East Suffolk and North Essex NHS Foundation Trust

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, 22 August 2023
CHAIR:	Hussein Khatib, Non-Executive Director
LEAD EXECUTIVE DIRECTOR:	Emma Sweeney, Acting Chief Nurse; Angela Tillett, Chief Medical Officer/ Deputy Chief Executive

Agenda Item	Details of Issue	Approval Escalation Alert Assurance Information
Executive Group Reports	Updates for assurance received from the Clinical Effectiveness Group, Patient Experience Group and Patient Safety Group**.** In relation to the Infection Control Committee, a deep dive had been undertaken regarding the increased incidence of clostridium difficile in one ward area. Training and enhanced cleaning has been provided and continued monitoring through that Committee. The Infection Prevention annual report was reviewed, providing assurance of compliance to the Hygiene Code 2015/2022 (Health and Social Care Act 2008) and the national IPC Board Assurance Framework (IPC BAF) (NHSE 2021-23). As part of the next Committee update an assessment will be included regarding compliance with the framework. The Committee thanked the team for all the work that they were doing. In relation to the Clinical Effectiveness Group report, members questioned theatre access/productivity. There was one item from the Health and Safety Committee for escalation in relation to self-inspection compliance, however, support from across the Trust was being sought to improve. The format of the Committee would change**.** A letter from the Health and Safety Executive confirmed an inspection of our violence and aggression processes and risks during September. Assurance was sought on the timeline for reporting, terminology definitions and the reasons for stress in the workplace. A verbal update on the Medical Devices Management Group referred to continuing improvements in compliance for servicing of equipment and a focus on training. The Terms of Reference and scheduling are under review with clear reporting lines to be confirmed. This would be considered by Executive Management Committee prior to	Assurance

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	presentation to this Committee. The update was welcomed. A report from the Medicines Management Group would also be reinstated.	
Chief Nurse/Chief Medical Officer Urgent Issues	**Impact of industrial action** - The focus remains on patient safety. Whilst there have been no reported incidents of patients coming to harm, teams are being asked to raise any concerns. Patient flow within the hospital more recently has been extremely challenging, significant planning has been undertaken, and teams have done an incredible job. The consultants' industrial action this week prior to the Bank Holiday weekend is of particular concern. Data was provided for patient cancellations and whilst there is no overt patient harm, we know that there will have been harm in terms of patients waiting longer for treatment. **The Lucy Letby trial outcome** was considered and the actions that we need to take as a Trust to review our own processes both in terms of encouraging a culture of speaking up and also the processes we have to review both individual cases and thematic learning. Staff communication was imminent to encourage use of all avenues available to speak up if individuals have concerns. The process for gaining assurance was detailed including review of the PMRT tool data (National Perinatal Mortality Review) which reports through to Board, the trust learning from deaths group, divisional peri-natal mortality and morbidity reviews and participation in external networks. A summary would be provided to the next meeting to consider how best to respond. A Committee member highlighted the importance of dialogue across Board Committees, for example, when considering the national staff survey outcome and staff concerns. **A Never Event** reported last week was detailed, including the steps being taken to avoid a recurrence. **Inquests** – the support provided to staff and preparations for the outcome of the Coroner's deliberations were detailed. This links with work underway regarding patients with a mental health need and a reset across the system. Good conversations with partners were described, working collectively and collaboratively to enhance patient pathways and minimise current challenges.	Alert
Learning from deaths/ mortality	The Committee received a stand-alone report on benchmarks/trends and shared learning. Deaths are returning to seasonal norms. The overall Trust picture is more complex following the pandemic with a higher number of excess deaths. Significant analysis had been undertaken and a new mortality review form will support more detailed shared learning, including evidence around a more risk-based approach when patient moves are necessary or where there are prolonged stays in the emergency department. Members sought additional assurance regarding corridor care, junior doctor/consultant working and trigger points for seeking advice, the form, whether capturing the number of consultants managing a patient's care would be a positive addition and monitoring plans.	Assurance
Integrated Patient Safety and Experience Report	ESNEFT is an early adopter of PSIRF (Patient Safety Incident Response Framework), which has been rolled out across the country, and the focus was on the new national NHS service for recording and analysis, Learn from Patient Safety Events. This will see the introduction of new levels of physical and psychological harm which are more descriptive. There is the potential that this will lead to reduced incident reporting with significantly more fields to complete. The changes will likely result in a higher level of harm being reported across the NHS. More clarity on	Assurance

