University Hospitals Birmingham
NHS Foundation Trust

INTEGRATED QUALITY REPORT

Report to Trust Board October 2021

Learning from Deaths

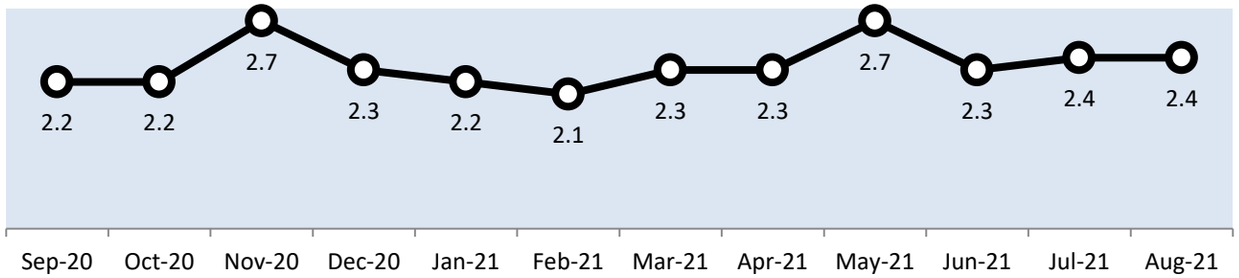
SHMI, HSMR, CUSUM

Data unavailable

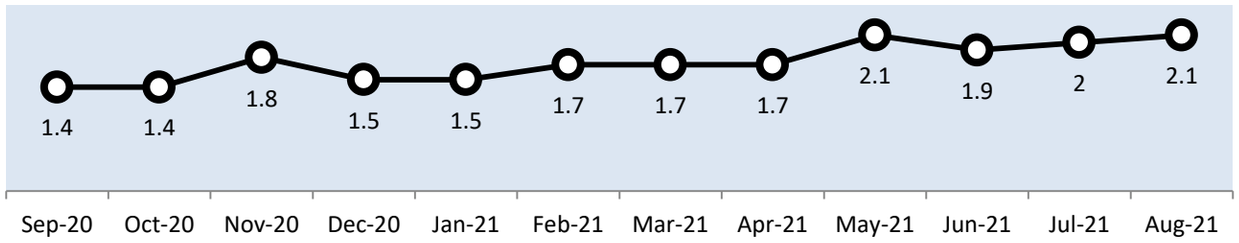
- Changes in the source data provided to the HED team has meant updates are taking longer than usual and as a result there is no CUSUM update this month
- Any triggers or higher than expected cases will be reviewed as soon as data is available as part of routine Learning from Deaths reviews

Perinatal Mortality

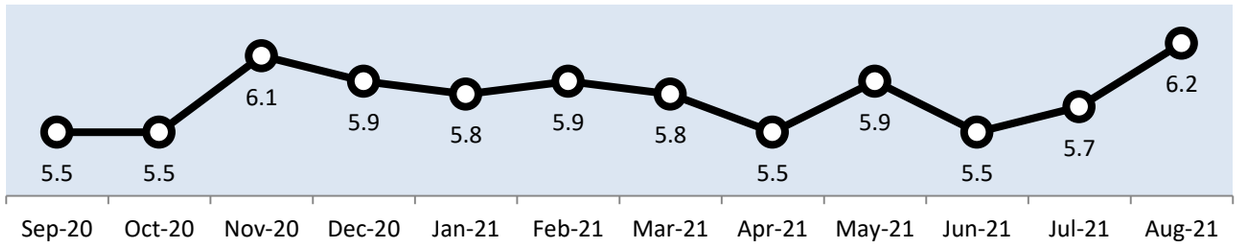
Neonatal death rate per 1000 births



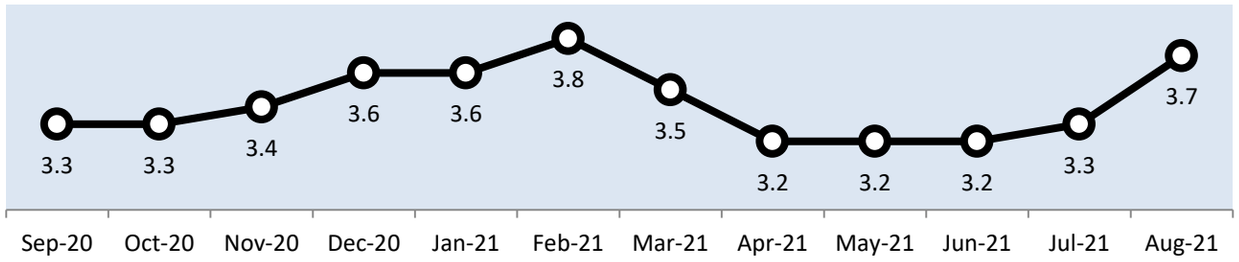
Early Neonatal deaths rate per 1000 births



Perinatal deaths rate per 1000 births



Stillbirth death rate per 1000 births



The following graphs demonstrate how University Hospitals Birmingham is performing against the national ambition in a rolling 12 month period. The data is reported nationally on the 29th of the month, so below is the latest dataset available.

Neonatal Death Rate

The 12 month rolling neonatal death rate remained static through August at 2.4/1000..

Early Neonatal death rate

The rolling 12 month Early Neonatal death rate per 1000 births increased slightly during August to 2.1 which is in line with the national average.

Perinatal Mortality

The 12 month Perinatal Mortality death rate per 1000 births increased during august to 6.2

Stillbirth rate

The Trust rolling 12 month rate has increased to 3.7 during august. This mirrors the national average of 3.7

Learning from Deaths quarterly reports

Learning from Deaths – Q2 2021/22

The Learning from Deaths, Quarter 2, 2021/22 update is at Appendix A

Child Death Review Process – Q1 2021/22

A summary of child death reviews for Quarter 1, 2021/22, is at Appendix B

Perinatal Mortality Reviews– Q1 2021/22

A summary of perinatal mortality reviews for Quarter 1, 2020/21, is at Appendix C

Inquests

Potentially Adverse Inquest conclusions

Theme	Inquest Date	Division	Location	Investigation	Outcome
Self-discharge prior to closure of safeguarding referral	13/09/2021	4	GHH	External review by Adult Safeguarding Review Board	Suicide
Splenic rupture following colonoscopy	14/09/2021	4	BHH	SI and complaint	Patient died from a rare but recognised complication of a necessary medical intervention
Delay in diagnosis of fracture	14/09/20231	3	GHH, QEH	Executive RCA	An old lady in declining health sustained a hip fracture
Fall on ward with fracture	16/09/2021	2	BHH	Falls RCA	Accident
Fall on ward with fracture	21/09/2021 (moved from 31/08/2021)	3	BHH	Falls RCA	Natural causes contributed to by injuries sustained by a fall
Missed opportunity to treat	30/09/2021	3	QEH	SI	Death was a consequence of a ruptured abdominal aortic aneurysm
Fall on ward with fracture	05/10/2021	3	BHH	Falls RCA	Accident

Inquests

Pending complex inquests

Theme	Inquest Date	Division	Location	Investigation	Status
Delay in surgery	21/10/2021	2	QEH	Complaint	Incomplete
Delay in treatment for PE	26/10/2021	3	BHH	Executive RCA	Investigation complete
Fall on ward with fracture	16/11/2021	3	GHH/QEH	Falls RCA	Investigation incomplete
Appropriateness of post-operative environment	17/01/2022	5	QEH	Divisional RCA	Investigation incomplete
Fall on ward with fracture	18/01/2022	5	QEH	Falls RCA	Investigation incomplete
C-difficile infection	26/01/2022	1 and 5	QEH	Post-Infection Review and formal complaint	Investigation complete
Possible delays in referral for treatment	04/02/2022	5	QEH	M & M	Investigation incomplete
Ownership/responsibility of patient following transfer	TBC	4	QEH	Executive RCA	Investigation complete

Regulation 28

- There are currently no Open Regulation 28s with the coroner.
- There are 2 open action plans following previous Regulation 28s for University Hospitals Birmingham- one is a new report and the other includes a final outstanding action on a historical HGS 2017 action plan.

New Action Plan Developed:

- A Regulation 28 has been raised for Good Hope Hospital, following an unwitnessed patient fall in the Emergency Department February 2021. The below action plan has been developed and will be monitored by the Clinical Compliance team;

Date Report Received	Site	Summary/ Issues	Action Owners	Remaining Actions	Progress
17/06/2021	GHH	The patient died on the 18th February 2021 at Good Hope Hospital, as a result of injuries he sustained following an unwitnessed fall from a chair in an ED cubicle. He was treated conservatively, however his condition deteriorated and he did not recover. He was not provided with a Zimmer frame to mobilise and no discussion took place between staff as to how he was to mobilise in the absence of a walking aid.	Director of Nursing	Trust OPAL team Leads and ED Senior Nursing Leads to meet and discuss a standardised process for the assessment and provision of walking aids in ED including how instructions for mobilising are communicated across teams.	Ongoing- Awaiting evidence of process and communication to teams.
			To be confirmed with the Deputy Chief Nurse	6 monthly audits which will look at the number of patients assessed as needing a walking aid, whether they were provided with one in ED and if they weren't, the reason for this.	Forthcoming- Deadline March 2022 for first audit cycle

Regulation 28

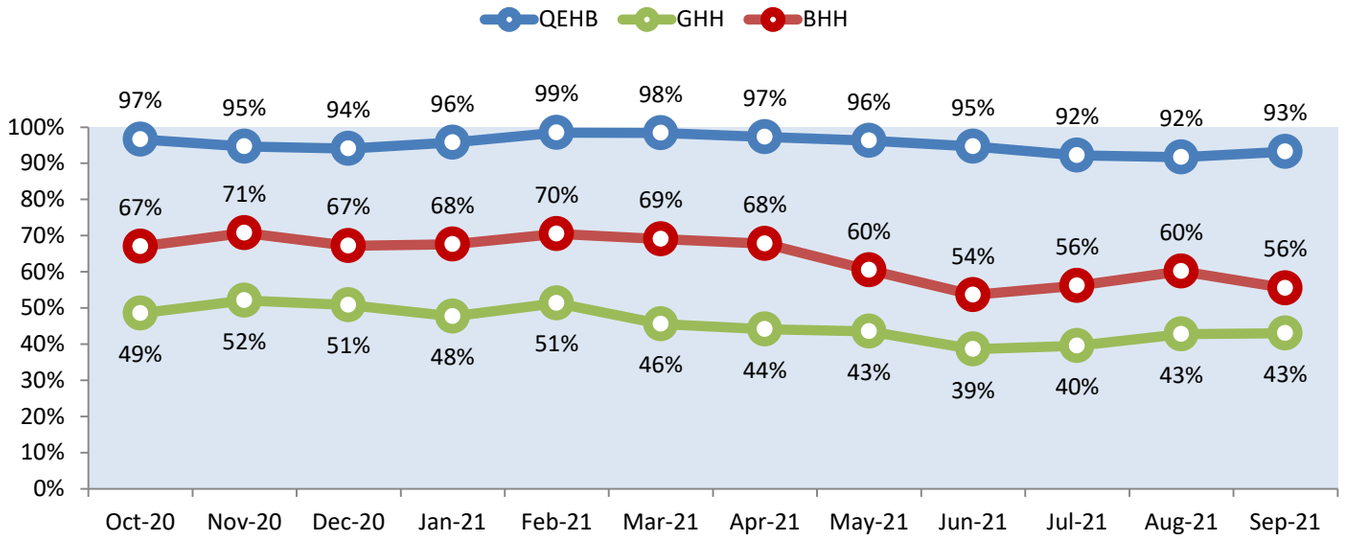
Outstanding Actions:

- There is 1 Regulation 28 Action Plan currently being monitored. This was raised in 2017 (this is a historical HEFT action plan) with a final action point remaining;

Date Report Received	Site	Summary/Issues	Action Owners	Remaining Actions	Progress
27/04/2017	BHH	The deceased suffered aspiration pneumonia caused by a small bowel obstruction. An abdominal x-ray was delayed, which meant the severity of condition was not identified earlier. Surgery was undertaken, however the deceased was too poorly to benefit. This incident highlighted inconsistencies with the MEWS SOP and escalation pathway in ED.	Emergency Medicine	**1 Action Remaining:** N.E.W.S 2 (National Early Warning Score) will be replacing the M.E.W.S (Modified Early Warming Score) policy at H.G.S sites and current patient observation policy at Q.E commencing in October 2018; An ED-specific MEWS Observation Chart has will be deployed for use in the BHH and, Good Hope EDs, and the Solihull Minor Injuries Unit.	NEWS2 has now superseded MEWS and is on PICS for QEHB, and paper copies for HGS sites. Awaiting PICs to be rolled out across BHH site- Once this is completed, the final action can be closed off.

Quality Indicators

Observations – within 15 minutes of arrival

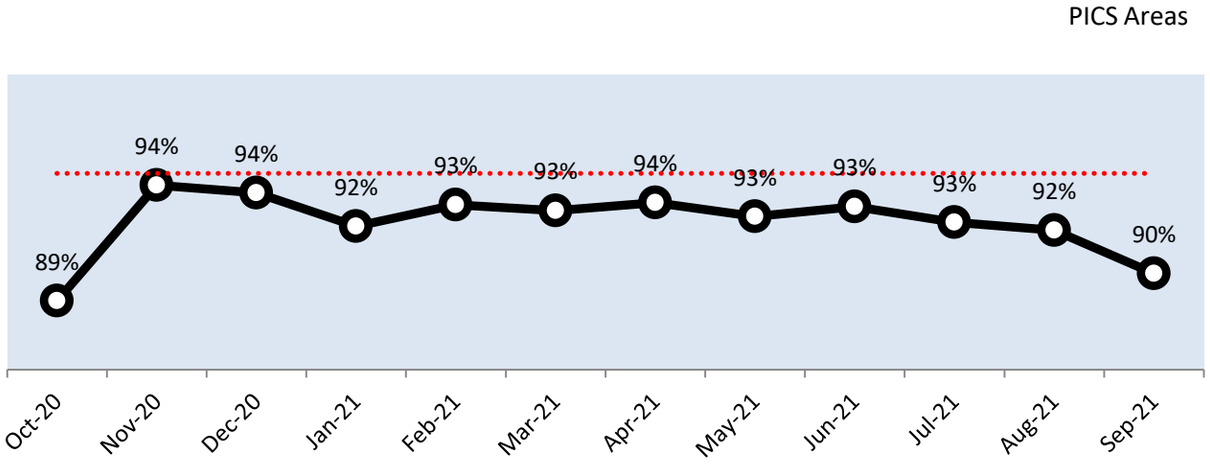


Initial assessment within 15 minutes

At present, the QEH site and those at BHH and GHH are using differing criteria to measure 15 minute assessment times within the Emergency Departments. This is due to be aligned in late 2021 where a direct comparison between the sites will be possible. During September there was variable performance across the sites with Good Hope remaining static, an increase in performance at the QE site, but a reduction to 55.5% at heartlands.

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
QEH	97%	95%	94%	96%	99%	98%	97%	96%	95%	92%	92%	93%
GHH	49%	52%	51%	48%	51%	46%	44%	43%	39%	40%	43%	43%
BHH	67%	71%	67%	68%	70%	69%	68%	60%	54%	56%	60%	56%

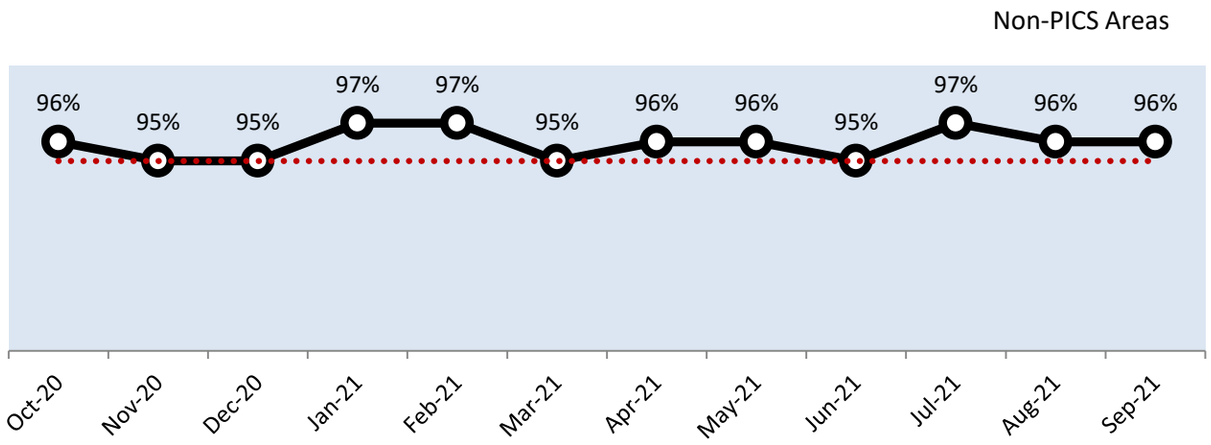
Inpatient observations and pain assessment



Observations and Pain

Performance against the number of patients receiving observations and pain assessment within six hours of admission is currently available for the Queen Elizabeth Hospital (QEH) and Solihull Hospital (SH) sites, with a selected number of wards at Heartlands also. Consistent figures across the whole Trust will follow with the implementation of PICS at all sites during 2021 and 2022.

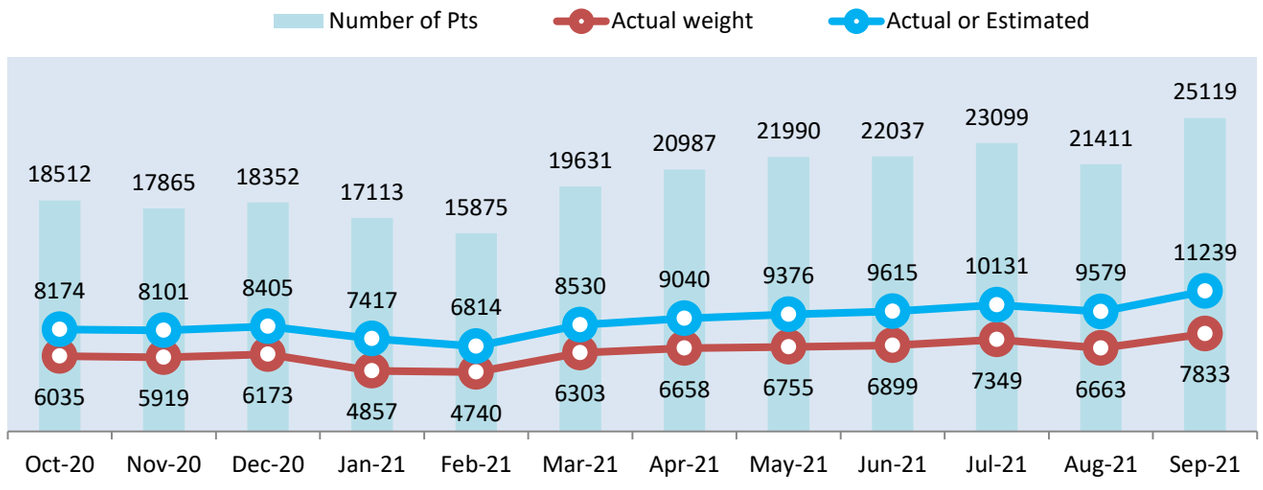
September saw a decrease to under 90% for the first time in 11 months to 89.9%

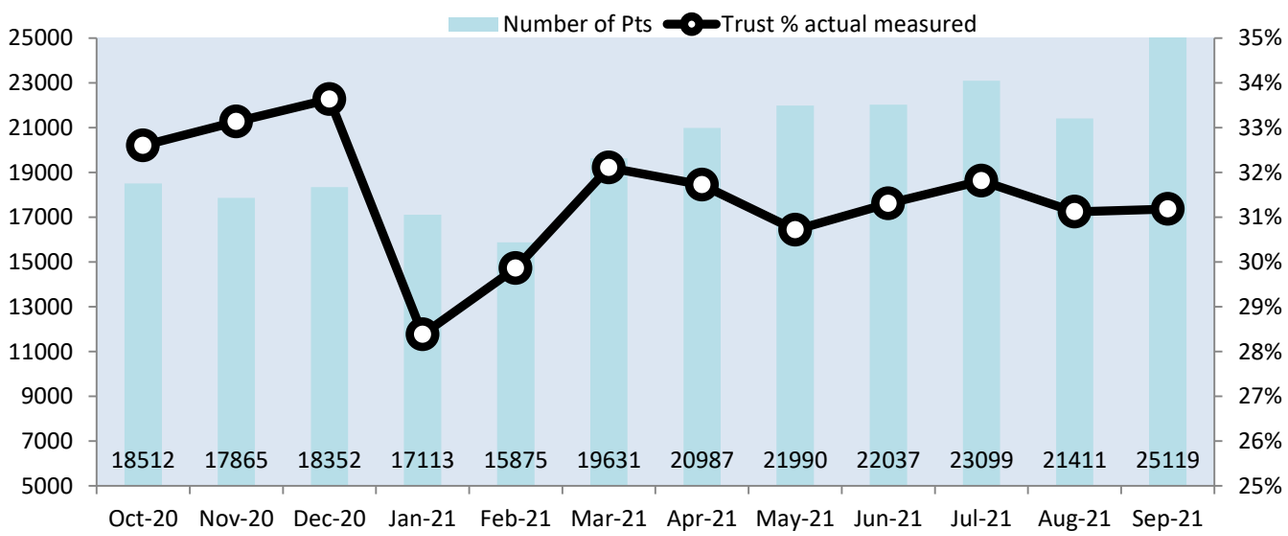


Observations assessment

At the Heartlands and Good Hope Hospitals the proportion of patients receiving an observations assessment is assessed each month as part of the Care Quality Metrics. Solihull Hospital merged onto the Prescribing and Information Communication System (PICS) system in April. Whilst some wards have started to migrate, the majority of BHH and all GHH hospital sites will continue with Care Quality Metrics, until the PICS is rolled out trust wide during 2021. September saw performance remain static at 96%

Actual vs Estimated weight





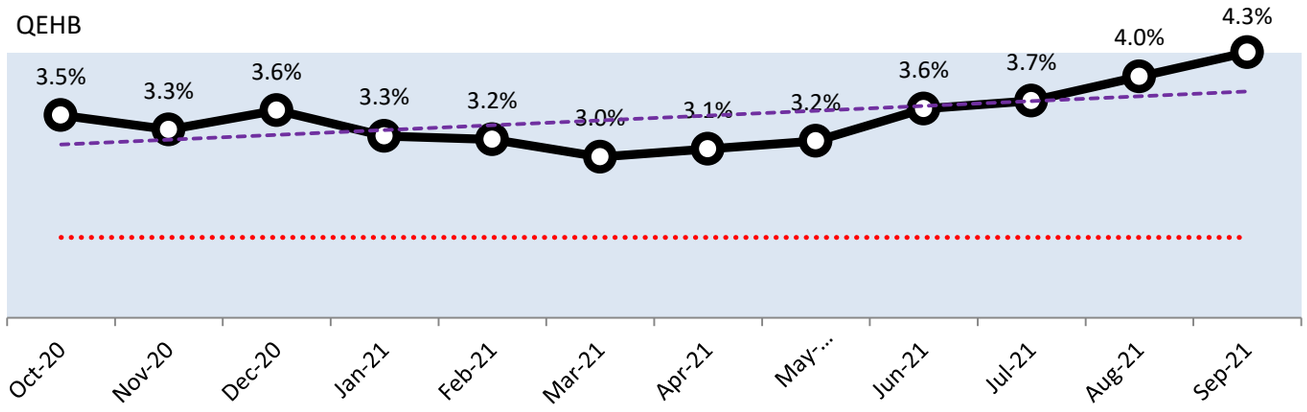
Nutrition and hydration are key components of effective, safe care. They have been highlighted through incidents and audit as requiring focus to ensure best practice and promote recovery and wellbeing of our patients. They have been identified as one of the Trusts Quality account, Priority 5 Improving Nutrition and Hydration, for 2021/22. Therefore the baseline indicator of patient weight has now been incorporated into the care quality report. Weight is also a key measure for the safe prescribing and administration of many medications.

