Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE UPDATE	
Date of meeting:	26th October 2018
Attendees:	**Ms O Dutton (Chair), Mr R Samuda, Mrs M Perry, Ms R Barlow, Miss K Dhami, Prof D Carruthers, Mrs P Gardner,** Mr D Baker, Ms C Parker
Apologies:	None received, all members present.
Key points of discussion relevant to the Board:	• **Safety Plan compliance v VTE performance variation**: Paula Gardner explained that the reporting timings, 48 hours and 24 hours respectively, plus the systems collecting and generating the data account for the compliance difference variations. The Committee was satisfied with the explanation provided. • **Paediatric ophthalmology services:** David Carruthers reported on the progress achieved since 2017 when the CQC identified potential risks with emergency services for children presenting to BMEC. The service changes put in place had improved access to paediatric trained doctors for both eye care and anaesthetics when needed. Issues to esolved related to maintaining the paediatric skills of the anaesthetists and building resilience in the service to support the single Paediatric Ophthalmologist. The national shortages in such posts were noted. the Strategic BAF would be amended to reflect the progress made. • Strategic BAF: verbal updates on the Quality entries were provided because written paper on Mortality and BMEC paediatric were on the agenda. The work to commission and internal audit review of the Safety Plan was underway. A Board presentation on R&D was happening in December. Care Home bed provision had just been assigned to the Committee; a report would be received at a future meeting. • A recovery plan for consistently achieving 100% **VTE performance** target compliance was received and discussed. The paper provided to the Committee on non-achievement of the **Stroke beds 4 hour target** did not include the requested information relating to clinical outcomes; this will be provided next time by Rachel Barlow • **Mortality and learning from deaths**: David Carruthers outlined the on-going work to understand the areas needing attention in order to improve Trust mortality. The Medical Examiner role is beginning to provide the intended benefit to families. The Committee requested a report on the learning arising from the mortality reviews.

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	• Updates on the **Neonatal Peer Review** and **Maternity Summit** action Plans were presented by Paula Gardner. Discussion took place on the environmental changes planned for the Neonatal Unit and the continuing nurse recruitment difficulties in this Unit. • **Complaints Q2 Report**: The Chairman suggested that staff complimented by patients and relatives should receive a 'thank you' from the Board. It was agreed to send a note from Olwen Dutton to the14 staff / teams complimented in Quarter 2 through Purple Point. • **Adult In-patient survey 2017**: Paula Gardner reported that the main area called out in the survey by patients was staff communication in various ways. She agreed to share a video on good/bad communication that was an interesting learning tool for staff. It was thought communication could be a future QIHD shared learning topic.
Positive highlights of note:	• A reduction in complain dissatisfaction with the Trust's response. • PDR and medical appraisal compliance
Matters of concern or key risks to escalate to the Board:	• Unplanned A&E re-attendances missed target for 3 consecutive months – report next time • Diagnostic performance – non recovery by October as planned.
Matters presented for information or noting:	• **4am Unannounced inspections**: Further visits planned in November. Timings of future visits to be varied, e.g. midnight, 6am and weekends.
Decisions made:	
Actions agreed:	• No specific additional actions beyond those being progressed by management.

Ms Olwen Dutton
Chair of Quality and Safety Committee
For the meeting of the Trust Board scheduled for 1st November 2018