

QUALITY AND SAFETY COMMITTEE - MINUTES

Venue: Room 13, Education Centre,
Sandwell General Hospital

Date: 25th October 2019, 11:00-12:30

Members:

Mr R Samuda (RS) Chairman
 Ms M Perry (MP) Non-Executive Director
 Ms R Barlow (RB) Chief Operating Officer
 Ms K Dhami (KD) Director of Governance
 Mrs P Gardner (PG) Chief Nurse
 Dr D Carruthers (DC) Medical Director

In Attendance:

Mr D Baker (DB) Director of Partnerships & Innovation
 Toby Lewis (TL) Chief Executive (*arrived at 11:40am*)

Support:

Ms R Stone (RS) Executive Assistant

Apologies:

Mr H Kang (HK) Non-Executive Director, Chair
 Prof K Thomas (KT) Non-Executive Director
 Dr Parmjit Marok (PM) GP, West Birmingham Medical Centre

Minutes	Reference
1. Introductions	Verbal
<p>The Committee members introduced themselves for the purpose of the meeting recording. The Chair noted that Mr Toby Lewis would join the Committee for agenda item 8.</p>	
1.1 Apologies for absence	Verbal
<p>Apologies were received from Mr H Kang, Prof K Thomas and Dr P Marok.</p>	
2. Minutes from the meeting held on 30th August 2019	QS (10/19) 001
<p>The minutes of the meeting held on 30 August 2019 were reviewed and the following amendments were noted:</p> <ul style="list-style-type: none"> • Page 3 – amend <i>QCQ</i> to <i>CQC</i>. <p>The minutes were accepted as an accurate record of discussions.</p>	
3. Matters and actions arising from previous meetings	QS (10/19) 002
<p>It was noted that most matters in the action log were included in the meeting agenda. Updates were provided on the following actions:</p> <ul style="list-style-type: none"> • <i>QS (08/19) item 3.1 - Discuss the upcoming amendments to the DNACPR form with Dr Marok.</i> PG noted that Diana Webb was working with the CCG and primary care to ensure they were all using the same forms going forward. Dr Marok had reported via email that the form was new to primary care; however, Diana Webb was working to get all parties on the same page. 	

- *QS (08/19) item 4 - Consider mapping the issues identified in the patient story to the Quality Plan and a gap analysis.*

PG advised that a gap analysis on patient stories against the Quality Plan would be prepared for presentation at the next meeting.

3.1 Feedback from the Executive Quality Committee and RMC

Verbal

KD provided an update on discussions from the Executive Quality Committee and RMC:

- Firmed up the batch of red-risks (10) – some would be escalated via CLE to the Board.
- Health and Safety now attend RMC to provide updates:
 - Reviewed a trend of needle stick injury. A lot of information had been disseminated but was not penetrating – a QHID shared learning topic would be organised.
- Safety Alert (anti barricade devices) – requirement to complete an assessment of all rooms in the ability to break down the door if someone had barricaded themselves in the room. The Safety Alert was signed off but not all rooms assessed; therefore, the Groups had decided to go back and assess every room to enable sign off.
- IT Risks – not where they needed to be and to be reviewed at the DMPA Committee.
- Duty of candour was a concern due to poor performance across the Trust. When patients come to harm, three things should be done; apologise, document it in writing, conduct an investigation. Was not document to confirm that this was happening consistently (except for the investigation). The backlog needed to be cleared as a priority.
- The Care of the Dying Audit – room for improvement. In cases where the End of Care Team were involved, patients were dying the way they wanted; in cases where the Team was not involved, patients did not die the way they wanted. Tammy Davies had presented an action plan to the Committee which would be monitored in 3 months' time.

4. Patient story for the November Public Trust Board

Verbal

PG advised that a female patient would present her story at the public Trust Board and highlighted the key points of her story:

- Systemic Lupus and Sjögren's (autoimmune disease)
- Had a vascular necrosis due to the steroid use to treat the autoimmune disease in her hip and ended up having a hip replacement in Lyndon 3
- Positive patient story of the pathway through the system
- Patient was due an MRI which took a while to organise causing delay
- Patient discharge experience; had the operation on a Tuesday and could have had a post-operative x-ray completed with discharge on the Wednesday or Thursday – was discharged on the Friday

DISCUSSION ITEMS

5. Strategic Board Assurance Framework: controls check

QS (10/19) 003

KD noted that subsequent to the last meeting, the confirm and challenge sessions had been held and the outputs of that session were detailed in the paper. They had agreed that to achieve a level of confidence, the score would need to be *Adequate* – some risks had achieved this with others moving to *Adequate*.

