Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE - MINUTES

Venue: Room 13, Education Centre, Sandwell General Hospital

Date: 26th July 2019, 11:00-12:30

Members:			**In Attendance:**		
Mr H Kang	(HK)	Chair, Non-Executive Director	Dave Baker	(DB)	Director of Partnerships and Innovation
Mr R Samuda	(RS)	Chairman	Mr T Lewis	(TL)	Chief Executive
Ms M Perry	(MP)	Non-Executive Director	Ms R Stone	(RS)	Executive Assistant
Ms R Barlow	(RB)	Chief Operating Officer			
Miss K Dhami	(KD)	Director of Governance			
Dr D Carruthers	(DC)	Medical Director	**Apologies:**		
Mrs P Gardner	(PG)	Chief Nurse	Prof. K Thomas	(KT)	Non-Executive Director

Minutes	**Reference**
1. Welcome and Introductions	**Verbal**
The Chair welcomed the members and those in attendance to the meeting. The Committee members provided an introduction for the purpose of the recording. The Chair noted that TL was in attendance for agenda items 6 and 7 only and therefore those items were addressed by the Committee first.	
1.1 Apologies	**Verbal**
An apology was noted from Prof K Thomas.	
2. Minutes from the meeting held on 28 June 2019	**QS (07/19) 001**
The Committee reviewed the minutes of the meeting held on 28 June 2019 and noted the following: • It appeared that the Non-Executive Director's did not verbally contribute to the meeting discussions, even though there was robust discussion with challenges to the papers. The Committee stated that the conversations in the minutes were summarised too much, whereas the Board minutes were to the other end of the scale. It was noted that that feedback would be passed to the transcription company. • Page 2, second paragraph – *lumbar* was spelt incorrectly. • Page 2, second paragraph – … *baby's bloods had been escalated to Heartlands Hospital* … amend to … *baby's bloods had been* ***transported*** *to Heartlands Hospital* …. • Page 6, item 11, dot point 1 - Pilonidal abscess spelt incorrectly. • Page 6, item 11, dot point 1 – last two hyphens to be amended to one comment. The minutes of the meeting held on 28 June 2019 were accepted.	
Action: To provide feedback to the transcription company in regard to the over summation of the meeting minutes.	

Action: To amend the minutes of the meeting held on 28 June 2019 as outlined at agenda item 2.

3. Matters and actions arising from previous meetings	**QS (07/19) 002**

The Committee reviewed the action list from previous meetings:

- *QS (06/19) 006 - Safety Plan: Discuss the issue of missed checks within surgery with the Group Director of Nursing.*
  PG advised that it had been discussed and noted that there had been no missed medication checks since the last meeting.

- *QS (06/19) 008 - 2017 Staff Survey: Conduct direct observations with regards to looking at allocation problems within wards.*
  PG noted it was being practised on an ongoing basis.

- *QS (06/19) 010 - Investigate the visibility of displays of nurse staffing numbers and identity of ward leads, together with standardisation of the display location.*
  PG provided the Committee with a mock example of a ward board that would be implemented. The ward board included the following information:
  - Nurse in charge,
  - Staffing numbers,
  - The current shift,
  - Consultant of the week,
  - Therapist [on duty], and
  - Patient feedback.

  PG explained that the purpose of the ward board was for relatives, visitors, staff to easily identify the *who's who* on the Ward. The boards would be updated each shift. It was suggested to add the Purple Phone information to the Ward Board. It was advised that the Purple Phones were already advertised well throughout the Trust.

- *QS (05/19) 005 - Cancer Delivery Plan: A deep dive every quarter into items of choice to be added to the agenda.*
  Action item due in September.

- *3.1 (VERBAL) - Bring the RAG rated CQC improvement plan update to the next meeting.*

  Action item discussed at agenda item 8.

