The Shrewsbury and Telford Hospital NHS
NHS Trust

Trust Board Summary from
Quality and Safety Committee held 19 October 2016

Summary of items to be taken to Trust Board:

- Concerns regarding the resignation of the A&E Consultant and the implications for the on-going fragility of the medical staffing of the service.

- The committee was worried at the lack of assurance in relation to the health system winter plan given that it is already October and increased pressures are already being felt by the Emergency Departments.

- The recent Never Events were discussed by the committee and the Scheduled Care Group leadership team were invited to the meeting to discuss the incidents and proposed actions. The committee welcomed the actions but will require on-going assurance over the coming months of their implementation and success.

- The preparation for the forthcoming CQC inspection was discussed and although a pleasing number of improvements and progress had been made, it was noted that there were some issues that had not been progressed due to resource limitations.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality & Safety Committee Meeting
Wednesday 21st September 2016 at 2.00 pm in the Ground Floor Meeting Room, Stretton House, RSH

Present:	Simon Walford (SW)	Non-Executive Director (Chair)
	Sarah Bloomfield (SB)	Director of Nursing & Quality
	Muriel Fellows (MF)	Patient Experience Information Panel Member
	Edwin Borman (EB)	Medical Director
	Debbie Kadum (DK)	Chief Operating Officer
	Paul Cronin (PC)	Non-Executive Director
In Attendance:	Janette McCloud (JM)	Lead Superintendent Radiographer
	Karen Breese (KB)	Dementia Clinical Specialist
	Sarah Jamieson (SJ)	Head of Midwifery
	Anthea Gregory-Page (AGP)	Deputy Head of Midwifery
Apologies	Helen Jenkinson	Graeme Mitchell
	Brian Newman	
In attendance	Louise Allmark (LA)	Personal Assistant

Agenda Items		***Action***
1.0	***Welcome and Apologies***	
	Chair welcomed the group to the meeting and apologies were noted.	
2.0	***IRMER Report***	
	The Ionising Radiations (Medical Exposure) Regulations 2000 require the Trust to comply by law. If a Patient receives a dose higher than intended or the wrong Patient receives the examination it is reported to the CQC, equipment incidents are reported to the HSE. SaTH performs on average 186,000 examinations per year, since August 2013 there have been 22 incidents reported to the CQC due to the Patient receiving a dose 'greater than intended' the threshold for reporting is determined by the body area exposed i.e. there are different doses for different parts of the body. During 2014/15, 7 incidents were reported to the CQC and to date in 2016, 6 incidents have been reported. Actions were identified following incidents and the CQC are happy with the actions put in place. CQC will review Trust's that under-report. Quality of Referrals: Formal process in place, information held in Radiology. Issues are being escalated to Consultants and images are available on PACS System immediately, patterns/themes will emerge via Datix Reporting system. The biggest issue is within Un-Scheduled Care, receiving multiple requests from several Junior Doctors, therefore moving to an electronic system to identify issues. Require support in the Ward environment with Medical teams requesting at the Patients bed side. SaTH are experiencing similar problems as other Hospitals, when improvements implemented in the Ward processes have seen problems resolve. Winter period is always a difficult time for Radiology, Radiologists are very diligent and will question referrals from Junior Doctors.	