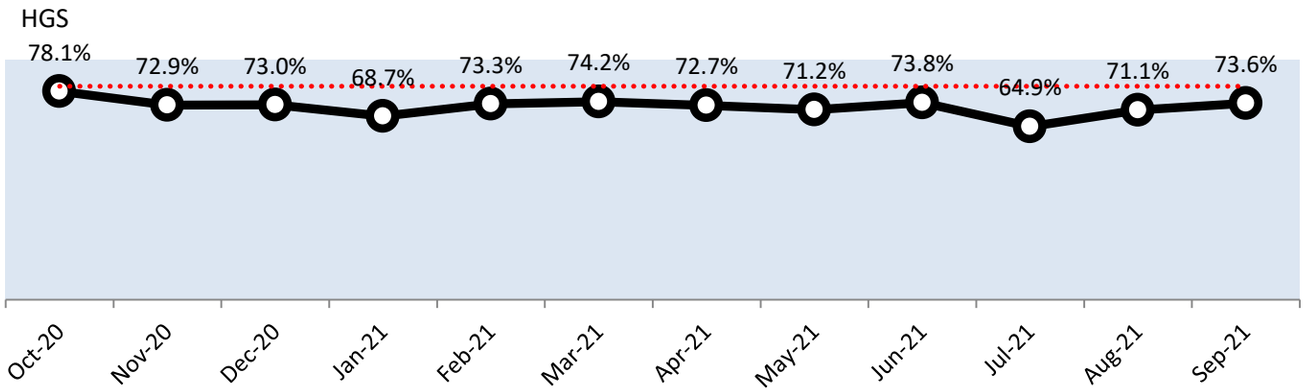
The first graph shows the number of patients admitted to the wards using PICS and the number of patients that had their actual weight recorded, and the number that had their actual weight or estimated weight recorded. There was a sharp increase in all 3 measurements during September with 25,119 patients admitted. The highest in over 12 months.

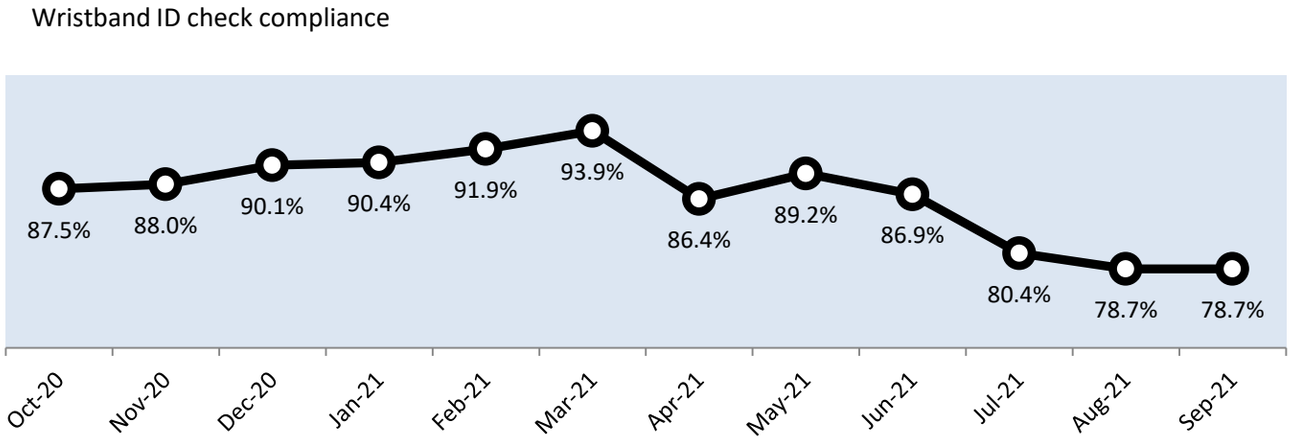
The second graph shows the number of patients across the Trust and the percentage of patients who had their actual weight recorded.

Whilst the number of patients during September increased significantly, the proportion of those patients in which their weight was actually measured remained static at 31%.

Medicines management







Omitted Drugs – Antibiotics

Consistent figures across the whole Trust will follow the full implementation of PICS at Heartlands and Good Hope Hospitals. In September 2021 with the omitted drugs percentage increased to 4.3%, and has not achieved the Trust target of 2% or less. Trust antimicrobial guidelines have been updated and were launched during September on a smartphone app to make these more accessible to users. Compliance is expected to be better with guidelines being more readily available and will be monitored on an ongoing basis through stewardship ward rounds.

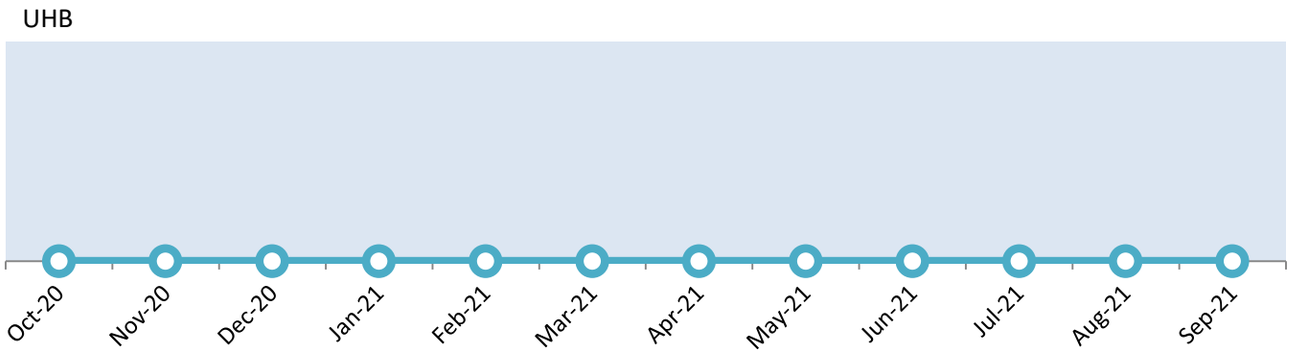
Antibiotic STAT Doses

Since the review highlighting the key issues inhibiting achieving performance and local actions being implemented and managed through Divisional Quality and Safety meetings, performance has positively started to improve. There was an increase of almost 2.5% during September on August to 73.59%. Showing a second month in succession of increased performance.

Wristband compliance

After issues around medication administration were identified through the Clinical Dashboard Review Group (CDRG), wristband ID scanning was recognised as a concern. This has led to a focus on improving overall performance and shared learning from the Divisions at the CDRG. September performance remained static during September at 78.7%

Sleeping accommodation breaches and Hospital Passports



Sleeping Accommodation Breaches

There were no sleeping accommodation incident breaches reported in September 2021. This represents now represents a full 12 month period without a breach

UHB Totals	July 2021	August 2021	September 2021
Brought in by patient	6	8	2
Completed in hospital	131	123	116
Passports completed	99%	99%	98%

Hospital passports

During September, of the 130 patients to whom the Standards applied, 3 patients refused a Hospital Passport, 7 patients were discharged the same day and 2 patients failed to have a Hospital Passport completed despite numerous requests. Of the118 patients, 106 (91%) were completed within the 24-hour Standard set.

Central Alerting System (CAS) activity, including National Patient Safety Alerts (NatPSA)

CAS Alerts

Type of alert	Alerts received	Linked to COVID-19?	Alerts closed	Currently open	Overdue
Chief Medical Officers Alert	2	1	0	3	0
Estates Alert	0	0	0	0	0
Patient safety alert	0	0	0	2	0
Supply Disruption Alert	1	0	2	2	0
Total	2	1	0		0

New National PSAs received this month:

NatPSA/2021/009/NHSPS Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures. Issued 25/8/2. Deadline 25/11/2. Executive team informed and will nominate a lead for the alert.

NatPSA/2021/008/NHSPS Elimination of bottles of liquefied phenol 80%. Issued 25/8/2. Deadline 25/02/22. Executive team informed and will nominate a lead for the alert. Pharmacy are checking stock and identifying products prescribed.

Closed National PSA's this month:

Two

Closed National PSA's with ongoing actions:

Seven

Other CAS alert related issues:

Nil

NHS National Patient Safety Alerts Update

Overdue	**0**
Open alerts within the allocated timescales	**3**
Open Alerts off plan	**0**
Closed this quarter	2
Closed alerts with on- going actions	**7**

Reference	Date Issued	Deadline	Alert Title	Status	Action
NatPSA/2021/009/NHSPS	25/8/21	25/11/21	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures	OPEN within the allocated timescales	Consultant Anaesthetist leading the alert. Procurement supporting implementation of the actions .FFP3 respirators with valves are no longer used across the Trust.
NatPSA/2021/008/NHSPS	25/8/21	25/02/22	Elimination of bottles of liquefied phenol 80%	OPEN within the allocated timescales	Chief pharmacist supported by associate chief pharmacist leading the alert. Currently checking stock and identifying products prescribed.
NatPSA/2021/003/NHSPS	16/6/21	16/11/21	Eliminating the risk of inadvertent connection to medical air via a flow meter	OPEN within the allocated timescales	Director of Nursing – Quality, Safety and Innovation leading the alert, supported by Medical Engineering leads. Air flowmeters were quarantined in 2018 by Medical Engineering Departments. Patient Safety Team are obtaining additional assurance from clinical areas.
NatPSA/2020/005/NHSPS	13/08/20	13/05/21	Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults	CLOSED with on-going actions	The changes to be built into PICS are an on-going project. An abstract of the UHB work to support this alert has won the Annette Louise Seal Award for 2021; this was awarded to a project that best advances steroid awareness and patient safety.
NatPSA/2019/003/NHSPS	13/12/2019	11/09/2020	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	CLOSED with on-going actions	Paediatric protocol amended to standardise to QE protocols, final draft produced, requires amendment, controlled documents team have deferred this for 6 months, to confirm when uploaded to intranet.

Reference	Date Issued	Deadline	Alert Title	Status	Action
NHS/PSA/RE/2018/005	25/07/2018	25/01/2019	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	CLOSED with ongoing actions	Task and Finish group led by Division 3 Director of Nursing. Training model to be implemented in specialities. Myth buster issued. Schedule for training agreed to commence in September.
NHS/PSA/RE/2018/003	25/04/2018	21/06/2018	Resources to support the adoption of the revised National Early Warning Score (NEWS2)	CLOSED with on-going actions	Paper : planned approach and standardisation across UHB to be presented at CEAG in October 2021 PICS integration and release planned November 2021
NHS/PSA/RE/2017/004		11/12/2017	Resources to support safe transition from the Luer connector to NRFit™ for intrathecal and epidural procedures, and delivery of regional blocks	CLOSED with on-going actions	New product for epidurals available, further meeting will be arranged to plan implementation once suppliers are allowed back on sites
NHS/PSA/RE/2017/001	23/02/2017	23/08/2017	Resources to support safer care for full-term babies	CLOSED with on-going actions	6 monthly update on progress and UHB rate compared to National standard. Q1 2021/2022 term to NNU rate below the national ambition of 5%. Next update due Jan'2022
NHS/PSA/RE/2015/008	14/09/2015	14/09/2016	Supporting the Introduction of the National Safety Standards for Invasive Procedures	CLOSED with on-going actions	Long term project across all specialities. Led by Assistant Medical Director, Clinical Fellow and the LocSSIPs Group support this improvement project. 12 monthly update on progress to continue to implement. Next due Feb'2022.

NHS Patient Safety Alerts Assurance and Audit Summary

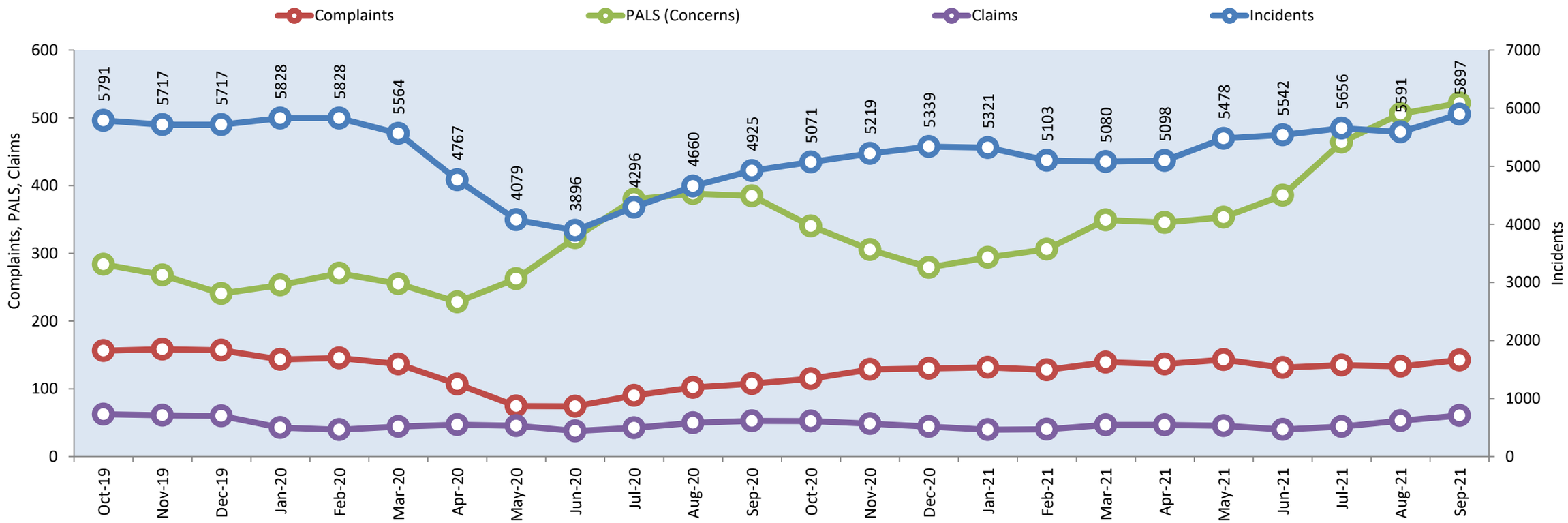
Definition	Number of alerts
Assurance/Audit plan in place Assurance current and confirmed with reassuring results and incidents	30
Assurance/audit in place, but non-reassuring results or results overdue Non-reassuring incident data	4
No audit agreed/assurance plan agreed	2

Name of Alert	Complete	RAG	Status	Incident Search
Risk of severe harm and death from unintentional interruption of non- invasive ventilation NHS/PSA/W/2015/003	27/03/2015		CQMG Presentation March 2021 Division 1 Identify a lead to identify audit and assurance of checks to ensure NIV is set up correctly. Further NIV update to CQMG in July. A modified version of the BTS RSU NIV checklist has been developed and the plan is to pilot this on all sites.	3 months (01/01 - 31/03 2021) No incidents directly related to the alert. 3 months (01/04 - 30/06 2021) 3 incidents of equipment disconnected (U258814, no harm; U266569, low harm; U267937, low harm / Level 2SI). 1 incident of incorrect setup leading to interrupted NIV (U266577, no harm). 3 months (01/07 – 30/09 2021) No incidents directly related to the alert.
Risk of using different airway humidification devices simultaneously NHS/PSA/W/2015/012	02/02/2016		CCU: Staff aware that a filter is not to be applied to humidified circuits. Acting Deputy Director of Nursing Division 1B exploring the current safety mechanisms in place.	3 months (01/01 - 31/03 2021) No incidents directly related to the alert. 3 months (01/04 - 30/06 2021) 1 incident of HME saturation due to use with wet circuit (U265367, no harm - training issue). 3 months (01/07 – 30/09 2021) No incidents directly related to the alert.

Name of Alert	Complete	RAG	Status	Incident Search
Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders NHS/PSA/W/2018/001	20/02/2018		Incidents discussed and reviewed at Medical Gas Group Bi Monthly meetings. Resuscitation department audit crash trolleys, Report exceptions to Resuscitation committee quarterly. Checklists adapted to include oxygen valve on / open. If there was a recurring issue it would be flagged to the resus committee. 12 month review of oxygen cylinder incidents in progress by Patient Safety Team and Pharmacy.	8 months (01/12/2020 - 30/06/2021) No incidents directly related to the alert. 1 month (01/07 - 31/07 2021) 1 incident of patient not receiving oxygen - valve closed (U277702, low harm). 2 months (01/08 – 30/09 2021) No incidents directly related to the alert.
Resources to support safer modification of food and drink NHS/PSA/RE/2018/004	01/04/2019		Assurance via incident review, reported to Nutrition and Hydration Steering Group and safer swallow QIP Financial Year 2020-2021: "Review of Nutrition/hydration incidents" - 8 safer swallow incidents Aug 21: Safer Swallow – "Patients with Dysphagia and those with recommendations for Nil by Mouth; Quality outcome measures": - 29 incidents (Jun/Jul), 4 RCA with open actions. PST monthly incident monitoring to commenced September 2021.	2 months (01/06 - 31/07 2021) 29 incidents; 4 RCA with open actions. 2 months (01/08 – 30/09 21 incidents of wrong consistency diet / fluids returned from safer swallow query (all no harm).

Name of Alert	Complete	RAG	Status	Incident Search
Nasogastric tube misplacement: continuing risk of death and severe harm NHS/PSA/RE/2016/006	21/04/2017		Fine Bore NG Feeding Tube Audit – May 2021 Areas for improvement : consent and best interests' procedures are followed, using line flags documentation	1 month (01/07 - 31/07 2021) 1 desaturation secondary to feeding via self propelling NJT coiled in the back of mouth. Position misidentified on CXR - Ryles tube seen below diaphragm (U273596, low harm) 1 month (01/08 - 31/08 2021) 1 difficulty removing wire x 2; hole made in tube (U278327, no harm) 1 blood aspirated from tube post insertion (U278694, near miss) 1 slit in tube; water in mouth on flushing (U279868, no harm) 1 month (01/09 – 30/09 2021) 1 NGT dislodged by 22cm; continued to feed (U2844096, no harm)
Harm from using Low Molecular Weight Heparins when contraindicated NHS/PSA/W/2015/001	02/03/2015		Reviewed through Medication Incident reports to SMPG. Reviewed through Medication Incident reported to Thrombosis committee. Two monitoring systems for anticoagulant related incidents in the Trust, one led by Pharmacy and a second one led by anticoagulation service providing a daily review of anticoagulation related incidents Assurance from Thrombosis committee chair. Monitoring clinical incidents on a daily basis, no concerns about falls and enoxaparin; no identified recurrent pattern. Unmonitored pause and omission to restart enoxaparin, is part of the HAT QI project.	1 month (01/01 - 31/01 2021) 1 incident of enoxaparin given against neurosurgical advice (U246465, no harm). 1 month (01/02 - 28/02 2021) No incidents directly related to the alert. 4 months (01/03 - 30/06 2021) 1 incident subdural haematoma post fall in a patient on enoxaparin (U249372, severe).Level 2 SI. 1 month (01/07 – 31/07 2021) 1 incident of enoxaparin given within 4 hours of lumbar puncture (U273072, near miss) 1 month (01/08 – 31/08 2021) 3 incidents of enoxaparin given contrary to prescription (U278203, allergy, low harm; U279780 and U281961, no harm,) 1 incident of local bleeding post clexane (U28238, no harm). 1 month (01/09 - 30/09 2021) No incidents directly related to the alert.

