Our ref:	TB (07/22) 006

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

Sandwell and West Birmingham NHS Trust

Board Committee Chair's Report

Meeting:	Quality and Safety Committee
Chair:	Professor Kate Thomas
Date:	29th June 2022
Present:	**Members:** Kate Thomas, Non-Executive Director (Chair) Lesley Writtle, Non-Executive Director David Carruthers, Chief Medical Officer Liam Kennedy, Chief Operating Officer Melanie Roberts, Chief Nursing Officer Kam Dhami, Chief Governance Officer Dave Baker, Chief Strategy Officer **In attendance:** Mike Hallissey, Assoc Non-Executive Director Helen Hurst, Director of Midwifery Dan Conway, Assoc Director of Corp. Governance

Key points of discussion		
1.	**Plan for Default Midwifery Continuity of Care**	
	Chair's opinion: The Committee heard of the five year plan by the LMN system to institute Continuity of Carer once staffing allows (an Ockenden requirement). Priority will be given to women from racialised minority groups and those living in socio-economic deprivation, for SWBH this is the majority of women booked with the Trust. The issue for the Trust of booking far more women than it delivers was highlighted.	Reasonable Assurance
2.	**Serious Incidents Summary**	
	Chair's opinion: The report was discussed in detail to investigate the circumstances around the Sis. Concern was expressed that there are 13 investigations outstanding. There are enough investigators trained but they do not have time to devote to the task. There is a business case under consideration for additional capacity in governance.	Reasonable Assurance
3.	**Maternity Dashboard**	

* See below for assurance classification

	Chair's opinion: Staffing within the neonatal unit remains a concern, it is judged to be safe but this relies on Consultants acting down and cross covering for sick colleagues and vacant posts. The Women and Chid Health Directorate is meeting with maternity and neonatology staff weekly to monitor the situation and a locum has been secured to cover sick leave for six months and another locum starting in September. Screening incidents included 11 late booking scans, discussions with imaging are ongoing. No harm has occurred. The five international midwives are progressing well.	Reasonable Assurance
4.	**Covid Gold Report inc IPC changes**	
	Chair's opinion: The number of Covid cases in the Trust had fallen to less than 40 but has risen again with increased community and inpatient numbers to over 60 patients. This is being managed as business as usual, although the limited number of side rooms available makes this difficult. The cases are not requiring ICU admission. IPC guidance continues to change, with masks no longer compulsory across the organisation other than in respiratory wards, where there are Covid positive patients or immunocompromised patients or where aerosol generating procedures are conducted. Some staff and visitors are electing to wear masks. Staff are still testing twice a week.	Reasonable Assurance
5.	**Monthly Mortality Dashboard for June**	
	Chair's opinion: For the second month running the Trust is not an outlier for sepsis. An improvement in coding is noted. HMSR and SHMI have plateaued for 2 months which is concerning.	Reasonable Assurance
6.	**Board level metrics and IQPR exceptions**	
	Chair's opinion: The committee discussed the performance in DM01, specifically 10k overdue non-obstetric ultrasounds and long waiting lists for MRI and CT scans. Referrals were increased by 160% for ultrasound and 210% for MRI. An MRI scanner at City had broken down, an additional mobile scanner was now on site. For the short term a combination of outsourcing and insourcing are being used.	Reasonable Assurance
7.	**Never event**	
	Chair's opinion: This involved a wrong procedure at endoscopy. The colonoscope was accidentally placed in the patient's vagina rather than the anus and rectal stump. A biopsy was taken from the cervix not the rectal stump. The patient has now had the correct procedure. Staff involved are being supported and a QIHD has been held with lessons learned.	Reasonable Assurance

Positive highlights of note

- For the second month running the Trust is not an outlier for sepsis.

- International midwives progressing well.

Matters of concern or key risks to escalate to the Board

- DM01 imaging diagnostics, short term plan in place
- Staffing in neonatology, safe but under pressure

Matters presented for information or noting:

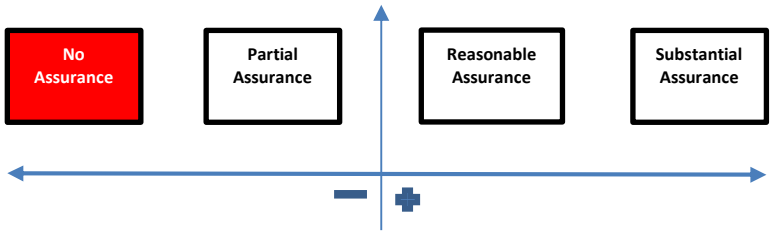
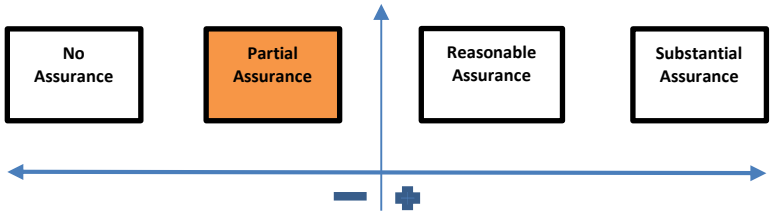
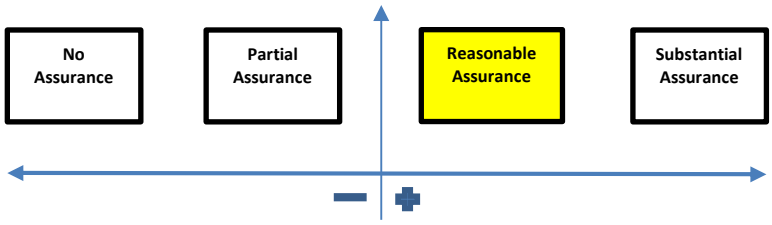
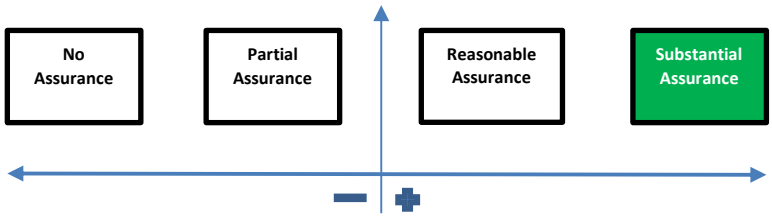
- Board level metrics and IQPR exceptions
- Quality Account 2021/22

Decisions made:

-

Actions agreed:

Assurance classification

	Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.
	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.
	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)