	EB thanked JM for a very good report. Discussions will be held this week regarding setting of professional standards for Doctors and will include referrals to Radiology. JM to present report to Clinical Governance Executive Meeting and present at monthly Radiology Board Meetings, the reports are based in calendar years not financial. Report to be presented to Quality & Safety Committee on a quarterly basis. Feedback on individual cases will be recorded on staff's personal records where appropriate. JM to review reporting incidents on SaTH Intranet system (similar to MRSA reporting), EB to include in Trust's One Minute Brief.	***JM*** ***JM/EB***
3.0	***Cervical Screening Update***	
	DK was the Executive Lead for Cervical Screening, now EB. A few gaps/concerns have been identified in the service, quarterly meetings have been arranged with Martyn Underwood to provide assurance that the appropriate results are being reported. This is following the issues with cases reported between 2012 and 2015, a total of 99 cases were reviewed and 25 were found to have significant upgrading of their smear results and Patients affected were offered a disclosure consultation with Mr Underwood and Dr Blackmore. Of the 25 11 have attended meetings, 6 haven't responded to invite, 6 have declined, 1 is in legal proceedings with the Trust, and 1 Patient who was invited did not respond but sadly passed away 3 months after the invitation. The service is altering the way the Ca Cervix disclosure consultations are dealt with, it has been noted that Derby Hospitals have an excellent system that SaTH intend to adopt. If a Patient is diagnosed with Cervical Cancer they are registered on the Cancer Register. SaTH have a Cytology contract with Stoke Hospital, Martyn Underwood is the Consultant Lead and is responsible for the QA contract, need to ensure the governance of the contract. Discussions held regarding Stoke or SaTH being responsible for diagnosis, Standard Operating Procedure (SOP) for smear testing to be reviewed by second Cytologist. DK to confirm that Contract/Service Level Agreement is in place.	***DK***
4.0	***C Difficile Review 2015/16***	
	The Trust reported one more case last year than previous years, 20 cases were reported during the first 6 months of the year and 10 during the second. During the first 6 months of this financial year 10 cases have been reported. SaTH have fewer side rooms on Wards than other Trusts and there are fewer at RSH than PRH which can cause delays when Patients require isolation. Ward 22 T/O used to be used as an Isolation Ward at RSH and Apley Ward was used at PRH. Hospitals are encouraged to assess each C:Difficile Case to determine if the incident was linked to lapse in the quality of care provided to Patients. Root Cause Analysis (RCA's) were completed for the 30 reported cases, 7 were not sent to appeals panel as it was decided that there was a lapse of care. Hand Hygiene assessments have been implemented for Doctors and compliance is gradually increasing. MicroGuide is being purchased which can be downloaded as an electronic application (app), the app is a guide for antibiotic guide lines and will be implemented in approximately 4 weeks. It will be down loaded onto iPods and iPads already on Wards and Junior Doctors can download onto their own phones too.	
5.0	***Pressure Ulcer End of Year Review 2015/16***	

	There has been a decrease in reporting Grade 3 and 4 Pressure ulcers by 27% and no Grade 4's have been reported for 3 years, the Trust have seen a small increase in reporting avoidable Grade 3's. There has also been a significant increase in reporting of Grade 2 Pressure Ulcers and moisture damage which is in synergy with Community acquired reporting. The Trust have seen improvements in record keeping, previously issues identifying the difference between Grade 2 Pressure Ulcers and moisture lesions. Patients receive a two hour assessment when presented on a Ward, challenges regarding AMU's on both sites due to the high turnaround in that area. Now that significant reduction in incidents have been achieved it is more challenging for the Trust to made further improvements but work is on-going. Experienced issues last year with devices i.e. ulcers on nose due to face masks etc., but this has improved. Discussions held regarding benchmarking SaTH against other Trusts, SaTH compares favourably with Safety Thermometer benchmarking data. Discussions held regarding incontinence and Patients dignity, Acute Trusts are not involved with Continence Service, Urology Specialist Nurse will work with Patients to advise correct pads to use, intervention from Acute Trusts depends on an individual Patient or case. Specialist Nurses will recommend pelvic floor exercises for Gynaecology and Urology Patients.	
6.0	***Dementia Update***	
	Three year action plan shared with the group for information. Executive Lead for Dementia within the Trust is Edwin Borman, Medical Director. Discussions held regarding Non-Executive to Champion Dementia for the Trust. SW to include request for Dementia Champion in Quality & Safety Summary for Trust Board to prompt discussions relating to roles of Non-Executives as leads. PC has volunteered to be the Non-Executive Lead for End of Life Care. There was a gap in the Lead for Dementia Service following Helen Coleman's change in role, Karen Breese (KB) has now joined the Trust and is leading Dementia and is supported by four support workers for the service. KB has chaired Dementia Steering Group Meetings since joining the Trust in February 2016. The Trust will see an increase in the number of Dementia Patients admitted during the winter period, if there are any concerns KB to contact DK to include in Winter Planning, screening of Patients during the winter period is very important as is on-going referral if required.	***SW***
7.0	***Medical Records Notes Audit - Maternity***	
	The aim of the audit is to determine compliance of correct documentation for Obstetric admissions in November 2014. SaTH follow local record keeping guidelines. 85 Patients were audited, documentation was good in over 90% of records, improvement still needed. Majority of Doctors had documented their name and GMC Number. An Action plan was produced following the audit, Mr Biswas is leading the action plan. Action Point 3: Karen Swain has been invited to present at Governance Meeting on 26th September 2016. Issue raised regarding consent is not reflected in Action Plan, this could be a high risk to the service and should be included. Consent forms are completed for Elective Patients. Service has identified two members of staff to be record keeping ambassadors who will promote the principles and standard of good record keeping.	