Overall numbers reported (3/12 rolling average)

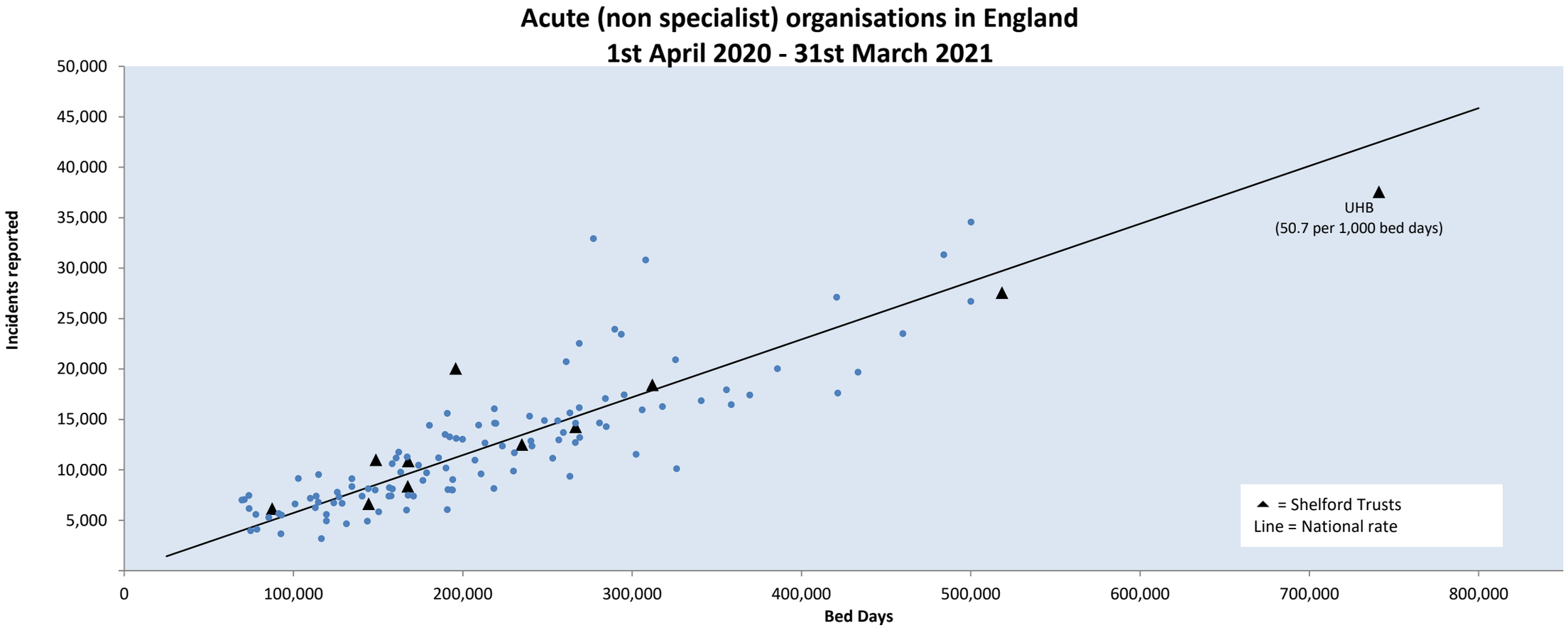


Comments**:** Following the decrease in Q1 2020/21, the volume of incidents and complaints is returning to pre-Covid levels. PALS concerns have remained high

	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Variance on last quarter
Incident	16,017	15,239	16,627	17,690	↑
Complaint	390	418	394	427	↑
PALS	838	1,048	1,157	1,566	↑
Claims	133	140	120	182	↑

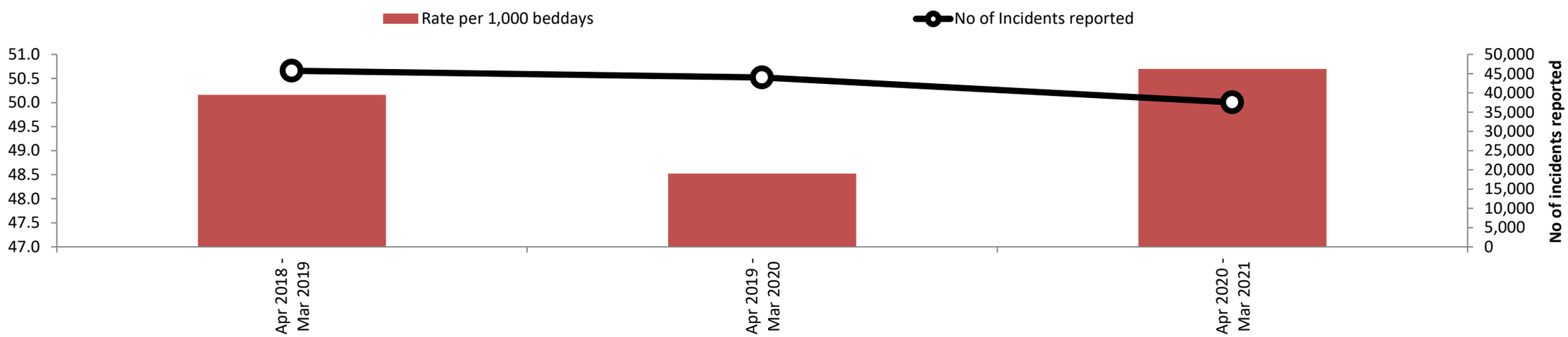
Incidents and Harm reporting

Incident reporting: NRLS



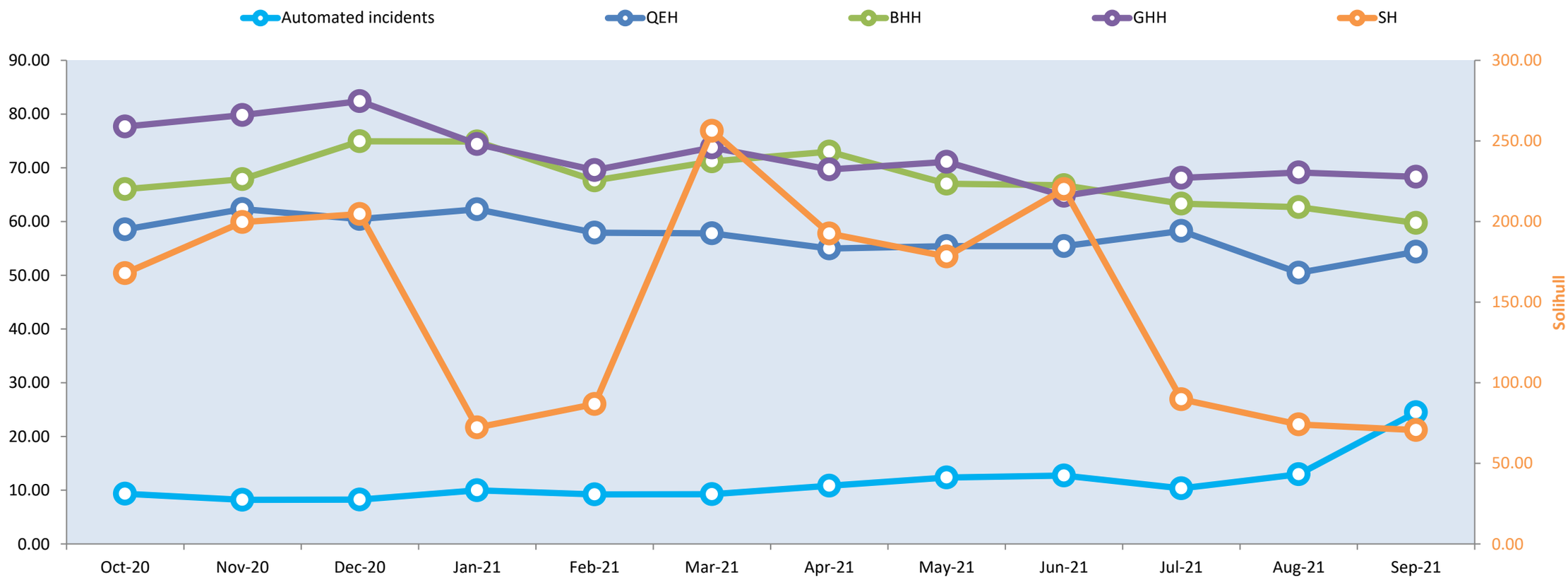
NHSI is no longer providing organisation reports for benchmarking purposes. The above chart has been developed using data available from the NRLS to compare reporting rates against other trusts. UHB reported the most incidents of any trust, and had the highest number of bed days. UHB was below the National average of 57.3 incidents per 1,000 bed days.

Incident reporting: NRLS



Organisation name	bed days	Median number of days between incidents occurring and being reported to the NRLS	Number of incidents occurring	Rate per 1,000 bed days
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	293695	24	23,433	79.8
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	484202	8	31,315	64.7
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	284312	4	17,057	60.0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	178770	23	9,691	54.2
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	280911	18	14,640	52.1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	385976	21	20,012	51.9
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	741074	13	37,572	50.7
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	355889	2	17,915	50.3
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	284854	41	14,259	50.1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	421600	47	17,603	41.8

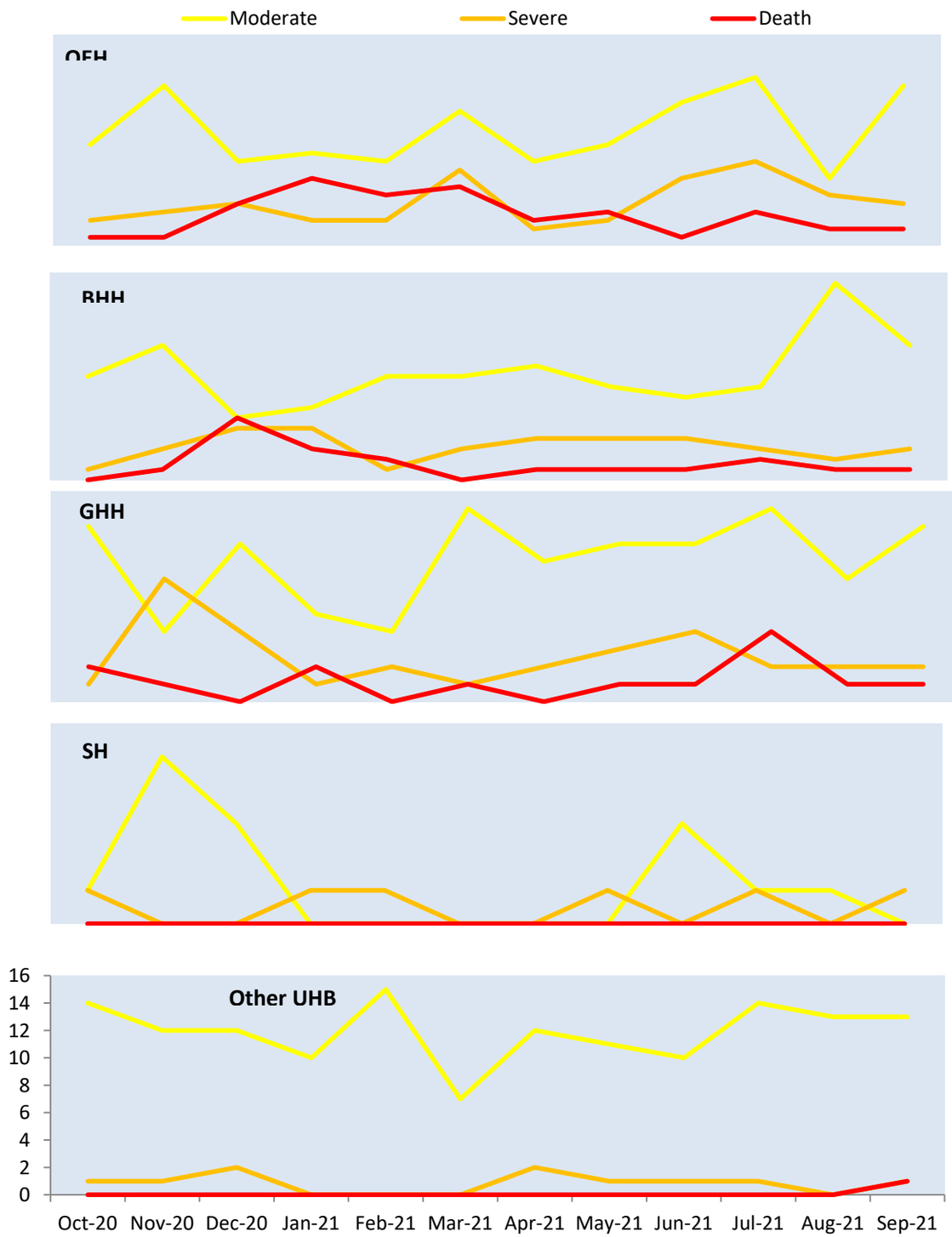
Incident reporting: rate per 1,000 bed days



Comments: UHB reporting rates per site have remained consistent during September 2021 compared to August 2021, The rate has returned to levels similar to the pre COVID-19 period. During August QEH reported 1,841 incidents, BHH reported 1,272 incidents, GHH reported 1,050 incidents, SH reported 200 incidents, Other UHB sites reported 338 and 1,798 automated incidents were reported across UHB site. An increase can be observed in the rate of automated incidents which is expected as PICS is implemented across the Trust.

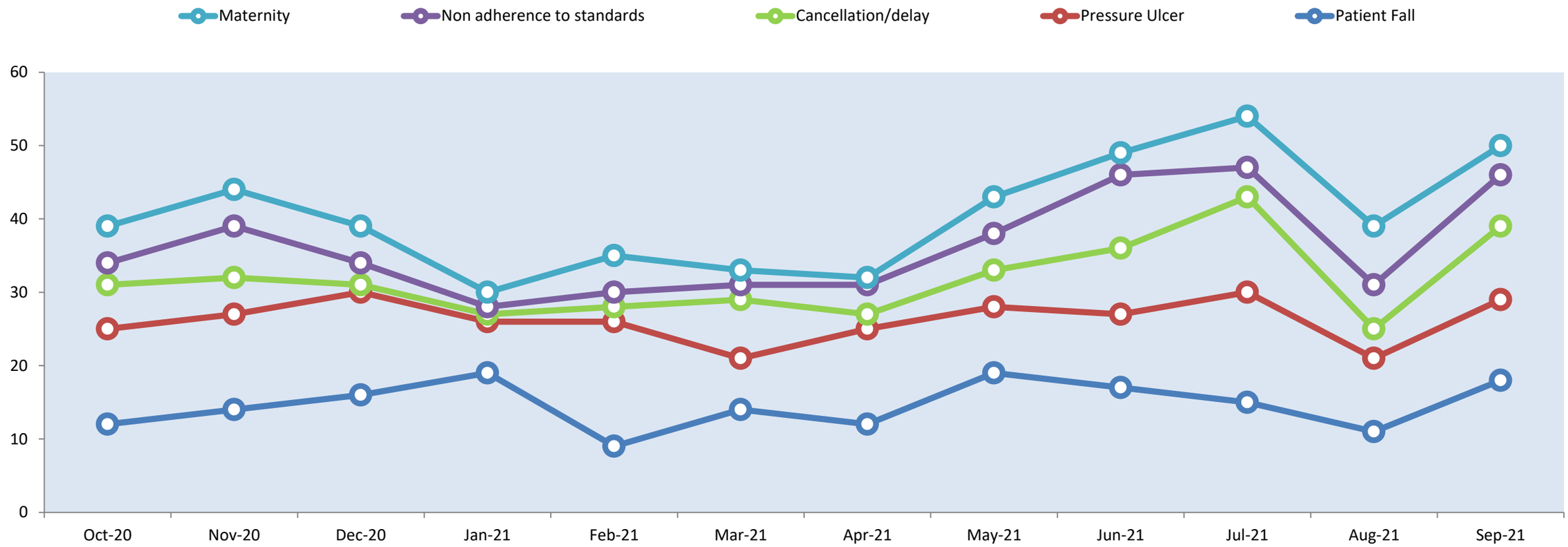
Note: SH rate plotted on secondary axis. SH bed days decreased significantly due to services being wound down in May 2020 for service reconfiguration. Incidents continued to be reported due to issues such as pre-operative testing problems and the arrivals at the closed MIU, resulting in an artificially high rate. The rate has continued to be higher than the other sites due to ongoing reduced bed days and issues relating to the configuration of the site

Incident reporting – level of harm per site



Comments: These graphs show a breakdown of incidents by site and level of harm for incidents which were moderate or above. During August 21 across UHB 1.11% (72) of incidents were initially graded as moderate, severe, catastrophic/death, which remained similar August 2021 at 1.12% (63). 5 incidents were reported with a severity of catastrophic/ death, and 12 with severe harm. Incidents resulting in staff or public harm are followed up with the appropriate line manager via Health and Safety. Incidents resulting in moderate, severe or death to patients are followed up with the appropriate manager and where relevant escalated to the Clinical and Professional Review of Incidents Group (CaPRI) to determine if the incident should be investigated as a Serious Incident (SI), internal SI or investigated by the division.

Top 5 harmful incident categories (Moderate, Severe, Catastrophic/ Death)



In Q2 there were 216incidents which were reported as moderate, severe or catastrophic/ death.

The top 5 categories these incidents related to were patient fall (44), Pressure ulcer (36), Cancellation/ delay (27), Non adherence to standards (17), Maternity (19).

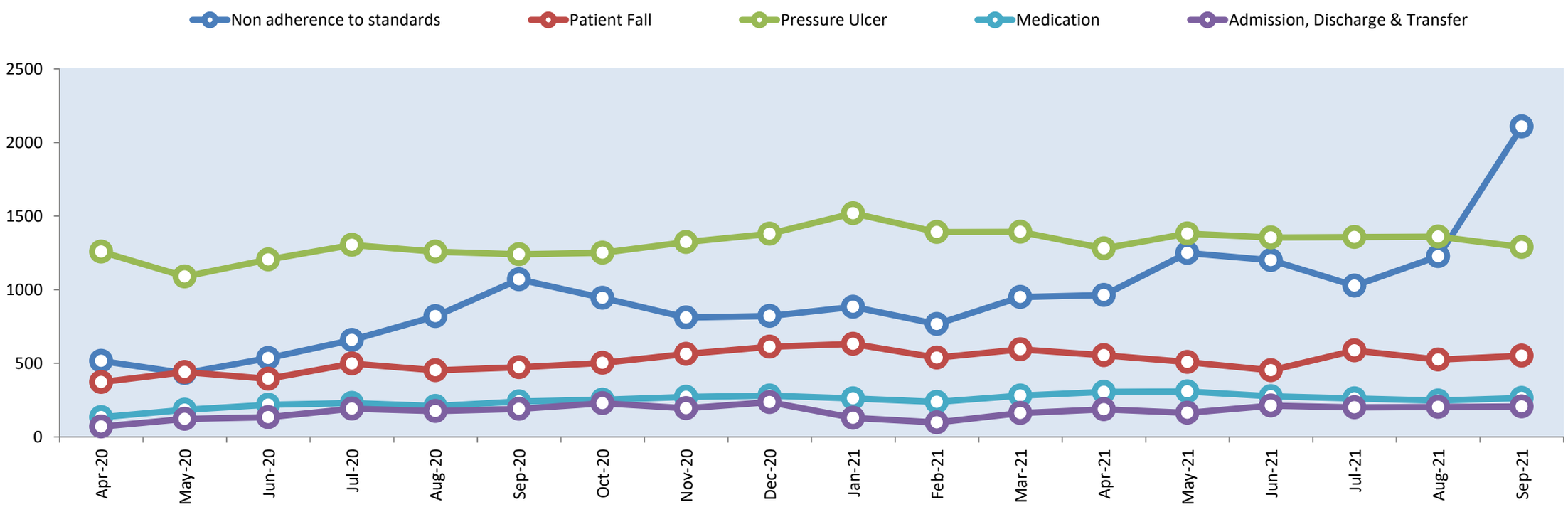
Top 5 increased incident categories

Category	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22
Cancellation/delay	215	164	277	399
Admission, Discharge & Transfer	662	390	563	611
Bed management	39	14	54	77
Admin error	33	36	36	35
Patient Fall	1678	1765	1516	1665

Note: this table was added to the report for the first time last quarter and is provided as an additional means of identifying trends. It is still in development.

The above issues reflect changes in activity and challenges in service delivery during the Covid-19 pandemic. These increases have peaked in Q4, and have all reduced in Q1 2021/22.

