Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: WebEx **Date:** 27th March 2020, 11:00-12:30

Members:

Mr H Kang	(HK)	Non-Executive Director, (Chair until 12:12pm)
Mr R Samuda	(RS)	Non-Executive Director (Chairman & Meeting Chair (12:12pm – 12:41pm)
Ms M Perry	(MP)	Non-Executive Director
Mr L Kennedy	(LK)	Chief Operating Officer
Mt T Lewis	(TL)	Chief Executive (Until 12:09pm)
Mr D Carruthers	(DC)	Medical Director
Prof K Thomas	(KT)	Non-Executive Director
Ms P Gardner	(PG)	Chief Nurse

In Attendance

Mr D Baker	(DB)	Director of Partnerships & Innovation
Ms R Biran	(RBi)	Assoc. Director of Corporate Governance
Ms P Marok	(PM)	GP West B'ham Med Centre
Ms Claire Hubbard	(CH)	Deputy Director of Governance

Apologies:

Kam Dhami	(KD)	Director of Governance

Minutes	Reference
1. Introductions for the purpose of the audio recorder	**Verbal**
Committee Members provided an introduction for the purpose of the recording. The meeting was conducted via WebEx to comply with COVID-19 lockdown restrictions.	
2. Apologies for absence	**Verbal**
An apology was received from Kam Dhami.	
3. Minutes from the meeting held on 28th February, 2020	**QS (03/20) 001**
The minutes of the meeting held on 28th February 2020 were reviewed. The minutes were **ACCEPTED** as a true and accurate record of the meeting.	
4. Matters and actions arising from previous meetings	**QS (03/20) 002**
RBi reviewed the action log and observed that most actions were not yet due or on the agenda. The following was updated: • *QS (02/20) Item 6 – Organise an audit of Sickle Cell patients and define and describe the treatment pathway for patients for presentation to the Board.* PG reported that the City Emergency Department (ED) and SCAT team had been due to meet but this had been postponed due to COVID-19 -19 demands.	

PG further reported that the ED's policy contained referral pathways and pain management and the experience in ED for patients with Sickle Cell disease would be audited, particularly around pain assessment, management and the administration of analgesia.
TL commented that it would be important for the Committee to cover non- COVID-19 issues generally, where patients were at risk of getting a poor service.

5. Patient story for the March Public Health Board	**Verbal**

PG reported that the patient story had been captured on video and centred on an autistic woman who had brought her similarly autistic son into Sandwell General Hospital's ED.

PG reported her experience had been unpleasant because the pair had been left waiting in a very noisy and bright department, which had a detrimental effect on the child, to the extent that he was distressed and non-compliant by the time he was examined by a doctor.

PG reported that the woman had told of a previous experience as a patient, where lights on a hospital ward and loud, incessant noises from equipment had been distressing. PG reported that creating a calmer area within the ED was being explored, taking into account décor, colour choices and sensory awareness considerations. PG also reported that the Paediatric team were currently investigating the provision of a sensory room for the paediatric wards to help autistic children relax.

TL commented that it was soon to be National Autism Week and therefore, the story was timely.

KT commented that the Autism West Midlands organisation had guidance materials for healthcare providers which might be helpful.

MATTERS FOR APPROVAL OR DISCUSSION

6. COVID–19: Reporting	**QS (03/20) 003**

TL noted that PG had been leading the initial phase of the Trust's response to COVID-19, LK would be taking over the tactical leadership of the clinical support and TL would be briefing the Board as the strategic/gold command on this issue. He suggested he would provide an overview to accompany the circulated paper, which included two annexes detailing the Trust's specific response to NHSE guidance.

He explained that General Practices were largely continuing and there were only a small number of surgeries out of action however, staffing absence might alter this position. In support of that there were 2 COVID-19 pods in Sandwell and West Birmingham. Most community-based services had been focused on triage work and had only been seeing selected clients. Some additional services to care homes had also been stood up. TL reported that the Trust had been organising its own meetings with local GPs to ensure a 'joined up' system response within Sandwell and West Birmingham.

TL also reported that most outpatients and discretionary diagnostic practice had been taken down and transferred at scale (where possible) to telephone based services. Staff had been moved to provide inpatient services. TL commented that the Board would have to pay attention in Q1 to waiting times and

the scale of numbers of patients who were waiting as a result of these measures. TL stated that the national narrative was that none of the 'standing back' of services should affect cancer care. However, TL reported that when ITU became non-functioning for other services, the Trust would not be able to operate some cancer pathways unless the team succeeding in moving them off site. He also noted some apparent interruption to MDTs and local radiotherapy appointments.

TL explained that extra wards had been stood up in inpatients and wards had been divided and labelled as Red 'hot' (probably COVID-19) and Blue 'cold' (probably not COVID-19). TL reported that 'Red' bed patients fell into 3 categories:

- Patients who had returned a positive COVID-19 test
- Patients awaiting the results of a COVID-19 test
- Patients who had returned a negative COVID-19 test but had been judged as highly likely to have the virus by clinicians and were being retained, with the appropriate barrier nursing arrangements in place.

TL reported that the volume of admissions with other conditions was beginning to fall and the volume of attendance at A&E with other symptoms was also falling, which was commensurate with the national picture. He explained that Intensive Treatment Unit (ITU) activity had been contained in the appropriate departments, however, an imminent expansion into D16 at City was expected. Theatre capacity would be opened up, for expansion for ITU and OPAU at Sandwell, at a point to be determined by events. The OPAU department had been identified for possible use for non- COVID-19 critical care.

TL reported that Leasowes had been stood up as a wholly end-of-life facility, with incumbent patients moved to Rowley. TL stated this had given the Trust some civilised, palliative, end-of-life capacity which could put SWB in a better position than other Trusts in the Midlands.