All Junior Doctors are issued with a stamp that has their name and GMC Number for documentation.

Need an improved understanding of when an episode is complete, Medway will identify issues in process. Clinical Audit don't automatically feed information to Governance Meetings, this creates a potential gap in receiving audit information. The Clinical Director is the accountable person, concerns raised regarding outcome of audit, requires a further audit and a stronger Clinical input.

AGP and SJ to present audit to Clinical Governance Executive Meeting and inform the group what actions have been taken and when a re-audit will take place.

Concerns discussed that audits and other processes don't appear to get automatically within service and are not always reported to the Care Group Board. Need ownership of Governance processes and a level of accountability over the Care Group. There were a number of concerns with the Maternity Service, Trust Board were ashamed of the response to the Ludlow 2009 case, they also recognise that they have to support the Care Group to move forward through a difficult period.

PC raised his anxiety of any further incidents of poor clinical input and leadership, the Quality & Safety Committee want to support the Care Group in a fair and supportive way. Discussions held regarding changes in behaviours and culture if the Quality & Safety Committee sought assurance that if the Clinical Director was approached regarding the audit would he be aware of the findings? SJ assured the group that he was aware.

If Care Groups and staff are transparent and open about when things go wrong they will receive support from the Quality & Safety Committee and Trust Board, want the Care Group to be encouraged to be more open.

Discussions held regarding how the Quality & Safety Committee can support Women's & Children Care Group, the introduction of the Exemplar Programme on the Wards seen as a step forward.

SJ has been in post as Head of Midwifery for 21 days, she has had a warm and encouraging welcome from staff and feels that there is a sense of relief and new beginnings expressed by staff, both Medical and Midwifery. SJ has had a very well organised induction period which allowed her to work clinically on Wards. Office base is now in Maternity and not out of the Department at PRH. Lack of communication was raised as an issue by staff, SJ has met with the Communication Team and sends out weekly updates to staff within the Care Group.

Issues have been raised that not all staff have a SaTH e-mail address, SJ has contacted IT and an implementation plan is in place to issue all staff with an e-mail address Ward by Ward. All Doctors have an nhs.net e-mail address or SaTH e-mail address.

Sign Up To Safety: developing a Safety improvement plan, working under 5 key domains aligned with the Trust objectives.

CQC Action plan is a stand-alone action plan, SJ is meeting with the Assurance Team tomorrow to discuss.

Maternity Services Review: Baroness Cumberlege visiting the Women's & Children Care Group during October 2016.

Reviewing Models of Care within the Care Group, will feed into the Women's & Children Strategy.

