Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE - MINUTES

Venue: Room 13, Education Centre, Sandwell General Hospital

Date: 30th August 2019, 11:00-12:30

Members:			**In Attendance:**		
Mr H Kang	(HK)	Non-Executive Director, Chair	Mr D Baker	(DB)	Director of Partnerships & Innovation
Prof K Thomas	(KT)	Non-Executive Director	Clare Dooley	(CD)	Head of Corporate Governance
Ms R Barlow	(RB)	Chief Operating Officer	Dr Parmjit Marok	(PM)	GP, West Birmingham Medical Centre
Ms K Dhami	(KD)	Director of Governance			
Mrs P Gardner	(PG)	Chief Nurse	**Support:**		
Dr D Carruthers	(DC)	Medical Director	Ms R Stone	(RS)	Executive Assistant
			Apologies:		
			Mr R Samuda	(RS)	Trust Chairman
			Ms M Perry	(MP)	Non-Executive Director

Minutes	**Reference**
1. Introductions	**Verbal**
The Committee members provided an introduction for the purpose of the meeting recording. The Chair welcomed the Committee members and Dr Parmjit Marok, GP West Birmingham Medical Centre, to the meeting. He invited Dr Marok to provide the Committee with a short self-introduction.	
1.1 Apologies for absence	**Verbal**
Apologies were received from Mr R Samuda and Ms M Perry.	
2. Minutes from the meeting held on 26 July 2019	**QS (08/19) 001**
The minutes of the meeting held on 26 July 2019 were reviewed and the following amendment was noted: • Agenda item 2 should read '*non-executive* directors. The Minutes were accepted as an accurate record of discussions.	
3. Matters and actions arising from previous meetings	**QS (08/19) 002**
It was noted that most matters were included in the meeting agenda. Updates were provided on the following actions: • *QS (07/19) 001 - Investigate the visibility of displays of nurse staffing numbers and identity of ward leads, together with standardisation of the display location.* PG noted that the senior nurses' uniform would be changed slightly to clearly identify them on shift. It was anticipated that the uniforms would be in place during September. • *QS (05/19) 005 – Cancer Delivery Plan: A deep dive every quarter into items of choice to be added to the agenda.*	

It was advised that this item was on track for September delivery.

3.1 Feedback from the Executive Quality and Risk Management Committees	Verbal

KD provided an update on discussions from the Executive Quality and Risk Management Committees:

- Discussions were dominated by experts' input into the red and amber related risks – a continuation of the work that had commenced by the CLE in June:
  - The scores were reviewed for accuracy/clarity in regard to their risk description and actions.
  - Had identified issues logged as risks, which posed the questions where were issues being logged.
  - The Board would review and discuss the red-risks that were left on the register.
- A list of risks where the likelihood of occurrence was low, but if it did occur would be catastrophic, would be presented to the Board annually to monitor. The Chair questioned how those risks were assessed. KD advised through; controls in place, dashboard, judgements based on data, discussions between staff and warning signals.
- Discussed a ward push to ensure that each ward had regular clinical team discussions around quality and safety. Confirmation of those meetings being held would be sought at the next EQC.
- DNACPR audit percentage results were discussed with appropriate follow up. PG advised that they were following up on any DNACPR linked to the Mental Capacity Act and deprivation of liberty to ensure that DNACPR forms were completed correctly, and everyone on the wards was aware of patients with a DNACPR. Continued to be satisfied that they were at the desired position.
- KT questioned if the information regarding DNCPRs for admitted patients was communicated across to the Hospital appropriately. PG noted that it usually was but in some instances it was not. The Hospital attempt to confirm if a patient had a DNACPR – there were processes in place and nursing staff confirm with nursing homes. MP noted that there was a piece of work that was in development around the update of the DNACPR form in primary care to assist with the information flow. PG noted that the Trust had adjusted their forms from the resource pack and would discuss the new form further with MP as it could cause some issue.

Action: PG to discuss the upcoming amendments to the DNCPR form with Dr Marok.