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

KD noted the following items arising from the Executive Quality Committee and RMC:

- Open referrals
- Result acknowledgement
- Quality Plan
- Security Management Plan

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

PG advised that the patient story would be delivered to the Board by Jasim, a 16-year-old patient who would be accompanied by his mother. PG noted the key points of the Patient Story:

- Jasim had numerous allergies since birth (particularly milk).
- Under Dr Makwana, Jasim went on the de-sensitisation program which effectively changed his life.
- Jasim would tell the story of his journey.
- Jasim had expressed that Dr Makwana was his role model and he now wished to pursue a career in paediatrics.

It was noted that there were issues with being accepted into Dr Makwana's program if the patient was 16 years old – try to push them into the adult service. DC noted that the transitioning process needed to be thorough/accurate, as a 16-year-old should be treated as an adolescent in an adult service.

DISCUSSION ITEMS

5. Strategic Board Assurance Framework: controls check	**QS (07/19) 003**

KD provided the Committee with an overview of the control checks:

- **SBAF 2** Care Homes – RB provided the following details:
    - Sandwell Council due to conclude in August (joint bed modelling). Dave Stevens had signed up to it with a positive attitude. The output would be an integrated bed model forecast on demand through to 2022.
    - There was no movement with Birmingham Council. It was anticipated to present the successes achieved with Sandwell Council model to Birmingham Council. There was a number of issues to raise with the Birmingham Council. The matter would need to be escalated to a high executive level with Birmingham Council
- **SBAF 4** Vulnerable Services - DC commented
    - September's Q&S would provide more assurance. DC noted that they need to map out their co-services and work out where to direct their efforts.
    - It was noted that TL had submitted their Vulnerable Services Description – the Trust had many co-dependencies on other organisations. HK queried how to get that to a robust assurance level. DC noted that they would need to get an understanding of where the work had already been done by specialties with specialities from other organisations, and work out which ones needed the work done or to pull back on. The internal work would be done by Liam Kennedy in collaboration with medical directors and specialities through the ICCS. DB noted that there was a lot of daily activity that linked into the system, but the response plan for the local system would be primarily prototyping around best start in life and end of life care. They would set up work streams and metrics in those two areas.
- **SBAF 5** weLearn – KD noted the following:
    - They were tightening up their controls, such as progressing their QHD accreditations (quality improvement half days – were they doing a good job).
    - Had their first QIHD accredited gold team (Children's Therapy Service) and lots of silver teams (Neonatology, Allergy, Health).
    - Quality Audit Plan – groups and directorates been given until the end of August to complete (to be presented at the Audit Committee for process, and QS Committee for assurance).
    - QIHD poster competition would be held again, with the awards ceremony in December
    - Launch Learning for Excellence in September.
    - Q3 would look more assured as items finalise.
- **SBAF 14** Mortality – DC provided an update
    - The Medical Examiner post and vacancies compared to other Trusts was queried. DC noted they were doing well and would appoint two more staff in the next month. He had advertised for the Medical Examiner Officer and were getting their software fixed for

consistency in the review process. Comparatively, they were not as advanced as other Trusts. They were currently reviewing 75-80% of deaths and trying to organise a system to review Rowley deaths as well.

- **SBAF 15** Research – DC advised that
    - That had had discussions with each of the Groups to support them to identify what commercial and non-commercial studies in which they could and could not get involved with. There was change in the R&D Committee with an improved structure and better representation from groups. All had trajectories for studies, particularly commercial studies, and support to take that forward. They had to advertise for a new R&D Director and confirmation was pending to advertise for a Deputy R&D Director.

      The eco system was starting to boost up the R&D piece in health care around the Birmingham Life Sciences Park and University. The West-Midland's combined authorities were driving the life sciences. HK noted that a big opportunity existed within the community and he queried if the Trust was tapped into that. DC noted they were tapped in to the traditional academic institutes. HK noted to have a discussion outside the room about it. HK advised that he was on the Life Sciences Audit Committee at the University of Birmingham and they were keen to work with the Trust. The Birmingham Life Sciences Park was due to open in 2022, which corresponded with the opening of Midland Met Hospital and the Commonwealth Games.

