The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 28.12.2023		**Report of:** Quality and Safety Assurance Committee
Date of meeting: 27.12.2023		Rosi Edwards, David Brown, Hayley Flavell, John Jones, Tim Lyttle, Kim Williams, Kara Blackwell, Mary Aubrey, Deb Millington ICB, Ruth Smith, Julia Palmer, Julie Wright.
1	**Agenda**	The Committee considered the following: • Industrial Action 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 • Neonatal Services External Mortality Review 2023 & Neonatal Review Letter • NHS Resolution – Letter B – Escalation • Infection Prevention Control (IPC) Assurance Committee Key Issues Report • CQC Update • Nursing, Midwifery & AHP Workforce Key Issues Summary Report • Quality Operational Committee (QOC) • Quality Indicators Integrated Performance (IPR) Report • Serious Incidents / PSIRF • PACE 4A Report • PALS Complaints & Patient Experience Report • Quality Strategy • QOC Terms of Reference
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Staffing - Therapies: inpatient staffing is still approx. 50% below the demand placed upon it across most clinical areas with the worst affected service being Occupational Therapy, particularly at RSH. There are significant limitations to the use of bank and agency to maintain safe staffing levels within acceptable parameters. Areas affected include Trauma Unit, Critical Care, Stroke, Renal, Elective Recovery. • Diabetes - an update for QSAC on progress with the Quality Strategy highlighted that while improvements to strategic goals within the Trust's control such as the Deteriorating patient escalation process, and Delivering Right Care, Right Place, at the Right Time can be progressed, the System-wide diabetic pathway transformation was more difficult as it required system-wide co-ordination and action. Medical Director and Director of Nursing to consider how to progress this within the system. • Fragility of some specialities: QSAC heard of the fragility of the consultant and nursing service in cardiology especially cardiac

		imaging. Medical Director and Director of Nursing to consider how best to alert the system.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Staffing: there is an improved picture with vacancy reduction for nursing in November and a number of pre-registration nurses are currently progressing through OSCE (Objective Structured Clinical Examination) so a change in vacancy rates for nursing will be seen in next few months. • Oliver McGowan training: Over 6,000 staff have completed the online Oliver McGowan Awareness Training. SaTH is one of the highest performing Trusts in England and the highest performing provider within the ICS • Maternity: inductions: following concerns raised through Maternity and Neonatal Voices Partnership (MNVP) that the reasons for induction were not always well enough explained to mothers, Maternity continues to monitor the reasons. Of 140 inductions, reasons were captured in 65 cases (twice the number captured in October), all valid, and work continues to improve data recording. Mothers are also being asked about communications with them and whether they are being given enough information about their care. • Perinatal deaths review: SaTH has had above average neonatal mortality compared to similar Trusts most years since the MBRRACE-UK(UK Perinatal Deaths) started providing Trust specific data. In view of this, the Royal College of Physicians were invited to conduct an external review of Neonatal Mortality for the years 2021 and 2022. This was completed in November 2023 and a letter with immediate feedback has been received. The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal service was sub-standard or directly contributing to the unit's outlier status in terms of perinatal mortality but did make some recommendations which will be used to create an action plan, in advance of the final report which will be brought to the board. • Maternity: Richard Kennedy has completed his 6 months' work in maternity, was generally positive about the progress made and has made some recommendations which will be followed-up with the division.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Paediatric Transformation Assurance Committee (PTAC): QSAC could see steady progress on the action plan and asked that PTAC consider at its next meeting preparing a report to the Board on the achievements so far. • QSAC heard that delays in C Sections in November, both Category 1 and Category 2, had been reviewed case by case, with some learning gained, and no poor outcomes. • Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS): QSAC reviewed all the papers, which confirmed that the Trust had met all the requirements of all 10 of the Safety Actions. QSAC agreed that these papers should go forward to the Board to acknowledge that they agreed that the evidence provided demonstrates achievement of these actions. • Papers seen were: Scorecard CQIM (SA2); ATAIN (Avoiding Term Admissions into Neonatal Units) Annual Action Plan (SA3); Audit and Action Plan Consultant in attendance (SA4); Director of Midwifery staffing Papers 2022/23 Q3/4 & 2023/4 Q1/2 (SA5); Education

		Report, Training Compliance (SA8); Safety Intelligence Dashboard/Safety Champions Minutes; Perinatal Quality Surveillance Model with LMNS and Chief Midwife evidence(SA9); 'Our staff said, we listened' posters; Perinatal Quad Safety Champions Quarterly Meeting minutes; NHSR Early Notification Scheme Report (SA10) • QSAC considered a letter of 13 December from NHS Resolution to the Trust and widely copied in response to a request from a member of the public that the Trust's CNST year 4 MIS be considered for reverification. NHS having thoroughly reviewed the letter against the MIS determined that the issues raised are not explicitly referenced within the detail of the MIS Safety Actions and will reply to the member of the public accordingly. They advised that their letter should be shared with the board. • MRHA (Medicines and Healthcare products Regulatory Agency) National Patient Safety Agency (NPSA) on bedrails - risk of death and entrapment: work is progressing as per action plan, with a review of cots or paediatric style beds in progress. Trolley rail written risk assessment rolled out to all areas and will be encompassed in existing quality metrics. This means that the mattresses to protect against pressure ulcers for patients on trolleys in ED have been withdrawn, as they raised the height of the patient and negated the effect of the bedrail. • Serious Incident: medication error: this error was identified at a clinic appointment but would have been identified immediately if staff had listened to the patient who queried from the start whether the right medication had been dispensed. QSAC noted that the learning from Ockenden and Oliver McGowan training stresses listening to the patient. This was one of the actions in the action plan and will be shared more widely by the Medical Director and Director of Nursing.		
2d	**Actions** ***Significant*** *follow up actions*	• Report from PTAC to come to QSAC, at the earliest in February, for onward transmission to the Board. • CNST papers to come to the special Board meeting on 11 January 2024. • NHS Resolution Letter to come to the special Board meeting on 11 January 2024. • Therapies: report on the impact of shortages and possible actions to come to QSAC in January/February.		
3	**Report compiled by**	*Rosi Edwards Chair of Quality and Safety Assurance Committee*	**Minutes availablefrom**	*Julie Wright*