The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 31/07/2024		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 30/07/2024		All NED and Executive Director members, and regular Trust Officer attendees, were present.

1	**Agenda**	The Committee considered the following:
		• Industrial Action update
		• Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Key Issues Summary Report AAAA – update from Dispatches programme 24.06.2024
		• 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
		  • CQIM Data Analysis
		  • CNST MSDS Year 6 Progress Report
		• CNST Update and appendices
		• Birth Trauma GAP Analysis
		• Infection Prevention & Control Assurance Committee Key Issues Report
		• Nursing, Midwifery & AHP Workforce Key Issues Report
		• Quality Operational Committee Key Issues Report
		• Quality Indicators Integrated Performance (IPR) Report
		• Incident Management Overview Report
		• Getting to Good Update Report
		• Legal Update Quarterly Report
		• Quality Priorities
		• BAF - Board Assurance Framework Quarterly Report
		• PALs, Complaints Patient Experience Annual Report
		• AOB - Neonatal Review Report

2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Due to a deterioration on Cancer Waiting Times performance and an increase in the backlog of patients waiting over 62 days on a cancer pathway, the Trust is being moved back into Tier 1 NHSE management. The validated May position showed a continuing improvement in both the 31 and 62 day performance however the forecast for June shows a deterioration. Whilst the backlog has continued to grow, the number of 104 day breaches has decreased month on month since January 2024. • Infection Prevention and Control: QSAC heard that the Facilities team had been asked to reduce the additional enhanced cleaning that is currently provided to the EDs, Escalation Areas, Urgent Care, ARA and AMA due to the cost pressures of this. QSAC asked for this to be

		actively reconsidered, as they were conscious of the need to prevent cross infection in these crowded areas.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Urgent and Emergency Care: QSAC received a report on progress with actions arising from analysis of the Dispatches programme and the Multi agency team Insight visit on 12 July which included NHSE, ICB, Safeguarding and Healthwatch Colleagues. A further visit will take place on 31 July. These actions have been integrated into the existing transformation programme. QSAC will receive future reports looking at patient experience in ED and noted other qualitative information about poor experiences arising from other sources (CQC Patient Survey). • Maternity Transformation Assurance Committee (MTAC): Ockenden actions: IEA 1.4 –Conversations are happening with other Trusts to progress this action (Local Maternity and Neonatal System should have more than one maternity department). A dashboard has now been agreed, allowing for benchmarking. Of those actions previously at risk due to lack of long term funding, 11 actions that were outlined within the business case had new timelines presented to the committee, bringing them back to "On Track". Deadlines have been established for all 11 actions to be Evidenced and Assured by July 2025. • Smoking at time of delivery (SATOD): down to 5.7% in June 2024, part of a long term trend. QSAC asked that the reasons for success be explored, so that we can learn from what works. Small for Gestational Age: this also was showing a downward trajectory, though still above the national average, and QSAC asked for more information about progress and the relationship with other factors including SATOD.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Royal College of Physicians' external review, commissioned by SaTH, of Neonatal Mortality for the years 2021 and 2022: the draft report was received on 26 July, will be checked for factual accuracy, and the final report should be ready to come to Board in the Autumn. In the meantime, any duty of candour issues will be followed up and any new actions added to the existing action plan derived from the letter received in December 2023. QSAC will be kept informed of progress. • Clinical Negligence Scheme for Trusts Maternity Improvement Scheme (CNST MIS): QSAC heard about two quality improvement programmes arising from areas identified for improvement to reduce admissions to Neonatal Intensive Care: nasogastric tube feeding (improving staff competence on the post-natal ward) and chorioamnionitis (training to improve recognition and responding to the condition). QSAC also reviewed the Safety Dashboard. QSAC discussed the recently received qualitative data in the CQC Maternity Survey for 2023. (The quantitative data has already been reported to Board.) The qualitative data gave useful feedback on pathways including the C-section pathways. It also contained examples of poor culture and behaviours. The Maternity department is already acting on culture in the postnatal ward with a quality project underway. • Birth Trauma Inquiry Report: QSAC received a report on a gap analysis against the 28 recommendations in this report. The All-Party

		Parliamentary Group on Birth Trauma established the first national enquiry in the UK parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. Progress will be monitored via MTAC.		
2d	**Actions** ***Significant*** *follow up actions*	• Culture and behaviours: QSAC noted a range of examples where cultural issues affected behaviours and hence patient care and asked for these to be drawn together and reported on in the Getting to Good report, reports from maternity where QSAC heard about initiatives underway or about to start, and in Urgent and Emergency Care; and for the Board Assurance Framework to also refer to what initiatives were being undertaken on culture, including safety culture, and what was being identified regarding outcomes and effectiveness.		
3	**Report compiled by**	*Ms Rosi Edwards* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*