The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 01.12.2023		**Report of:** Quality and Safety Assurance Committee
Date of meeting: 29.11.2023		Rosi Edwards, David Brown, Hayley Flavell, John Jones, Sara Biffen, Kim Williams, Mary Aubrey, Deb Millington ICB, Kelly Pardy, Kath Preece, Mei-See Hon, Julie Plant, Roger Slater, Fiona Robinson Julie Wright.
1	**Agenda**	The Committee considered the following: • CQC Update / Improvement Plan Update • Emergency Care Transformation Assurance Committee (ECTAC) Key Issues Summary Report AAAA • Swipe Cards update • Paediatric Transformation Assurance Committee AAAA • Safeguarding Assurance Committee Key Issues Report • Maternity Transformation Assurance Committee Key Issues Report • Maternity & Neonatal Safety Champion Key Issues Report • Maternity Dashboard and AAAA Report • CNST Update • MBRRACE State of the Nation Report • Infection Prevention Control (IPC) Assurance Committee Key Issues Report • Serratia Outbreak Action Plan Update • Getting to Good • Nursing, Midwifery & AHP Workforce Key Issues Summary Report • Quality Operational Committee (QOC) • Quality Indicators Integrated Performance (IPR) Report • Serious Incidents Overview • PSIRF update • Bi annual staffing report summary • Assurance review into the increase in deaths within the Emergency Department Quarter 3 2022-23 • Complaints/PALS Policy – approved at QOC
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Elective recovery: QSAC heard that while progress on over 65 weeks and 78 weeks waits was on course in October, this will be severely compromised should funding for insourcing and outsourcing end in order to meet expectations that the system will reduce its deficit. While SaTH proposes to continue to progress to zero waits over 78 weeks, numbers of those waiting over 65 weeks are projected to reach 2212. There is a risk that the disease in patients on low risk pathways will progress with some of these needing to come to the Emergency Department. This will be a theme that PSIRF should monitor. A communications plan will be needed to explain the reason for cancellations and how risk is being managed. • Learning from deaths: a detailed review of increased mortality in ED in Q3 2022-23 found no pattern of omissions in care, noting that the increased deaths within ED are likely to have been in part related to the increased length of stay within the ED. Learning has been identified

		in respect of documentation by clinical teams whilst patients are boarded in the ED. Internal professional standards in respect of clinical team assessment are regularly breached because of workload. The incidence of out of hospital cardiac arrests increased, which is unexplained. There is published evidence that morbidity and mortality increases in older patients who have to wait overnight or for long periods of time in the ED for a ward bed. The increase in deaths within ED at SaTH is representative of the national picture albeit the increase is greater. • Infection Prevention and Control: cleaning in the Emergency Department - while routine cleaning is still taking place, deep cleans cannot be done due to the intense overcrowding caused by high demand and insufficient flow. • Ockenden Report: there are a number of actions within the final report that require additional, recurrent investment to be able to deliver. A business case has been developed which outlines the funding requirements which is supported by the Trust Executive team. Some ring-fenced, national funding has been made available this year that will contribute to the funding of this case. Discussions will be held with regional and specialised commissioning colleagues regarding sourcing of the remaining funding requirements as part of planning for 24/25. Failing this, consideration will be given to providing funding for the next financial year to support the recruitment of the required workforce through annual budget setting processes.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Safeguarding: 100% of women who delivered in October 2023 were screened for Domestic Abuse at least once in their pregnancy, compared to 20% 18 months ago. • PPH (Post Partum Haemorrhage) over 1500mls (4.1%) in October compared to (3.6%) in September which demonstrates a slight increase. All cases have been reviewed via Incident Review Meeting, with any learning identified disseminated widely. Rates of low-volume PPH are being monitored (500 - 1500mls) to see if changes in practice could be made to prevent or reduce them. An audit of PPH is currently underway looking at themes and trends, this will be presented and shared in line with Governance processes. • Serratia outbreak: deep dive into the possible causes of the 3 cases in the Neonatal Unit. QSAC noted a thorough approach in identifying contamination and a detailed action plan, already being implemented with successful outcomes, and augmented by further actions arising from a supportive NHSE visit on 29 November.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports into stillbirths and neonatal deaths 2021: QSAC received the national and SaTH reports analysing the data on these deaths. Perinatal mortality rates increased across the UK in 2021 after 7 years of year-on-year reduction. Nationally the data show increasing inequalities in stillbirth and neonatal mortality rates by ethnicity and deprivation. This was not apparent in the SaTH data. While SaTHs stabilised and adjusted stillbirth rate is around the average for similar Trusts, SaTHs neonatal mortality rate is more than 5% higher than the average for the last 5 years - hence the review commissioned by SaTH from the Royal College of Physicians.

		External experts from the Royal College of Physicians supported by specialists from the Royal College of Paediatrics and Child Health, who had been invited by SaTH to review neonatal deaths occurring in the calendar years of 2021 and 2022, have completed their work and will be preparing a report, which will come to the Board via QSAC as soon as possible. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme: QSAC received papers on: Obstetric Workforce, Anaesthetic Rota, Neonatal Workforce August 2023, Neonatal nursing workforce strategy, Core Competency Framework Training Plan, Safety Intelligence Dashboard, Minutes of Perinatal QUAD/ Board Safety Champions meeting in November 2023. QSAC noted that SaTH is on course to meet the requirements of Safety Action 6 (previously "at risk") and may well meet the training requirement in Safety Action 8, although the status currently is "at risk". "Hospital full" protocol was agreed in principle by the Quality Operational Committee, with an implementation date of 30th November 2023. It sets out a standardised process for making decisions in circumstances of extreme demand on services.		
2d	**Actions** ***Significant*** *follow up actions*	• Report from RCP invited review will come to QOC, then to QSAC and as soon as possible to the Board,		
3	**Report compiled by**	*Rosi Edwards* *Chair of Quality and Safety Assurance Committee*	**Minutes availablefrom**	*Julie Wright*