The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee Key Issues Report

Report Date: 29th June 2022		**Report of:** Quality & Safety Assurance Committee
Date of last meeting: 29th June 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 • Nursing, Midwifery and AHP Workforce Key Summary Report • Maternity Dashboard triple A report • CNST Submission • Getting to Good Highlight Report • Quality Operational Committee Summary Report • Quality Indicators Integrated Performance Report • CQC Update • Serious Incident Overview • PALs Compliments, Complaints and Patient Experience • Learning from Death report • Medical Examiner and Bereavement Service • Children and Young People with Mental Health Problems update • Biannual staffing report • Quality Account • Ambulance Handovers • Paediatric Triage
2a	**Alert**	• The requirement to triage paediatric cases arriving at our A&E departments remains well below the target of 85% being triaged within 15 minutes. Performance is declining. QSAC believe this is unacceptable and believe that urgent remedial action is required to address this • There remain challenges with respect to the number of Healthcare Assistant vacancies. The current status is worthy of an alert to the Trust Board although actions are under way (see assurance section) • The Biannual staffing report was considered. The many metrics give valuable insights into our nursing establishment and there are impressive initiatives to improve recruitment and retention. The key factors which are most linked to poorer quality of care are: ○ Substantive staff availability? ○ The levels of temporary staffing • The documentation of Venous Thromboembolism screening is deteriorating. QSAC has asked for an audit looking at prescribing of prophylaxis to understand whether this is linked to busy clinicians not documenting the assessment or whether patients are not receiving the necessary prevention in the absence of an assessment • Hospital Acquired infections have increased over the first 2 months of the current financial year. The Infection Prevention

		and Control function together with Nursing Leadership have introduced more rigorous approaches to address this
2b	**Assurance**	• The PALs Compliments Complaints and Patient Feedback is an excellent review of the year 2021/22. There are plans to increase patient feedback with the use of QR codes on notices and discharge summaries as well as person interactions • The chaplaincy function is reported as being increasingly robust, active and visible within the organisation • There are positive developments to recruit additional HCAs, to develop Nursing Assistant roles and to enable pathways from HCA to Nursing Assistant and onwards to Registered General Nurse roles for those who wish to pursue • The Quality Account Submission was, after careful consideration, approved by QSAC to enable it to be uploaded to the NHS system on 30/6/22. This will be considered and adopted at the Trust Board in July • There are increasing numbers of children and young people with mental health challenges and physical issues being admitted to SATH. • A “mock CQC inspection” and been undertaken across SATH’s Children and Young People’s services. It is striking how many of the improvement comments were associated with child / young person facilities that were not ideal for their treatment • Children and Young People with mental health challenges are often waiting in A&E for long periods (the committee heard 70 hours) for mental health assessment or suitable placement
2c	**Advise**	• Progress to develop a virtual ward is slow and impact is unlikely until the first quarter of 2023 • The approval of the CNST submission (Jan 2023) requires careful choreography to ensure that there is appropriate oversight and key performance targets are hit. This also requires system approval. One route could be to hold an extraordinary meeting of QSAC with extended invitations to system partners. Positively, the risks of not achieving the scheme’s targets have reduced • Some increased pressure is expected on SATH’s clinical haematology service following the loss of haematology medical resources at Wye Valley. SATH are working collaboratively with other providers to ensure any additional work is carefully planned and managed • The Quality Operational Committee have discussed concerns with respect to the digital transformation programme and of staff wellbeing during times of high operational pressure • Overdue Incidents within the Datix system are largely within the Emergency and Medicine Care Group. This is being actively managed, and it is hoped that the proposed new assurance structures (which mirror those introduced in maternity) will gain greater grip • There are multiple initiatives to reduce the pressure on the A&E department by offering different routes to admission or assessment, diverting care to more suitable services and ensuring supervision of patients with reduced reliance on West Midlands Ambulance Staff. These are yet to impact
2d	**Review of Risks**	
For Quality & Safety Assurance Committee the strategic risks that the committee are 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.				
3	**Actions to be considered by the Board**	• Report to be noted • Instruct the organisation to urgently address the paediatric triage performance		
4	**Report compiled by**	*Dr David Lee* *Chair QSAC*	**Minutes available from**	*Julie Wright,* *Executive Support Team Supervisor*