4. Patient story for the September public Trust Board	Verbal

PG advised that she would not present an individual patient story, but rather a synopsis of each patient story from April to date, which would include:

- Synopsis of each patient story,
- Actions arising from each story,
- Discussion around the desired format of the patient story moving forward; report, presentation, video, relative presentation. The context of the patient story; themed approach (align to the theme of the Board) and where the paper linked to their promises.

She noted that the Paper would be discussed at the Trust Board.

The Chair queried if there were gaps in the topics/areas covered and if a map of issues had been produced. PG confirmed that she had not prepared a gap analysis. She advised that she didn't believe there were any gaps – but the process was about learning from the stories. RB suggested that it could be mapped to the quality plan, was it the complaints and incidences in which should be mapped.

KD noted that it would be beneficial to include stories from an external perspective i.e. GPs.

Action: PG to consider mapping the issues identified in the patient story to the Quality Plan and a gap analysis.

DISCUSSION ITEMS	
5. Strategic Board Assurance Framework: control check	**QS (08/19) 003**

KD noted that the SBAF control check was to gauge the Committees level of confidence in controls and assurances to mitigate the risk.

SBAF Ref 2

RB provided an update:

- The winter proposal (Sandwell) had an agreement and funding – looking positive.
- Nursing Home data presented and was also presented to the Board.
- Mental health aspect – presented a paper to the CLE to make a recommendation around mental health broadly across the organisation. The proposal to put mental health skills into a broad range of their workforce with the possible expansion of the Liaison Service to ensure they had specialists in post. The costs of which, were yet to be analysed.
- The integrated bed model was a month behind due to delay in the data sharing agreement.
- Birmingham Council (locally and operationally) – PG had informed of good engagement through Multi Agency Discharge Event (MADE) events that were looking at length of stay. However, from a SBAF perspective there was a lack of engagement. The planned activities over the next 4-6 weeks would strengthen the Sandwell position, however Birmingham was questionable. The Chair asked if the Trust was being 'heard' by the Council. RB noted that she often thinks she has been heard; however, the actions do not transpire. It was noted that it could be a Council resource issue.

The Chair questioned if their position on assurance was the same. RB confirmed that assurance was the same with the expectation that it would move forward in the next couple of months. KD noted that there were a lot of activities happening.

SBAF Ref 4

DC provided an update:

- Vulnerable service improvement plan – were not many gaps and actions. Information for vulnerable services flows through the various meetings; Board, CLE, CQC and group reviews to try and identify those service challenges.
- DC stated that he planned to look at all the inter-dependencies for each specialty from outside the organisation to create a dependency map that links to the Group feedback about the challenging services.

DC stated that the assurance was still Limited as they need to identify clear actions.

The Chair questioned if there would be more clarity on the risk to the various services as the STP developed. DC agreed that it would help as there were some areas in the STP that were clearly defined and strong, and other areas in need of development. DB noted that a paper and presentation would be brought to the Trust Board next week on STP Plan progress. MP noted that the STP plan was lagging behind, however there was a lot of discussion around place-based care.

SBAF Ref 5

KD provided an update:

- Looking at including as part of the **we**learn platform next year:
    - Competitiveness about accreditation – by the end of March 2020 each of the QIHD teams would need to be accredited.
    - **we**learn poster competition: 64 applications, would close in October. PCT were the leaders

with 20 posters.

- Learning from Excellence programme: decided to delay the launch of the programme due to Unity Go Live.
- The **we**learn Hub team would relocate next week from City Hospital to Trinity House. The space would be professionally designed to provide an inviting place for staff to visit.

SBAF Ref 14

DC provided an update:

- Two additional Medical Examiners would commence in September.
- The Examiner Officer post had been advertised to support the work of the Medical Examiners and developing the SJR for more detailed review of groups of patients or patients identified by the ME as having problems in care.
- Some delay in SJR training with Unity Go Live next month.
- Work continued on the Trust mortality data; using the data to identify and monitor alerts for increased mortality in Quality Plan areas, stroke and sepsis.

SBAF Ref 1

DC provided an update:

- The vacant Head of R&D post had 60 applicants. Shortlisting had taken place and interviews set.
- The Director of R&D post would be advertised later as to not overwhelm R&D with two new lead roles.
- By January posts expected to be filled.
- Ongoing work around recruitment for CRN. The targets for the year were the same as last year (which had been achieved) with a focus on commercial studies. The Chair noted a letter that had been received that congratulated the organisation in that area of work.