SBAF Ref 2

RB provided an update:

- Bed modelling had been deferred to November due to the P&I Team prioritising reporting post Unity. The delay hadn't impacted Sandwell Council.
- Better Care Fund proposals and decisions around extending the care home projects:
 - The results from the project were looking really good.
 - The Better Care Fund had committed to half the money and the Trust the other half.
 - The A&E Delivery Board to make a decision.
 - There were funds to cover the project and the workforce was readied.
 - Thought to reduce 147 admissions over the next six months.
 - GPs were engaged.
- The West Birmingham story was different and required further consideration. The limited score was due to the lack of engagement from West Birmingham Council. Mel Roberts and Tammy Davies had met with the Council during the week to discuss implementation of the 48-hour follow up on discharged patients, either for the Council or via the Council.

SBAF Ref 4

DC provided an update:

- Investigated the definition of vulnerable services and reviewed the differences between venerable services within the Black Country and that of the Trust.

SBAF Ref 5

KD provided an update:

- There had been some movement.
- Launched the 2019 QI poster content with the awards ceremony taking place on 5 December 2019. There was a steady stream of posters received with good-quality entries.
- The Clinical Audit programme was underway and would go to the Audit and Risk Management Committee and the Trust Board.
- Launch the Learning from Excellence model – staff to call out excellence amongst peers for recognition across the Trust.
- There were lots of activities at their early stages – not enough to progress to an *Adequate* score.

SBAF Ref 14

DC provided an update:

- 75% to 80% of all deaths reviewed.
- Medical examiner officer appointed had pulled out of the offer.

SBAF Ref 1

DC provided an update:

- New Head of Research and Development was due to commence in mid-January. The Directorate Manager was providing coverage of the role in the interim. The Director of Research

and Development was off long-term sick.

- Challenges in progression due to leadership position challenges.

KD advised that the assurance levels would remain as they were and hoped for movement and decision at the next meeting.

The Chair queried if the Committee would address any of the Unity data risks. RB noted that there were some emerging data concerns, which was expected at five weeks in to Unity. There were concerns that two of those risks may have patient implications. The Chair requested a watch and brief on that data.

Action: RB to conduct a watch and brief process for any Unity data risks.

6. Quality Plan: action plans

QS (010/19) 004

DC noted that the Paper was an update on the current position with the Plan (QP 2 to 10, as QP 1 focused on mortality). Seven of the nine plans had been returned – there was further work to be done with the two cancer plans. There was a meeting arranged to discuss the national cancer screening. There would be a GP component to that and it was suggested to appoint a GP to the Cancer Board. DC noted that he would work with the plan authors to determine the gaps in regard to support and timelines needed to accomplish the Plans.

MP noted that there appeared to be a big gap in the tracking towards the target to end of life care. DC noted that the broad service was driven through the Community Palliative Care team. PG noted that sometimes situations happen quickly that tools from the Community Palliative Care Team are passed to the Acute Team in order to deal with the situation. The Chair noted that there was a business case approximately 12 months ago for a palliative care person to contribute to palliative care and into frailty. DC noted that there would be staffing and resource issue arising from it and it was a hard to recruit area.

DB noted that ICP had dying in place of choice as a local priority. In the work that had been done, the system (Sandwell and West Birmingham) identified six overall priorities of focus, four in Sandwell and two in West Birmingham – with the common theme of dying in place of choice.

7. Respiratory reconfiguration quality indicators

QS (10/19) 005

RB advised that the paper arose as a result of a Board discussion around the respiratory reconfiguration proposal. The initial draft KPIs were focused on the City part of the proposal. There was need to consider both the patient pathway to City respiratory services and the residual service for patients at Sandwell, and what that would look like. Both site's activities had be reviewed in regard to:

- Length of stay and well-defined pathways.
- Patient experience
- Staff engagement scores in terms of a checklist of impact of reconfiguration.

DC queried if consideration had been given to the inclusion of indicators and tracking around training and support for staff, reviewing feedback from trainees as part of their national and local services around respiratory.

TL arrived at 11:40am.

