Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE MEETING MINUTES

Venue Room 13, Education Centre, Sandwell General Hospital

Date 26th April 2019 11-12.30

Members present

Harjinder Kang, Non-Executive Director **(Chair)**	(HK)
Marie Perry, Non-Executive Director	(MP)
Kate Thomas, Non-Executive Director	(KT)
Rachel Barlow, Chief Operating Officer	(RB)
Kam Dhami, Director of Governance	(KD)
David Carruthers, Medical Director	(DC)

In attendance:

Dave Baker, Director of Partnerships & Innovation	(DB)
Paul Hooton, Deputy Chief Nurse	(PH)

Committee Support:

Ruby Stone, Executive Assistant	(RS)

1. Introductions and Apologies	**Verbal**
Introductions were given. Apologies were received by Paula Gardner and Richard Samuda.	
2. Minutes from the meeting held on 29th March 2019	**QS (03/19) 001**
The Chair called for any comments on the previous meeting. The minutes of the previous meeting were deemed an accurate record.	
3. Matters and actions arising from previous meetings	**QS (04/19) 002**

The following updates on the actions arising from the meeting held on 22nd February 2019 were provided:

- *Agenda item QS (03/19)004 Patient Story: Look at the medical records prior to this death and to review it as part of the hospital's review of deaths.*
  DC updated the group and confirmed that discussions with medical examiners had taken place. The expansion of medical examiners and the developing role of the medical examiner officer would be beneficial in getting this right. This item would be picked up by PG in the quarterly patient story review.

- *Agenda item QS (03/19)008 Purple Point: Supply data surrounding foreign language enquiry figures.*
  KD advised that this initiative had been in place for a year now and a discussion had taken place around next steps. Several questions had been raised and were being followed through. KD confirmed that the system was unable to capture data for patients using language line and this would be investigated. In the mean-time KD was able to tell from the invoices received from the language line that Points had been used.

- *Agenda Item QS (02/19)003 Cancer Priorities. Provide detailed delivery plan for this year with a trajectory date in order to assist with the compilation of a higher-level plan over the next two years*.
  RB gave a brief update and confirmed that the delivery plan would be presented at the May meeting

- *Agenda Item QS (21/12/18) Carry out a review of the clinical decision to discharge in the case of unplanned re-attendance to A&E.*
  RB gave a brief update and confirmed that the review would be presented at the May meeting.

3.1 Feedback from the Executive Quality Committee and RMC	**Verbal**

KD gave an overview of the March Executive Quality Committee and Risk Management Committee meetings and the following points were discussed:

- The Board had decided that some risks did not require Board level monitoring, these were around DTOCs, unfunded beds in ED, ED consultant numbers and ENT staffing.

- The over 21-day incidents were discussed at the EQC meeting and it was confirmed that these incidents were now at 38 and a plan for sustainability of this achievement would be created.

- The management of security risks would be investigated at the RMC. RB advised that a monthly meeting with clinical groups and corporate reps would be implemented to manage the action points and with security staff would be trained accordingly. A Security Risk Committee would be set up to manage risks and ensure that the Trust's categorisation of security risks where consistent with the NHS as a whole.

- DC clarified that the Executive Quality Committee focussed on organisation-wide learning from recent never events.

- A route to achieving a good or outstanding CQC rating and working out why the Trust had not yet reached this standard was called out, together with coaching staff to assist them with responding appropriately to inspectors' questions.

- It was noted that it was necessary to view the quality data using the CQC national data set and work closely with the CQC to resolve misunderstandings via setting up regular engagement meetings with the CQC in advance of an inspection.

- The weekly or regular ward team meetings were discussed, and it was suggested that by giving staff standard objectives and encouraging standardised slots for meetings would ensure regular and relevant meetings took place.

Action: KD to bring the CQC data to the next meeting.

3.2 Unplanned C-section rates	**Verbal**

PH confirmed that there were 28.3% C-sections carried out in February, of that 28.3%, 64% of those were emergency and the remaining were elective. Of the 64% that were emergency, 26% of those

were because the foetus was in trouble and the remaining were a variety of reasons (a breakdown was available of these). It was confirmed that a monthly report would be created in order to monitor the position of the Trust regarding C-sections.

A general discussion commenced regarding concern for patients presenting late which may cause a higher risk of having to have an emergency c-section, and how to engage with this portion of the population who were not receiving any midwifery care throughout their pregnancy. It was noted that this potentially contributed to higher emergency C-sections being carried out at the hospital.

The percentages were discussed, and it was agreed that the statistics would be validated.

4. Patient story for the April Public Trust Board	**Verbal**

PH gave an overview of the patient story for the April Public Trust Board.

The story revolved around a patient who attended the hospital for colorectal surgery and was based on a complaint made by the patients' family about the ward, and what they had done about that complaint.

The patient attended the hospital and was admitted as an in-patient for a period of two weeks following major surgery. The family felt at the time that there was poor communication between the ward staff, the patient, and the family. They raised a complaint through the complaints process while the patient was an in-patient at the hospital. The ward staff and matron met with the family and between them they discussed the issues and concerns. An action plan was developed, describing how they would deal with the concerns that had been raised and ensure that communication improved.

