Sheffield Teaching Hospitals
NHS Foundation Trust

Meeting Assurance Report to the Council of Governors Being held on 19 September 2023

Name of Committee / Group	Quality Committee
Date of Meeting	17 July 2023
Chair	Ros Roughton, Non-Executive Director
Lead Officer	Angie Legge, Quality Director
Meeting Administrator	Andrew Timms

Purpose

The purpose of this report is to provide in summary an update on the key discussions and outcomes of the above meeting.

Agenda items covered at the meeting

The agenda included the following items:

- Maternity Improvement Programme update
- CQC Action Plan update
- Annual Ward Accreditation Process Review
- Integrated Quality and Safety Report - annual report 2022-3, including Q4
- New never events and closed serious incidents reports
- Patient Safety Incident Response Pan
- Learning from Deaths Q2 and Q3
- Clinical Effectiveness Trust Clinical Audit Programme 23/24
- Findings and action plan from Internal audit report of clinical effectiveness - clinical audit

The committee also received:

- CQC Compliance Report (Quality)
- Information Governance and SIRO Annual Report
- Annual Report on Trust Implementation of NICE guidance
- Quarterly report on Trust implementation of National Patient Safety Strategy
- Highlight reports from Quality and Safety Executive Committee; Health and Safety Executive Committee; Patient Experience and Engagement Executive Committee; Mental Health Executive Committee; and Infection Prevention and Control Committee.

Matters to highlight

Specific areas to highlight are as follows:

- Maternity Improvement Programme: The Committee heard from the Clinical Director and Interim Director of Midwifery about the new priorities for 23/24, including the incorporation of neonatal care into the programme going forward. The Committee heard about an event to gather views from staff on "What Matters to You" day, which had been positively received. The Committee received an in-depth presentation, triangulating the main themes from the last 10 years of maternity claims; alongside the themes from complaints and incidents over the last three years. Key issues that were highlighted as impacting on the safety of care and the experience of women were: fetal monitoring; the management of pain relief; and communications - all issues being addressed through the maternity improvement programme.
- CQC Action Plan: The Committee agreed to the closure of the workstream on deteriorating patients, in light of the progress made; and to the closure of the "risk, health and wellbeing" work stream within the specialised cancer services programme.
- Annual Ward Accreditation Process Review: the Committee noted the impact of this comprehensive review over the past year, and the positive views of nurse leaders about its usefulness in driving up and maintaining standards. It noted that this had been resource intensive.
- IQSR Annual Report: the Committee welcomed the greater detail contained within this report, and the examples gives on how individual wards are responding to feedback from families and friends.
- Learning from Deaths Report Q2 and Q3: the Committee noted that there continues to be close monitoring of any changes in the HSMR (Hospital Standard Mortality Ratio).

Documents approved were:

- The Patient Safety Incident Response Plan
- Clinical Effectiveness Trust Clinical Audit Programme 23/24

Significant issues / concerns escalated including proposals on the next steps to address this

The Committee considered that it would be important to maintain a focus on addressing the main themes identified through the work on reviewing maternity claims, complaints and incidents. Updates will continue to come to the board and Quality Committee. It was agreed to look at whether some of the data could be benchmarked against similar NHS acute Trusts in future.

The Committee will maintain a close focus on the learning from deaths figures, with further information to be presented in the autumn when the latest figures were available on outcomes for people with fractured neck of femur.

Concern was expressed that with the move to the Patient Safety Incident Response Plan at the end of September, that the learning from some incidents which currently qualify as Serious Incidents, but which would not under the current process, could be lost. An executive led process of review was noted, with new investigation methods for incidents not meeting the PSII level, but it was agreed to monitor for gaps.

Implications

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	

2	Provide Patient Centred Services	
3	Employ Caring and Cared for Staff	
4	Spend Public Money Wisely	
5	Create a Sustainable Organisation	
6	Deliver Excellent Research, Education and Innovation	

Recommendations

The Council of Governors is asked to **NOTE** the update provided and respond to any specific points raised within the report.