

Quality and Safety Committee

Key summary points from the Quality and Safety meeting held on 22 December 2017:

1. Neonatal Retinopathy

The committee was really impressed with a presentation made by the neonatal team with regard to work undertaken to examine the incidence of retinopathy in premature babies. The team had noted a potential small rise in the number of cases requiring treatment and had then undertaken a detailed investigation to look at the potential causes of the increase, the risk factors for the condition and potential actions. The investigation extended along the full neonatal pathway and included neonatal intensive care units on which affected children had been nursed for periods within their neonatal period. There is now a clearer understanding of risk factors and active debate within the network. The findings have been presented at a national conference as well as within the West Midlands. This is an excellent example of how a positive approach to data can lead to a proactive process to improve care along a pathway;

2. Maternity Services

The committee met with representatives from Maternity services and, in the light of discussions, will maintain a high degree of scrutiny on this service. Action plans, dashboards and a response to the Coroner were all reviewed. The sense is that there is much activity that has the potential to address concerns about the service. The committee did not, however, receive the assurance it required with respect to the implementation of expected practice on a day to day basis. A specific issue that the committee require is assurance as to how the expected level of monitoring of the foetal heart rate is implemented operationally;

3. National Cancer Patient Experience Report

The National Cancer Patient Experience report was presented to the committee. This shows improvement from previous reports but still gives rise to some concerns. Of particular concern are the reported lower performance against questions about confidence in medical professionals and the availability of medical records to support consultations. It is easy to see that these two issues will have some interlinkage. Whilst there may be some questions about the methodology applied to developing the report, SaTH should be developing an action plan to address these issues.

4. Pre Meet Clinical Visit

The formal meeting was preceded by a visit to the operating theatres at PRH. These were found to be orderly, clean and in good condition. The committee heard from the theatre manager about plans for further improvement and development of services, about workforce challenges and of strong collaborative working across the two SaTH sites.