RB noted that at other committee meetings there had been discussions and challenges around the length of time that *Limited* Assurances would be tolerated.

6. External review into five maternal deaths: final report	**QS (08/19) 004**

PG noted that she had presented an element of the Report at the last committee meeting. She reiterated that it was a learning review and <u>not</u> a peer review. There were five maternal deaths between August 2017 and January 2019 and the review was intended to provide assurance that everything possible was done for the women, and if it wasn't – what would they do to take that forward. She stated that four of the deaths occurred whilst the women were pregnant or during childbirth, and the fifth death was one-month post-childbirth.

The Trust had set review terms of reference and engaged external reviewers comprising of; an obstetrician, an anaesthetist and a midwife. The Report presented to the Committee was in the following format:

- A summary report that focused on their position of notable practice, themes for future learning and documentation.
- The full review report; with an internal team workshop that went through each case and each terms of reference. The workshop was well received with a matrix of Q&As developed.

The issues were:

- The notable practices identified by the external reviewers:
  - Cardiology were present in two of the cases.

- Evidence of great support for the families at the time.
- Excellent follow up by community midwives.
- Good continuity of care in regard to obstetric input.
- Good use of interpreters.
- Senior support for staff was given.

PG advised that she had held a staff forum last week with two more to follow on the 3 and 6 September to ensure that staff had the opportunity to express their feelings and work a way forward. At the time of the fifth death, the Trust had engaged an external company to provide support and some staff had taken up the offer.

Improvements identified:

- Patients were expected to attend a number of appointments resulting in a high DNA rate. Investigating having a 'one stop shop' where the patient can see the obstetrician and midwife on the same date to alleviate the need for multiple appointments.
- There were diabetes, epilepsy and hypertension issues with a couple of the women. Would look at those algorithms of where they might have deviated from disease guidance, but could be justified.
- In two of the cases the Massive Obstetrics Haemorrhage Protocol was instigated. Treatment for an embolism had commenced when in fact it was an amniotic fluid embolism – which the treatment applied for the embolism had aggravated coagulopathy. PG noted that she was considering introducing a bell in the theatres. She noted that it was the anaesthetist's job to call a MOH.
- One of the patients had arrived from another organisation at 36+4 weeks, but refused treatment as she was vociferous about things done pertaining to her. The Trust would look into further support for patients that were non-compliant or had limited compliance.

Recommendations:

- Risk assessment.
- Early identification by measuring blood loss.
- Multidisciplinary team working (training – explicit instigation).
- Introduction of ROTEM.
- All maternity SI Reports from the last two years would be reviewed to understand the action outcomes and findings. Those findings relating to the whole team would be shared via QHID, Risk and Governance newsletter and MDT training.
- An algorithm for late bookers to identify the patient needs and to reiterate the importance of scans, procedures etc to their health and that of the baby.
- PG noted that the table at 5.9 sets out the Trust's challenges based on its professional opinion to those professional opinions of the Review Report.

PG noted that simulations were currently performed in the maternity ward. KT suggested that the Simulation Suite be used to conduct simulations – it was time away off site for staff and was officially logged.

KT noted that learning from serious incidences go into **we**learn and queried what controls were in place to ensure they were completed and not forgotten about. KD noted the process of flowing through the Groups for sign-off by DC followed by an audit process by the Governance Team.

KD questioned if all the cases had a SI investigation and were new recommendations/learnings picked up. PG confirmed that they had and that was the workshop element. By overlaying the learning review and SI investigations ensured that everything was picked up. The two reviews (SI and external) had different perspectives and identified different detail. There were good professional challenges to decisions and actions made during cases, and learning opportunities were identified.

The Chair noted the continuity of care and queried if that was with one individual. PG confirmed that it would be one individual that saw the patient for the whole journey – although it was difficult to see that through for the whole nine months, they would try. The 'one stop shop' would assist with that.

MP noted the use of hand held records and whether the Trust still used them and there was a discussion.

The next steps would be to commence the recommendations and to have any update of progress made in six months' time.