Over the course of time the patient was discharged, re-admitted and discharged for different reasons, into the same ward until eventually they patient passed away. The family returned to the ward after the death of the patient to discuss how well the action plan had worked and how things had improved. They were pleased with the care and communication received during the post implementation of the action plan.

PH advised that it would be a good learning point from the ward's perspective and the family's perspective to talk together about the journey they went on to improve that communication between them.

PH advised that the patient's family may attend together with ward staff. However, this was yet to be confirmed.

DISCUSSION ITEMS	
5. CQC Improvement Plan	**QS (04/19) 003**

KD noted the paper and the following points were discussed:

- A workshop had been arranged together with the CQC to work through the Mental Capacity Act and ensure that the intention was in line with the CQC.

- The Well-led Self-assessment Action Plan would be monitored separately to the Improvement Plan and the Use of Resources Plan.

- The Improvement Plan would be a recurring item on the agenda of the Quality and Safety Board. It was agreed that whilst the plan would be circulated, the work philosophy of monitoring and calling out items of concern only, would be adopted.

- An update of the Well-Led, Improvement and Resource Plan would be reviewed at the Board Committee meetings on a quarterly basis.

- It was confirmed that the paediatric reconfiguration to City Hospital was on-track.

The Committee discussed the CQC's perception of Rowley Regis Hospital, and that a relationship with the same individuals from the CQC attending the hospital each time would be benefit their understanding of the Trust's vision and help to resolve mis-understanding between the two organisations.

It was confirmed there were no current red/ambers of concern. KD confirmed that all red/ambers had an action plan apart from the Mental Capacity Act issue which would be considered at the work-shop.

6. Developing a patient safety strategy for the NHS	**QS (04/19) 004**

KD noted the paper and confirmed that the consultation had been completed. The following items were discussed:

- Patient safety alerts and how the Trust deals with them. KD confirmed that these would be discussed at the Executive Quality Committee and at the Quality and Safety Committee on a quarterly basis.

- Incidents, audits and complaints data would be scrutinised via the **we**learn programme to be able to learn from these incidents and apply safety improvements.

- DC confirmed that he was responsible for circulating drug alerts to the relevant speciality to deal with appropriately. A report via the Pharmacy Leadership Team would be created to capture drug alert learning.

- The harm data was well reported at the Trust.

- KD confirmed that the monitoring of outcomes of actions of serious incidents would be scrutinised.

- DC advised that morbidity and mortality reviews for the (Executive Quality Committee) EQC were being carried out.

7. Safety Plan Update	**QS (04/19) 005**

PH noted the paper and called out the following:

- The plan had been embedded in the organisation over the last year and a half.
- The checks were occurring daily. Although monitoring and compliance had slipped and would be re-focussed.
- The 38 wards completed the safety plan checks and there were no missed checks within 48 hours.
- The overall compliance for submission was 99%.

PH clarified the data submissions question and it was confirmed that the BT correlation would be resolved by the Unity implementation.

PH confirmed that the safety plan would be revisited to ensure that the Safety Plan had good governance in place and would be monitored daily. The action plan was discussed, and PH said that he felt that the action plan did have traction but had lost an element of oversight and monitoring.

It was confirmed that overall the Safety Plan was positive and that it showed that care was improving.

The Safety plan was being audited and audit report will be circulated (PG to provide update)

8. Integrated Quality and Performance Report: March	**QS (04/19) 006**

DB advised the Committee that there would be changes made to the IQPR. Some parts of the paper would be briefer and the at a glance page would be reintroduced. There would be a focus on variations and picking up the persistent reds, with more detail on forward action.

DB advised the Committee as follows:

- The ED had improved, although they had dipped again recently.
- The diagnostic waits had held steady for three months.
- That Cancer had delivered for the whole year.
- The RTT was above 93.
- There was only one speciality which was below at 91 and that should recover by June.

The persistent reds which had been achieved would be removed from the report, the two to remain were:

1. Cancellations, whilst they were still hitting the national target of .8%, they were not hitting the Board target of less than 20.
2. Stroke, which had hit for the first month and needed to hit for a couple more months before it could be removed.

The one 28-day breach in Gynaecology was not considered significant and the 6 serious incidents were not considered significant. Although the 2nd spike around readmissions going up to 8.7% was considered significant and was being investigated at Board level.

Overall Neutropenic Sepsis had improved this month.

It was suggested to start reconfiguration of the IQPR and consider exceptions in the following sections:

1. Exception reporting.
2. A deep-dive into one item per meeting.

3. Forward action.	
Action: DB / RB to investigate the IQPR restructure.	
9. Future Q & S Agenda	**Verbal**
Extend discussion surrounding IQPR restructure.	
MATTERS FOR INFORMATION/NOTING	
10. Matters to raise to the Trust Board	**Verbal**
The discussion surrounding the IQPR restructure	
11. Meeting effectiveness	**Verbal**
The Chair noted that the meeting was considered effective.	
12. Any other business	**Verbal**
KT called out the rapid discharges at 23 hours procedure, the quality of the discharge and if the patient point of view had been investigated. DC confirmed that a meeting had been arranged for next week to explore this and confirmed that an exercise was being carried out regarding the patient led outcome measure point of view.	
13. Details of next meeting	**Verbal**
The next meeting will be held on Friday 24th May 2019 from 11:00 to 12:30 in Room 13, Education Centre, Sandwell General Hospital.	

Signed ……

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Date ……