The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee Key Issues Report		
Report Date: **23 November 2022**		**Report of:** Quality & Safety Assurance Committee
Date of last meeting: **23 November 2023**		Membership - The meeting was quorate as defined by its Terms of Reference
1	**Agenda**	The Committee considered an agenda which included the following: • The future PSIRF Framework for Serious Incidents • Safeguarding Assurance Committee Summary Report • Maternity Transformation Summary Report • Maternal and Neonatal Safety Champion Report • Maternity Dashboard triple A report • Health Service Investigation Branch Maternity Investigation Programme Key Themes (National not Trust specific) • CNST Report and Timeline for approval and submission • Emergency Care Transformation Assurance Committee • Infection Prevention and Control Summary Report • Quality Operational Committee Summary Report • Quality Indicators Integrated Performance Report • Nursing, Midwifery and AHP Workforce Key Summary Report • Biannual Staffing Report • Board Assurance Framework • Getting to Good Highlight Report • CQC Update • Serious Incident Overview • Breast Screening- Change of national approach not implemented
2a	**Alert**	• There is currently a significant assurance gap in staff Disclosure and Barring Service Checks. Previously certificates were stored on individual files, but these should now be on the ESR system. At present there are over 2000 staff without documented DBS checks. Work is in place to review this and prioritise clinical staff's status and take any necessary remedial action • Whilst there is some oversight of Datix reports, there are still significant delays in formal assessment of those reports and feedback to individuals raising incidents on Datix is poor. This is not a feature of an organisation with a safety culture and needs to be addressed • The Trust's performance with respect to completing SI reports is deteriorating. This is due to clinical pressures. The committee encouraged the consideration of PSIRF approaches in prioritising and managing the backlog (see advice section) • The Okenden IEA 1.4 requiring the establishment of a local maternity network is not showing the same progress as other requirements that are within SATH's direct control
2b	**Assurance**	• There is ongoing positive progress with respect to safeguarding and protect training. This is a significant achievement given the current pressures on the organisation • The Committee received detailed assurance with respect to the CNST submission for maternity. Key further review dates

		are 1/12/22 (Board Seminar) 8/12/22 (Board meeting) 28/12.22 (QSAC) with organisational sign off and system sign off after 26/1/23 for submission 2/2/23. QSAC approved the Transitional Care Audit and the Atain Audit and considered and approved audits on PMRT letters along with "Saving Babies' Lives" updates. The committee noted the following: o Safety action 1- complete o Safety action 2 – complete o Safety action 3 -**Board to approve HRG activity** o Safety action 4 – complete o Safety action 5- complete o Safety action 6- **In final week of data collection but positive outcome predicted** o Safety action 7- complete o Safety action 8- **multidisciplinary training report to be finalized by 5/12/22 and approved by QSAC 28/12/22** o Safety action 9 complete o Safety action 10- for **QSAC to approve 28/12/22**
2c	**Advise**	• The Patient Safety Incident Response Framework sets out the NHS' approach to developing effective systems and processes for responding to and learning from patient safety incidents. The framework represents a significant change to approaches that have been embedded within the NHS. Fewer incidents will be investigated at an individual level, there will be a greater emphasis on thematic reviews and on the involvement of patients and their families. SATHs progress towards implementation is encouraging. QSAC recognised future roles for supporting the Trust Board in agreeing strategic safety themes and in assuring the programme. Whilst full implementation is not scheduled until September 2023, the direction of travel towards PSIRF can be used to help better manage some of the backlogs. It is important to know that the ICB plays an important role with respect to assurance. • The Committee has been informed that there are vulnerabilities linked to outdated equipment and associated software. The Committee has requested a deeper dive to determine which equipment might be of safety concern unless replaced or risks mitigated

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*