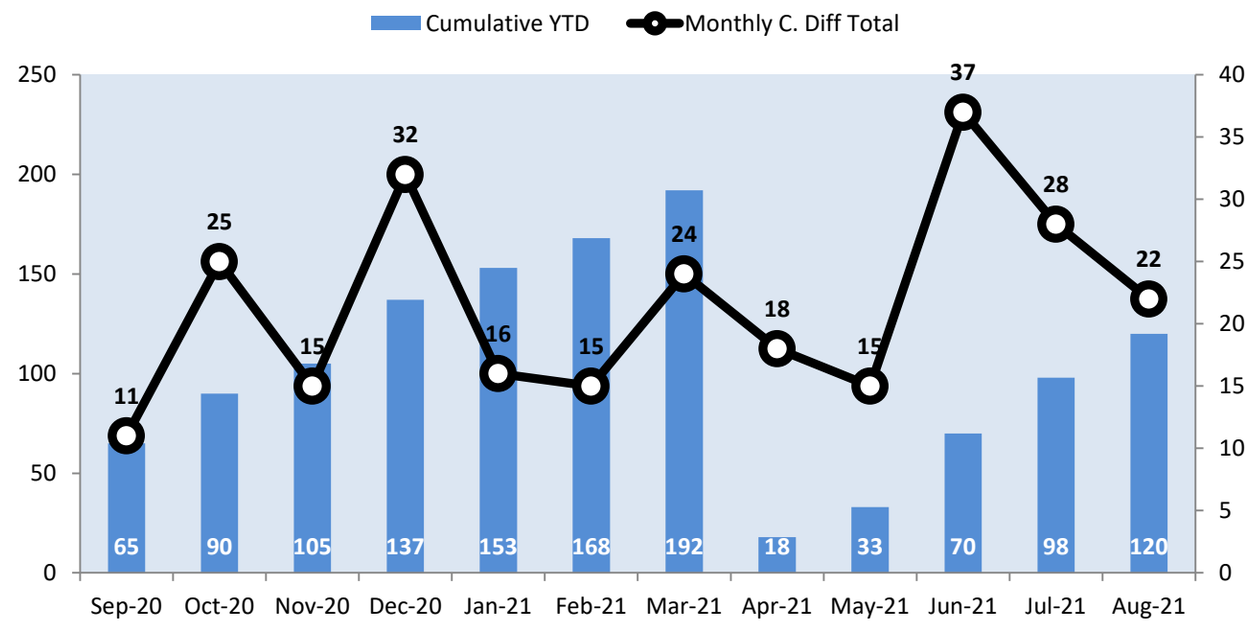
Top five incident categories



Comments:

The top five incident categories accounted for 64.6% of all incidents reported for Q2 2021/22 (11,418) Pressure Ulcer was the highest reported incident category, accounting for 22.6% of all incidents reported. Non adherence to standards has also increased compared to last quarter due to the increase in automated incidents as PICS is implemented across the sites

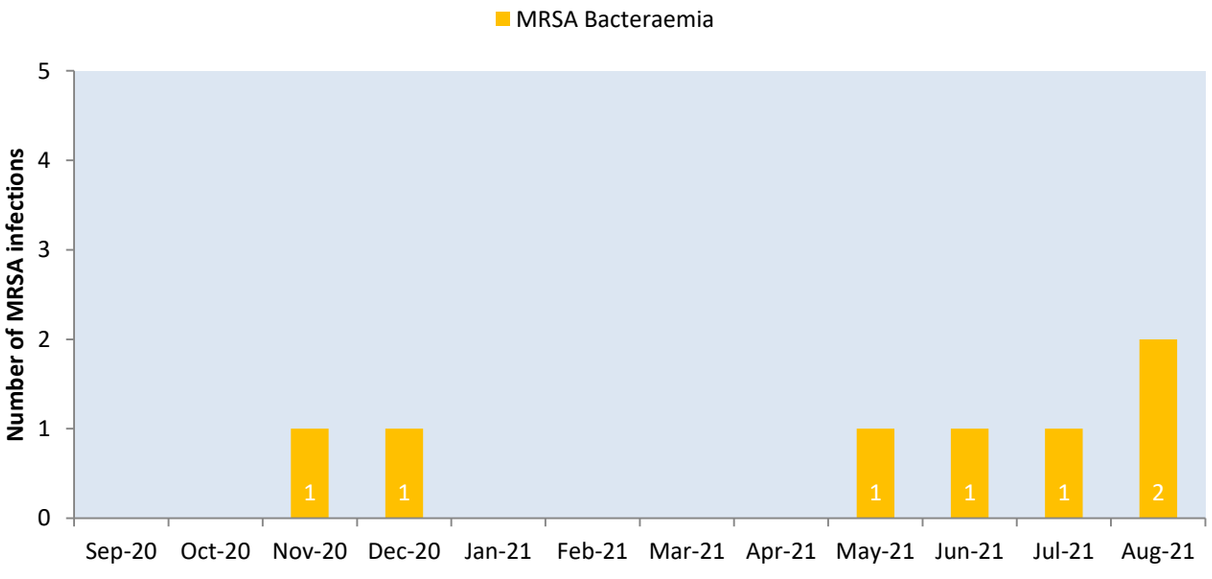
Infection Prevention and Control - C.Diff and MRSA



Number of post-48 hour C. difficile monthly cases year to date

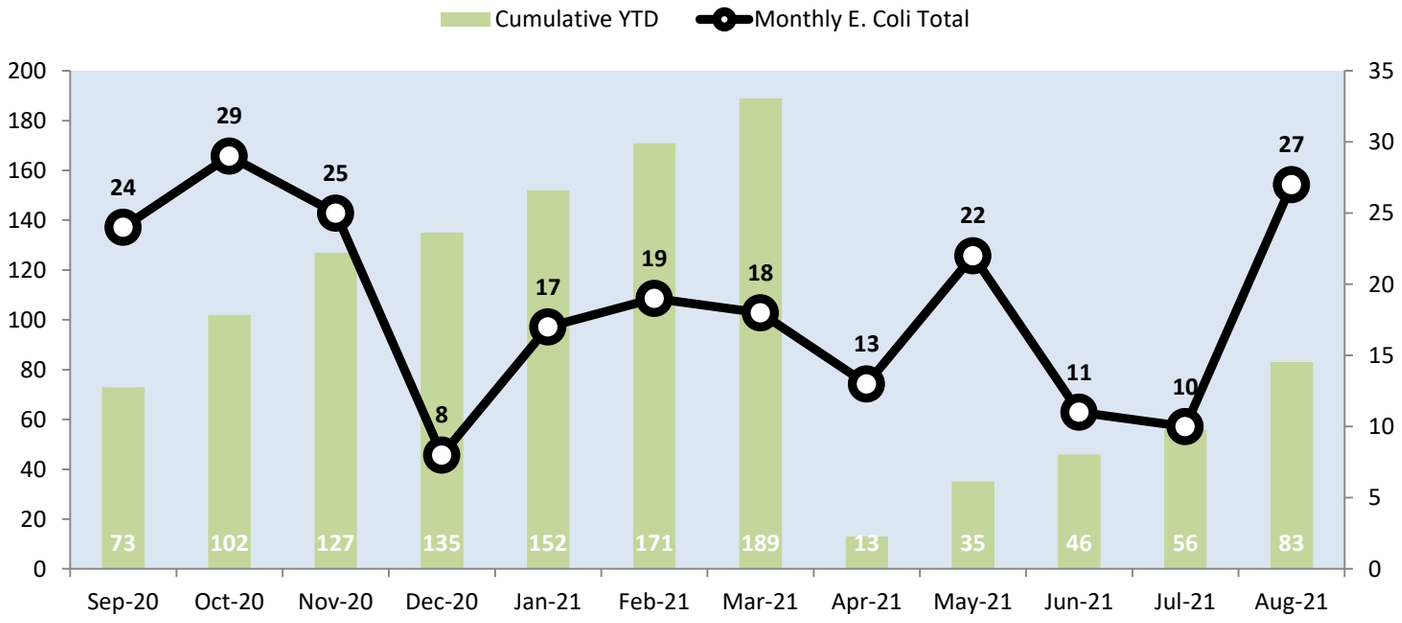
The annual objective for *Clostridioides difficile* infection (CDI) for 2021/22 at UHB is 233 Trust Apportioned cases. In August, UHB had 13 Trust Apportioned cases, and 9 Community Onset Healthcare Associated Infections (COHAI) which displayed a reduction in comparison to July.

Learning from the Post Infection Reviews includes antimicrobial prescribing not in line with guidance, lack of timely stool sampling, environmental factors related to cleaning, delayed clinical recognition of *C. difficile* when patients are symptomatic with *C. difficile* and overuse of laxatives. This will all be fed back into AMSG and the Trust's joint clinical quality assurance group

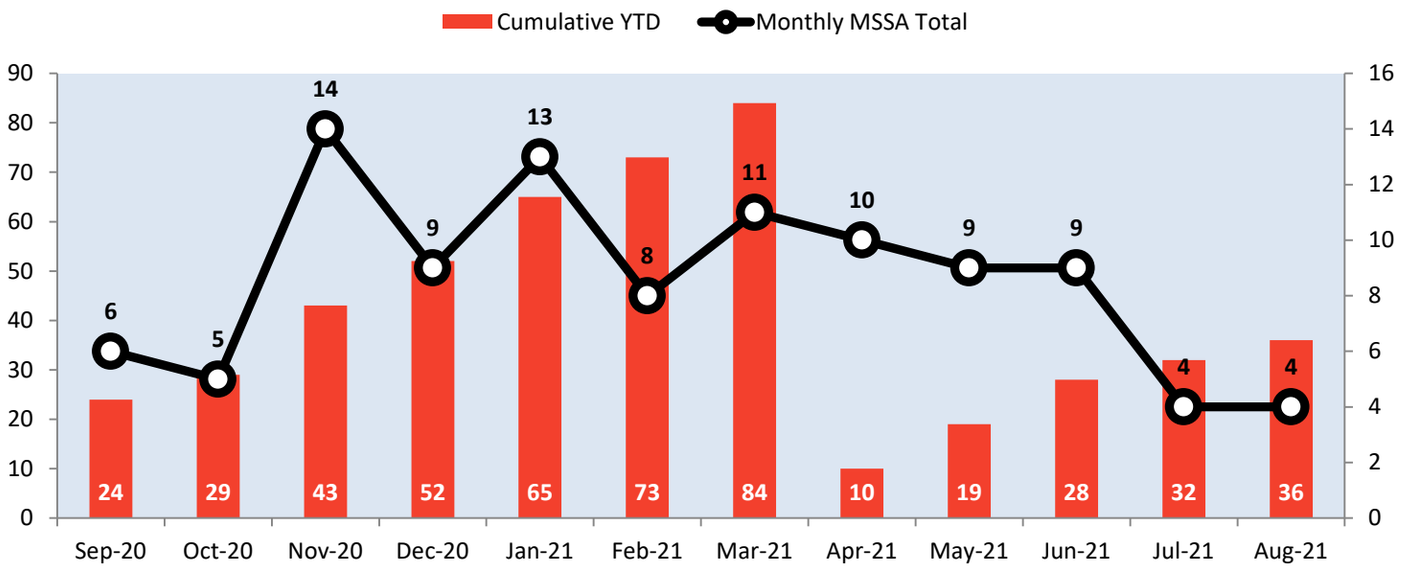


There were two Trust apportioned MRSA bacteraemias identified during August at UHB. For the year to date there have been 5 Trust apportioned cases of MRSA

Infection Prevention and Control – E. COLI & MSSA



The number of E.Coli cases during August saw a steep increase to 27 cases, bringing the year to date total to 83. MSSA cases remained static at 4 in month. there has been a total of 36 cases for the year to date

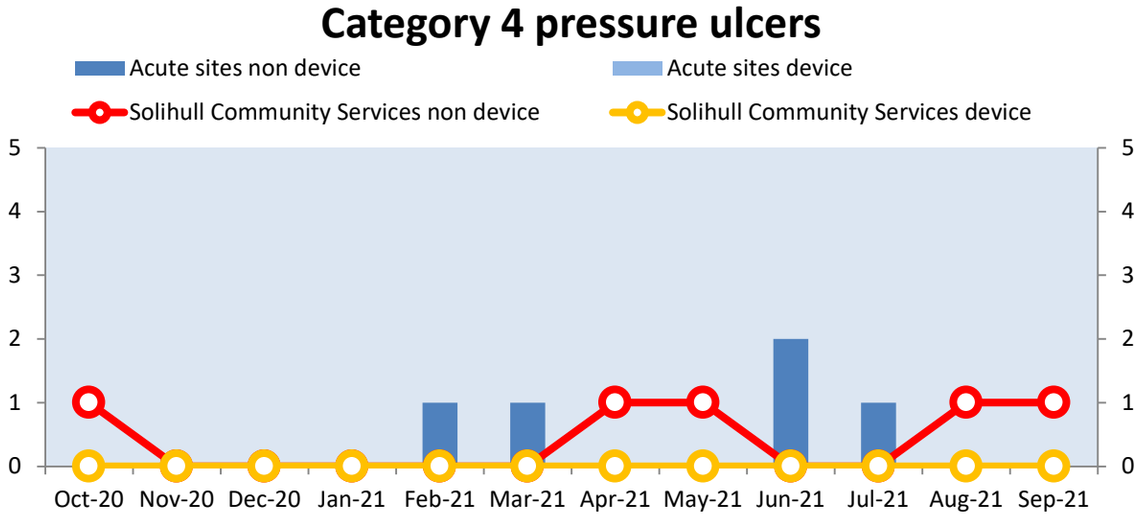


Infection Prevention and Control – COVID-19

Site	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Total
QE	13	19	10	2	1	0	0	0	0	5	3	58
BHH	7	13	2	5	2	0	0	0	1	2	1	40
GHH	7	6	4	9	0	0	0	1	2	2	2	36
SOL	0	0	3	0	0	0	0	0	0	0	0	3
Staff	8	8	14	3	0	0	0	0	2	0	0	48

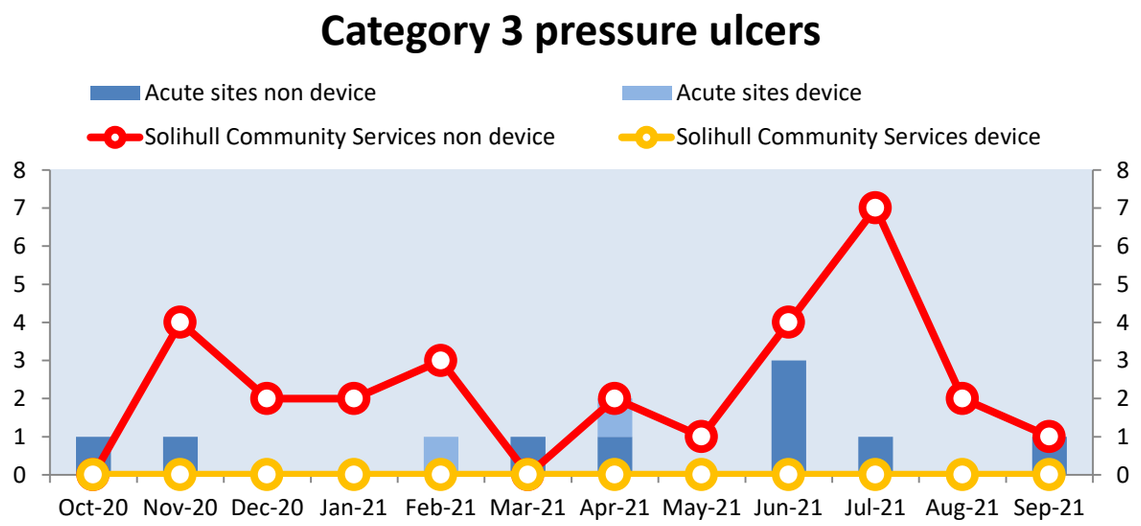
UHB saw six outbreaks of COVID-19 during August 2021. Daily outbreak meetings were held to review actions around the outbreak. All outbreaks have been reviewed in detail and are summarised in Table 1. During August, the Trust saw 24 definite and 19 probable hospital onset cases. This was an increase in the number of Hospital Onset cases of COVID-19 compared to July. In July we had 9 hospital onset cases. The Trust saw 1211 patient positives for SARS-CoV-2 during August which was a marginal improvement to that of July, where we had 1215 cases. This equates to 3.5% of the total number of our positive patients in August being healthcare associated, compared to July which was under 1.5%.

Trust Acquired Pressure Ulcers



Category 4

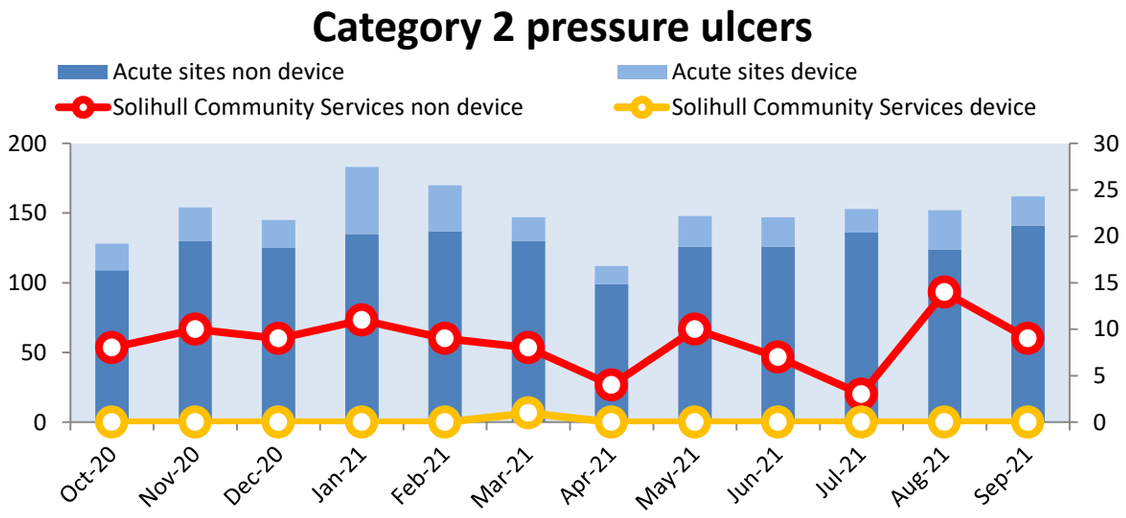
There were no acute Trust acquired category 4 non-device related pressure ulcer reported in September 2021. There was 1 non-device related Category 4 pressure ulcer reported for Solihull Community Services.



Category 3

There has been 1 reported category 3 non-device related pressure ulcer for the acute trust in September 2021. There was 1 Trust acquired non device related category 3 pressure ulcer reported within Solihull community services.

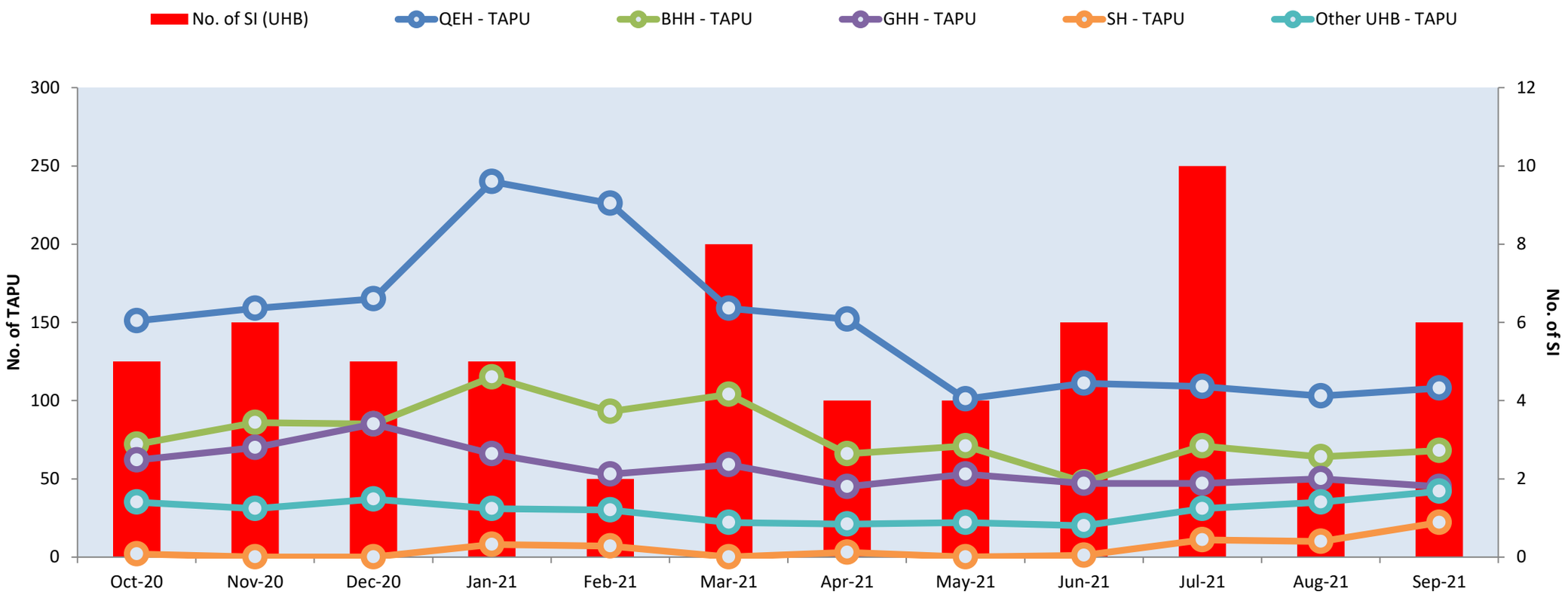
Trust Acquired Pressure Ulcers – Category 2



There were 162 Acute/Inpatient acquired category 2 pressure ulcers reported in September 2021 across the four acute hospital sites (141 non-device and 21 device related). There were 9 Category 2 pressure ulcers reported for Solihull Community Services patients. All 9 were non-device related

The number of category 2 acute Trust acquired non-device related pressure ulcers has remained relatively high but static since May 2021. The average is slightly less when compared with the data for the period November 2020 - March 2021. The high numbers continue to be attributed to the data not being verified by the Tissue Viability Team (TVT).

