The Shrewsbury and Telford Hospital NHS Trust

Paper 7

Quality and Safety Assurance Committee
19 September 2018

Never Events - No change to risk

The committee are tracking the action plans linked to recent never events. Despite significant work to understand and address the problems within the operating theatres that have contributed to recent never events, there remains much to do. The committee is not yet assured that appropriate changes in culture and process have been achieved and will continue to seek evidence of on-going actions and improvement. The committee was clear that, where there are behavioural issues that mitigate against the implementation of safe practice, these must be addressed. At the August meeting the Trust Medical Director indicated that he still could not be assured that the necessary cultural and behavioural changes have been made. Key elements of the surgical never events have been characterised by the procedure being minor and known safety checks having been bypassed.

Sepsis

At the July meeting, the committee reported that, the recognition and management of sepsis is both a national and local priority. Improving sepsis management has been the focus of transforming care work streams. The committee were pleased that it has been agreed that the Critical Care Outreach Sisters will now have a mandate to support improvements in sepsis care. This change was associated with a “launch” by the team to raise sepsis awareness. This showed commitment, innovation and pace in a campaign to raise awareness of sepsis and of the team’s contribution.

Sepsis recognition and management needs to retain a high profile within the Trust. CQC findings suggested that sepsis was not necessarily being identified. This is despite quality improvement work undertaken and tangible evidence of improved sepsis management provision on ward visits.

Maternity Services (BAF1204)

Since the August 2018 meeting the maternity service has been subject to a further CQC visit. This culminated in the issue of a section 31 notice requiring action by the Trust and weekly reporting of actions to the CQC. The committee reviewed the CQC findings:

- That, where Mums were concerned about a reduction in their baby’s movements, the required monitoring of the foetal heart was being performed in midwife led units. This recognises the rurality of the county and attempts to provide accessible services. CQC are concerned that the monitoring should have medical oversight. Further work is required to ensure that appropriate risk assessments and quality impact assessments are conducted. In the meantime, the service will be solely based at Princess Royal Hospital
- CQC also expressed concern that Mum’s on the labour ward with known increased risk were selectively reviewed by obstetricians with the review being guided by a midwifery assessment. CQC felt that all women with risks should be reviewed. The midwife triage and prioritisation is used in other maternity units including some reviewed positively by CQC. Further work is required to review the current approach.

As a result of the adverse publicity linked to the section 31 letter and additional media attention, the committee recommend that the risk in BAF1204 is increased.

The committee note that the EMBRACE data for 2016 shows that SATH is in a band that is 10% higher than similar trusts for “stabilised and adjusted” stillbirth rates. The care group produced an overview paper setting out how known risk factors for still birth are managed by the Maternity services. There are some significant

public health issues that contribute to risks including smoking, obesity and diabetes. There is evidence of progress in reducing smoking within women who present as smokers and who are pregnant.

Patient Flow

Since the CQC section 31 Notice with respect to the boarding of patients, the Trust has opened additional bed capacity (ward 27 and ward 8), the wards are currently being staffed by redeployment from other wards but this is not sustainable. Whilst this is a temporary solution, it is important to recognise that boarding is a symptom, not of insufficient beds, but of inadequate patient flow. The committee heard that:

- It was difficult to identify patients within the hospital who meet the criteria set down for admission into one of the escalation wards. This needs to be addressed.
- Should the wards remain open and patient flow remain unchanged; the Trust will find it difficult to provide short term increases in bed numbers required to meet “winter pressures”. This could mean that there is pressure to provide additional beds on day surgery wards an unsatisfactory solution that the committee has previously criticised
- At present only 15% of planned discharges are achieved before 12 noon. The NHS target is 33% and even this seems low. The committee have advocated criteria led discharge and are hugely disappointed that this is still not in place as a potential contributor to effecting earlier discharges.
- The Trust is also attempting to roll out approaches developed on the respiratory ward developed during a Virginia Mason Improvement Project. This needs to proceed at pace in order to be impactful
- Successfully managing pressure on the hospital will require:

    - On-going support for the management of delayed transfers of care
    - A review of admission criteria to community beds
    - Improved transport provision- the current patient transport system is failing to meet contractual KPIs and lacks an adequate demand and capacity model.

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