Paper ref:	TB (03/20) 008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: Room 13, Education Centre, Sandwell General Hospital

Date: 24th January 2020, 15:00-16:30

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

Minutes	**Reference**
1. Introductions for the purpose of the audio recorder	**Verbal**
Committee Members provided an introduction for the purpose of the recording.	
1.1 Apologies for absence	**Verbal**
Apologies were received from Paula Gardner and Dr Parmjit Marok.	
2. Minutes from the meeting held on 29th November, 2019	**QS (01/20) 001**
The minutes of the meeting held on 29th November 2019 were reviewed and the following amendments were noted: • Page 3, Item 4, SBAF Ref 14, point 2 – Beginning of sentence to be amended to: *'Had appointed a Medical Examiner Officer…'* • Page 6, Item 9 – Further clarity to be added to the sentence clause *'… which was due to a blip that was under control.'* The minutes were **ACCEPTED** subject to amendments.	
3. Matters and actions arising from previous meetings	**QS (01/20) 002**
• *QS (11/19) Item 3.1 - Provide an update to the Committee on the status of current 'live' CAS alerts.*	

- To be discussed later in the agenda.

- *QS (11/19) 005 - Present a Safety Plan report*
  - To be discussed at the next Q&S Committee meeting.
- *QS (11/19) 005 - Risk-assess the unavailability of Unity reports.*
  - RB reported there was now a dashboard that had been data assured for the Safety Plan and it was anticipated this would be used from 1st February 2020. In the meantime, manual checks were being made on the wards.
  - RB further commented that improvement team resource would be used to roll out the system to achieve timely progress.
- *QS (08/19) 004- Review progress made on results acknowledgement 3 months after the Unity Go Live date.*
  - DC reported work was ongoing in two areas:
    - Radiology reports requested pre-Unity and therefore in the old system, were being examined to ensure that red flag and non-red flag results were being properly acknowledged.
    - An email containing a short video had been sent out to explain the current process for results acknowledgement within Unity.
  - DC commented that the reports gave a good indicator of areas where process needed to be fine-tuned. These would be targeted with a short, educational video and tips.
  - DC expressed the view that the system should be reviewed around 6 months from Unity going live. Committee Members agreed.

- *QS (08/19) 004 - Present an update on progress made with the recommendations arising from the Maternal Death External Review Report in February 2020.*
  - To be discussed later in the agenda.

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

KD reported that staff were reporting incidents generally well, but RMC had agreed to look at a backlog of 'saved for later' incidents which had not been investigated. KD further reported that hard and fast rules would be introduced to tackle this issue in a timely manner because saved incidents were currently clogging the system. KD informed the Committee that each of the Groups would produce a report identifying their numbers of 'saved for later' incidents to ensure these were addressed.

KD further reported that RMC had examined the list of red risks that had been downgraded to amber to check there was evidence to support the change. These risks were found to have been correctly categorised because there had been appropriate action taken to mitigate the risk.

RB reported that there were a number of clinical areas interested in piloting body cameras on security guards. These were Maternity, community wards, Gastro, Toxicology and A&E. Work had started with an

engagement discussion about the issue with clinicians. A Birmingham wide workshop attended by different providers, mental health acute care and community representation had been attended by Trust security.

RB further stated that a meeting would take place with a provider shortly. She commented that the body cameras worn by security guards would be too bulky for clinicians, but a product would be investigated for trial. RB reported there was evidence that it helped with de-escalation with staff training, therefore it was important for it to be seen as part of a package.

RB expressed the view that the pilot was an opportunity to include a research element, which would be a strong USP and therefore, the Trust was looking to form a strategic partnership with a provider company. Conversations were being held with the police liaison team and mental health areas who had experience in this area. DC agreed that it would be important to embed R&D into the project.

RB confirmed there would be SOPs in place to guide use, protect patient privacy and regulate the storage of information.

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

In PG's absence, KD reported that the patient story would be a Sickle Cell patient who had a poor experience in A&E. The issues identified would be around communication and staff attitude. A video would be played.