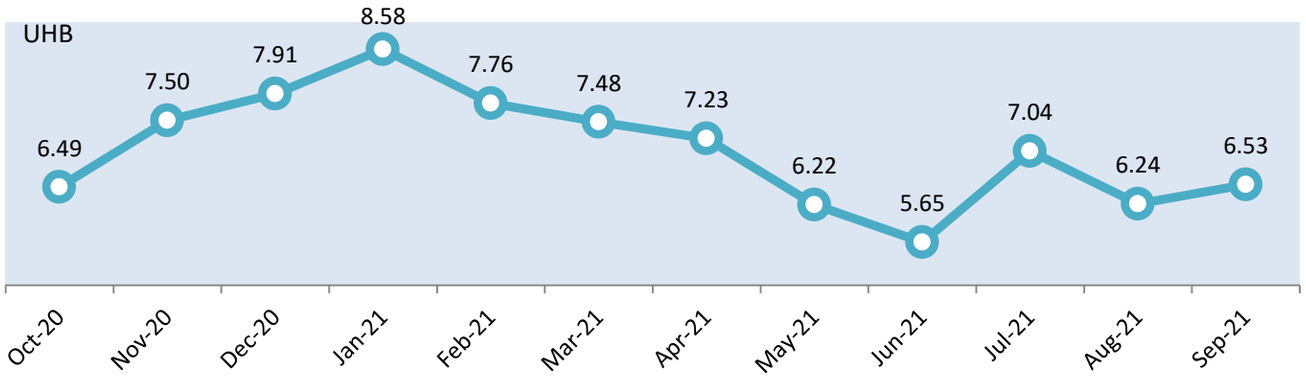
Pressure ulcers – Serious Incidents



Acute care:

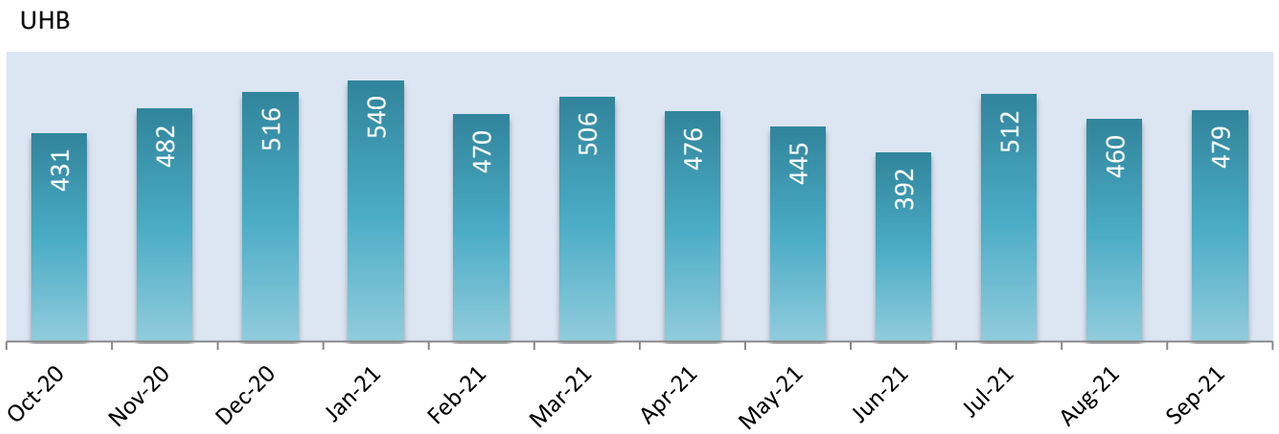
There has been 1 reported category 3 non-device related pressure ulcer for the acute trust in September 2021. This was a gentleman who developed an ulcer to his coccyx that extended to his buttocks. An RCA is in progress. There is also an unconfirmed category 3 non-device related pressure ulcer for September that is currently being investigated. The lead TVN has attended Coroner's court regarding a patient that developed a category 4 pressure ulcer during admission to the trust. An RCA was completed for this incident and Tissue Viability are supporting the ward with education as outlined in the action plan.

Inpatient falls



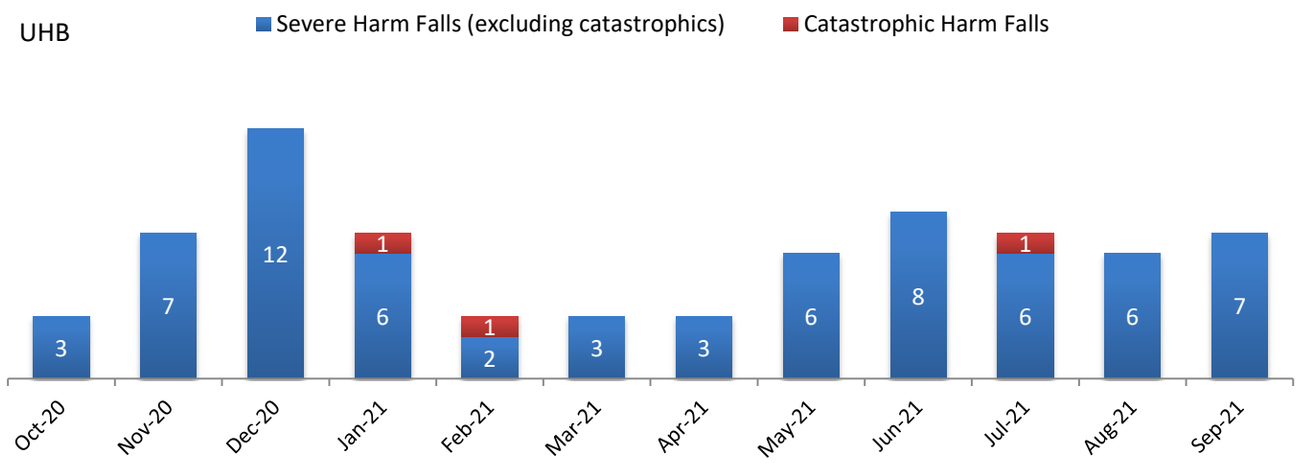
Falls rate per 1,000 occupied bed days

The Trust inpatient falls rate increased in September to 6.53.



Total number of inpatient falls

During September the total falls increased slightly from August to 479 in September



Falls resulting in severe harm

There were seven Falls resulting in severe harm during September, two of which are subject to a Coroners Inquest. Three patients sustained a head injury, and the remaining four patients suffered fractures to their femur. The Inquest cases relate to; a patient who appeared to lose balance and fall backwards whilst talking to staff, hitting his head as he fell; and the other case relating to a patient who exited her bed unaided and fell to the floor sustaining a small head injury, however deteriorated further the following day as the bleed increased in size. This patient required 1:1 supervision however this was not in place at the time due to staffing shortfalls on the ward, therefore the fall was unwitnessed.

Inpatient Falls

We have seen a significant improvement in practice around the provision of walking aids in ED following OPAL assessment after a recent Inquest where the Coroner issued a Regulation 28; Report to prevent future deaths. The Coroner was not satisfied at the time of the Inquest that the action plan to improve this practice had been robustly implemented, however since then the Emergency Departments across sites continue to report 100% compliance with issuing them to patients assessed as requiring one.

The Falls Team are working with the Deputy Divisional Medical Director and Deputy Director of Nursing for Older People services looking at effective ways to address shortfalls in falls prevention knowledge across the medical teams, with a view to ensuring that falls prevention across the speciality remains multidisciplinary, and proactive rather than reactive. GHH site will be the initial focus in view of recently raised concerns regarding the number of falls resulting in harm and identified gaps in knowledge around the falls procedures. As part of this we will be reviewing the post fall imaging pathways following a scoping of imaging times where gaps in knowledge were highlighted around the escalation of urgent post fall imaging.

Other falls activity and focus currently underway includes;

- Development of patient information regarding how to identify, prevent and manage postural hypotension, of which is currently under review with our Trust readership panel to maintain patient and public engagement and ensure resources remain user friendly;
- Reviewing and updating the Trust falls procedure and associated pathways;
- Progressing the falls education Moodle;
- Trialling alarmed seat pads in ED at BHH;
- Busy launching the new PICS falls risk assessment which finally went live on the 6th October

Serious Incident and Never Events

	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	**2020/21 Total**	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	**2021/22 FYTD**
Number of SIs Reported	28	46	61	44	38	43	**379**	27	31	43	44	37	30	**212**
Number of Never Events	0	2	4	0	1	1	**13**	0	1	1	0	0	1	**3**
Number of SI/NE actions set	98	103	108	122	70	120	**1076**	171	125	114	101	83	156	**750**

Comments: The table provides the number of SIs and Never Events reported over the last 12 months.

There was one Never Events confirmed in September 21. An increase has been observed in the number of Serious Incidents commissioned in the last 12 months.

Never Event investigations underway

Site & STEIS Ref	Date of incident *Date NE reported	Type of Never Event	Summary Findings	Immediate actions taken
QE 2021/4570 U250936	06/02/2021 *01/03/2021	Retained Foreign Object – chest drain guidewire	Investigation in progress	Department reviewing competency sign off process for this procedure
QE 2021/9317 U259800	22/03/2021 *04/05/2021	Retained Foreign Object Retained guidewire within the patient's IVC/SVC	Investigation completed. Waiting for the Division to approve an action plan.	Who checklist updated to ensure nurses check with the doctor that wire is removed
QE 2020/24401 U240973	05/12/2020 *21/12/2020	Wrong site surgery Wrong site block performed.	Investigation in progress	The Anaesthetist involved discussed the case with the deputy CSL and it was felt that no other immediate actions were required.
QE 2020/24408 U241078	03/12/2020 *21/12/2020	Wrong implant/prosthesis A LCP reconstruction plate was used instead of the plan to use an LCP plate.	Investigation in progress	No immediate actions were identified. The checking procedures in theatres (including the WHO checklist/implant checklist) will be reviewed as part of the investigation).
QE 2021/9317 U259800	09/04/21 *04/05/21	Retained lost object/instrument. Retained guidewire within superior and inferior vena cavae	Investigation completed. Waiting for the Division to approve an action plan.	The procedure room on the ward was using a modified WHO checklist. This has been altered into a new LOCSSIP. Further recommendations re assurance and monitoring adoption of this have been included in the report
QE 2021/12437 U268759	03/06/21 *14/06/21	Wrong implant/prosthesis Wrong power intra-ocular lens implant inserted	Investigation completed. Waiting for the Division to approve an action plan	No immediate action taken. Both surgeons completed a reflection. Practice of the fellow was reviewed by senior consultants who praised his general ability and discussed ways to learn from the incident. The ST1 discussed and reflected with their training supervisor.

Closed Never Events with on-going actions

Site & STEIS Ref	Date of incident & date NE reported *	Type of Never Event	Summary Findings	Update on outstanding actions
QE 2020/7660 U202792	06/03/2020 *24/04/2020	Retained Foreign Object Swab correct at the first count and final count. At the time of discarding the swabs one small swab was missing.	The process for completing the final swab count was incompatible with existing clinical practices within the vascular specialty regarding wound closure. Increasing likelihood that safety barriers will not be effective. Recommendations: • The Theatre Standards Group will: ○ review policies, procedures and/or SOPs (cases finishing and pts moved from theatre). ○ develop communication/handover procedures (consultant not lead/not present for final count) ○ all site audits ensuring recommendations are implemented.. • Workshop days - “gold standard” post-surgical safety procedures should incorporated into annual governance days.. • Develop Moodle/educational packages - safety procedures in theatre. • Surgical/anaesthetic/wider surgical teams to follow policies, procedures and/or SOPs maintaining safety in theatres.	Remaining action not completed: • To develop Moodle program for theatres due 30/11/21.
QE 2020/9084 U209770	05/05/2020 *18/05/2020	Retained Foreign Object Retained swab following vascular surgery. X-ray completed, swab identified. Patient returned to Theatre to have swab removed under local anaesthetic.	There were deviations from the swab count procedure, including either, clean swab being removed from tray without communication with Scrub Nurse, or miscount. The WHO surgical checklist Sign Out was completed before the final “off table” count had been completed. Recommendations: • Anaesthetic weaning, recovery and final safety ‘Sign-Out’ not to occur until all safety procedures have been completed. • Staff awareness, engagement and understanding surrounding safety procedures must be enhanced including: surgeons understanding correct count process/requirement not to interrupt the scrub nurse during count. • Drive professional standards/ theatre team working across specialities including: need for surgeon/practitioner to always request swabs/instruments from appropriate team member. • All site audits ensuring recommendations are implemented.. • Workshop days - “gold standard” post-surgical safety procedures should incorporated into annual governance days.. • Develop Moodle/educational packages - safety procedures in theatre	Remaining action not completed: • To develop Moodle programme for theatres 30/11/21.

QE 2019/16642 W170747	18/07/2019 *29/07/2019	Wrong site surgery Patient underwent an operation for release of contracture of joint on the small finger of the left hand. The initial incision was made on the patient's ring finger rather than the intended finger.	This was an individual error by the surgeon in making his incision in the wrong finger. This incident was checked against previous incident recommendations and it was noted that they did not apply to this case. The previous recommendations applied to hand surgery where the hand is repositioned during surgery, e.g., turned over during surgery which didn't occur with this patient. The incident highlighted inconsistencies in the processes for checking and marking the site for hand surgery. The current practice is being reviewed and standardised.	Remaining actions not complete. • Both relate to providing an update to the Medical Director in the Clinical Quality and Monitoring Review Group.
QE 2020/24900 U237096	11/11/2020 *29/12/2020	ABO Incompatibility Patient was transfused the incorrect red blood cells.	This incident was the result of human error, by a member of staff who incorrectly believed that the shared care form was a duplicate. They did not confirm this with staff on other sites. Recommendations • Acts/omission of staff reviewed by DMT to identify and implement any appropriate actions. • Initiate formal teaching programme focusing on transfusion pathways/safety of transplant protocols. • Continue with actions identified in investigation reports (STEIS 2020/16732 and STEIS 2020/20734).	Remaining actions not complete. • 2 actions relate to ensuring learning is communicated to relevant staff at appropriate meetings.
SH 2020/24452 U241730	15/10/2020 *21/12/2020	Wrong site surgery Wrong sided stent removed	The string on the stent broke – this is a rare and unusual occurrence. There was insufficient information available in the pre-operative planning and documentation. Consequently, prior to the procedure staff were not aware the patient had bilateral stents. A second stent was not seen during the procedure. Recommendations • Confirmation in subsequent operation notes more than one stent in place, and. • Triangulation of information by nursing/clinical staff. Clinic diary, discharge summary, prior operation note to indicate more than one stent and state which stent must be removed. • Review of relevant prior stent imaging before removal. • New LocSSIP checklist used in all clinical areas where these procedures are carried out (including stent on string removals). • Report to manufacturer	5 actions to be completed • Review current LocSSIP • Report malfunction to manufacturer • Feedback to the patient • Discuss at Q7S meeting • Develop register of patients with Ureteric stents: including side of stent/timeline for maintenance of changing stents

QE 2020/20734 U233585	29/10/2020 *02/11/2020	ABO Incompatibility Patient was transfused the incorrect red blood cells.	Breakdown in communication and understanding surrounding the coordination of patient information for patients receiving cross site care. As a result the patient's medical record was not updated following sharing of the shared care form. Recommendations • Confirmation that dissemination of learning and information has been embedded with all relevant staff. • Establish common, integrated electronic patient I.T. systems (e.g. LIMS2), through the Trust Blood Banks. • Present update on progress with actions, particularly with regards to the transfer of shared care forms between sites while awaiting the alignment of LIMS, to the Trust's CQMG.	2 actions to be completed • Laboratory staff to obtain access to cross-site LIMS (Telepath) used to cross-reference patient information if required. • Long term project underway for integrated electronic patient I.T. systems
QE 2020/16732 U225477	27/08/2020 *07/09/2020	ABO Incompatibility Patient was transfused the incorrect red blood cells.	Blood was stored on the ward in temporary blood fridge, rather than being administered upon collection. There were deviations from established practices/procedures. The use of the interim blood fridge was an approved measure whilst a full I.T. system is implemented. Staff have advised it is their usual practice to complete these checks as described in the policy and procedure documents. Recommendations • Continue implementation of haemonetic fridges and business case for bedside scanning and validation system. • Review the handover/safety briefing procedures to include patients who have undergone recent SCT ABO incompatible procedures. • Familiarisation workshops for staff from other sites. • Collaboration with the digital team to develop a PICS alert • Initiate formal Stem Cell Transplantation Teaching Programme • Revise patient management Shared Care Form proforma to prominently display blood group to transfused during transplant. • Consider developing an admission checklist for transplant patients,	10 actions to be completed • 2 relate to training and education of staff and doctors of ABO compatibility • 2 relate to providing feedback/sharing learning with staff at S&G/BMT meetings. • 2 are in relation to the business case/concept paper and installation of bedside tracking system. • Work commenced with PICS re alert • Implementation of haemonetic blood fridges across QEHB. • Patient management plan being redone.

QE 2020/8250 U207576	16/04/2020 *04/05/2020	Retained Foreign Object Retained guidewire.	The guidewire broke during the procedure, and this has been reported to the manufacturer. Contributory factors including: Working Conditions due to PPE, unfamiliarity of non-critical care doctor with lines used in ITU, misinterpretation of radiology imaging possibly identifying guidewire. Recommendations: • broken guidewire should be reported to the manufacturer via MHRA reporting (Yellow Card) system. • consider the introduction of available guidewire products with greater engineered safety features. • radiology trainees/advanced practitioners to have greater exposure to critical care images during training.. • Review critical care LocSSIP/guidewire removal step of the Critical Care Local Safety Standards for Invasive Procedures (LOCSSIP).	All actions completed
QE 2020/22265 U236725	03/11/2020 *23/11/2020	Wrong site surgery Wrong site dermatology biopsy	The Trust's protocol and practice for skin biopsies was not adhered to, biopsy site incorrectly identified and performed on the wrong lesion Recommendations • Dermatology Department must continue to engage with the Trust's LocSSIP team to develop and implement LocSSIPs for all of their skin surgery procedures including: ○ use of electronic booking forms. ○ availability of clinical photography prior to skin biopsy surgery. ○ standardised way for marking skin biopsy site. ○ mirror check - question on WHO until LocSSIP in place ○ rebooking of procedure if clinical photography not available and consultation with appropriate Consultant regarding biopsy site not possible. ○ Trust protocol to include use of, confirmation with mirror, with the patient to confirm the biopsy site. ○ Patients having a biopsy on the same day as clinic appt not to given clinical wipes and informed not to remove site marking.	All actions completed

QE 2020/8250 U207576	16/04/2020 *04/05/2020	Retained Foreign Object Retained guidewire.	The guidewire broke during the procedure, and this has been reported to the manufacturer. Contributory factors including: Working Conditions due to PPE, unfamiliarity of non-critical care doctor with lines used in ITU, misinterpretation of radiology imaging possibly identifying guidewire. Recommendations: • broken guidewire should be reported to the manufacturer via MHRA reporting (Yellow Card) system. • consider the introduction of available guidewire products with greater engineered safety features. • radiology trainees/advanced practitioners to have greater exposure to critical care images during training.. • Review critical care LocSSIP/guidewire removal step of the Critical Care Local Safety Standards for Invasive Procedures (LOCSSIP).	All actions completed
BH 2021/2295 U247085	14/01/2021 *01/02/2021	ABO Incompatibility	Investigation completed.	Waiting for the Division to approve an action plan.

Complaints, PALS, Patient Experience

Complaints

	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	**20/21 total**	Apr 21	May 21	Jun 21	Jul 21	Aug 21	**Sep 21**
Complaints	124	141	125	127	130	159	**1,353**	129	159	139	132	145	**151**
Follow ups	16	16	14	23	21	25	**208**	12	11	17	15	18	**23**
Complaints per 1,000 WTE staff	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	6.7	8.3	7.3	6.9	7.6	**7.9**
Trust Response rate %	67.7	72.9	68.1	64.8	81.7	75.3	*	89.2	81.9				
CCG Response KPI – commissioner led	100%	100%	100%	100%	n/a	100%	*	100 %	100 %				
CCG Response KPI – non-commissioner	91.1%	96.7%	95.5%	97.7%	97.1%	94.3%	*	93.8	91.2%				

The Trust recorded a total of 151 complaints in September 2021, an increase of 4.1 per cent on the 145 new complaints recorded in August 2021. For context, in September 2020, 121 new complaints were recorded, as the first wave of COVID-19 continued to impact on complaints activity.

Division 3 continues to record the most complaints and the ratio of total complaints increased from 35.9 per cent in August 2021 to 39.7 per cent in September 2021. The greatest number of cases is still being recorded for Emergency Medicine (26 in August, 20 in September 2021) followed by Healthcare for Older People (11 in August, 17 in September 2021) and Acute and Short Stay Medicine (13 in August, 17 in September 2021). The main issues raised through complaints in September 2021 continued to be communication (with patients and relatives), clinical treatment (especially delays in treatment) and staff attitude. The Trust recorded a total of 18 follow-up complaints in August 2021 and 23 in September 2021. This compares to 14 in August 2020 to 16 in September 2020.

The final response performance for May 2021's cases was 81.9 per cent, just below the Trust target of 85 per cent. At the time of writing, the unvalidated performance for June 2021's cases was 72.2 per cent.

