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AMBITION RESPECT COMPASSION

NHS
Sandwell and West Birmingham
NHS Trust

Sandwell and West Birmingham NHS Trust
Board Committee Chair's Report

Meeting:	Quality and Safety Committee
Chair:	Mike Hallissey
Dates:	29th March & 26th April 2023

Present:

	29th March 2023	26th April 2023
Mike Hallissey, Assoc Non-Executive Director **(Chair)**	Attended	Attended
Lesley Writtle, Non-Executive Director **(Member)**	Attended	Apologies
Jo Newens, Chief Operating Officer **(Member)**	Attended	Attended
Mark Anderson, Chief Medical Officer **(Member)**	Apologies	Attended
Mel Roberts, Chief Nursing Officer **(Member)**	Attended	Attended
Kam Dhami, Chief Governance Officer **(Member)**	Apologies	Apologies
Dave Baker, Chief Strategy Officer **(Member)**	Attended	Attended
Daren Fradgley, Chief Integration Officer **(Member)**	Attended	Attended
Helen Hurst, Director of Midwifery	Attended	Attended
Chizo Agwu, Deputy Medical Director	Attended	Apologies
Liam Kennedy, MMUH Delivery Director	Attended	Attended
Dan Conway, Assoc Director of Corporate Governance	Attended	Attended
Jo Clews	Attended	
Susan Hunt	Attended	
Rebecca Bates, EA and Committee Support	Attended	Attended
Lakshmi Thirumalaikumar , Clinical Director		Attended

* See Reading Room for assurance classification

29th March 2023		
1.	**Quality & Safety (Fundamentals of Care) metrics**	
	Chair's opinion: This first presentation of the new metrics was well received. There was a good discussion about minor changes which will develop a more robust data set.	Reasonable Assurance
2.	**Maternity Dashboard and Neonatal Data Report**	
	Chair's opinion: The report identified the success in recruiting to midwifery posts but this will not be seen until the current student cohort is employed in September. More detailed work on neonatal and obstetric workforce will be presented next month. No concerns about outcomes raised.	Reasonable Assurance
3.	**Learning From Death & Mortality Report**	
	Chair's opinion: The HSMR and SHMI remain stable. The areas of focused work show improvement with sepsis no longer an outlier though higher than wished.	Reasonable Assurance
4.	**Mental Health Report**	
	Chair's opinion: The approach across the ICS is improving. New Lead now in post in conjunction with Black Country Mental Health and they are undertaking a stock take. A formal SLA with BCMH is being developed. There were concerns around the use of section 136 detentions and the response after 24 hours. There is continued work to develop the approach to the Oliver McGowan training which is no required of all staff.	Reasonable Assurance
5.	**Planned care – patient care**	
	Chair's opinion: There remains some challenges over meeting our access standards for the current year and material risks were identified around the requirements for the next year, with the junior doctors strikes providing a further risk of providing access to timely care	Partial Assurance
6.	**MMUH metrics**	
	Chair's opinion: There have been some favourable changes in the admission rates for >65 which reflects the value of Frailty SDEC but this has been associated with increase length of stay so challenges remain over bed days. Theatre activity is in line with BADS and not a concern.	Partial Assurance
	Fundamentals of Care Delivery Programme	

7.	**Chair's opinion:** The FoC have been aligned with MMUH business models and 12 key projects have been developed with align to the 3 pillars. Project scoping is underway and there is confidence this will deliver the required transformation. Further detail will be present at future meetings and a clear Governance structure is in place.	**Partial Assurance**

Positive highlights of note	Matters of concern or key risks to escalate to the Board	Matters presented for information or noting	Actions agreed
FoC metrics are developing and will add oversight of safe care Improvements in the sepsis mortality figures show the rate is now just within 95% confidence limits. Alignment in placement between the FoC and MMUH project to deliver best care	Bed occupancy remains a risk for delivery of the MMUH care model. The trusts ability to deliver timely care remains a significant risk for the coming year	COVID figures remain low and are now part of BAU	

26th April 2023		
8.	**Quality & Safety (Fundamentals of Care) metrics**	
	Chair's opinion: The April review has identified that a focus on the drivers of the key items to be set out in the annual plan are required and at present they are not clearly articulated. A session to explore this will be held after the June meeting. Concerns were raised about failure to escalate and manage the deteriorating patient, highlighted by death following surgery.	**Partial Assurance**
9.	**Maternity Dashboard and Neonatal Data Report**	
	Chair's opinion: There was positive feedback form the Peer review on leadership in maternity. There is a plan to increase the ST3+ on call frequency from the current 1 in 8 to 1 in 7 which will impact on training opportunities and this will require an educational QIA. Detailed workforce information at the April meeting highlights significant concerns about the sustainability of the current neonatal consultant workforce due to sickness. This is being managed but will need more mitigation.	**Partial Assurance**
10.	**Learning From Death & Mortality Report**	
	Chair's opinion: The overall figures remain satisfactory though SHMI has risen following the peak of deaths in December but this likely to return when the figures form January and February are incorporated. There remains weakness in the completion of the sepsis 6 bundle with obtaining blood culture being a particular issue which requires focus though the sepsis mortality is within limits. .	**Partial Assurance**
11.	**Infection Prevention & Control Report**	
	Chair's opinion: The IPC report was brought for noting. A review by NHSE has raised the rating to Green. Some areas for improvement remain and being addressed. Some factors are the responsibility of contractors and discussion at a senior level are taking place. The current figures for C dif remain a concern and work is being undertaken to understand the cause.	**Reasonable Assurance**
	MMUH metrics	

12.	**Chair's opinion:** Theatre efficiency is noted to have fallen significantly to 70% which will impact on our ability to deliver planned care. The failure of imaging to meet standards for both ED and the first 24 hours of in patient care remain a significant challenge and a risk to patient care. There is encouraging reduction in LoS in Frail, stable patients suggesting SDEC is impacting on this cohort. Significant more impact is required to deliver the bed numbers required for safe care in MMUH.	**Partial Assurance**
13.	**Quality impact assessments of group's CIP schemes**	
	Chair's opinion: The process for undertaking the QIA which underpin the CIP programme was pressure. There was assurance that then process is robust and 2 of 21 schemes were returned for further work. Concern was expressed that only £18 of £30 million had been identified and some schemes were non-recurrent.	**Noted**

Positive highlights of note	Matters of concern or key risks to escalate to the Board	Matters presented for information or noting	Actions agreed
• Good feedback on leadership in Maternity • Green rating for IPC, rising from Amber on the last visit	• Consultant neonatologist staffing is a concern. • Last Neuro-ophthalmology consultant has left leaving a service gap with significant quality and safety implications.	• Robust QIA process for the CIP proposals • Introduction and deficiencies of a new IT system in Primary care has resulted in a spike in complaints	• Time set aside to review the Q&S metrics.