TL stated that NIV Service was discussed in the Critical Care Board who had agreed that the pathway was that no one should stay longer than 12-hours at the base hospital. He noted that one of the risks was the possible outcome that the relocation of Respiratory Medicine to City makes no difference to

Acute Medicine. KPIs around that scenario would need consideration.

DC queried if there was a way to assess a negative effect on the Sandwell site. TL suggested to determine a baseline to pre-transfer.

It was noted that urgent GP referrals would be sent to the single point of access. TL noted that the GP and patient experience could be improved by referrals bypassing emergency and going directly to the Respiratory Hub.

Action: To consider KPIs around the scenario of the relocation of Respiratory Medicine moving to City having no impact/difference to Acute Medicine.

Action: To determine a baseline to pre-transfer of Respiratory Medicine by the compilation of 2-3 weeks' data prior to the move.

8. Frailty and hospital required deterioration

Presentation

TL noted the presentation was a piece of work that would be delivered as a paper to the November Trust Board. He delivered the presentation to the Committee with the following key points:

- People were getting older and therefore hospitals were being overwhelmed. In essence that was not the whole explanation of the situation:
 - Emergency admissions were rising in all age groups.
 - The ageing population were not ageing well.
 - Ambulatory care sensitive conditions (UTIs etc) in older people were driving admission growth and avoidable admissions.
 - For consideration:
 - Of all the patients admitted, what was the number in their cohorts and what were the alternative pathways?
 - What was the diagnostic abilities of the community (in the care home and A&E) to reach that conclusion?
 - Diagnosis that can be reached and prevent admission, but not reached inside of 4-hours.
 - Whether there was a need for a better option for diagnosis over 6-10 hours, but not on acute A&E and not with proposition that they are in a bed.
- Greatest area of non-elective admission growth were people that stayed less than one day in a bed – why were they admitted and was there an alternative? There was a distinct day and night difference in the decisions made.
- For most of the last seven years, there had not been big rises in NEL admission, only in the last 12-18 months. The Trust would need to respond to that.
- Desire to get to the position where frailty is considered a long-term condition rather than a series of injuries or diseases that happen to older people. A condition which can be supported and mitigated rather than treat. Unclear if the Trust currently had services to address that.
- The NHS focus work on admission prevention, not the prevention of disruption and disjointedness after admission – there was a way to measure Hospital Acquired Functional Decline (HAFD). He noted a video from Dr Ian Sturgess which could be circulated.
- Desire to make HAFD a common acronym around the Trust.
- He noted that they would do two things:
 - As part of the respiratory move, they would follow that on with the development of a

Frailty Service at Sandwell Hospital.

- Try and find a way to track HAFD, set some considerations on how to link that with the length of stay reduction projects and then link that to the Midland Met therapeutic model.

TL noted that he would arrange the video from Dr Ian Sturgess and the presentation for delivery to the Board. The 'system' had decided this area was important and it was also important to implement a programme. It was around the implementation of the programme that they need to consider the desired programme outcomes. Action was needed now before the move into Midland Met.

The Committee discussed the following points made:

- Suggested to incorporate in the data the settlement action on a patient and carers views (how do they baseline themselves and their expectations).
- Patient education around whether they need to be in hospital.

9. Safety Plan: Unity Reports (October 2019)

QS (10/19) 006

PG advised that the paper was a short report on the difficulties in regard to the safety plan data. There were some data anomalies that would be worked through for interpretation with Dave Baker, Matthew Maguire and Martin Chadderton on 4 November. In handover of shifts, the system identifies what tasks were outstanding in priority order. Accurate output reports were required to determine if tasks were being done as they should.

The following points were noted:

- Unity provided doctors with an array of information available at their convenience.
- Accuracy in entering the data at the beginning was vital – common practice to remove problematic data instead of treating the root cause of it. Dave Baker agreed.

PG noted that more iteration was required to get the data where they need it to be, for example, not all patients would need the same treatments and how to identify that (add a N/A value).

10. GP practice readiness for CQC Inspection

QS (10/19) 007

KD advised that the Paper was for noting. The Trust had three GP practices which had been inspected by the CQC and rated as *Good*. Due to the change in provider, the practices would be inspected again within the next six months.

