The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 27/06/2024		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 25/06/2024		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Industrial Action update • Paediatric Transformation Assurance Committee • Safeguarding Assurance Committee Key Issues Report • Safeguarding Annual Report • Maternity Transformation Assurance Committee Key Issues Report • Maternity & Neonatal Safety Champions Key Issues Report • Maternity Dashboard and Key Issues Report • CNST Update • Midwifery Staffing Report • DOM 6 Month Safe Staffing report • Saving Babies Lives Q4 report • Education and Training Q4 report • Safety Intelligence Dashboard Q4 • Triangulation of the NHSR Score Card Q4 • MBRRACE • Infection Prevention & Control Assurance Committee Key Issues Report • Infection Prevention and Control (IPC) Annual Report • Nursing, Midwifery & AHP Workforce Key Issues Report • Quality Operational Committee Key Issues Report • Quality Indicators Integrated Performance (IPR) Report • Incident Management Overview Report • CQC Report and New CQC ratings • Learning from Deaths / Medical Examiner and Bereavement Services Q4 and annual report • Health, Safety Security and Fire Annual Report • Medication Safety Annual Report • Palliative and End of Life Care Quarterly Report • Quality Account update
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• QSAC discussed the implications of the Dispatches programme of 24 June 2024 concerning the Emergency Department at RSH. QSAC was aware of overcrowding in ED, the prolonged delays and use of corridor for care, the resulting increased risk of harm and the increased mortality associated with long delays in ED from regular reports to the committee and from the recent CQC report, and of actions being undertaken to improve them and to mitigate harm. QSAC heard that all issues raised in the programme were being examined and would be brought within the action plans for improving Emergency and Urgent Care and subject to external scrutiny via the Emergency Care Transformation Assurance Committee.

		• Workforce fragility in Cardiology means that in-patient cover is 12 hours over 3 mornings per week, resulting in delays in in-patient review, increase in waiting times and backlog of patients waiting for diagnostics. • There are increases in waiting times for a number of other specialities in Medicine and Emergency Care, including Diabetes,Endocrine, Dermatology, Respiratory, Renal. Stroke patients being assessed by a stroke nurse in an appropriate timeframe has dropped significantly. • Infection Prevention and Control: Tuberculosis: challenges being faced by the TB service include: significant change in the demographics in STW and Powys areas; a diverse workforce arriving from countries considered high risk for TB; change in the general community with a significant increase in community incidents; significant challenges during any community outbreaks (Schools, Factories, Prisons, Pubs, Asylum Hotels). Due to these challenges, our current workforce is not able to support the implementation of the TB Action Plan 2021/26. This is on the Risk Register (listed as high risk with a score of 25) and there are actions in place to mitigate the risk which includes an improved service specification that is currently with the ICB to enable the demand to be met. • Whooping Cough: a meeting is planned with National Colleagues from UKHSA and Public Health to discuss our current position and whether any further advice can be sought or actions taken.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• How We Learn from Deaths and Medical Examiner/Bereavement Service Quarter 4: Expansion of the ME Service across the Integrated Care System (ICS) has progressed well. The statutory system will start on 9th September 2024. QSAC heard that the ME service is in a good position regarding the checklist for actions, and that the funding arrangements are improved and longer term. • Paediatric Care Transformation Assurance Committee agreed to move PTR 21 on liaising with tertiary centres from amber to green after auditing showed good compliance with the recommendation that tertiary referrals be consultant-led. • The power outage in June 2023 in Women's and Children's Department was classed as a critical incident and investigated as a serious incident (SI). The cause was an internal electrical overload with a secondary failure when the diesel generator failed to operate. Both technical issues have been dealt with and the system subject to testing, which was successful. A full review of patients affected had previously been undertaken, with no harm identified.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Maternity Transformation Assurance Committee will from July include action plans relating to Neonatal Care to become the Maternity and Neonatal Care Transformation Assurance Committee and ensure these action plans are subject to the same level of governance. • Patient Safety Incident Review Framework (PSIRF): existing actions arising from Safety Incident investigations under the previous system are being amalgamated into PSIRF so that they either are brought into existing themes or if they don't fit into these, as standalone actions. • Following discussions during the development of PSIRF with Workforce colleagues, a Board Safety Culture session and a PSRIF oversight training day, work is about to be undertaken to review alignment between safety assumptions under PSRIF and HR processes following patient safety incidents. • Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS): QSAC considered the following reports: CNST Update Report; Midwifery Staffing Report; Director of Midwifery 6 Month Safe Staffing report; Saving Babies Lives Q4 report; Education and Training Q4 report; Safety Intelligence Dashboard Q4; Triangulation of the NHSR Score Card Q4. • QSAC liked the NHSR Scorecard, which brings together data on Maternity in SaTH from a range of sources including reviews of Litigation Claims/NHSR Scorecard, themes from Complaints/Compliments/Friends and Family, themes from PSII's/PMRT/External reviews (Ockenden, CQC), national Reviews of themes/MNSI Safety Recommendations and Publications/MBRRACE/National Reports. This will also be considered at the Safety Champions' meetings.		
2d	**Actions** ***Significant*** *follow up actions*	• Item for Audit and Risk Assurance Committee: Chair to send a copy of the Health and Safety Management Annual Report for information, as this may fit in with ARAC's plans for internal audit.		
3	**Report compiled by**	*Ms Rosi Edwards* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*