KD reported that further details would be circulated in advance of the Board meeting in the usual way.

DISCUSSION ITEMS

5. GIRFT Reviews: Ophthalmology and O&G	**QS (01/20) 003**

DC introduced the GIRFT reports and reminded the Board that the aim was to speed up the process whereby five top actions to focus on had been identified by Groups and specialties. Action plans would be put in place in conjunction with the GIRFT team with clarification by DC.

Progress would be reported at 6 monthly time points to CLE. This would ensure motivation to deliver improvements.

DC reported that ENT and Orthopaedics had been presented to CLE in January with learnings shared from the process.

DC commented that regional benchmarking of Trust activity was interesting and useful, for example, the costs of litigation had been separated out in each specialty to give an overview of performance.

DC reported that the GIRFT discussions at CLE had been well received. DC and KD confirmed that information would be cascaded through various channels throughout the Trust to spread information and key learnings. Short videos would be instrumental in this education.

RS expressed the view that the focus on the top 5 actions was an effective process.

DC reported that there were around 15 further GIRFT reports to catch up with over the next 3 to 6-month

period.

RS raised the issue of where GP services fitted in with the programme. DC suggested he give this issue further reflection.

Committee members agreed that it was valuable for the QS Committee to continue to receive reports from the GIRFT process for discussion.

Action: DC to consider where GP services might fit into the GIRFT report/review process and introduce a cover sheet to information discussed at QS meetings, setting out CLE reflections on the GIRFT reports.

6. Maternal Deaths Learning Enquiry: Action Plan Update	**QS (01/20) 004**

KD referred Committee members to the report in PG's absence.

- MP raised the issue of an apparent delay of actions 2 (putting in place a 4-stage approach) and 3 (renewal of policy) in the report. She commented that it would be helpful to get clarity and follow up from an audit perspective.
- DC reported that the ROTEM system was in place for onsite testing for coagulopathy in pregnancy. The system was being installed and would be tested. On 14th February 2020 there would be a Safety Summit and Forum looking at the reasons for patient collapse in maternity.
- DC further reported he had asked the Forum to provide a list of the top reasons for collapse of maternity patients so that trainees could be educated on the escalation pathway during induction i.e. have a clear understanding of the instances where senior medical staff should be alerted.
- DC also commented that a piece of research work would be undertaken to better understand amniotic emboli and their occurrence and attempt to predict patients at risk.

Action: PG to provide clarity regarding the status of 2 and 3 in the maternal deaths action plan report.

7. 4 Hour ED Standard Delivery	**QS (01/20) 005**

RB reported the ED specialty team had been invited to present to the Board about the ED improvement plan, the workforce and CQC plans and staff engagement activity.

RB referred Committee members to the paper explaining some of the improvement activities, but commented that further opportunities to expand the proof of concept included:

- The SMART Clinical Care model and times extension
- Increase GP streaming

RB reported 4-hour performance in ED was now operating above 75% in the latest result, while bed occupancy was slightly down.

Extra cubicle space was expected from the Estates work.

The new paediatric unit would come into working in May.

Sustained performance improvements had led to the planned relocation of minors and GP facilities from

the front of Sandwell A&E to respiratory out-patients space which was a major incident expansion space. Relocation was expected to happen in the next two months. Cubicle spaces would need to be expanded.

RB reported medical expenditure had recently been an issue in A&E for a few months, however, the Trust was about to be fully recruited to Registrar posts which was very positive and would reduce agency costs and improve consistency of practice. RB noted that 4-hour delivery performance in comparison with other Trusts regionally was volatile – sometimes above and sometimes below the regional average.

RS commented there had been positive cultural feedback following the CQC review with regards to listening to how improvements could be made and speed of action. On discharge, constructive criticism had not been as forthcoming.

RS suggested that the team be asked for ideas when they presented to the Board.

RB reported that the specialty team that would present to the Board was keen to pitch ideas to improve the safety and dignity of patients who had to spend time in corridors through lack of treatment space.

RS asked about the relevance of the Babylon service being used at University Hospital Birmingham which was using algorithms to direct patients. HK commented that algorithms would be driven by data collection.