11. Integrated Quality and Performance Report

QS (10/19) 008

DB noted that some information in the paper had been updated subsequent to its submission to the Committee:

- Some of the metrics were not reported – less of those now.
- TIAs – investigating why the table was not being populated
- Maternal death – the second bullet should not say that the serious incident was a medication issue. More investigation needed before further reporting
- Worth noting the success in the Q2 cancer target

- 16 x MSAs (not 7) all authorised in month
- RTT had achieved at 90.01% and VTE had been successful achieving 96.6
- Bed moves noted the pre-Unity and post-Unity situation to work through the workflow issues
- Persistent reds – noted the low number of patients admitted to stroke ward within 4-hours
- Good news that Neck of Femur had achieved for two consecutive months
- For the first time, long term sickness was below target
- In the table; RTT functions were still at four (cardiology, gastro, oral and ophthalmology), 52-week waits reported - none (either incomplete or completed pathways)
- Emergency Care unplanned re-attendance rate, paper due to OMC to determine a trajectory
- MRSA screening, now had a trajectory and a plan – first target due in November
- Friends and family now had a trajectory and a plan

The Stroke Ward admissions were questioned. DB advised he had no further detail. PG noted that RB would be able to provide further detail at the Trust Board meeting.

IQPR simplification was discussed and DB noted that TL would work with him on that. The Committee offered their support too.

12. SWB/CQC engagement update

Verbal

KD advised that the CQC and Trust were now better engaged and our local Inspectors would attend on 22 November and spend time with services, staff, and the Board. Timeline of activity:

- 22 November, Children and Young People and Woman and Child Health Management Board.
- December, observe the Trust Board meeting and the poster contest awards ceremony
- January, risk management and ED process.

13. Results endorsement update

Verbal

DC reported that since Unity's implementation, the number of reports requiring endorsement were:

- 15,456 blood tests (70% endorsed),
- 9554 radiology reports (57% endorsed).

He noted that the result was an improvement and there was now visibility of staff that were endorsing and those that were not. Staff were in the routine of the process with some high-volume environments experiencing some challenges in maintaining routine. There was improved data available and some process issues in the data which were being reviewed.

14. Control of infection inspection update

Verbal

PG advised that the NHSI had conducted a site visit based on the Trust's CQC results for infection control and cleanliness. PG noted that she had selected four areas for inspection; Lyndon 3, Lyndon 4, Critical Care and D11 at City. The NHSI had selected control wards; Newton 4 and D27.

The four areas were cited as great for cleanliness and infection control – a couple of issues with mattresses (in the midst of mitigation). ED at Sandwell were spot-on, City not as good. The control areas were not great – were not clean, no hand sanitisers at the end of bed, physio room had dirty

equipment (no cleaning schedule). D27 was ok – work station trolleys were getting dusty.
Overall, the NHSI were pleased and would return in February for a follow-up check.

MATTERS FOR INFORMATION/NOTING

15. Matters to raise to the Trust Board

Verbal

The following matters to be raised to the Trust Board:

- Frailty
- Inspection report

16. Meeting effectiveness

Verbal

Not discussed.

17. Any other business

Verbal

Emergency Department update

TL provided the Committee with an update on the ED:

- On the 24 October, the NHS Midlands was taken through a set of patient pathways for ED and discharge. They considered the views of staff, practices and external recommendations and put some support and focus around how they may implement that with focus around how to get to diagnostic decisions within 32-hours.
- Ben Owens had 5-8 things which he wanted the Trust to do (the Trust had done some), divided into two categories; things that the Trust had done but not consistently, and things the Trust had not done. There was a big emphasis on how A&E works better with the Malling service and the Acute Medical Service.
- In regard to discharge, the data would be presented to the Trust Board. Pre-Unity it tended to be above 40 medical discharges approximately 4-5 days out of 7. Post-Unity was at 3-4 days. It was fundamentally a discharge volume per day and per hour.
- The A&E narrative to enable to reach 4-hour compliance, was to deal with the 4-5-hour breach patients and minor’s patients. In the last three weeks there were more than 150 a day waiting more than 4 hours – a new category of problem. The Trust need to get in the space of A&E and harm.
- The Trust volunteered to be a trial site for the interplay in harm between the different sections of a hospital system. Apparently, there were tools and data available that could help them.
- Had also committed to the National Director to be back above 80% in December.

18. Details of Next Meeting

The next meeting would be held on Friday, 29 November 2019 from 11:00 to 12:30 in Room 13, Education Centre, Sandwell General Hospital.

Signed
Print
Date