	Discussions held regarding restoring Patient's confidence in the service, the only way is through openness and transparency, need to build trust with Patients. Need to ensure any outstanding workforce and Governance issues are resolved. The building and geography of the service has changed, the workforce is open to change. Chair informed SJ and AGP that they have the full support of the Quality & Safety Committee and Trust Board. The Quality & Safety Committee members expressed confidence in the new Head of Midwifery but would like to continue with monthly updates to the Committee for time being.	
8.0	***Safeguarding Maternity Report***	
	Over 90% staff are compliant in training. The Trust has had a good year in terms of performance, overall results are positive and the service has good practices in place and a good reporting system. The Trust is very open with the CQC regarding any Safeguarding incidents and are showing an improvement year by year. There are 4 Local Safeguarding Boards, 2 in Shropshire (1 Children/1 Adult) and 2 in Telford & Wrekin (1 Children/1 Adult). Telford & Wrekin Children Safeguarding Service invoice SaTH £5,000 per year for Board membership, this year the invoice had increased to over £10,000 without discussion or explanation. SB has declined to pay the invoice and has written to the Chairman of the Board requesting an explanation of the increase, stating that it is unreasonable to increase by over 100% There is a slight risk for the Childrens Safeguarding Service as the Named Doctor is due to retire from the Trust in the next couple of years. Women's & Children Care Group will need to identify a new Named Doctor. Locally there are still issues regarding Mental Health of Children, Grooming rings in the Telford area and Human Trafficking, one case of Human Trafficking has been reported during the last 12 months. Teresa Tanner, Named Nurse for Safeguarding Children and Young People provides staff with Female Genital Mutilation Training. There continues to be a high number of Looked After Children from Out of County placed in Shropshire. This results in difficulties supporting and placing children admitted to SaTH as their Social Workers are often based in a different part of the Country. There were 38 adult cases/referrals against the Trust, cases are reported at monthly Clinical Quality Review Meeting (CQRM), discharge from Hospital remains a theme in some cases.	
9.0	***Annual Review of Incidents relating to Patients with Learning Disability***	
	The Trust will have a bigger focus on Learning Disability next financial year, SB is working with a Carer who's adult son has a learning difficulty. SB is meeting with the Carer next week to discuss ways forward. MF has received a good news story regarding a Learning Disability Patient and will share with SB. Any un-expected death of a Patient with Learning Disabilities has to be reported. The West Midlands Quality Review Service (WMQRS) is planning to complete a review of care for Learning Disability Patients in a number of Trusts across the region, SaTH will be visited in November 2016. Big improvements have been seen in Deprivation of Liberty applications.	

10.0	***Annual Safeguarding Report***	
	Discussed under agenda item 8.	
11.0	***Policy Approval***	
	Paper distributed to group for information prior to meeting and approved. Carbapenemase-Producing Enterobacteriaceae (CPE): One case regarding Overseas Patient admitted with CPE, was extremely challenging for staff caring for Patient due to challenging behaviour relating to cognitive impairment.	
12.0	***Key Agenda Items for Future Meetings***	
	SB to contact Julia Clarke regarding CQC Framework and criteria for agenda for Quality & Safety Committee Meeting. TEMS Community Service for Orthopaedics, service is delaying referrals by approximately 18 months. Quality & Safety Committee requested further update following previous presentation from MSK, LA to invite to future meeting. Winter Planning: challenges in resourcing winter plan, this will be discussed at next Trust Board Meeting.	***SB*** ***LA***
13.0	***MRSA Bacteraemia, CDU, RSH***	
	SB wrote to Un-Scheduled Care Group regarding recent MRSA Bacteraemia case in CDU, RSH, the response has been received today and does not provide details of the questions raised, SB asked for assurances from the Care Group in their response and no assurances have been made. The Patient required surgery due to the cannula insertion. SB will contact Carol Mcinnes, the new Assistant Chief Operating Officer as required assurance that this incident will occur again.	***SB***
14.0	***Minutes & Actions from Previous Meeting***	
	Minutes to read that Paul Cronin was present at the last meeting on 23rd June 2016. Ophthalmology Paper to be presented to Trust Board next week, Past Max Waits are currently under 1,000. Still some HR issues on-going in service. SB will present CQC Action Plan at next meeting.	***SB***
15.0	***Integrated Performance Report/ Ophthalmology Dashboard/ Maternity Dashboard/ Single Sex Breaches***	
	Poor MRSA Non-Elective Screening performance has improved but close monitoring to continue until this is solved. Low number of births at Ludlow Maternity Unit. 98.8% of women recommend the service overall. SB has a one to one meeting with Bruce McElroy next week to discuss medication discharge and if we can measure the percentage of TTO's written the day before. Discussions held regarding outstanding Serious Incidents, incident outstanding from July that involves Pharmacy, SB to confirm with Samantha Carling that a Serious Incident involving other services is extended to 60 days.	
16.0	***Parliamentary & Health Service Ombudsman Report***	
	Parliamentary & Health Service Ombudsman Report shared with Committee for information. No questions or comments raised.	