8. CQC Insight Report: Update on outlying data	**QS (01/20) 006**

KD referred Committee members to the paper and reported that the Executive Quality Committee (EQC) had agreed to request that Groups produce reports every month to detail the actions they were taking, for those indicators flagged as outliers.

RS raised the issue of reattendance within 7 days. KD reported there was currently a declining trend. RB commented that this metric was expected to be back in target within the month. She reported that the main problem was IT system related and post-Unity there had been some data process issues and technical changes had been put in place to address the problem. RB predicted there would be a marked change in February.

RB confirmed that, in relation to 4-hour ED delivery, the Trust occupied a median position nationally in relation to other Trusts for the latter part of December and into January.

9. Integrated Quality and Performance Report: Exceptions	**QS (01/20) 007**

DB introduced the IQPR Report, explaining the following key points:

- There had been continued success with the DMO1 target two months running.
- A&E performance had improved slightly and there was only one 12-hour trolley breach.
- Cancer achieved in November but there was some risk in December.
- RTT had not been signed off but it was sitting at 91.3%.
- There was an MRSA case.

DB updated on the IQPR and reported there would be a new IQPR format aligned with the CQC's 5

domains that would be ready by February, utilising existing indicators.

RB reported the 12-hour trolley breach had been investigated within two weeks. Contributing factors had been a breakdown in management escalation, the identification out of hours, to use available beds at another site was not actively pursued and the booking and responsiveness of transport. No harm was caused to the patient.

HK raised the issue of sickness absence (short-term) by ward. RB expressed the view that it appeared to affect the same ward – the Day Unit – and offered to investigate the numbers.

Action: RB to investigate the reasons of high rates of sickness absence affecting some wards and report back to Committee members.

10. Complaints, PALS & Purple Point Q3 Report 2019-2020	**QS (01/20) 008**

KD reported on the Q3 complaints report which included PALS and Purple Point.

KD reported that 98.9% of complaints had been responded to within 30 working days which amounted to 99.1% in the year to date. This result had exceeded the team target of 97%. There had been around 7 breaches overall and this was positive.

9 complaints in the quarter had bounced back (reopened due to a level of dissatisfaction), which was a reduction in numbers. KD expressed the view that handling of complaints was getting better.

KD commented that getting feedback about the process from complainants had been a struggle. Questionnaires had been tried and a texting pilot was ongoing. A follow up phone call had now been added to the process.

HK observed the numbers of complaints had fallen. KD commented that the reasons for this were uncertain. Some quality outreach work had been undertaken to engage with diverse community groups to ensure they knew how to complain.

KD reported that the complaint response was being reviewed to ensure changes were happening as a result of complaints.

KD reported that Purple Point would be celebrating its 2-year anniversary in February and this milestone would be promoted to staff.

MATTERS FOR INFORMATION/NOTING	
11. Central Alerting System (CAS) Status update on 'live' alerts	**QS (01/20) 009**

KD reported that there had been many safety alerts which were now up to date. The anti-barricade alert was now in date.

12. Assurance on cannulas at discharge	**Verbal**

KD reported that there had been a case of a patient that had been discharged with a cannula still in place.

KD reported that PG had stated there was already a discharge checklist on Unity which advised that patients needed to be checked with frisking. DC asked if there was an automatic system on Unity which recorded insertion and removal. KD reported that PG was checking the recording system.	
13. Matters to raise to the Trust Board	**Verbal**
It was agreed that 4-hour ED Standard Delivery, Complaints and Maternal Deaths should be reported to the Board.	
14. Meeting effectiveness	**Verbal**
Not discussed.	
15. Any other business	**Verbal**
RS raised the issue of stroke rehabilitation pilot sites which had been reported through NHS internal communications but expressed the view that the process surrounding this topic was unclear.	
16. Details of next meeting	
The next meeting will be held on Friday 28th February 2020, from 11:00 to 12:30, Room 13, the Education Centre, Sandwell General Hospital.	

Signed …….

Print …….

Date ……