Our ref:	TB (06/22) 014

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:	25th May 2022	
Present:	**Members:**	**In attendance:**
	Kate Thomas, Non-Executive Director (Chair)	Mike Hallissey, Assoc Non-Executive Director
	Lesley Writtle, Non-Executive Director	Helen Hurst, Director of Midwifery
		Chizo Agwu, Deputy Medical Director
	Liam Kennedy, Chief Operating Officer	Parmjit Marok, GP Rotton Park Medical Centre
	Melanie Roberts, Chief Nursing Officer	Dan Conway, Assoc Director of Corp. Governan
	Kam Dhami, Chief Governance Officer	
	Dave Baker, Chief Strategy Officer	

Key points of discussion		
1.	**Maternity dashboard and neonatal data report**	
	Chair's opinion: 2 still births and one neonatal death. One of the stillbirths has been reported to HSIB which has sent an escalation of urgent concerns. The Trust has responded with the learning identified in the 72 hour review. A failure to escalate when an absent fetal heart beat was found. Actions taken to put learning in place straight away. Progress on recruitment of midwives, should be slightly over establishment by March 2023 if all offers come to fruition. Still problems with staffing in neonatology, a slow HR process meant a locum consultant secured a post elsewhere, and in Community.	Reasonable Assurance
2.	**Monthly mortality dashboard**	
	Chair's opinion: SWBH is no longer an outlier for the Sepsis SHMI. SHMI for myocardial infarction remains high leading to an audit to determine causes. Fewer deaths than expected for both heart failure and stroke. HMSR and SHMI continue to fall but remain high. Coding improving but still work to do.	Reasonable Assurance
3.	**Gold update on COVID-19 position, IPC**	

* See below for assurance classification

	Chair's opinion: Number of Covid positive patients continues to fall and additional beds are being closed slowly. IPC guidance is changing frequently causing some confusion for staff. Visiting now one hour for two members of family booked in advance. ED allowed one accompanying person (children both parents). Mask wearing in patient facing areas including corridors. Bringing back contractors, Volunteers and **NEDs**.	Reasonable Assurance
4.	**Fundamentals of Care**	
	Chair's opinion: Forms patient strategy. Has been discussed with groups of patients and staff. Interdisciplinary approach which patients support. A framework and set of standards were discussed and feedback given. A dashboard will be developed using metrics we already have.	Reasonable Assurance
5.	**Draft Quality Account**	
	Chair's opinion: Noted and accepted.	
6.	**BAF Risk Assessment**	
	Chair's opinion: The high risk attributed to the BAF "There is a risk that the Trust fails to deliver safe, high-quality care" was felt to be appropriate. Fundamentals of Care and its metrics will help provide assurance and move the score. Further work is needed hence the 'partial' rating.	Partial Assurance
7.	**Board-level metrics and IQPR exceptions**	
	Chair's opinion: A large increase was noted in Serious Incidents (moderate harm or above), due to Hospital Acquired Covid was because they were all notified at the same time. DM01 performance is problematic due to a huge backlog of ultrasound – 260% increase in requests in 1 year. Non-obstetric community provider identified but waiting funding agreement by system. Until Allocate is fully implemented Safer Staffing will use Band 5 and HCA vacancies as a proxy measure. Work will be done to reduce the number of Board Level Metrics from the current 80.	Reasonable Assurance
8.	**Incident reporting as part of our safety culture**	
	Chair's opinion: Nationally SWBH is a high reporter, but staff report that their confidence that reporting incidents will lead to change has reduced. Covid interrupted **we**learn and this needs re-establishing, along with a culture shift to ensure there is both a learning culture and a safety culture. A Patient Safety Specialist is being appointed. Areas that report few/no incidents are to be scrutinised.	Partial Assurance
Positive highlights of note		

- The Trust is no longer an outlier for sepsis SHMI
- Fewer deaths than expected for both heart failure and stroke

Matters of concern or key risks to escalate to the Board

- Stillbirth being investigated by HSIB

Matters presented for information or noting:

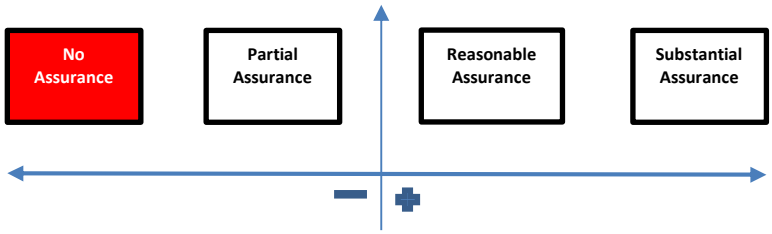
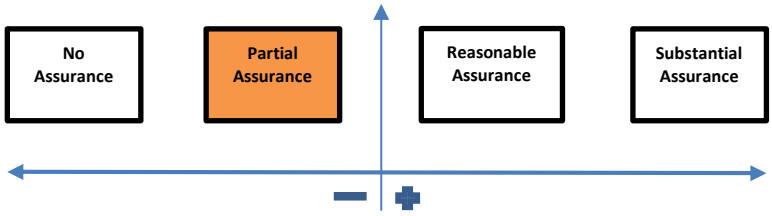
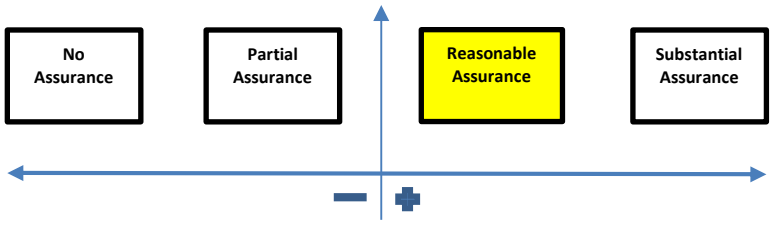
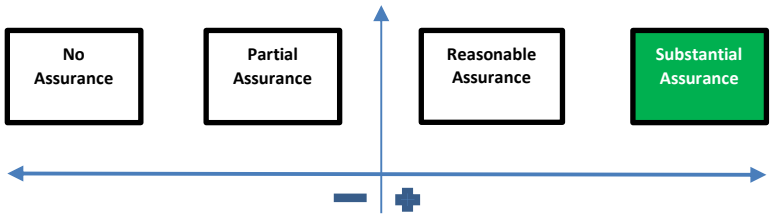
- Draft Quality Account

Decisions made:

- Draft quality account accepted
- Use of Band 5 Nurse/HCA vacancies as a proxy for Safe Staffing until Allocate fully operational

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)