NHS
The Shrewsbury and Telford Hospital
NHS Trust

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<tr><td colspan="3">Quality and Safety Assurance Committee, Key Issues Report</td></tr>
<tr><td colspan="2">Report Date:
29/10/2024</td><td>Report of: Quality & Safety Assurance Committee (QSAC)</td></tr>
<tr><td colspan="2">Date of meeting:
29/10/2024</td><td>All NED and Executive Director members, and regular Trust Officer attendees, were present.</td></tr>
<tr><td>1</td><td>Agenda</td><td>The Committee considered the following:
• Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Key Issues Summary Report AAAA and Dispatches appendix
• Paediatric Transformation Assurance Committee and Terms of Reference
• Safeguarding Assurance Committee Key Issues Report
• Neonatal Review Report and briefing paper
• Maternity & Neonatal Transformation Assurance Committee Key Issues Report
• Maternity & Neonatal Safety Champions Key Issues Report
• Maternity Dashboard and Key Issues Report
• CNST Update
• CNST Safety Action 2 CQIM MSDS Report
• Infection Prevention Control (IPC) Assurance Committee Key Issues Report
• Nursing, Midwifery & AHP Workforce Key Issues Report
• Quality Operational Committee Key Issues Report
• Quality Indicators Integrated Performance (IPR) Report and Exception Report
• Incident Management Overview Report
• Therapy Improvement Strategy
• CQC Update Report
• Legal Update Report
• BAF – Board Assurance Framework
• Corporate Risk Register – quality and safety risks</td></tr>
<tr><td>2a</td><td>Alert
Matters of concerns, gaps in assurance or key risks to escalate to the Board</td><td>• A paper on the invited neonatal review set was presented. The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal service was substandard or directly contributing to the unit’s outlier status in terms of perinatal mortality. QSAC heard that the review of record identified incidents of poor care, or very poor care in one instance. The medical director has written to all families whose care was reviewed and offered to meet them. An update on actions in response to immediate actions was provided, some of which require support from the regional network.

• 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 continues to remain in Tier 1 NHSE management. The validated August performance shows slight improvement in the 31-day and 62-day cancer waiting times standards but a reduction in 28-day performance. External support from NHSE and WMCA funded posts</td></tr>
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		within the ICB remains in place to support the improvement work required. An update on how the Trust is monitoring potential harms is to come to board. Delays in treatment were responsible for three of the ten clinical claims received between 1 June and 31 August. • There were three incidents of patients who were detained under the MHA not having correct documentation in place between 1 April 2024 and 30 September 2024 (2 at PRH and 1 at RSH). This has been addressed by the training of the clinical site teams who will scrutinise MHA forms following completion. • Radiology services are fragile with delays in access and an increase in reporting turnaround time leading to emerging theme in incidents. Staffing issues at RSH have meant that the CT and MRI Imaging Pod have not been operational. The CDC remains operational 6 days a week for CT, NOUS, MRI and x-ray.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Following the recent CQC inspection of radiotherapy, the Trust received positive initial feedback: "We've just had our decision-making meeting and I'm sure you'll be pleased to know that there is not going to be any enforcement…. Obviously!! You have a great department and fantastic team – we were really impressed." • The Trust DoLS Policy & Procedures has been commended by the NHSE regional MCA group as exemplar practice and has been shared regionally. The feedback includes how proportionate the policy is. • The Obstetric & Gynaecology trainee survey has several positive outliers and no negative ones which indicates a positive training experience.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• UECTAC following feedback from clinicians are reviewing how all the improvement actions from the CQC inspection, enforcement conditions and Dispatches programme can be brought together to reduce duplication. The ICB are in support of his approach. A report about Dispatches will be brought to board in January. • There is a 12-month notice being served on the Stanley Blick Bleep system, which creates a number of risks. There is a business case in progress for approximately £250-£300k investment with a number of options that will require urgent decision making to progress the mitigation. This is to be discussed at executives for escalation and agreement on next steps. • Clinical Negligence Scheme for Trusts Maternity Improvement Scheme (CNST MIS): SaTH remain on target to achieve all ten safety actions though one is at risk relating to anaesthetic training. An action plan has been put in place and updates will be provided to QSAC. • In maternity there were delays in Category 2 caesarian sections (which should be completed within 75 minute) continue. It was identified that there were a number of other indicators that were under target (10 week

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• A meeting with another LMNS to address the Ockenden action relating to being the only acute Trust in the local maternity neonatal system took place. Further meetings are in train to ensure that the arrangement meaningfully addresses the requirement.

• The backlog in subject access requests has been addressed however the maintenance of performance is reliant on staff being recruited.</td></tr>
<tr><td>2d</td><td>Actions
Significant follow up actions</td><td colspan="3"></td></tr>
<tr><td>3</td><td>Report compiled by</td><td>Ms Sarah Dunnett
Chair of Quality and Safety Assurance Committee</td><td>Minutes available from</td><td>Julie Wright
Committee Support</td></tr>
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