable patients. Improvements in complaints management, PALS feedback and 15 steps were noted. More time would be devoted to patient experience at the next meeting.	Alert
3.3 CNST Highlight Report	A detailed update was presented against the 10 safety standards prior to the 2 February submission. Non-compliance was being declared on standard 1, use of the Perinatal Mortality Review Tool (PMRT), and	Escalation – separate

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	mitigation will be submitted as all investigations were completed within the timescales. For standard 4, system of medical workforce planning, compliance in two areas cannot currently be evidenced with further assessment underway regarding specialty nursing for neonates to confirm that the action plan will be sufficient. For standard 8, multi professional training, compliance was met except for medical trainees, due to be completed prior to presentation to Board on 12 January. The detailed evidence to support the submission had been reviewed by the Chief Nurse, which was extensive and complex, and assurance was provided that this was an accurate position statement. In response to a question on reporting, it was confirmed that the PMRT report is included within the integrated report to Board on a quarterly basis rather than being reported separately. The Committee thanked the Division for its clear presentation of the detail and recommended presentation to the Board, whilst recognising the further work to be done on standards 4 and 8. Due to the one point of non-compliance for standard 1, a non- compliant position will be submitted to NHS Resolution.	report on agenda
3.4 Safeguarding Quarterly Update report	The quarter 2 report detailed positive developments including a new safeguarding adults practitioner; the role of independent mental capacity advocates as a focus of further training; specialist children safeguarding nurses providing briefings on the Mental Capacity Act for 16-17 year olds; dementia associate practitioner band 3 roles are role modelling best practice in the wards, championing the 'This Is Me' document; work on delivering the Accessible Information Standard has received positive feedback from those with a learning disability. The Committee questioned whether ICB level support was required to deal with increased numbers of patients with complex physical, mental and emotional problems. It was confirmed that robust partnership conversations are taking place. Our patients are facing multi-factorial challenges and these cannot be taken in isolation. There were clear routes of escalation within the ICB should the care surrounding people in our communities not meet their needs.	Assurance
3.5 Clinical Update mid-year update report	This is about learning and taking a quality improvement approach. Low compliance was presented at the end of quarter 2. Divisions have been asked to review those audits which will be achieved and identify any emerging risks. Actions being taken will be reported through the Clinical Effectiveness Group with onward escalation to the Committee.	Assurance
3.6 Health Inequalities Strategy	The final strategy was developed with key stakeholders. The Committee complimented the Chief Medical Officer on its style and content whilst the challenge would be its delivery. Details of the roll out of Making Every Contact Count and progress/outcomes would be included in the six-monthly update report. The strategy was recommended to the Board for approval	Assurance
3.7 PSIRP Update (Patient Safety Incident Response Plan)	ESNEFT has been an early adopter of the Patient Safety Incident Response Framework which replaces the Serious Incident Framework. This requires development of a plan to support a strategic, risk management approach to balancing the activity and range of incident responses with those of safety improvement. The approach taken to developing this plan was set out and the Committee questioned how child deaths are progressed. It was confirmed that these are considered externally on a case-by-case basis to agree the	Assurance

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	appropriate route for investigation. The three-year plan was approved. Formal thanks were given to the Chief Nurse and the Deputy Chief Nurse – Quality for their leadership in this work.	
5.1 Programme for Development of Quality Priorities 2023/24	The Committee agreed how the support of stakeholders will be requested through a survey undertaken in January to identify priorities within the three domains: patient safety, clinical effectiveness, patient experience. The totality of the quality programme will continue with some rolling forward into the next financial year, medication safety, nutrition and hydration and end of Life care.	Assurance
5.2 BAF – QPS Aligned Risks	For the first time the Committee considered the Board's strategic risks delegated for ongoing oversight: patient safety and quality and health inequalities – ensure equitable access to our services and improve health outcomes for all of our patients. The digital maturity risk had also been allocated, which may require a deeper review in future. The Committee questioned the potential to achieve with further consideration required to reflect the current position and what could be achieved in the best possible circumstances. Additional comments would be provided to the Interim Director of Governance.	Assurance