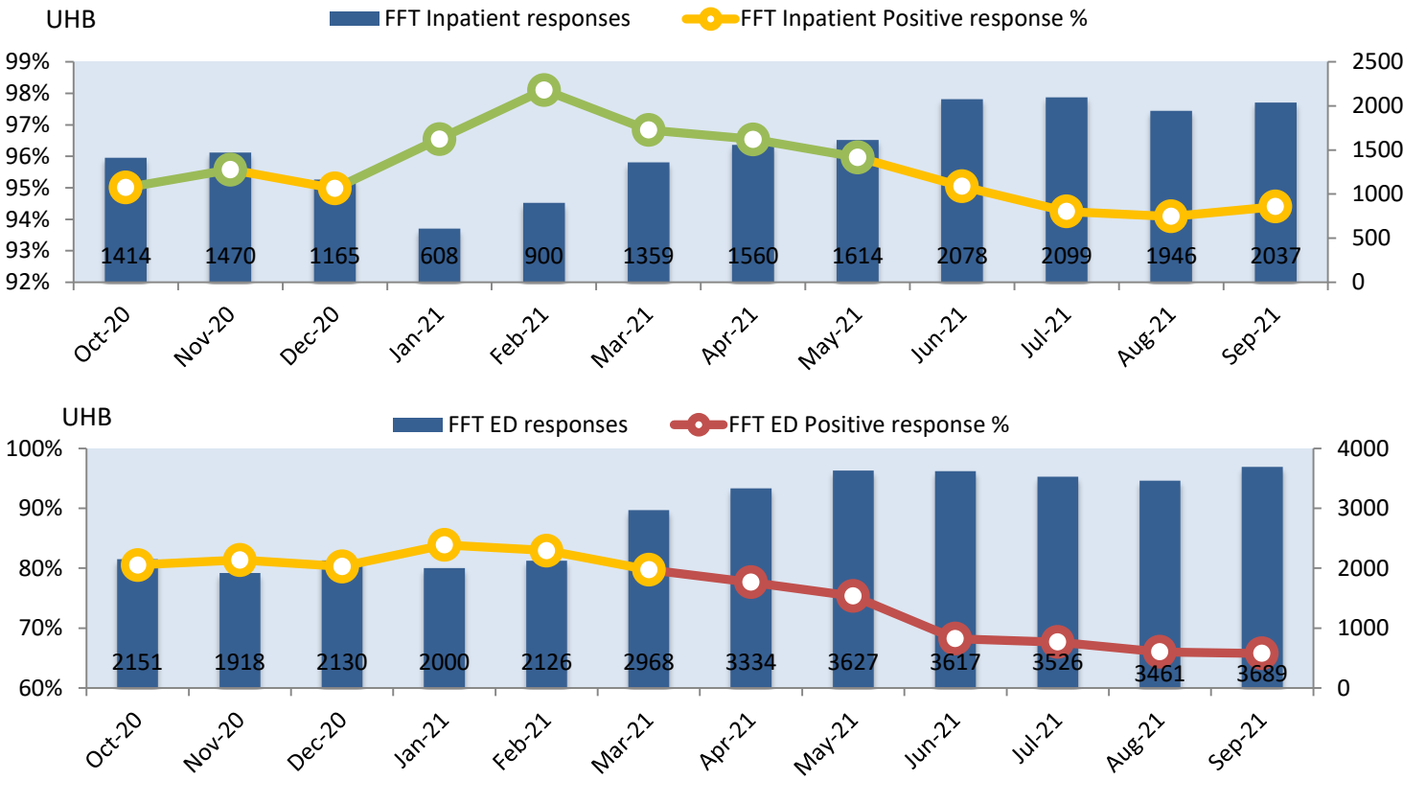
Patient Advice and Liaison (PALS)

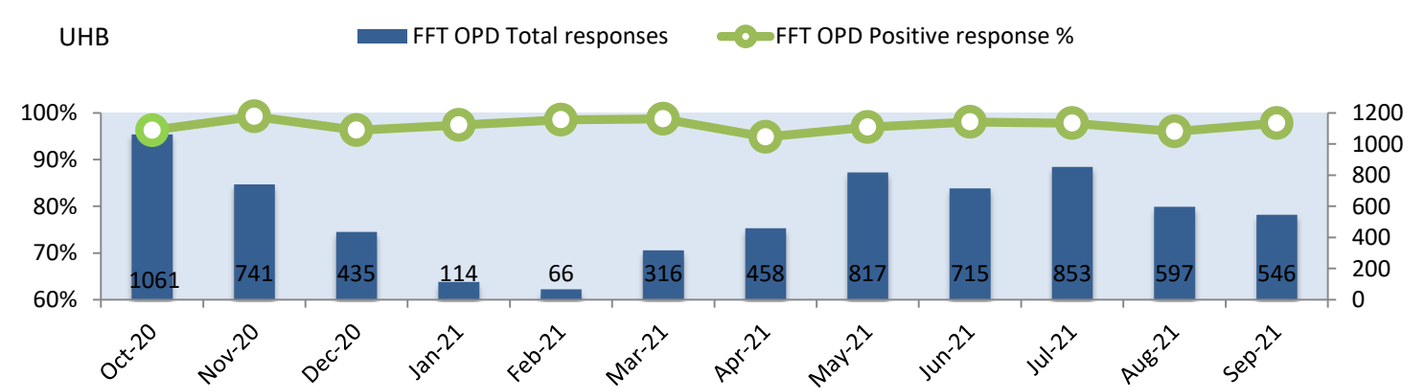
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	TOTAL
Total calls - PALS	1451	1150	958	1025	1176	1448	1255	1291	1286	764	746	684	13234
Avg. time to answer	0.05	0.05	0.06	0.05	0.05	0.06	0.06	0.06	0.04	0.03	0.03	0.03	0.05
Concerns received	271	310	283	300	351	410	381	402	530	569	531	567	4859

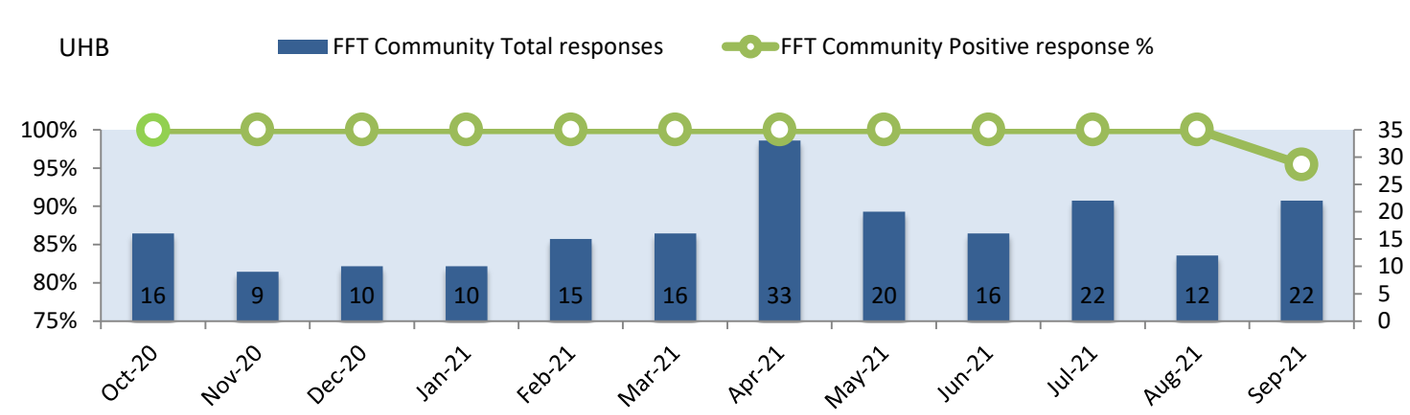
During September there has been a continuation of the increased levels in the number of concerns recorded. The most significant numbers received were for Neurology and Neurosurgery (14.5% of total), Acute Medicine (9%) and Emergency Medicine (6%). In addition Urology and Respiratory also had relatively high levels of concerns raised. The call volumes have continued to drop over the last month.

Communications (35% of total) and queries regarding appointments (26%) continue to account for the majority of concerns received into the PALS team. Enquiries have continued to increase regarding the patients requesting updates for elective surgery and appointments. Families trying to contact relatives who are inpatients still account for 16% (90 cases) of all concerns received.

Friends and Family Test (FFT)







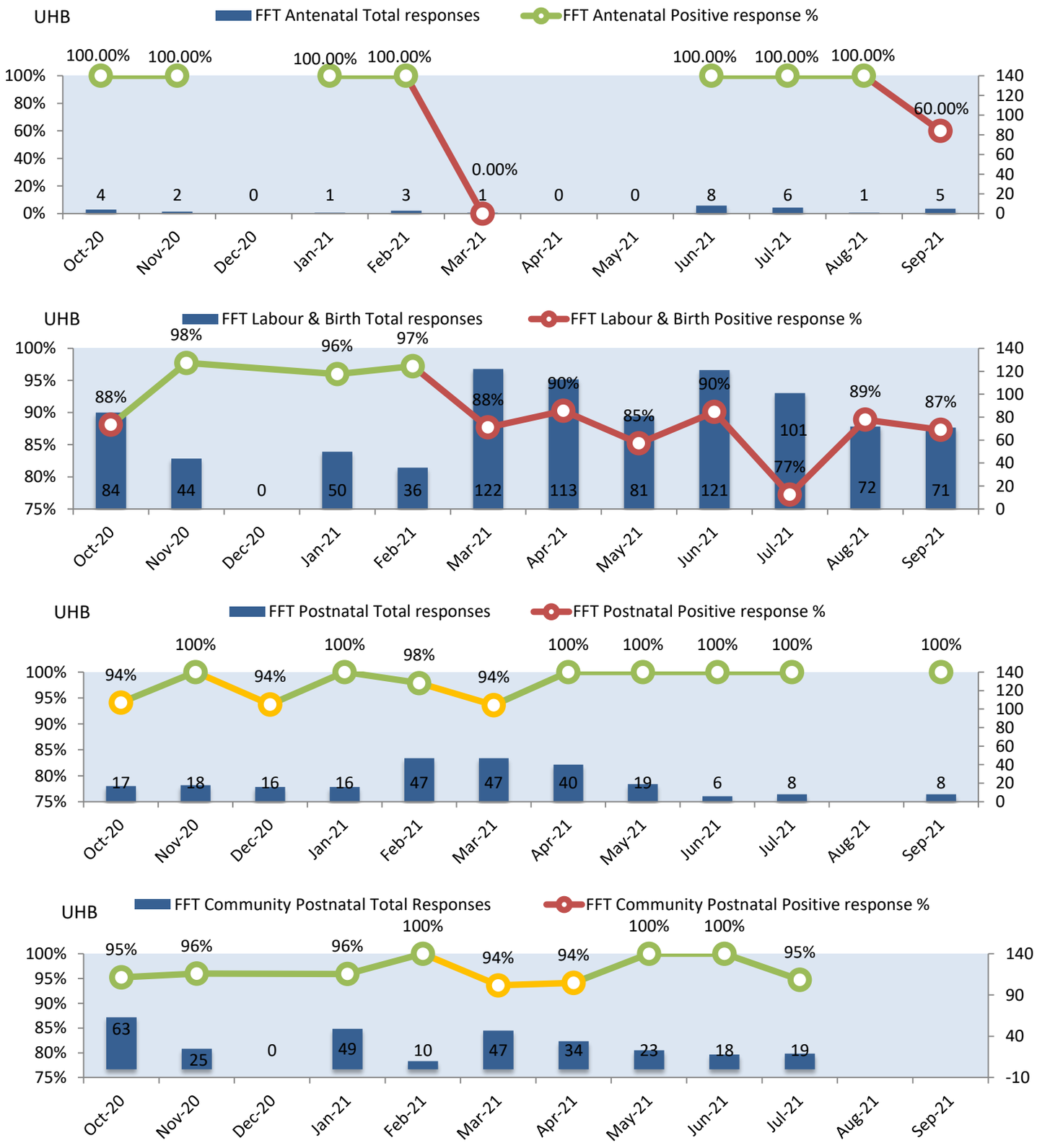
In September 2021 the Trust target was achieved for outpatient and community services FFTs positive recommendation.

ED and inpatient scores had declined across the quarter and didn't meet the internally set targets. However, as can be seen below, the inpatient score is in line with regional and national averages.

The table below shows the Trust score vs national and regional averages for July (latest national data available).

FFT scores July 2021	Trust	National	Regional
Inpatient	94%	94%	94%
A&E	68%	76%	68%
OPD	98%	93%	97%
Community	100%	94%	95%

Friends and Family Test (FFT) – Maternity



Antenatal care saw a significant decrease in score from 100% to 60% however this was based on just five responses. Comments cited name badges, waiting times and crowded waiting room as reasons for low score.

While postnatal ward and community generally remain within target this data should also be considered with caution due to low response rates.

Labour and birth score saw a slight decline in score of 2% in September.

The table below shows the Trust score vs national and regional averages for July (latest national data available).

FFT scores July – Maternity	Trust	National	Regional
Antenatal	100%	90%	95%
Labour & birth	77%	93%	78%
Postnatal ward	100%	91%	100%
Postnatal community	95%	92%	95%

Compliments

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	20/21 total	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21
QEHB	69	66	74	119	98	136	93	**1014**	69	111	52	102	102	73
BHH	15	16	20	13	19	28	36	**253**	25	19	18	26	12	29
GHH	21	9	13	19	19	28	21	**198**	19	12	22	16	5	28
SH	18	8	9	10	18	10	5	**132**	8	5	11	11	8	26
Trust	0	0	0	0	5	6	49	**70**	0	2	6	1	0	0
Total	123	99	116	161	159	208	204	**1667**	**121**	**149**	**109**	**156**	**127**	**156**

QEH

"Mr Chaudhry was able to remove the whole tumour around the brachial plexus with absolutely no side effects or damage to the nerves and I had almost immediate relief of my chronic pain! The weakness in my hand also improved. I was absolutely shocked by these remarkable results all thanks to the exceptional skills of Mr Chaudhry. I honestly did not think I would recover so well and so quickly from such a difficult situation I was in; I don't know if there are miracles but this definitely felt like one and the results defied all my expectations! It is difficult to put into words the true impact his surgery has had on my life."

BHH

"A few weeks ago my daughter was induced and I was very impressed with the care she received on labour ward. She is deaf and lip reads, the staff on labour ward were extremely considerate of this and always ensured they removed their face mask when communicating with her. The level of deaf awareness was overwhelming and this greatly improved her experience and was greatly appreciated by myself and her husband. She also spent time in Neonatal Unit who were equally considerate and accommodating. All staff that looked after her were lovely but in particular, Tamar Tarrant, student midwife Amelia Smith and coordinator Lisa Cerrone"

GHH

"Just wanted to say a big thank you for the care my mom received when she visited GHH ED with a nasty head injury after falling in her garden. I fully understand the pressure you are all under at the moment and how busy ED is. Your treatment of my mom was fantastic you were so caring towards her, on top of this she was triaged, x-rayed and treated all within 2 hours. You are a credit to UHB and wanted to make it known how grateful my mom was for the treatment she received."

SH

"I had a Sigmoidoscopy and Endoscopy at Solihull Endoscopy Dept. and was so impressed with the service received and friendly staff. The paperwork and advice received was very clear. I would highly recommend this dept. to anyone needing either procedure."

Feedback themes – Quarter 2 2021-22

Negative feedback themes	Positive/Compliment feedback themes
Communication	Professionalism and skill of staff
Delays (appointments and electives)	Kindness and compassion
Waiting	Information (quality, timing and amount)
Care and treatment (incl pain)	Organised, efficient services
Staff attitude	Reassurance (during traumatic situations)
Care of vulnerable patients	Clinical care and treatment
Food and drink	Staff working really hard

The negative themes have been received across PALS, Complaints and patient experience feedback such as surveys and the Friends and Family test and the themes remain consistent from quarter one. Communication with relatives and waiting for appointments continue to be a cause of distress for many patients and relatives.

Positive feedback continues to outweigh the negative. Again themes remain consistent from quarter one though more people are starting to highlight how hard staff are working and how much they appreciate telephone contact where face to face is not possible.

> No one was ever available to speak with us. It felt like my father was locked up and we couldn't see him.

> My daughter is getting into depression and has started writing about self harming. I keep chasing her appointment and am told another 6 months.

> I tried for hours to find out what was happening, the phone rang out. I was called next day to say he was terminal. I still don't know which ward he is on or how he is.

Learning from feedback – Quarter 2 2021-22

Feedback received	Action/learning
Various wards – issues around communication with relatives	• Hand held phone for relatives held by ward clerk during their shift then by nursing staff. Call data improved. • One ward utilising a log/proforma which is signed off by the clinical staff returning the call. • Family liaison role introduced onto a ward, undertaking proactive updates. • Member of staff who cannot work clinically covering afternoon/evening shift to provide post operative updates – ward advises that having this familiar consistent person is reassuring for families.
Feedback was received regarding a staff member who had allegedly inappropriately discussed the uptake by staff of the Covid vaccine with a patient. The staff member had reported that 30-40% of staff would be lost if they were forced to have the vaccine. This was very distressing for the patient to hear as the patient is clinically vulnerable.	This was reported back to senior staff who advised that the group of staff mentioned are shortly going to be attending Customer Service training. They decided to use this scenario as a training example to help staff understand the impact of what they say to or around patients. The patient was very happy with the outcome.
Patient was discharged without an Occupational Therapy assessment despite having mobility issues.	Improving communication between nursing team, therapy assistant staff, occupational therapist and patients/families. Escalation process put in place if no documentation of an assessment is in the record. Follow up phone call to ensure patient is managing at home and discuss any equipment requirements if discharged prior to the assessment.
Patient raised concerns that their pain needs were not met following a procedure under local anaesthetic.	As a result the team is reviewing its post-procedure practice to ensure that suitable pain relief is prescribed to be available if it is required.

National Urgent and Emergency Care Survey 2020

- The results of the National Urgent and Emergency Care Survey 2020, undertaken with a sample of patients aged 16 year or older attending A&E during **September 2020** were published on 15 September 2021 .

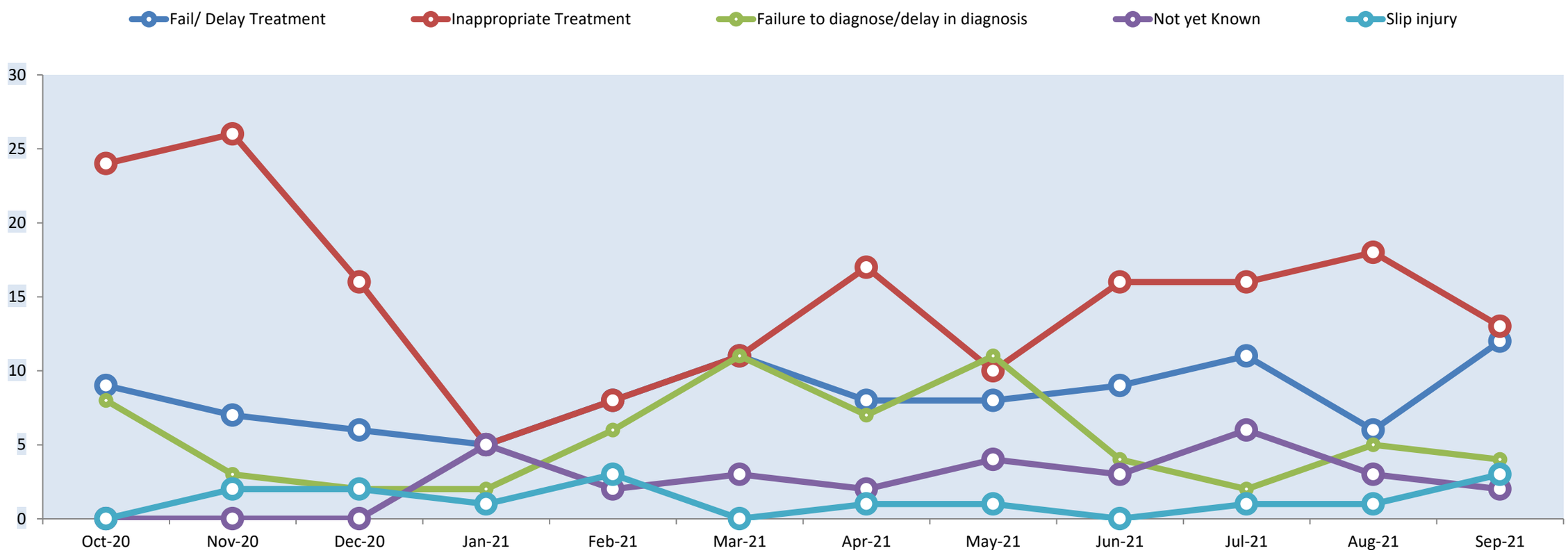
  - UHB results were better than most trusts for **0** questions
  - UHB results were worse than most trusts for **1** question (after leaving A&E was the care and support you expected available when you needed it?)
  - UHB were about the same as other trusts for **37** questions

- Comparisons to the 2018 survey showed no results that were significantly lower, but **5** questions that had significantly higher scores:

  - Once you arrived at A&E how long did you wait with the ambulance crew3 before you care was handed over to the A&E staff?
  - How long did you wait before you first spoke to a nurse or doctor?
  - Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?
  - In your opinion, how clean was the A&E department?
  - Overall, I had a very good experience.

Legal Claims

Claims categories



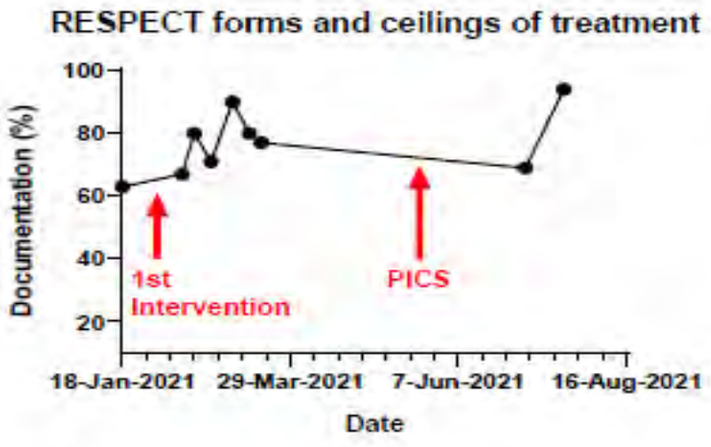
The key themes continue to be failure/delay in diagnosis and/or treatment. There are currently no specific areas across the Trust that are seeing an increase in claims around this theme to cause concern. The number of claims recorded as 'inappropriate treatment' will continue to fluctuate and be updated as detailed allegations and a specific category for the claim is identified.

