The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 28.09.2023		**Report of:** Quality and Safety Assurance Committee
Date of meeting: 27.09.2023		Rosi Edwards, David Brown, Hayley Flavell, Jenni Rowlands, Tim Lyttle, Sara Biffen, Annemarie Lawrence, Kath Preece, Pete Jeffries, Sharon Fletcher (ICB), Deb Millington (ICB), Nikki Greenwood (NHSE), Lindsay Barker, Sara Bailey, Fiona Richards, Emma Corbett, Lindsay Roberts, Julie Wright.
1	**Agenda**	The Committee considered the following: • Industrial Action update • Update on BAF • Learning from Deaths and Medical Examiner / Bereavement Service report – Q1 • Emergency Planning, Resilience and Response Annual Report 2022/2023 • Emergency Care Transformation Assurance Committee (ECTAC) Key Issues Summary Report AAAA • Paediatric Transformation Assurance Committee AAAA • Safeguarding Assurance Committee Key Issues Report • Integrated Maternity Report to Board proposal • Maternity Transformation Assurance Committee Key Issues Report • Maternity & Neonatal Safety Champion Key Issues Report • Maternity Dashboard and AAAA Report • RCOG 2018/2020 Action Plan Closure • CNST Update • Infection Prevention Control Assurance Committee Key Issues Summary Report • Getting to Good Key Issues Report • Nursing, Midwifery & AHP Workforce Key Issues Summary Report • Quality Operational Committee (QOC) • Quality Indicators Integrated Performance (IPR) Report • Serious Incidents Overview • Palliative End of Life Care Annual Report • Patient Safety Incident Response Plan and PSIRF Policy
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Industrial Action: in addition to disruption to emergency care and elective activity the recent action is having an impact on staff training and the programmes of improvement work. • Neonatal staffing: the shortage of staff Qualified in Specialty results in staffing gaps which are being met by bank and off-framework agency staff. • Clinical Negligence Scheme for Trusts (CNST): safety actions (SA) 6 and 8 are still at risk, though agreement is being sought on a local divergence from the standard regarding care of mothers with diabetes which may enable this standard to be met; regarding SA 8, training is progressing well, but industrial action and urgent demands can reduce staff availability for training.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Learning from deaths: the number of Structured Judgement Reviews completed is now at a level to give SaTH enough data to make wider quality improvements. • The tier 2 Rota in Paediatrics and Neonatology has now been split, with consequent additional benefits regarding training. • SaTH received extra monies from CNST of over £400k which is going towards meeting current CNST requirements, including kit for diabetes monitoring. • Serious Incidents Report: QSAC were assured by the extensive review of one particular service and the many changes made in response to one incident raised through a complaint.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Learning from Deaths: review of deaths in ED continues, with no specific concerns identified to date. SaTH rate is higher than the national average but is following the same rising trend. Reasons for this will be explored in the final report. • QSAC received the Emergency Planning, Resilience and Response Annual Report and heard that SaTHs self-assessment is that it is fully compliant with 53 of the 62 relevant standards, and partially compliant with 9. This report will also go to ARAC. • Maternity: QSAC agreed a template to be populated to provide information to the Board, starting in October. Regarding CNST, the guidance requires the Board itself to see reports on various aspects. QSAC agreed that QSAC will see the detailed papers with a summary going to the Board in order to meet CNST requirements, with any detailed papers in the information pack. QSAC reviewed a paper on the actions arising from the Royal College of Obstetricians and Gynaecologists' 2018 report, considered that all actions have been completed and agreed that it should go to the Board. • Patient Safety Incident Response Framework (PSIRF): QSAC approved the Patient Safety Incident Response Plan and the Patient Safety Incident Response Policy and agreed that they should go to the Board.		
2d	**Actions** ***Significant*** *follow up actions*	• Medical Director, Director of Nursing and QSAC chair will meet Governance to discuss BAF risks 1 and 2 and the best way to cover the safety culture in response to NHSE guidance of October 2022. • Deep dive into causes of rising CDiff levels and actions - for October QSAC. • Emergency Planning, Resilience and Response: update on any actions arising from the system level confirm and challenge to come to QSAC via QOC.		
3	**Report compiled by**	*Rosi Edwards* *Chair of Quality and Safety Assurance Committee*	**Minutes availablefrom**	*Julie Wright*