PATIENTS
PEOPLE
POPULATION

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:	25th January 2023 & 22nd February 2023		
Present:		25th January 2023	22nd February 2023
	Mike Hallissey, Assoc Non-Executive Director **(Chair)**	Attended	Attended
	Lesley Writtle, Non-Executive Director **(Member)**	Attended	Attended
	Jo Newens, Chief Operating Officer **(Member)**	Attended	Attended
	Mark Anderson, Chief Medical Officer **(Member)**	Attended	Attended
	Mel Roberts, Chief Nursing Officer **(Member)**	Attended	Apologies
	Kam Dhami, Chief Governance Officer **(Member)**	Attended	Attended
	Dave Baker, Chief Strategy Officer **(Member)**	Attended	Attended
	Daren Fradgley, Chief Integration Officer **(Member)**	Attended	Apologies
	Helen Hurst, Director of Midwifery	Apologies	Attended
	Chizo Agwu, Deputy Medical Director	Attended	Attended
	Liam Kennedy, MMUH Delivery Director	Apologies	Attended
	Lakshmi Kumar, Clinical Director, Maternity	Attended	N/a
	Dan Conway, Assoc Director of Corporate Governance	Attended	Attended
	Sarah Carr-Cave, Deputy Chief Nurse	Attended	Attended
	Amanda Geary, Group Director of Operations	Attended	N/a
	Louise Wilde, Head Midwifery	Attended	N/a

* See Reading Room for assurance classification

25th January 2023		
1.	**Discussion items Infection Prevention & Control Update**	
	Chair's opinion: The annual report was received and provided good assurance that processes are in place. There remain estates issues which it is not possible to resolve but mitigation is in place. An NHSE visit is expected in March and the aim is to maintain an amber rating as a minimum.	**Substantial Assurance**
2.	**Safeguarding Review update**	
	Chair's opinion: The report highlighted the progress made. Further work is required across both ICS to ensure all standards are met. The implications of the Oliver McGowan training requirements on workforce were discussed. An internal audit report has also been done and reflects similar process which will be presented ay Audit and Risk Committee	**Reasonable Assurance**
3.	**Maternity Dashboard and Neonatal Data Report**	
	Chair's opinion: Community midwife staffing remains a risk and are affecting screening rates. Currently over 50% of first contacts are virtual. The PHE action plan requires continuous monitoring to ensure we achieve the required standards. Two new consultant appointments but medical staffing in obstetrics and neonatology remains a pressure.	**Partial Assurance**
4.	**Maternity Incentive Scheme- Year 4**	
	Chair's opinion: The team achieved 9 of 10 standards and actions are in place to rectify this	**Partial Assurance**
5.	**Mortality Report**	
	Chair's opinion: There has been a spike in deaths in December which is being explored. SHMI has risen and a review identified coding in a neonatal deaths which contributed to this. Feedback on SJR's to be reviewed	**Partial Assurance**
6.	**Gold Covid Report**	
	Chair's opinion: The numbers of primary COVID cases did peak before Christmas but most cases are now predominantly in patients admitted for other issues.	**Reasonable Assurance**
7.	**MMUH Verbal Update**	
	Chair's opinion: A modelling error has been identified which may impact on plans. A deep dive and review is in place and a formal structure to report to Q&S is being developed	N/a

Positive highlights of note	Matters of concern or key risks to escalate to the Board	Matters presented for information or noting	Actions agreed
• IPC report has been delivered and provides assurance on our performance and safeguarding developments should be noted	• Staffing obstetrics in Medicine, Midwifery and Neonatology remain a concern. There were episodes of consultants in Obstetrics having to act down due to gaps. Mortality spike in December is a concern and we are not seeing a fall in SHMI over recent months.	• New Q&S metrics being developed	•

22nd February 2023

Q&S BAF Report

Chair's opinion:
4 new actions added to underpin the work streams and the improvements in SI completion and a stable SHMI were positive outcomes. The Fundamentals of Care has been launched with a safety summit for the Emergency Department has been arranged

Partial Assurance

Maternity Dashboard and Neonatal Data Report

Chair's opinion:
Work to revise admin processes to free clinical time has started. This should support earlier access for mothers and better screening access. Cross LMNS triaging is planned and all screening incidents closed

Reasonable Assurance

weAssure Update

Chair's opinion:
A clear dashboard has been developed, awaiting the self-assessment of core services. Further report in 8 weeks to set the context for future planning

Partial Assurance

Mortality Report

Chair's opinion:
The overall SHMI is stable. Sepsis remains an outlier and further work was in hand. Work was required following review of HAVTE cases

Partial Assurance

Patient Experience Quarterly Report

Chair's opinion:
Great patient and public engagement has been going forward. Expansion of Patient Reported Experience form and further local engagement in development.

Partial Assurance

Interim report on MMUH and PLACE based rightsizing

Chair's opinion:
Concerns over data modelling for MMUH noted. A formal report on the revised model to be submitted in the coming weeks

N/a

	Planned care – patient care	
	Chair's opinion: Work has shown gaps in adherence to processes for patient monitoring at a time of long waits. The process is being reviewed to establish what is reasonable and clinically appropriate.	**Partial Assurance**
	CQC inspection of YHP Report	**Partial Assurance**
	Chair's opinion: Inspection reports for Your Health and Great bridge were noted and action plans received. Will need monitoring going forward.	
	Safeguarding Quarterly Report	
	Chair's opinion: Basic structures are in place but large gaps in assurance around training and implementation in the clinical setting.	

Positive highlights of note	Matters of concern or key risks to escalate to the Board	Matters presented for information or noting	Actions agreed
• WeAssure dashboard is now in place which will allow services to be fully sighted on the areas which require focus.	• The CQC inspections of our PCNs	• Pathology turnaround time issues following Black Country pathology network initiation. MMUH modelling error	•