The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee Key Issues Report

Report Date: 27th April 2022		**Report of:** Quality & Safety Assurance Committee
Date of last meeting: 27th April 2022		Membership- The meeting was quorate as defined by its Terms of Reference
1	**Agenda**	The Committee considered an agenda which included the following: • Safeguarding Summary Report • Infection Prevention and Control Summary Report • Maternity Transformation Summary Report • Maternity Safety Champion Summary Report • Nursing, Midwifery and AHP Workforce Key Summary Report • Maternity Dashboard • CNST Submission • Getting to Good Highlight Report • Quality Operational Committee Summary Report • Quality Indicators Integrated Performance Report • CQC Update • Serious Incident Overview • Legal Report • Critical Care • Urology (report commissioned for May meeting • Board Assurance
2a	**Alert**	• There remains a significant system issue with respect to the management of children and young people with mental health crises. The CQC conditions rightly prevent SATH from admitting children and young people who do not have acute medical needs. This is currently resulting in long A&E waits (up to 70 hours reported). System partners are collaborating but there is little evidence of progress on this issue. This needs to be escalated within the system. • The provision of mental health liaison services to SATH is uncertain as the psychiatrist currently providing this service is retiring. Indications are that there is no immediate replacement recruited and the service is planned to be delivered by the use of other psychiatrists on an ad hoc basis or through the use of locums • Delivering the CQC best practice required paediatric triage “within 15 minutes” performance continues to be problematic. There are intentions to identify dedicated space and staffing to this function, but the Trust is currently in breach of this condition • The committee received a number of reports from maternity. There are concerns about the availability of staff resulting in staffing challenges. This is currently addressed by moving staff within the maternity system but is not sustainable • Further challenges exist within the Nursing workforce. March saw a significant increase in agency and bank staff usage but even this was insufficient to fill all vacant shifts. Further work is required to understand how the Trust can retain substantive staff

		• There is a significant risk with respect to the sustainability of the Trust's 2 site critical care provision. The potential long-term absence of a consultant exacerbates existing workforce challenges. Business continuity plans are in place should there be a short-term issue, but a longer-term solution is required that provides a sustainable model that is compelling for existing staff and potential new recruits.

2b	**Assurance**	• The Neonatal and Maternity champions reported staff within the departments as being enthused and keen to engage with the champions. It was also reported that there is currently an encouraging number of midwives in training who are keen to work within the Trust. The quality walk was augmented by the participation of an anaesthetist and there is an intention to continue anaesthetic participation.
		• The "Getting to Good" programme shows encouraging progress
		• The CNST submission was considered
		  ○ There are some elements that need to be considered in private board to preserve patient confidentiality
		  ○ QSAC proposes a deep dive into the evidence in May as, whilst supported by the Women's' and Children's' committee, QSAC had not had enough time to review aspects of the report in detail
		  ○ The reporting and governance around this is impressive and gives strong assurance

2c	**Advise**	• The rates of screening for VTE risk have been an area of particular scrutiny for QSAC. The acting medical director is developing a proposal for a paper-based assessment to encourage proper completion of the assessment • The Badgernet system in maternity is now the only active system of record. There remain some data quality issues but the system does offer real time reporting. The lessons learned from implementation must be identified and used to inform future digital deployment programmes • Proposals are in development to enhance the nursing workforce in line with ward templates that have been developed. QSAC is supportive of this approach as it has the potential to enhance quality, safety, patient experience and staff satisfaction
2d	**Review of Risks**	

For Quality & Safety Assurance Committee the strategic risks that the committee was asked to consider are

BAF1 Poor standards of safety and quality of patient care across the Trust results in incidents of avoidable harm and / or poor clinical outcomes.
BAF 2 The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.
BAF 4 A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.
BAF 8The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.
BAF 9 The Trust is unable to restore and recover services post-covid to meet the needs of the community / service users
BAF 10 The Trust is unable to meet the required national urgent and emergency standards.

The committee notes that there is an intention to add risks linked to

- The current configuration of services and concern about its ability to support the needs of the population
- To potential non delivery of integrated pathways within the system as hospital activity is dependent upon the implementation of evidenced based, effective pathways

		○ A specific risk linked to the organisational impact of responding to the Ockenden report The committee received a paper with respect to the period to 31/12/21. The committee was content that its deliberations cover the identified BAF risks but will review these in more detail with the quarter 4 report		
3	**Actions to be considered by the Board**	• Report to be noted		
4	**Report compiled by**	*Dr David Lee* *Chair QSAC*	**Minutes available from**	Julie Wright Executive Support Team Supervisor