PG advised that the Trust had met the duty of candour with all families. The Trust had sent letters to the families to invite them to either:

i. Attend the Hospital and review the Report,
ii. be sent the Report, or
iii. not review the Report.

Action: PG to present an update on progress made with the recommendations arising from the Maternal Death External Review Report in February 2020.

7. Results acknowledgement: medicine/surgery delivery date	**QS (08/19) 005**

DC noted that it had been undertaken that all radiology reports up to 1 April 2019 would be either red flagged or acknowledged, and to also review 2018 to identify red flags that require further investigation.

A lot of work had been done by groups to work with clinicians to ensure they know what they are doing and how the system works.

Numbers as at 29 August 2019 indicate the following progress:

- Overall reduction of outstanding un-acknowledged red flag reports by 20%
- Medicine reduced outstanding log by 38%
- Surgery reduced by 23%
- PCCT reduced by 5%
- Women and Child Health remained stable.

Overall there was a slow but gradual turnaround of acknowledged reports. Routines were being established with some clinicians struggling (due mainly to system issues).

DC noted that they had always recognised that there were some areas that would be harder to achieve than others (inpatients and outpatient specialities).

RB noted optimisation performance indicators; results endorsements – all results to be endorsed within 4 weeks. DC advised that the pool system within the results endorsements process would make that achievable – everyone needed to be doing it and doing it regularly to ensure it did not form a backlog.

The Chair suggested that 3 months into Unity Go Live that they review their progress.

Action: Review progress made on results acknowledgement 3 months after the Unity Go Live date.

8. ED safety: planned clinical audits	**QS (08/19) 006**

RB noted that the Paper arose from discussions at the last committee meeting.

She noted that section 2.1 and 2.2 a, b, and c were in the previous document – everything below that had been viewed by teams:

- Sepsis within ED (not just neutropenic sepsis) and instigation of sepsis 6 within an hour.
- Compliance with Head injury protocol – quarterly audit.
- Compliance with metastatic spinal cord compression assessment.
- Identification and treatment of delirium.
- Use of pressure relieving mattresses and pressure ulcer prevention care.
- Pain assessment and appropriate prescription and timely administration of medication for

children.

She noted the weekly audit proposal and that Consistency of Care would continue. A weekly audit of patients who had to wait to be seen (by a senior clinician within 4 hours) would be developed. That work would be done in collaboration with the Governance Team to develop the scope. The Executive Quality Committee would have oversight of it.

KT noted that when people are in hospital for a certain period of time and they fall under two teams' care – that in fact no treatment occurs. She queried if there was a way to ensure that things don't get forgotten and patients are left without any care. PG noted that there was a process to escalate patients up the chain if treatment advice was required – seek the advice of leaders. The Chair questioned how that was audited. PG advised that ultimately it was the reduction in 21-day length of stay.

9. Integrated Quality and Performance Report: July	**QS (08/19) 007**

DB noted that the paper differed slightly from the one that would be presented to the Trust Board as it written at the time of PMC and amendments were made to the paper. He provided the following update:

- *The July performance exceptions and the risk to August access targets.*
  - Expected to deliver and therefore mitigated to that extent.
  - Diagnostic DM01 would fail in August, but would recover in September.
  - Cancer 62-day standard would fail in July, August was tracking and they expected to deliver the standard. The 2-week target would be achieved despite increase in demand.
- *Acknowledge the route to outstanding recovery trajectories.*

  Another four boxed off with three outstanding:
  - Bed moves
  - Non-plan exemption rates
  - FFT response target.
- *Acknowledge the removal of the falls indicator from persistent reds now that we have the evidence that the Trust is performing well and that MRSA screening rates is now a persistent red.*

MATTERS FOR INFORMATION/NOTING

10. Matters to raise to the Trust Board	**Verbal**

It was agreed that KD would present an update to the Trust Board as the Chair would be an apology.

11. Meeting effectiveness	**Verbal**

Not discussed.

12. Any other business	**Verbal**

No other business to note.

13. Details of Next Meeting

The next meeting will take place on Friday, 27 September 2019 from 11:00 to 12:30 in Room 13, Education Centre, Sandwell General Hospital.

Signed ……..
Print ……..
Date ……..