Paper 4

Quality & Safety Committee:

Summary from meeting held on 23rd June 2016

The committee used much of the time available for in depth reviews of two services.

Ophthalmology

The Deputy Medical Director described the review he has been undertaking of all the factors which have put such great pressure on the ophthalmology service. Gaps in the establishment of clinicians, inadequate facilities and relentlessly increasing demand, which outstrips the reasonable capacity of a very hard-working clinical team, all contribute to the delays in treatment and the concerns Q&S Committee have about the quality of patient experience. We have supported the leadership and strategic planning he is providing and have discussed some of the options which he is considering. There will undoubtedly be substantial investment pressure, both for the trust and for the CCGs to consider if we are to see a sustainable specialty service in the county. Due to continued concerns with the Ophthalmology Services there was discussion on reducing current activity. The review and recommendations will be completed in the next week or two.

Women & Children's Services

The clinical leaders of the Women & Children's Care Group presented a thorough review of all the data about maternal and perinatal deaths in S&TH using all the available benchmarks and external reviews undertaken, including the most recent re-examination of a maternal death by the specialist team from Southampton and the independent expert review of the neonatal care network centred on UHNM (Stoke), of which we are a part.

There are good grounds to assure the Board that for maternal deaths we are at the lower end of the risk spectrum. In relation to perinatal mortality,(comprising neonatal deaths and stillbirths), and despite a larger number of neonatal deaths in 2015 than would have been expected, the clinical details of those cases and the general trends over recent years also provide assurance that S&TH provides a maternity service at least as safe as any average hospital. In the context that the West Midlands has the highest perinatal mortality rates in England there is no complacency and trend analysis shows that stillbirth and perinatal mortality here is falling and remains below the peer comparison benchmarks.

We have emphasised to the maternity team, the importance of compassionate support to families who lose a baby. We acknowledge the considerable progress in the openness and candour with which the clinicians approach the difficult task of reviewing the circumstances of each of these sad cases and the rigorous peer review which supports that task. We are encouraged by the extensive training and validation programmes now required of clinical staff. We have asked them ensure that on-going support is provided to families and it is our view that this element of the evolving cultural transformation requires continuing, high level engagement.

Simon Walford
Chairman,
23rd June 2016