6. Briefing on the External Review into Five Maternal Deaths	**QS (07/19) 004**

PG noted that the Trust had requested an external review of five maternal deaths. She noted that the deaths were caused by:

- Two non-preventable (cancer and out-of-hospital cardiac arrest).
- Three related to amniotic fluid emboli (AFE).

PG called out the following notable practices that were acknowledged:

- Good evidence of antenatal care.
- Good evidence of team working.
- Excellent evidence of support for the family.
- Excellent evidence of follow up from the Community Midwife.
- Good continuity of care around obstetrics.
- Appropriate use of an interpreter.

An internal workshop would be held next week focusing on the following:

- Notable practices.
- What was being picked up in conversations.
- Risk assessments – high BMI etc.
- Decision making around the Major/Massive Obstetric Haemorrhage protocol.
- Decision making for Pulmonary Embolus versus AFE in the collapsed patients and in the presence of DIC (abnormal clotting and bleeding).

It was noted that there had been a discussion in regard to the out-of-hospital cardiac death and whether a peri mortem caesarean section should have been performed. It had been agreed with the Ambulance Service that the outcome would have been the same regardless – the patient had been down for 15 minutes and West Midland Ambulance Service protocol stated not to carry out the procedure if a patient had been down for 15 minutes.

TL noted that on completion of the final report, that the questions A-D listed at 1.4 of the Paper be addressed in a tabular format for each of the patients that had died. He noted that the patients had foreseeable but unusual complications, and in some areas, where the national number of occurrences were 1 in 5 years, they had 3 cases in 18 months. There was national guidance for some cases, but not all.

The outcome of the report would see that they establish local guidance where there was no national guidance, and that those local guidelines were followed.

TL noted 3.1 of the Paper – a series of errors at A-G for further investigation, especially item E. He noted that item G had been added. Each of the items had its own internal Trust SI Investigation and whilst the external review did not reveal huge gaps, it was worth an internal review. He stated that when the Committee reconvened, that they be prosaic about A-E to assure the credibility of the answers to the Board.

PG noted that all maternal deaths were reported to MBRRACE-UK where there was a national review.

TL noted that the final report would be presented to partner organisations.

TL noted that the fact that the Trust did not have a pregnancy pathway for epilepsy came as a surprise to him – even though it wouldn't have changed the outcome of the situation.

DC noted that with AFE there were no associated risk factors that could be predicted.

The next steps were noted:

i. Workshop would be held next week.
ii. The final report due in August and would then go through each item.

It was advised that all late patients' families had been contacted except one, where we had exhausted all means of communication.

TL noted that Committee members communicate any questions bi-laterally to PG over the next week.

PG noted that all involved staff had peer-to-peer support and external support was engaged.

Action: Committee members to communicate any questions about the maternal deaths bi-laterally to PG over the next week.

7. 4-hour Emergency Care Standard	**QS (07/19) 005**

RB provided some introductory comments to the Paper with the following key points:

- Attendance up 3.5%.
- Admissions up 10%.
- Breach distribution between sites, focus on 4-5-hour breaches in minors (30 breaches a day).
- First wave of PDSA cycles appeared to have impact – from 70's to 90's.
- Workforce – big developments in people in posts. Efforts to retain staff was needed.
- No consistency in behaviours and shift management.
- NHSI verbal feedback – reinforced the context of what the Trust was doing.
- Consistency of achieving 85%+ would come down to their people, the leadership and behaviours.
- Deficit of medical leadership chain in emergency care – defining leadership roles, job descriptions, terms and conditions and recruit a speciality lead.

RB welcomed discussion.

TL noted that it was improbable to achieve the results with an overcrowded ward – staffed for 26 beds and seeing 60+ patients. The impacts on staff was that they were working hard all of the time resulting in reduced patient experience. There was a need to identify areas of concern for serious incidents and complaints. The link between staff frustration and patient care lapses was discussed. The lack of instinct or empathy in staff due to frustration of increased workload. RB noted that they would need to look at what the audit lines of enquiry were to systematise – look for compliance with various clinical policies and procedures, and also look at the demographics. That was a good way to get better insight into quality.