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	other organisations' trends and themes will also be possible. Divisions will be supported through this change, particularly regarding Duty of Candour requirements and reporting. The grading of psychological harm and national thinking in this regard was questioned. Operationally it has been challenging with significant escalation areas remaining open. The preventable measures put in place to avoid falls were described and the work to be done to provide assurance that all potential actions are being taken to reduce the risk. Community prevalence of pressure ulcers has increased. The complexity of patients was highlighted and the continued education to ensure that all elements of care are recorded. The reduction of falls within acute care was welcomed. Enhanced analysis of SPC charts would be beneficial, members suggested reviewing data in a slightly different way in relation to mode of delivery of babies, questioned how death certification is reviewed and PPH (post-partum haemorrhage) measurement.	
Deep dives: Perinatal and paediatric/neonatal mortality QI faculty	In the 2020 MBBRACE report, ESNEFT had higher than expected perinatal mortality as compared to peers. A four-year data analysis and thematic review findings was presented. As anticipated, the highest number of deaths are seen in very premature neonates, all of which are subject to PMRT review. A summary of learning, the key points and actions to be taken were detailed. The Committee welcomed the report, questioned triangulation and tracking of data in relation to communication and language, ethnicity, teenage pregnancies, external representation and whether there were early indications of improvement. A request was made for progress to be included in future reports. Mandatory reviews are required for child deaths in hospital, expected or unexpected. An overview of all deaths from 1 January 2021 to 30 April 2023, birth to the 18th birthday, included in-hospital mortality and all child deaths. Learning from cases and changes made were described. Members questioned risk factors and sought assurance on the changes. QI deep dive deferred to next meeting.	Assurance
Cancer quality of care	The quarter 1 report provided an overview of performance against standards with a particular focus on the quality impact and the actions in place to improve. Breast and colorectal services remain challenged with referrals continuing to increase. The Committee was advised of the delays and the processes in place to complete clinical harm reviews - changing the emphasis to clinical pathway review - for those who had waited more than 104 days for treatment. A new approach to be piloted would consider whether unnecessary actions, delays or decisions could potentially have changed the outcome for a patient.	Assurance
External visits	The six-monthly report gave an overview of all external visits or inspections and progress in delivering agreed improvement plans. 16 visits had been recorded since February 2023 and four visits were planned. The Committee Chair asked for the separation of formal/informal visits for future reporting.	Assurance
Maternity transformation	An update on PMRT supported meeting Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Safety Action 1 requirements. A revised self-assessed position against all 10 safety actions detailed the	Assurance

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	areas of risk and the work to be undertaken. The actions following Care Quality Commission inspections in March and July 2023 were also considered. The Chair confirmed that detailed monitoring was through the Every Birth Every Day Programme Board. Members questioned safe staffing and it was confirmed that work continues to ensure alignment with the CNST timeframe.	
Quality programme and priorities and clinical outcomes six monthly update (previously national and clinical audit)	Trust quality priority updates covered falls, nutrition, dementia, mental health, tissue viability, continence and medication safety. Quality Improvement (QI) projects are: GIRFT (Getting It Right First Time), End of Life, deteriorating patient, QI Faculty and inequalities. The milestones for each project and an update on progress were presented. Improvements in continence were specifically highlighted and sustained improvements are being seen for falls and pressure ulcers. A new model of working was supported, bringing audit and QI together under the umbrella of Clinical Outcomes and QI. This will see enhanced engagement with divisions to drive improvement from audit action plans. Full details of the clinical audit review were presented including assurance on completed audits. The audit plan is being remodelled to ensure best use of time and a focus on meaningful outcomes for patients.	Assurance
Safeguarding	The quarterly report detailed the challenges seen in both adult and children's safeguarding services and the resulting delays in investigations and delivery of training. Progress updates regarding dementia, learning disabilities and mental health were included.	Assurance
Governance	Patient safety horizon scanning would include 'what it means for ESNEFT' for future reports. The Board Assurance Framework (BAF) relevant to the Committee's remit was received. The Chair questioned target risk ratings, which were not complete. This would be clarified outside the meeting. Premises Assurance Model Assessment, the benchmark of estates and facilities across the NHS, was recommended for presentation to the Board. Self-Certification recommended to Board with some minor amendments. A verbal update described future reporting to Committee on legal services following publication of the NHS Resolution scorecard. This would include thematic analysis of themes arising from inquests and claims. The annual review of Committee Terms of Reference was approved for presentation to Board with some amendments.	Alert