The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 02/01/2024		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 31/12/2024		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Paediatric Transformation Assurance Committee – items for escalation • Maternity & Neonatal Transformation Assurance Committee - items for escalation • Maternity & Neonatal Safety Champions - items for escalation • Maternity Dashboard - items for escalation • CNST Update • CQIM scorecard and AAA for 2 months • CQC Maternity Survey 2024 • Antenatal and Newborn (ANNB) QA visit report • Infection Prevention Control (IPC) Assurance Committee Key Issues Report • Nursing, Midwifery & AHP Workforce Key Issues Report • Bi-annual staffing review • Quality Operational Committee – items for escalation • Quality Indicators Integrated Performance (IPR) Report • CQC Update Report • Medical Regulatory Group Q2 Report • How We Learn from Deaths Q2 Report • Medical Examiner and Bereavement Service Q2 reports • Experience of Care Strategy • Quality Strategy
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Pressure in emergency services has led to a significant increase in delays offloading patients from ambulances in November and December, along with an increased length of stay in ED including fit to sit areas. The impact of this is being monitored via harm reviews. • Data warehouse issues are impacting on submission of data for SHMI. In order to mitigate the impact on understanding of mortality in ED, the learning from deaths team are working with leads on mortality to review the crude data.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Trust is on track to achieve CNST MIS Year 6. The committee received and were satisfied with closure papers for the three remaining safety actions (Safety actions 1, 4 and 10) and agreed compliance with safety action 8. The committee also discussed the quality surveillance dashboard. The committee also reviewed the CNST papers from October.

		• There was 94% acuity in maternity against a national target of 85%, 100% one to one care in labour and 100 % supernumerary status for shift coordinators. • Nurse staffing reports were reviewed. Going forward it was agreed that the Nursing Midwifery and AHP workforce reports would be taken through the people and organisational development oversight committee. Registered nurse fill rates remain over 100%. Recruitment into all nurse groups continues. The committee reviewed a comprehensive bi-annual staffing review which was commended for its quality and depth. A number of actions have been identified and it was agreed that the report would be shared with the chairs of the finance committee and people and organisational development oversight committee. • The report from the medical regulatory group provided a number of updates relating to ongoing regulatory changes and anticipated inspections. Work continues to comply with the change of HFEA regulations with regard to storage which must be completed by 01 January 2025. • The medical examiner and bereavement service reported a smooth transition to the statutory service with the Trust the host site for the system, is the Trust responsible for reviewing all deaths in the system including all those in primary care. Where some challenges in compliance in completion of forms in primary care had been identified, these were being addressed and signs of improvement in compliance seen. There has been an improvement in providing certificates within three days of death, although it is important to acknowledge that there had been a reduction in the number of deaths this quarter.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Delays in category 2 caesarean sections continue. All delays are reviewed and no harms have been identified. A number of contributing factors have been identified and a multi-disciplinary group has been established, which will meet in January to progress improvement work. QSAC heard of immediate mitigations that had been taken with effect, such as actions to stop handovers contributing to delay. This issue will continue to be monitored and an update brought back to the committee. • An update on the deep dive to understand the deterioration in performance relating to the care of the deteriorating child and PEWS recording was received. An audit in November of paediatric vitals had shown sepsis screening was consistent however the percentage of children receiving antibiotics within 60 minutes was low. A review of the audit data by the Paediatric team identified that this had been recorded as “no” for antibiotics within 1 hour when it should have been recorded as “not applicable” as these patients did not require antibiotics and had other underlying conditions. The revised data following this review returned 100% compliance and was corrected on the system. • An update on dementia screening rates was received which identified that a number of factors, including the change in dementia screening tool had contributed to the decrease in dementia screening. Work

		continues to embed new processes, and performance will continue to be monitored. • The results of the NHS national survey of women's experiences of maternity services has been received, with the Trust's performance 'about the same as other' trusts for all 10 C-sections. The results were similar to last year's survey. An action plan is being produced to continue improvement work so that we can improve women's experiences of care. • The report from the medical regulatory group provided a number of updates relating to ongoing regulatory changes and anticipated inspections. Work continues to comply with the change of HFEA regulations with regard to storage which must be completed by 1 January 2025. There had been an unannounced inspection by HFEA. No immediate concerns were identified. • There has been a visit by the environmental agency to the nuclear medicine service at Princess Royal Hospital. The report has not yet been received but actions are anticipated.		
2d	**Actions** ***Significant*** *follow up actions*	• None		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*