RB noted the following timeline:

- PDSA cycles had commenced.
- After the NHSI visit, the team would go to Leicester to look-in-practise as well as hear from Ben (ED Consultant).

- The minor works were impacting both BMEC and the two A&Es.
- They were behind on professional standards.
- Work to be done on optimising flow – a few policies and procedures to be released soon in regard to flow. Meeting Malling to discuss flow streamlining opportunities.
- She noted the difficulties in recruiting for the Deputy Chief Operating Officer role.

MP queried if their system was so stressed that it offered unsafe practise. RB noted that:

- Staffing level – based on hourly arrival rates (demand model), over seven days and by day of the week and updated regularly. The staffing levels were safe.
- Establishments – safe staffing for medics and nurses.
- People in posts – safe staffing for medics and nurses.
- Sickness issue with medics 5-7% rota gap, rectification in progress.

RB noted that it was different when there was a 70 patient case load in A&E – need to manage A&E more effectively.

The Committee agreed to bring back an Audit Proposal to provide assurance.

Action: To bring back to the Committee the Audit Proposal (4-hour Emergency Care Standard) to provide assurance.

8. CQC Improvement Plan: RAG ratings	**QS (07/19) 006**

KD noted that she had presented the full plan at the previous Quality and Safety Committee meeting and the Paper was the requested RAG ratings. She advised that she had appointed an Associate Director of Quality Assurance (the person that would visit each of the Wards). She noted that there was a 3-month notice period for the individual to commence and had appointed someone in the interim (who would start next week). There was progression on movement with providing assurance on some items on the list.

9. A good night's sleep: implementation plan	**QS (07/19) 007**

PG advised that they had launched the program at the Board meeting and were moving forward with the Quiet Protocol. She noted the following key points:

- The Quiet Protocol would provide information to patients, relatives and staff – waiting for customised posters to arrive.
- Working with RB on reducing bed moves at night – moves to be completed by 8pm at the latest in the deep beds, and therefore create admissions in the AmU to produce flow and 4-hour target.
- There were 70 staff on permanent nights that were in the habit of talking at daytime volume. Decibel counters had been installed. The WHO standards state that above 40 decibels was loud, tests revealed some wards were at 90 decibels. That would link into Connect and identify areas for improvement.
- All bins to be replaced by the end of August.
- Sleep mats – worked out how to link to a system to identify if the patient had slept well and may be able to link to vital packs. The sleep mat company that they were working with have desire to get into the NHS – may be a good research opportunity. Whilst they had pitched the Quiet Protocol, they had gone two or three steps further to be able to publish.

PG noted that sleep was vital for the body to heal. The launch date had been moved around to accommodate the launch assistant's leave for two weeks – launch in August.

10. Speak up scorecard	QS (07/19) 008

KD noted that they had talked a few times about actively capturing those who were 'speaking up' in a variety of ways. It would link in with the Speak Up Policy (former whistleblowing policy). It would be populated by Group and Directorate, not just who went through the formal route of using the policy, but people who were embracing concern about patient safety as well. It would be done in a balanced way and not in an intimidating manner where people were afraid to raise concerns in fear or being reprimanded, victimised or to their detriment.

The heat map would provide a full picture of the staff that were speaking up once the Speak Up Policy was launched and the Freedom Speak Up Guardians share their data.

HK questioned if its purpose was to provide visibility to the things being raised to encourage others – that they were not the only ones speaking up. KD noted that was correct. People tend to want to remain anonymous and it would build that confidence to report. Some staff prefer to report to the Guardians to remain anonymous. Speak Up days were beneficial as it provided the opportunity for staff to speak up – the next Speak Up day would be on Wednesday, 11 September 2019 (all day, lots of activities happening).

