The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 28/08/2024		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 27/08/2024		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 and Dispatches update • Paediatric Transformation Assurance Committee • Neonatal Review Report update on immediate actions (from December letter) plus update on position with full report • Safeguarding Assurance Committee Key Issues Report • Maternity Transformation Assurance Committee Key Issues Report • Maternity & Neonatal Safety Champions Key Issues Report • Maternity Dashboard and Key Issues Report • CNST Update and appendices • 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 • CQC Update Report • Learning from Deaths and Medical Examiner / Bereavement Service Q1 reports • Neonatal MBRRACE update • Patient and Carer Experience Panel Key Issues 4A Report (PACE) • PALS, Complaints & Patient Experience Q1 Report • AOB - Late papers – Maternity Governance Move 31 December 2024 QSAC meeting QSAC handover to Sarah Dunnett
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Endoscopy: QSAC heard of a significant impact on capacity due to concern about the quality of decontamination in the endoscopy washing machines. While we can control for patient safety, this limits throughput. Meetings to identify further actions and mitigations are being held, and the Medical Director will be able to give an update to the Board at the September meeting. [Update provided shortly after the meeting: endoscopy back up to capacity on 27 August but requiring twice weekly water checks and disposable scopes will provide continuity for some procedures should another shut down be required while a more permanent solution is being scoped]. • QSAC heard in several reports the impact shortages of staff in the bookings team and in medical records were having on patient experience, with the PALS team receiving an increase in complaints

		about booking problems and this emerging as a theme in the Incident Overview report. Delays in accessing medical records also affected incident investigation and the legal team. • Badgernet electronic system in neonatal care: QSAC heard yet again of the difficulties this was causing regarding data quality and completeness of record keeping. Attempts to improve paper record keeping has had limited success, whereas Badgernet would require staff to record each action before they could move on. While SaTH had been promised support regarding data quality via the ICB from other trusts whose Neonatal care isn't covered by Badgernet, this hasn't been forthcoming, and most other neonatal units in the region had either adopted or were in the process of adopting Badgernet. QSAC considered it would be helpful to have a firm date for extending Badgernet to the Neonatal unit.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Urgent and Emergency Care Assurance Committee (ECTAC): QSAC heard that Patient satisfaction regarding waiting room experience increased from 24% to 71% following test of change. • Medicine Transformation Programme: the Frailty Assessment Unit pilot continues with 70 patients at PRH and 62 patients at RSH utilising the unit in the first 4 weeks, resulting in reduced length of stay for people in this category in Emergency Departments by 2 hours. There was a 23% increase in weekend discharges from June – July 2024 following an electronic flag being added to Careflow. The Frailty advice line has started operating, with no data yet on the impact but some anecdotal evidence of benefits. • Safeguarding: additional sessions on Oliver McGowan training have been provided by the ICB.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• QSAC saw the action plan developed after the Dispatches programme and asked for sight of the Dispatches dashboard when this has been finalised. QSAC asked how culture was to be monitored and were told it would be covered in quality matrons' walk rounds. QSAC asked for work to be done on metrics for culture to be adopted, possibly using observation framework. • Royal College of Physicians' external review, commissioned by SaTH, of Neonatal Mortality for the years 2021 and 2022: factual accuracy checking is complete and SaTH's response would be sent in on 28 August. The final report will need redacting to remove case descriptions which could lead to identification. Families will be contacted before the report comes to board, in October or November 2024. • One recommendation in the report concerned the removal of Nitric Oxide equipment. Consultants have expressed concern that not having access to Nitric Oxide equipment could increase the risk of harm to a neonate who needed it during transfers to a tertiary Neonatal Intensive Care Unit. The Medical Director is to convene a meeting with the tertiary unit to discuss the best way forward for safe patient care.

		• The Integrated Performance Report now includes readmission data, but QSAC were advised that this very useful metric was still under development. • QSAC received a report on the revised CQC Action plan incorporating the Must and Should actions from the latest CQC report and heard about progress with the existing Section 31 Conditions, particularly the improvements in initial assessment in ED for children and adults and in reducing the number who leave before being treated. The percentage of those children who do leave whose carers are contacted within 48 hours is now high (typically 100%). • CNST: Clinical Negligence Scheme for Trusts Maternity Improvement Scheme (CNST MIS): QSAC received assurance from the update on progress with Year 6 and considered the Safety Intelligence Dashboard, the Maternity Services Data Set AAA & Clinical Quality Improvement Metrics Dashboard, a summary of MNSC Our Staff Said - We Listened, Triangulation of NHSR Scorecard (Q1), Education and Training Report including 5-day Training schedule and Training Needs Assessment, Quarter 1 Saving Babies' Lives version 3 report. QSAC also agreed governance for the assurance of actions arising from contacts with families: progress on these will be reported through Maternity and Neonatal Transformation Assurance Committee (MTAC).		
2d	**Actions** ***Significant*** *follow up actions*	• None		
3	**Report compiled by**	*Ms Rosi Edwards* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*