The Shrewsbury and Telford Hospital NHS Trust

Paper 10

Quality and Safety Assurance Committee

19 June 2018

This meeting reflected recommendations with respect to strengthening governance arrangements, arising from NHS Improvement's review. The relative timing of the Q&S meeting and the Clinical Governance Executive meeting have been adjusted to strengthen the framework. The Medical Director, Edwin Borman presented a summary of the Clinical Governance Executive Meeting. It was also evident that some of the items considered at "Check and Challenge" meetings also need consideration by the Clinical Governance Executive to ensure that the Quality and Safety Meeting can be appropriately assured.

Accident and Emergency Services (BAF 1134)

The committee visited the accident and emergency department at Royal Shrewsbury Hospital prior to the meeting. During the formal meeting the Unscheduled Care Group presented to the committee as part of the quarterly, more detailed engagement with care groups. Whilst progress is reported with respect to the recruitment of Accident and Emergency Consultants, it is clear that there are considerable strains on the nursing and middle grade doctor elements of the staffing. The 2 A&E departments are surviving on the extreme commitment of SATH staff and their impressive resilience. There have, however, been recent resignations from the nursing staff and reports that on many nights there has not been a Registrar Doctor working to support nursing staff and more junior doctors. The committee were not assured that this is a sustainable position.

Breast Screening

The committee heard that there were about 2500 women affected by the national breast screening programme's error with respect to recalling women. Of these around 400 are considered urgent as they are under 72 years. Women over 72 years are encouraged to self-refer to the service If they wish further investigations. In supporting the remedial programme required, the committee was impressed to hear that SATH are ahead of NHS timescales and confident of delivering the requirements by the end of July (for women in the urgent category) and the end of October for the less urgent cohort.

Never Event

Unfortunately, there has been a further "Never Event" occurring within the operating theatre at Princess Royal Hospital. This involved a retained swab during an ENT procedure. The problem was identified rapidly within the recovery room. There is no reported harm to the patient. The investigation is being led by an independent clinical safety expert with support from SATH's experts in Human Factors.

Maternity Services (BAF1204)

The Committee met with the Women and Children Care group within a specific segment of the agenda. We discussed the findings of the Royal College of Obstetricians and Gynaecologists report and noted that there is clear progress against its recommendations and that this progress has been recognised by the RCOG. One area that is not resolved is the lack of full consultant anaesthetic cover for the consultant obstetric unit although the unit does have round the clock senior anaesthetic cover.

The committee were also briefed about the programme to contact families who may have experienced care problems in the past. This piece of work is highly sensitive 31 letters have been sent out of which 3 were returned and one is awaiting collection from the post office. A number of families have given consent for further investigation of cases. Senior staff from the care group are meeting with families to discuss cases.

Dr David Lee
Chairman, Quality and Safety Assurance Commitee