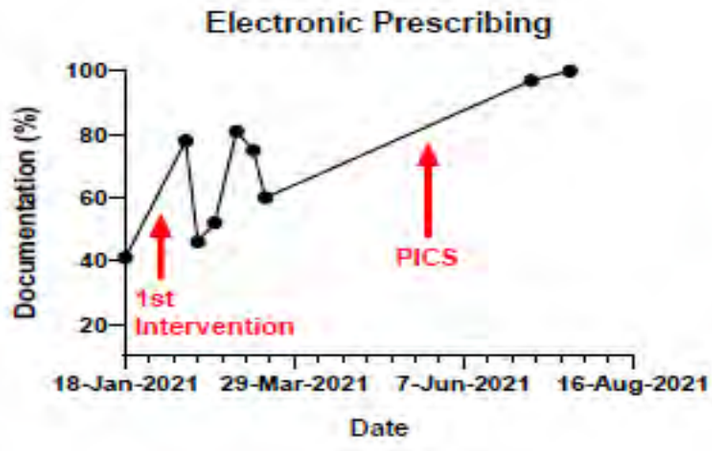
Corporate Quality Improvement Projects

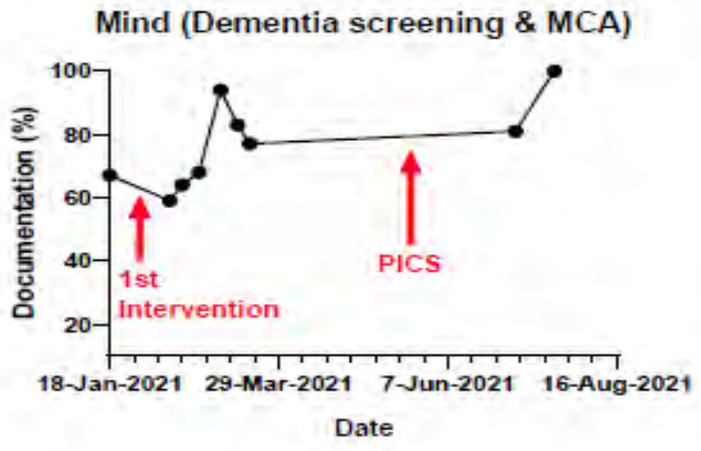
Improving Ward Rounds (incl. safety briefings)

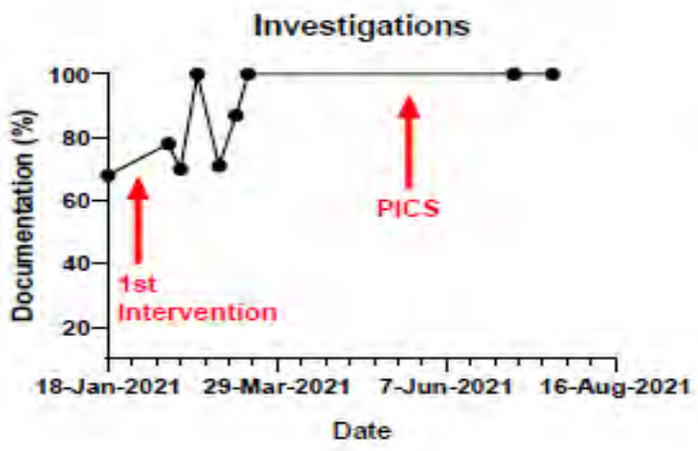
	3.0 - Modest improvement
Project Aim	Improve consistency and efficacy of ward rounds, ensuring key issues identified such as oversight of vulnerable patients, VTE prophylaxis. Improve team working and safety culture amongst the whole professional group.
Project Measures	• All emergency admissions should be reviewed with 14 hours of admission by a Consultant • All emergency admissions should be reviewed daily by a Consultant • Timely VTE risk assessment completion • Timely administration of preventative VTE medication if required • ReSPECT form completion • Dementia risk assessment completion for patients over 75 • Mental capacity assessment completion Broader measures: • Reduction in the number of serious incidents where ward rounds is a theme • Reduction in complaints around ward based care • Reduction in incidents related to nutrition and hydration • Positive staff and patient survey responses • Length of stay (LOS) • Increased patient discharges before 11am
Project update	On-going work with informatics and Quality Development Team to develop measures. Clinical Governance Fellow recruited to support the project.; Key Elements developed and agreed, liaising with Moodle team on ward rounds training. One key element is 'multidisciplinary' and this is proving challenging To focus on effective communication between nursing and medical staff as achieving nurse presence challenging with current staffing difficulties. Respiratory has shown significant increase in adherence to the REMIND following the introduction of PICS. **Part of ECIST project – very positive feedback at recent feedback session**

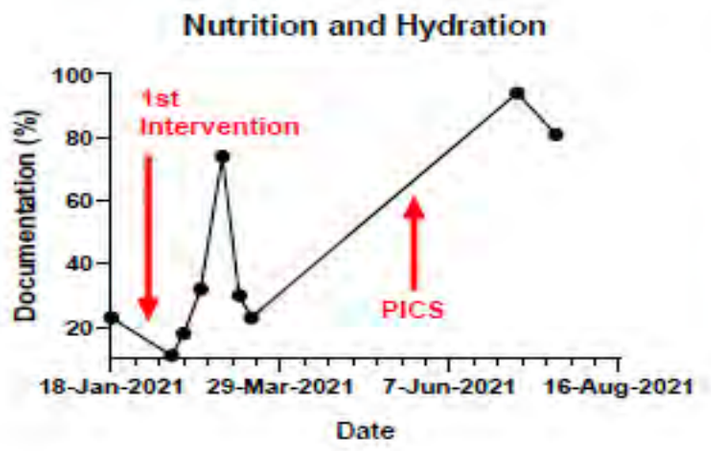
Respiratory implementation of ward round project and PICS

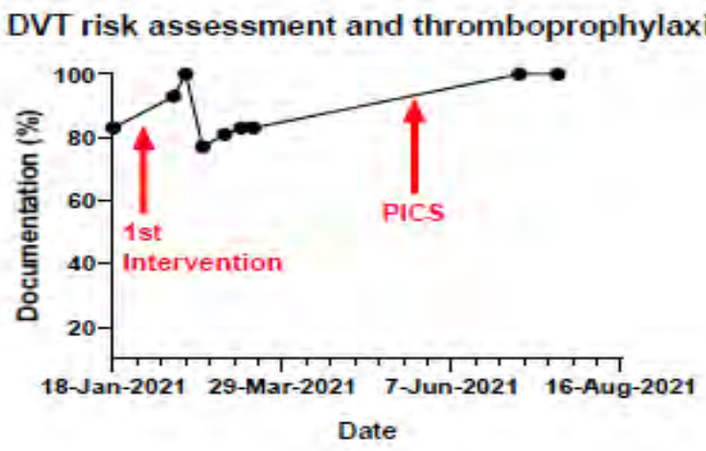








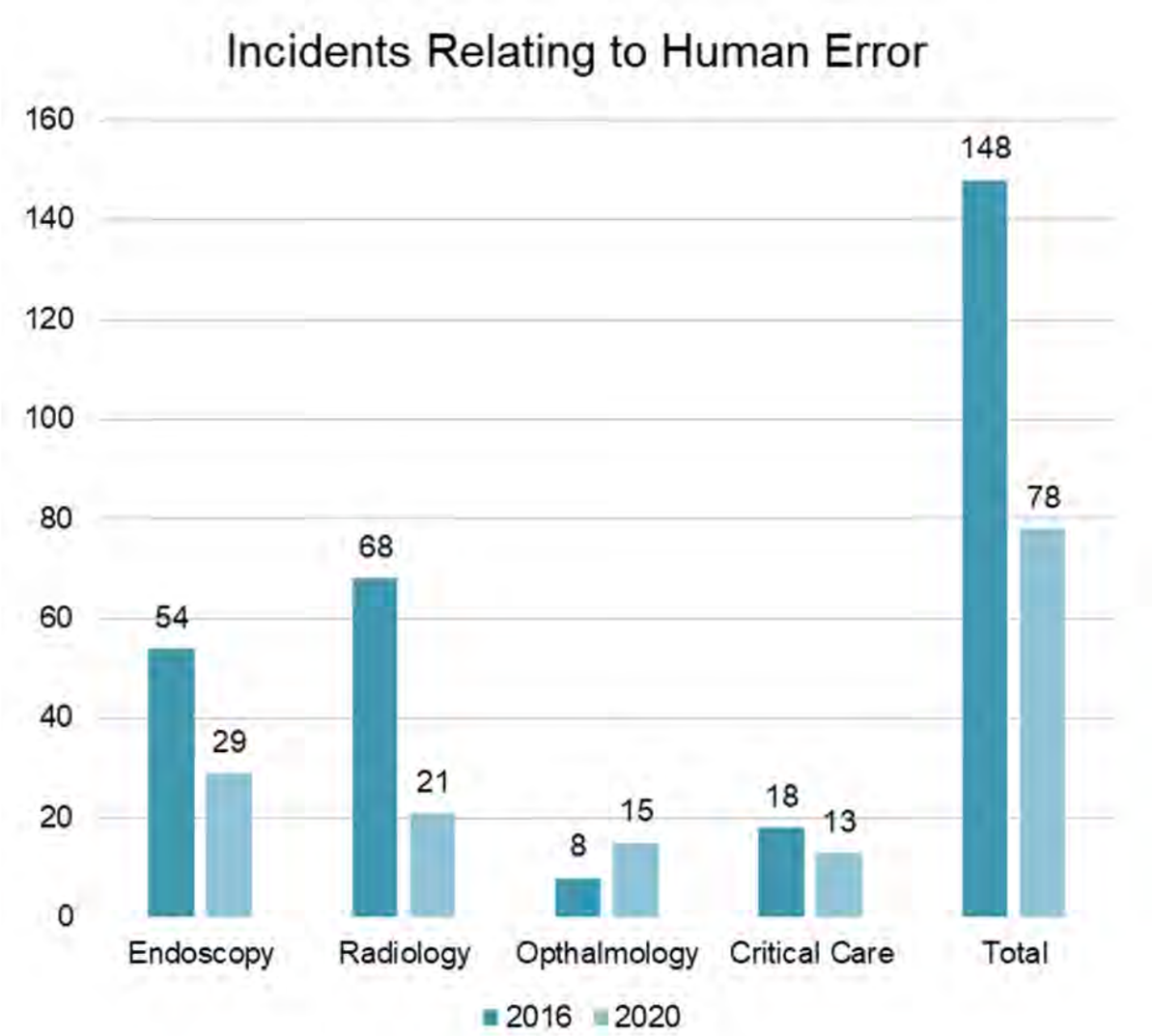




Combined data from wards 24 and 26

Improving the Safety of Invasive Procedures

3.5 - Improvement

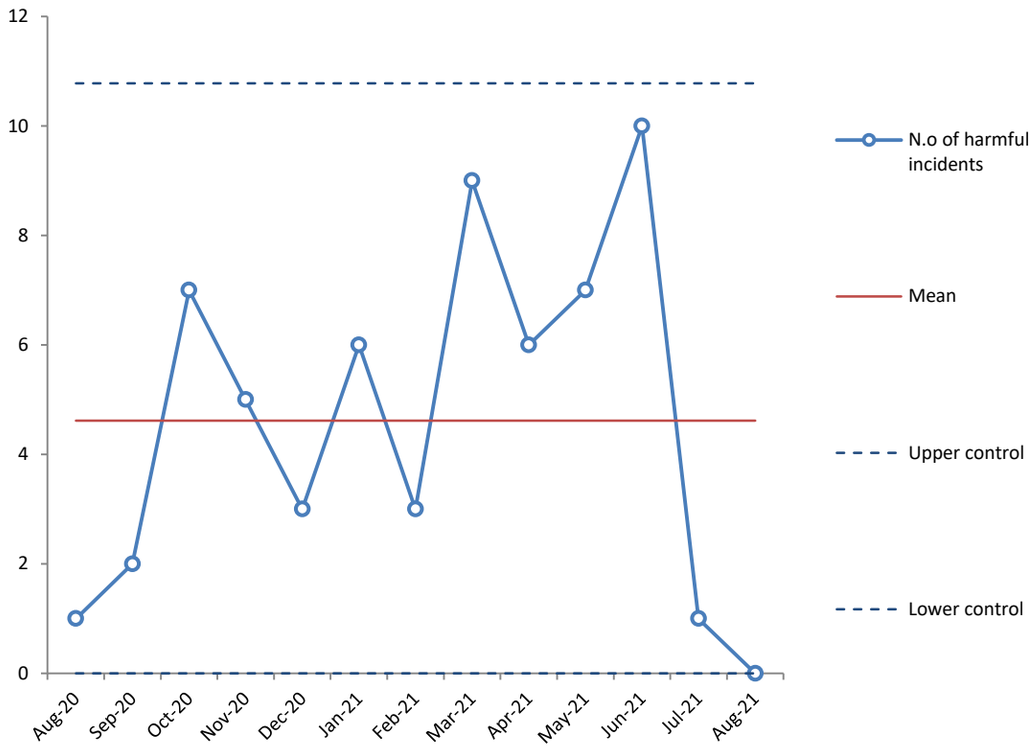


Project Aim	• To improve the safety of care during invasive procedures and reduce the number of Never Events.
Project Measures	• Reduction in incidents and serious incidents related to invasive procedures • Increase compliance using audit tools • Staff feedback on satisfaction, compliance and improved education
Project update	The fourth LocSSIPs fellow commenced the post in August 2021. Work has started on the development of LocSSIPs for Gynaecology procedures. Outcome measures-incident numbers remain low. The Group also monitor the number of Never Events and near miss incidents related to invasive procedures. SI and RCA investigation reports are also reviewed. Speciality LocSSIPs Audits are presented to the group. The development and implementation of a staff education module via Moodle is on-going. **Project shortlisted for BMJ Award – QI Team of the Year.**

Improving VTE Prevention

2.5 - Changes tested, but no improvement

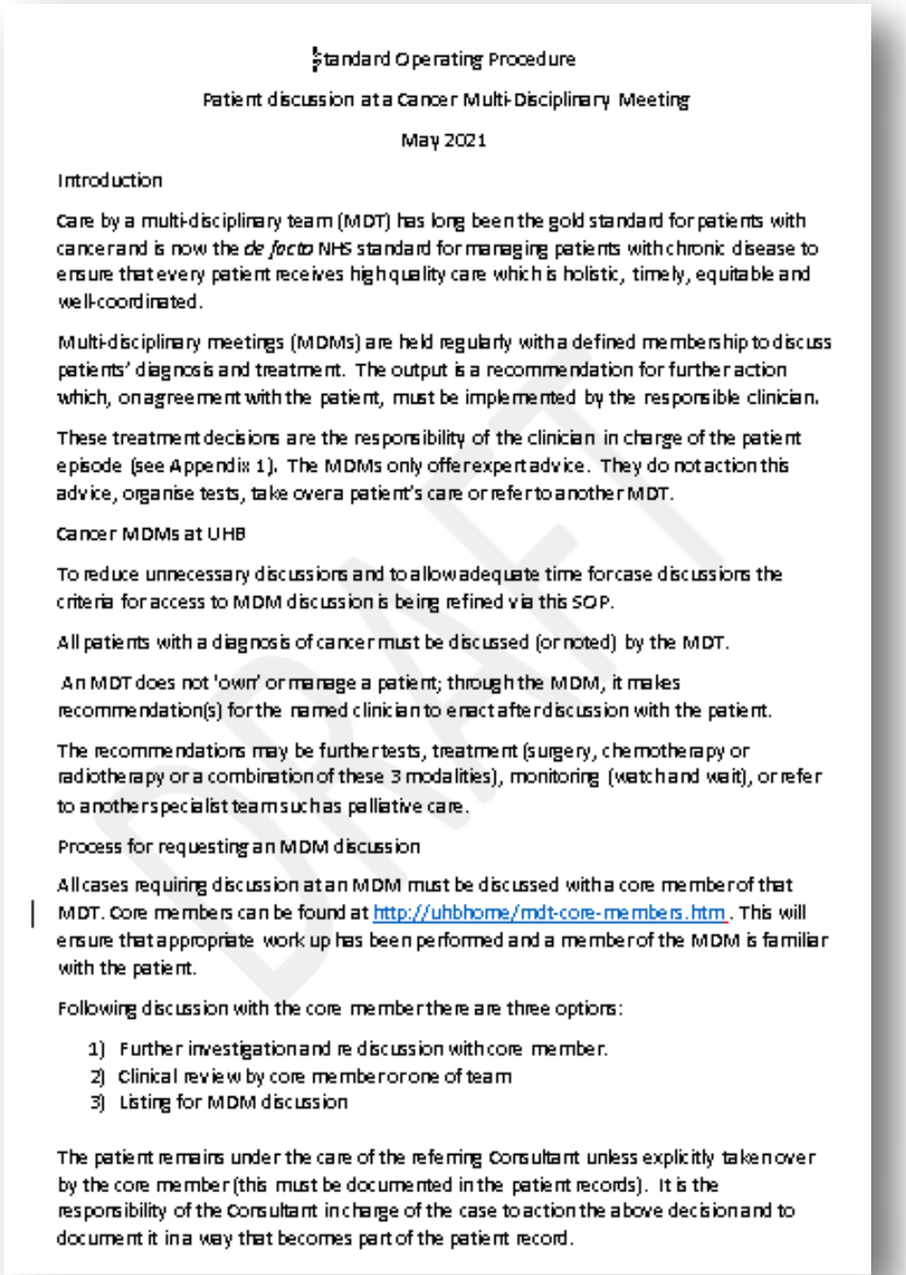
Number of harmful incidents relating to DVT and PE



Project Aim	To reduce the number of harmful incidents associated with Hospital Acquired Thrombosis. In order to keep the scope specific, two key areas will form the focus of this project: 1. Improving completion of VTE risk assessments and prescription/inappropriate suspension of thromboprophylaxis. 2. Improving VTE assessment for outpatient lower limb immobilisation (VTE assessment in ED/ plaster)
Project Measures	• Suite of new VTE indicators covering inpatient and lower limb pathways • Preventable HAT rate • Number of HAT related SIs
Project update	The VTE Lower limb guidelines are now in place and on the guidelines page of the intranet. The patient information leaflet has been delivered to the relevant areas for issue to patients / carers. This is also included in the PAID system on the BH/GH/SH sites. The UHB Lower Limb guidelines and changes are to be included in education and training sessions for staff in ED/T&O. Audit tools are being devised and will be undertaken once Lower Limb guidelines have been fully embedded. Initial suite of VTE indicators to go live once validated and approved at site and speciality level. QD team to create one indicator report. The QI group are now focusing on the inpatient part of the project.

MDT/MDM review

2.0 - Activity, but no changes



Standard Operating Procedure

Patient discussion at a Cancer Multi-Disciplinary Meeting

May 2021

Introduction

Care by a multi-disciplinary team (MDT) has long been the gold standard for patients with cancer and is now the *de facto* NHS standard for managing patients with chronic disease to ensure that every patient receives high quality care which is holistic, timely, equitable and well-coordinated.

Multi-disciplinary meetings (MDMs) are held regularly with a defined membership to discuss patients' diagnosis and treatment. The output is a recommendation for further action which, on agreement with the patient, must be implemented by the responsible clinician.

These treatment decisions are the responsibility of the clinician in charge of the patient episode (see Appendix 1). The MDMs only offer expert advice. They do not action this advice, organise tests, take over a patient's care or refer to another MDT.

Cancer MDMs at UHB

To reduce unnecessary discussions and to allow adequate time for case discussions the criteria for access to MDM discussion is being refined via this SOP.

All patients with a diagnosis of cancer must be discussed (or noted) by the MDT.

An MDT does not 'own' or manage a patient; through the MDM, it makes recommendation(s) for the named clinician to enact after discussion with the patient.

The recommendations may be further tests, treatment (surgery, chemotherapy or radiotherapy or a combination of these 3 modalities), monitoring (watch and wait), or refer to another specialist team such as palliative care.

Process for requesting an MDM discussion

All cases requiring discussion at an MDM must be discussed with a core member of that MDT. Core members can be found at http://uhbhome/mdt-core-members.htm. This will ensure that appropriate work up has been performed and a member of the MDM is familiar with the patient.

Following discussion with the core member there are three options:

1) Further investigation and re discussion with core member.
2) Clinical review by core member or one of team
3) Listing for MDM discussion

The patient remains under the care of the referring Consultant unless explicitly taken over by the core member (this must be documented in the patient records). It is the responsibility of the Consultant in charge of the case to action the above decision and to document it in a way that becomes part of the patient record.