Dave Baker noted that when the CQC visit – they want the staff to say that they enjoy working at the Trust and queried what evidence did they have to indicate these things were driving that. KD noted that the output measure was around the engagement question.

11. Integrated Quality and Performance Report: June	QS (07/19) 009

DB noted the positives in the Report:

- Bed moves between 10pm and 6am had decreased from 698 to 183 in June.
- Diagnostic performance recovered in June ahead of the July target.

There were a couple of indicators that had moved back to being persistent reds; cancellations and A&E re-attendance rates. 52-week breaches were still coming through and work was still progressing on open referrals. There were some processes agreed to on 25 July that would make impact on open referrals. An addition since PMC, was the number of serious incidents in June had increased to 12. The highest it had been was 9 – it was likely an isolated event for the month.

KD advised that there were no particular theme or pattern in the serious incidents but they would need to monitor it.

RS questioned the user friendliness of the process and it was confirmed that it was an easy process.

It was noted that 52-week breaches were related to open referrals and expected that to decrease to previous levels once the work had been completed (as discussed at Board).

RS queried if they had extracted the reattendance that related to Sandwell primary care when the home care work was done. RB reference the Paper that was tabled at the Quality and Safety Committee two months ago, reconciled if they discharged safely from the first attendance, or did it cause re-attendance. It was concluded that it was safe decision making and appropriate discharge.

12. Quality Plan – thresholds for most objectives	QS (07/19) 010

DC noted that he was requested to provide the figures for the Quality Plan objectives (those available) and that there may be some shift on those as the Work Plan developed. The thresholds were based on national and local data/targets, and where there were gaps in data, they would make up their own.

HK queried if they had created trajectories. DC noted that they had defined areas and targets that they would pull together in a project plan to follow and monitor – would be difficult as data/input was coming from a variety of sources.

FOR INFORMATION/NOTING	
13. Matters to raise to the Trust Board	**Verbal**

The Committee identified the following matters to raise to the Trust Board:

- Maternity deaths Review.
- 4-hour emergency care standard (already a paper at Board).
- Quality Plan thresholds.
- Acknowledge the CNST.

14. Meeting effectiveness	**Verbal**

Not discussed.

15. Any other business	**Verbal**

Never Event

DC advised the Committee of a Never Event which occurred at the beginning of the week and confirmed that no patient harm came from it (patient was already blind in the eye). It was another surgical issue of discrepancy between the counting in and counting out of very small tubes which are used in eye surgery. A tube was left in the eye. The tube was removed one month after the procedure. It was the second count in and out error in a short period of time (retained swab being the first).

DC noted that Mr Roy was on leave, however the clinical Director of Theatres would attend the Board meeting to discuss the case.

An immediate review had been conducted and a more in-depth review was underway. The final report for the retained swab would be released soon to allow identification of any common themes in both instances.

RS noted that it was hard not to be concerned about these things especially since the procedure was happening in a regional specialty.

CNST Standards

RB noted the CNST. There was one standard that they had not passed (training), which was impossible to achieve as the training was not available. The goal posts had now moved and the team were performing excellently in training and the Standard had now been met. The evidence base was being concluded for the rest of the document, but they were assured. She advised that she had met with Helen Hurst, Director of Midwifery, and there was evidence to substantiate that they had met all ten criteria. They had also discussed at Group Review. She recommended that the Committee support the submission of the criteria to meet the standards.

The declaration had been discussed with the Commissioners was questioned. RB noted that had been done and were content with that. A lot of their submissions (such as 7-day standards) the Trust shared with the Commissioners; they support that and it is then submitted with their support. It would be shared with the Commissioners next week (in terms of the two items they were working on).

HK queried if the maternity reviews would impact on the submission. PG confirmed they would definitely not, they were separate.

16. Details of Next Meeting

The next meeting will be held on Friday 30 August 2019, 11:00am-12:30pm in Room 13, Education Centre,

Sandwell General Hospital.

Signed ……

Print ……

Date ……