17.0	***National Clinical Audit Report***	
	Clinical Audit Report shared with Committee for information, information from report is included in the Quality Account.	
18.0	***Staffing Data***	
	Staffing Data shared with Committee for information. Report includes Care Hours per Patient per day requirement, the Carter Review reports that hours per Patient per day requirement should be approximately 9.1 hours, SaTH will benchmark against other Trusts. Will introduce Quality indicators into the report for each Ward i.e. Falls, may then include sickness and training hours.	
19.0	***Minutes of Meetings for Review***	
	Minutes from Infection Prevention Control Committee, Clinical Governance Committee and Patient Experience Information Panel shared with Committee for information.	
20.0	***Board Assurance Framework***	
	Board Assurance Framework (BAF) to be discussed on a quarterly basis at Quality & Safety Committee Meetings. Reviewed notes owned by Committee and some changes suggested. Need to include: Conversations with TDA regarding Ophthalmology Appointment of Head of Midwifery CQC Preparation BAF does not currently accurately reflect Board concerns regarding Maternity. Delayed transfers of Care should be scored red. SB to discuss with Julia Clarke. The BAF is actively reviewed and will feedback to Julia Clarke. Discussions held regarding additional risks to add, Quality & Safety Committee would like to review any risks relating to Accident & Emergency. Increasing concerns regarding staffing combined with decreasing performance against 4 hour performance target.	***SB***
21.0	***Dates of Meetings: 2017***	
	Dates of next years' meetings shared with the Committee.	
22.0	***Trust Board Summary***	
	Summary for Trust Board to include: • Non-Executive Champion for Dementia Service and recognise service environmental challenges plus discussion needed about role of Non-Executives as leaders • Frank and positive discussion with Head of Midwifery and support from Quality & Safety Committee	
23.0	***Any Other Urgent Business***	
	Turnaround Delays: has been a query as to why SaTH haven't reported as Serious Incidents for the Trust. SB will discuss with Samantha Carling and feedback at next meeting.	***SB***
24.0	***Date and Time of Next Meeting:***	
	Monday 24th October 2016 at 3.00 pm in the TCI Training Room, Copthorne Building, RSH	

Quality & Safety Committee Meeting
Actions

Agenda Item	Action/Recommendation	Responsibility
2.0	JM to present report to Clinical Governance Executive Meeting and present at monthly Radiology Board Meetings.	**JM**
2.0	JM to review reporting incidents on SaTH Intranet system (similar to MRSA reporting), EB to include in Trust's One Minute Brief.	**JM/EB**
3.0	DK to confirm that Contract/Service Level Agreement is in place for Cytology Service.	**DK**
6.0	SW to include request for Dementia Champion in Quality & Safety Summary	**SW**

	for Trust Board to prompt discussions relating to roles of Non-Executives as leads.	
12.0	SB to contact Julia Clarke regarding CQC Framework and criteria for agenda for Quality & Safety Committee Meeting.	**SB**
12.0	LA to invite MSK Service to future meeting to provide an update on TEMS Community Service for Orthopaedics	**LA**
13.0	SB to contact Carol Mcinnes regarding recent MRSA Bacteraemia case in CDU, RSH	**SB**
14.0	SB to present CQC Action Plan at next meeting	**SB**
20.0	SB to discuss BAF with Julia Clarke	**SB**
23.0	SB to discuss turnaround delays with Samantha Carling and feedback at next meeting.	**SB**