The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 28.04.2023		**Report of:** Quality and Safety Assurance Committee
Date of meeting: 26.04.2023		Rosi Edwards, Hayley Flavell, David Brown, Jenni Rowlands, Tim Lyttle, Annemarie Lawrence, Peter Jeffries, Carol McInnes, Julie Plant, Sara Biffen, Donna Hadley, Laura Graham, Julie Wright
1	**Agenda**	The Committee considered the following: • Emergency Care Transformation Assurance Committee (ECTAC) Key Issues Summary Report • Emergency Care Transformation Assurance Committee – Deep Dive • Junior doctors strike update • Paediatric Thematic Review • Follow-up Quality Assurance visit to SaTH ED and Paediatrics • Safeguarding Assurance Committee Issues Key Summary Report • Maternity & Neonatal Safety Champion Key Issues Summary Report • Maternity Dashboard and Triple A Report • Infection Prevention Control Assurance Committee Key Issues Summary Report • Nursing, Midwifery & AHP Workforce Key Issues Summary Report • CQC Update Report • Quality Operational Committee (QOC) • Quality Indicators Integrated Performance (IPR) Report • Serious Incidents Overview • Demographics and complaints (operational action from Board) • Quality priorities (action from Board)
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Junior Doctors' Strike: due to a great deal of preparation and planning and commitment from Divisions cover was maintained, with no patient safety issues arising. However providing cover in this way is not sustainable if action continues. • Emergency Care Transformation Programme: ongoing industrial action including ambulances and junior doctors is creating disruption to attendance and delivery of actions within ECTP, and funding not identified for 2023/24 to backfill roles - having such roles has been crucial to the progress with Maternity Transformation. • Safeguarding: SaTH are still unable to access MPFT Rio electronic system, this is due to issues with information governance, and has been an ongoing issue for over 12 months. The issued has been raised with MPFT and further work is ongoing.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Paediatrics Transformation Programme: QSAC were assured by the thoroughness and breadth of a themed review of child deaths and the programme of action that has been developed, which will be based on the approach used in Maternity. The presentation will be taken to the STW System Quality Meeting on 3 May.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Emergency Care Deep Dive: showed improvements were being made in average time for initial assessments for adults and children, though with more work to be done, and staff engagement through Improvewell has led to improved consumables being identified and procured. • Nursing, Midwifery, AHP & Facilities Workforce Steering Group Report: QSAC heard that SaTH are working to a fill rate of at least 85% Registered Nurses and Nursing Associates. This includes Agency Nurses. Staffing levels and requests for agency support are monitored twice daily with a view to ensuring safe staffing levels are maintained, while avoiding where possible additional agency spend. This is a difficult balance and DoN offered to provide a paper to the People Board. • Maternity Dashboard: QSAC heard there were 11 occasions where knife to skin timescales exceeded the <75 minutes in grade 2 caesarean sections in February and in March on 10 occasions. A thematic review has been undertaken to identify any actions required and presented at Maternity Governance in April. Issues identified include delays due to 2 theatres in use at the time, handover periods and delays in siting spinal anaesthesia. • IPC: C.Difficile: a deep dive is being carried into the causes of the spike in C.Diff numbers. • QSAC responded to a Board delegated action on the demographics of complainants, and whether there were any equalities issues to explore, and will set up a way to capture such delegated Board actions and the outcomes in the minutes.		
2d	**Actions *Significant*** *follow up actions*	DoN to offer a report to People Board on Ward Fill Rates, mitigation and oversight at a future meeting.		
3	**Report compiled by**	*Rosi Edwards Chair of Quality and Safety Assurance Committee*	**Minutes availablefrom**	*Julie Wright*