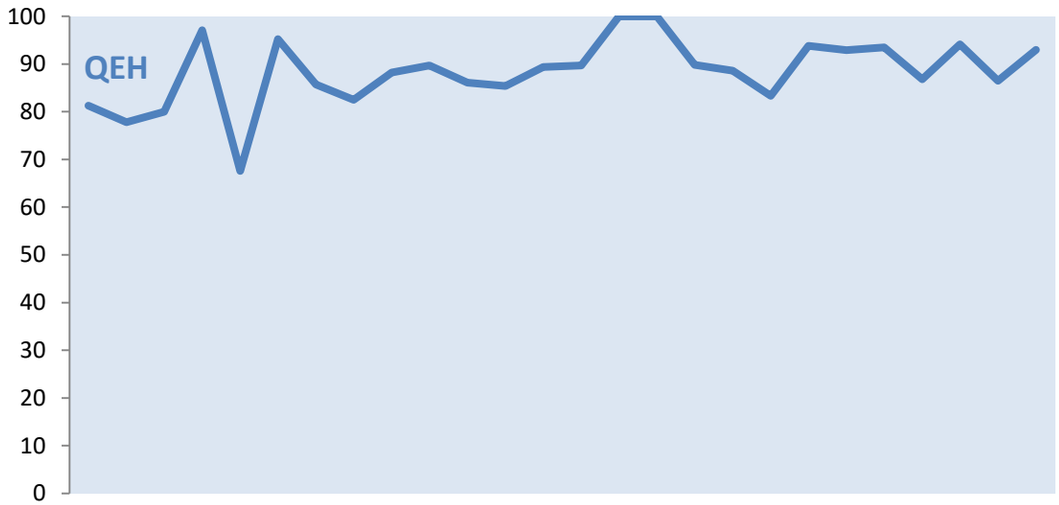
Project Aim	To reduce the preventable harm and improve the consistency and quality of care for patients being referred to and managed within cancer MDTs
Project Measures	• Reduction in serious incident themes and trends that involve the cancer MDT process • Percentage of clinicians referring to cancer MDTs that have knowledge of their responsibilities under the newly developed SOP (target TBC)
Project update	A SOP for cancer MDM is being finalised and a flowchart to be used alongside the SOP will be developed. PICS referral process and notifications to be rolled out trustwide. Once the SOP has been signed off and thoroughly implemented, the lead will be proposing that the project is closed.

End of Life Care/DNACPR

2.0 - Activity, but no changes

Percentage of inpatient deaths with an active TEAL assessment at time of death

26/03/2021 to 23/09/2021



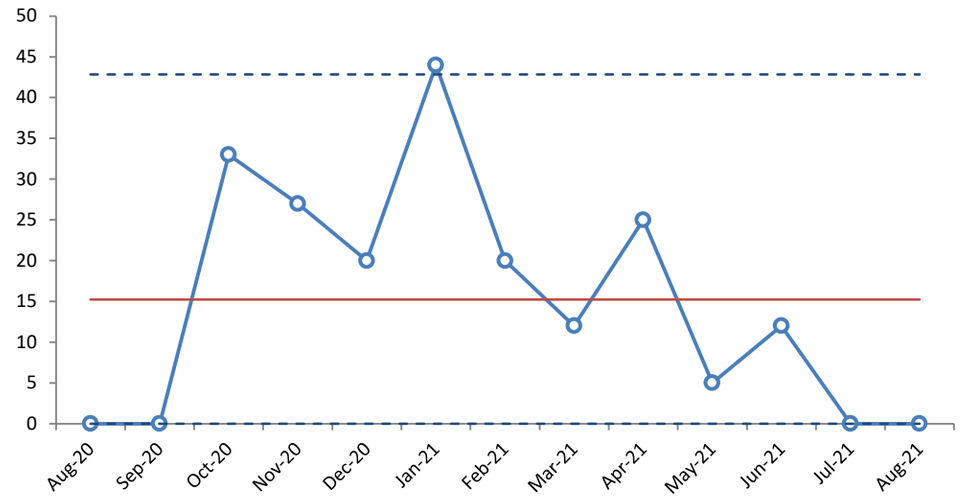
Complaints review: Recurring themes
End of life discussion excluding family
Communication / quality of discussions
Family challenging medical decision re: CPR
Family believe that DNACPR led to poor subsequent supportive care / patient 'written off'
Concerns re capacity of patient
Visiting restrictions

Project Aim	To improve the standard of end-of-life advanced care planning and to reduce incidents/complaints related to end-of-life care.
Project Measures	• % of deaths with a valid DNAR • % of all inpatients with a valid DNAR • Months since last SI • Number of complaints related to EOL care
Project update	Standard agreed - all unplanned admissions that re-present within 12 months must have RESPECT/TEAL within 48 hours. Proceeding with digitalisation of RESPECT/ TEAL, QI project lead working with PICS team. Moodle educational package is being updated and will be more interactive for staff. Webinars, podcasts and a web page are also being considered. 12 month review and theming of complaints completed.

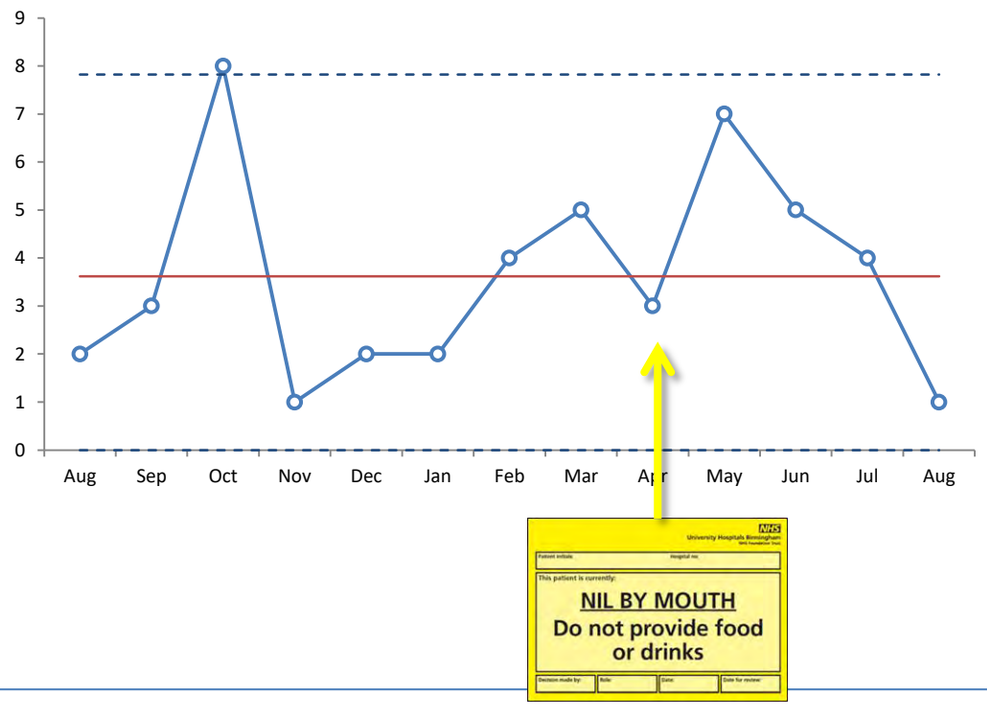
Safer Swallow

3.0 – Modest improvement

Percentage of incidents reported causing harm (low-death)



NBM 01/08.Incident numbers
01/808/20 – 31/07/21



Project Aim	Reduce incidents of patients being given inappropriate diet and fluids. To improve the management of patients who are nil by mouth (NBM)
Project Measures	• Reduction in level of harm incidents • Reduction in incident themes and trends • Meal service audits • Nursing Metrics • Training records (Moodle/ward based) • Audits of NBM signs following implementation • Reduction in incidents related to patients who are NBM.
Project update	A standardised NBM sign has been introduce across all sites. A document for practical advice and principles for managing patients who have complex swallowing problems has been put together and is currently under review and approval. To highlight within the Trust's electronic Prescribing Information and Communication System (PICS) how long patients have been nil by mouth for. Audits are being commenced in relation to the new NBM and pink SLT signs and agreement to undertake these regularly. Education team working with staff across sites to explore barriers to patients receiving incorrect diet and fluids to inform further improvement work. Review of current peri and post operative fasting signage and processes with a plan to make improvements and to standardise across the Trust.. SLT's to be trained to prescribe thickeners on discharge for GH as PICS will not be in place for a while. The project group will also feed into a new project group – for improving nutrition and hydration (details on next slide)

Other QI Projects

QI Project	Exec Lead	Status		Progress
Sepsis	CMO		3.0 - Modest improvement	Awareness raising underway, list of sepsis champions being finalised and training to start in the Autumn ,education ecosystem progressing and guidelines being standardised. Ward specialty level audit & feedback re-initiated. Automated sepsis dashboard being trialled, work on going by QD team to establish measures.
Improving Diabetes management	Exec Chief Nurse/ CMO		2.5 - Changes tested, but no improvement	Re-focusing on reducing the number of DKA incidents and recurrent hypoglycaemic episodes suffered by inpatients on diabetic medication. September has focused on hypo awareness and the Trust have implemented new Hypo boxes on all wards and departments. Measures for improvement being developed. Further educational packages being developed with role specific training and Moodle. Comparison review of site diabetes incident themes and trends is being undertaken to inform further improvement works.
Standardising Early Warning Score (NEWS2)	CMO		2.0 - Activity, but no changes	A standard EWS is required across all sites. NEWS2 is the national standard, however research shows that implementation of the national thresholds on an automated system would generate excessive notifications to the clinical teams. Modified escalation thresholds and a response framework have been developed for UHB sites. It is proposed NEWS2 and the new alert thresholds will be implemented via the PICS roll out in 2021/22. CQMG have agreed the proposed alert thresholds and proposal going to CEAG October 2021.
Radiology alerts	CMO		1.5 Planning has begun	The process for alerting in Radiology is under review with a number of potential solutions in development.
Consent	Chief Legal Officer		1.5 Planning has begun	Procedure launched and audit planning underway

Other QI Projects

QI Project	Exec Lead	Status		Progress
Communication	Chief Nurse		2.0 - Activity, but no changes	Communications training packages reviewed; training in written communications skills being sourced (Plain English Society). Writing clinic letters directly to patients (as opposed to a cc) in plain English has been agreed with the Medical Director. IT to advise on suitability of mobile phone handsets (to facilitate contact for relatives). Discussion with IT to establish existing capability to support digital communication directly with relatives and carers. Facilities staff focus groups to hear suggestions about improving communication with patients and relatives. Therapy leads have agreed to conduct similar sessions with teams. The 'my name is . . .' campaign has been re-launched.
Discharge	Chief Nurse, CMO		2.0 - Activity, but no changes	Three of the four sub-groups have now met and have an action plan in place. Development of policy and procedure underway. PICS checklist being updated – copies of all local checklists requested. Work underway with Chief Registrars and junior doctors re audit of quality of discharge letters. Metrics being drawn up. Incidents, Safeguarding, PALS and Complaints being monitored. Pharmacy team added to complex discharge daily list to aid timely dispensing. Pharmacy team prioritising patients being discharged on the day via discussion with ward nurse leads.
Patient property	Chief Nurse		1.0 Forming team	Lead and core team have been identified and initial meeting set. Project/admin support agreed.

Assurance visits

Board Unannounced Visits

The Board of Directors Unannounced Governance Visits re-commenced at QEHB in September 2021. As this was the first set of visits since the start of the covid-19 pandemic, the visit teams were kept small, and two wards were visited – 408 and 625. Action plans following these visits will be sent to the Divisional Teams for review and update.

Ward reviews

The ward review was ward 11 BHH following concerns raised via the students who had been on placement/CQC. There is a formal investigation ongoing but Davina did an informal review and found the following;

I am pleased to report that there are no further incidents on the ward, The students on current placements on ward 11 are all enjoying their placements and being supported by both the ward team and the practice placement team. We will respond to any necessary recommendations on completion of the formal review.

Quality Accounts

The Quality Development Team are working on the half-year report for 2021/22. All the chosen Priorities for 2021/22 are part of the Quality Improvement Programme which is covered elsewhere in this IQR.

Learning from Excellence (LfE)

Month	Number of reports
July 2021	13 (9 intranet, 4 Datix)
August 2021	20 (12 intranet, 8 Datix)
September 2021	12 (5 intranet, 7 Datix)
Total	45 (26 intranet, 19 Datix)

Examples of recent reports	Specialty
K was very proactive and managed the care of a deteriorating patient very well. Identified the red flags and acted promptly. Whilst doing this she also noticed the patient in the next bed space was in distress and monitors alarming. She immediately went there and tried to address the issue. Helped the bedside nurse with few jobs. K was very compassionate in her approach and also very helpful to her colleagues. As the doctor on the unit I felt the patient was very well cared for and we could deliver the best care.	Critical Care
Showed flexibility by accompanying the consultant to the wards to see a patient (also a HCP) with extremely complex medical problems. Having a dermatology nurse in attendance enabled the patient to feel comfortable, supported and treated with respect. S showed initiative by continuing to communicate directly with the patient afterwards as a further procedure needed to be performed in Area 4. The patient appreciated this additional support, and the input from S to work out the timings of the procedure (and to be present herself) meant that other activities such as a multi-consultant ward round were not missed by the patient.	Dermatology
Cord prolapse at full dilatation at 01:30am - achieved caesarean section under spinal anaesthetic with normal umbilical cord gases. I was the obstetric registrar on call. RM R identified cord prolapse with fetal bradycardia, pulled emergency buzzer, kept her hand in vagina elevating pp. RM K performed bladder filling and facilitated effective communication between team members adopting a leadership role herself, RM M maintained auscultation of the fetal heart throughout. With these prompt and effective measures the fetal heart normalised in theatre and we were able to proceed with spinal anaesthesia with patient in left lateral position with the pp being elevated by RM R and the FH being monitored by RM M. Dr A performed efficient successful spinal anaesthetic with patient in lateral position, which is challenging as it is not the usual patient position for spinal. At caesarean section cord prolapse was confirmed on delivery of the head.	Maternity
Extraordinarily complex (& urgent) neurosurgical case which required prolonged surgery which could only be completed on the QE site. The theatre team as always went above and beyond to ensure the patient accessed the 12 hours of surgery without complaint. Indeed removing all the stressors allowing the anaesthesia and surgical teams to focus on the complex job at hand. At the end of surgery, after recovery, the EPOC team provided the final piece to this complex perioperative pathway.	Theatres
Worked alongside the delivery suite Coordinator on Saturday to manage and lead the delivery suite staff during a very busy shift. Rachel helped to prioritise and escalate cases effectively to enable delivery suite to run smoothly and effectively. Great team work and leadership.	Maternity

Themes and Learning

Overarching theme(s), trend (s) identified in L1 and L2 SI's, patient experiences, PALS, complaints, inquests and claims

L1 and L2 SI's

There were 25 closed L1 and L2 Serious incidents in Quarter 2 of 2021/2022.
In 13 investigations it was identified that task was a contributory factor to the incident.
Themes in relation to task are summarised in the table on the next slide.

Communication was a contributory factor in 11 incidents, with the following issues identified:
Investigations (failure to communicate/respond to results, incidental scan finding not shared with GP)
Handovers (medication not discussed, ward staff not informed of possibility of operative complication)
Suboptimal completion of paperwork and escalation.
No routine use of interpreters.

Patient experiences, PALS, complaints

Communication still featured as an increasing trend in 151 complaints, 293 PALS and 484 patient experiences. These were consistent with the themes identified in the previous report and remains one of the highest themes overall in patient experience again this quarter.

Inquests and claims

Communication and documentation remain the key themes for inquests and claims.

Task Factors

The table below summarises themes related to task factors within key stages of care/patient journey

Stage of care	Task/activity	SI/ISI's task factors	Patient experience, PALS and complaints
Inpatient care	• Observation and monitoring • Medication prescription • Delay in diagnosis and treatment • Post-operative deterioration	• Missed observations on a deteriorating patient • Missed interval dosing of a patient's enoxaparin • Delay in reporting scans • No observations as patient appeared to be asleep • Not acting on blood results • No escalation for a review by doctors when NEWS 5 and 7	• Unnecessary tests being repeated • Regular medications not prescribed • Patients left without medication due to long delays • Staffing levels causing delays in medications and treatment • Delay/failure in treatment • Failure to undertake scans/X-rays • Delay/failure in undertaking observations
Emergency care	• Diagnosis and treatment • Action following CT scan	• Inadequate X-ray request limited to specific areas. • Referral closed due to inactivity without a clinical conclusion	• Sent home without full assessment • Lack of information about condition • Poor/ absent follow up plans • Delays in results • Delays in medication
Intraoperative care	• Surgical intervention • Implant check • Nerve block	• Surgical plan not discussed before procedure commenced • Implant recorded in two different locations. • Lead surgeon not present for the time-out checks, • Lead surgeon not checking implant prior to insertion • No recollection of checking side of block, no 'stop before you block'.	• Surgical delays and cancellations

National Audit

HQIP state that statistically derived limits around the target (expected) performance should be used to define if a provider is a potential outlier: more than two standard deviations from the target is deemed an 'alert,' more than three standard deviations is deemed an 'alarm.'

New Outlier Notifications:

•The table below details all mandatory national audit outliers for the Trust received in Quarter 2 2021/22

Site	Title	Issue causing Outlier Status	Progress	CQC Involvement
BHH GHH	National Paediatric Diabetes Audit (NPDA)	'Alarm' Level outlier for Case-mix adjusted mean HbA1C and the Completion rate for key health checks for patients aged 12+	Ongoing	Request for Information
Update from Deputy Medical Director for Division 6: This outlier was presented to CQMG in September, with actions outlined for service development. This will continue to be monitored.				
Site	**Title**	**Issue causing Outlier Status**	**Progress**	**CQC Involvement**
UHB	National Bowel Cancer Audit (NBOCA)	'Insufficient data - Two-year survival' outlier	Ongoing	Request for Information
Response from Lead for NBOCA: This was presented to CQMG in September with actions agreed. Raw 2-year mortality rates have improved and data completeness has also improved since 2017-18. The latest NBOCA submission data from April 2021 was satisfactory in terms of data completeness and this is due to having a data manager at the QE site. This will continue to be monitored.				

National Audit

Outlier Notifications from Previous Quarters:

The table below details all mandatory national audit outliers within the Trust received in previous quarters:

Site	Title	Issue Causing Outlier Status	Progress	CQC Involvement
BHH	National Emergency Laparotomy Audit (NELA)	"Alert" – BHH - post-operative mortality for the period 01/12/2018-30/11/2019 by 2 standards deviation (2SD).	Ongoing	No direct request- included in the monthly CQC Insight Reports
Update from BHH NELA Lead: A detailed review of BHH's Emergency laparotomy practice has now been completed and was presented at CQMG in March 2021. This has been fed back to NELA and the team await confirmation on if mortality figures will be amended to reflect the investigation. Data Entry for 2019-20 has now been submitted and the Team believe all eligible cases have been captured. Once results are published, the Team will be able to confirm if mortality figures no longer flag as an outlier concern.				
Site	**Title**	**Issue Causing Outlier Status**	**Progress**	**CQC Involvement**
QE	National Neurosurgical Audit Programme (NNAP)	The Trust received a letter from the NNAP office on 28th September 2020 informing UHB that the neurosurgical unit was a two standard deviation (2SD) alert level outlier assessed on the last five years risk adjusted Mortality data (2014 to 2019).	Closed	The HQIP advice is that NNAP inform the CQC as this feeds into their routine monitoring of providers and will assist their quality improvement aims.
Update from Head of Clinical Quality Benchmarking: NNAP have reviewed and changed the methodology and inclusion/exclusion criteria for 18/19; The Trust is no longer an outlier. This was presented to CQMG in July and the outlier status is now considered closed.				

Key Issues

Executive Chief Nurse Care Quality Group: Oct 2021

1.1 The patient story, in the form of a video, highlighted issues with digital technology experienced when accessing out-patient consultations via DrDoctor. Due to the lack of knowledge about the system, the patient ignored emails for fear of them being an email scam. This story also included issues experienced when trying to cancel an appointment, and when the appointment was subsequently not cancelled, how this caused anxiety about having a 'Did Not Attend' on their patient records. The Care Quality Group discussed the requirement for increased communication to be made available around the DrDoctor system, and a report to be requested to go back to the Patient Experience Group from Director of Patient Services and Director of Applied Digital Healthcare.

1.2 Safeguarding made the Care Quality Group aware of a new risk; Resilience of the Paediatric Liaison Team, with prioritising cases and maintaining essential function whilst the recruitment of new staff into the team is undertaken due to leavers. Recruitment process due to end 30/01/22.

1.3 Priorities for safeguarding remain in (i) supporting frontline services in ensuring the safety of children is embedded in their practice (ii) continuing to develop the safeguarding alerts and assessments within the PICS systems and (iii) fulfilling statutory responsibilities in completing health assessments for children in care in a timely manner.

1.4 An Inclusion Strategy 2022-2025 is underway, with an update of progress presented to the group today on the six objectives (i) Knowledge, Skills and confidence (ii) Having a voice (iii) Patient focus (iv) Partnership working (v) Inclusive culture (vi) Practical inclusion. The Governors in attendance were keen to ensure there is awareness in the nine legal characteristics of inclusion as well as all other aspects. The Deputy Director of Health & Wellbeing, Inclusion and Social Cohesion discussed the removal of bias from processes and paperwork.

1.5 The PICS system was referenced a number of times throughout the different sections of the meeting and a training session for the Governors is being arranged, so they have a meaningful understand of any issues and good work practices shared at this meeting.

1.6 Transition is young people and their families moving from paediatric care into adult services was presented by the Consultant Nurse for Youth and Transition. Delivery of this care is in reality complex, occurring across systems, organisations and traditional service boundaries. Initial scoping has taken place across the Trust identifying approximately 40 different specialties with complex and overlapping pathways. A Transition Steering Group has had an initial meeting and will feedback to this group in three months' time on methods to share good practice across the specialties and agreeing strategic principles with key leaders at Birmingham Women's & Children's Hospitals (BWCH).