TL reported that correct arrangements had been put in place for discharge with COVID-19 and wards in Sheldon and non- COVID-19 at Rowley Regis. Discharge volumes of COVID-19 and non- COVID-19 had fallen. National guidance on discharges had been followed.

HK thanked TL for his overview and invited questions from Committee members.

RS queried the discharge approach. TL reported that it was perfectly possible for a COVID-19 positive patient to be discharged. DC commented that how long people remained positive and infectious was uncertain. DC reported that the Trust was working with community services to ensure appropriate transfer out of the hospital however, this was a complex judgement. TL commented that whilst a large amount of data had been fed to the Centre, very little had been returned and therefore, it was difficult for the Trust to compare its performance with others, on this matter and others and that he was aware that the Chair had raised this with NHS Midlands.

In response to a query from RS, TL reported that online consultation had not been taking place in the Trust's Primary Care provision, however, he was aware that many GPs were carrying out consultations this way. PM reported that GPs had found the video consulting system to be excellent and commented that it required no more sophisticated technology than a smartphone. PM further reported that the system protected personal numbers and video quality had been very good. LK reported that a different but similar

platform had been piloted in the Trust, with a view to early introduction.

LK reported that COVID-19 patients were being discharged as per any other patient, i.e. when they were asymptomatic and fit to be discharged. Services across the hospital were being split into COVID-19 and non- COVID-19 to assist patient flow.

In response to a query from HK, TL reported that staff had been given briefings about the disease, but it was felt that nuances about COVID-19 transmission were required to be communicated directly. TL commented that staff were frightened, and that support would be required to prevent this sense of strain being passed onto patients. TL commented that site lockdowns had been implemented, in part to give staff physical space outside of clinical areas.

In response to a further query from HK, TL expressed the view that cancellations and changes to services as a result of COVID-19 demands were being tolerated in the context of a reasonable period of national lockdown. TL reported that he had personal concerns regarding diagnostics, and this would be constantly reviewed and a possible transfer to non- COVID-19 sites considered.

HK queried the Trust's position regarding Personal Protection Equipment (PPE) in relation to the national picture. TL reported that the situation had improved in recent weeks and was now satisfactory. TL reported that PG was addressing supply issues affecting the provision of scrubs (not PPE, but related). TL reported that internal supply of PPE throughout the hospitals was the current focus. DM would take a leadership role across both procurement and distribution. He noted the Trust was providing PPE to Care Homes, and had highlighted this to regional bodies as our "use" was perceived to be higher. HK reported that it was his understanding that significant imports of PPE supplies would soon be arriving in the country from overseas.

In response to a question on ventilator capacity from HK, LK reported that the Trust had submitted a national return that had assumed a significant expansion of ITU beyond our steady-state. The Trust had capacity to expand to between 400-500% of the current ITU capacity and this model included the extra medical and nursing staff required. Additional ventilators had been applied for from the Pandemic Stockpile and feedback was awaited.

LK reported that the Trust had enough liquid oxygen combined with flow rates to cover the expansion plan (up to 10% of leniency). RS queried the oxygen flow required and the issue of freezing pipes causing equipment malfunction (as seen in Italy). LK confirmed this issue had been investigated. LK reported that some strength testing would be carried out but there was confidence the Trust could use up to 5000 litres per minute of oxygen supply without it being an issue.

TL summarised the status of supply as follows:

- Ventilators – good supply
- PPE – satisfactory supply
- Staff sickness – poor, but similar to other Trusts nationally.

In response to a query from MP about staff sickness rates, TL reported that the Trust was planning on a

total absence level of 30% and targeting a level of 20%. Absence included annual leave, general illness and self-isolation. TL reported that many people were expected to return from isolation but many of these worked in corporate services which would not improve clinical numbers on their return to work. TL suggested that absence levels be separated into patient facing and non-patient facing.

TL reported that more than 120 members of staff had been swabbed for COVID-19 with a relatively high positive rate. Those who had been tested but PHL had declined to process the test had received a letter of apology from TL and the NHS which had been received positively. TL commented that some further staff swabbing would soon be in operation with the possibility of antibody testing. TL reported that staff were being encouraged to isolate themselves from family in hotel accommodation provided.

In response to a query from RS, TL reported that a mortuary plan was in place and the Trust was relatively well provisioned. Outflow (funeral provision) however, was still uncertain. TL reported that it was reasonably foreseeable that mortuary provision was likely to be sequestered for the benefit of the wider system. LK stated that mortuary provision had recently been expanded. In response to a query from KT, DC reported that the process from ward to mortuary was no different for a COVID-19 patient.

HK raised the issue of the West Midlands being a COVID-19 hotspot. TL commented that the region was an industrial heritage with a higher rate of underlying respiratory disease in the population, but it was difficult to demonstrate scientifically the cause and effect. DC commented that a project was due to commence looking at all the Trust's COVID-19 positive patients and those who had died of the virus, with the aim of identifying common factors and susceptible profiles using clinical data. This would include gender, age, ethnicity, and other key data that is reported locally and nationally.

TL invited the Committee to note the governance of COVID-19 as set out in the paper and the considerations for the Board. TL reported that an updated report on COVID-19 would be prepared for the Board papers and asked for Committee members to forward feedback via email ahead of the Board meeting.

TL reported that there had been 17 externally reported COVID-19 -related deaths at SWB to date and 1 recent unreported death. TL reported that one of the issues concerned deaths which subsequently tested positive. Test delays had been reducing.

LK confirmed there were 16 patients on ventilators in ITU. There were currently 22 [ITU] beds at City and 22 at Sandwell. Expansion plan (Stage 1) would provide 16 extra beds at City and around 14 more at Sandwell. TL reported that the Trust had been asked to co-ordinate ITU planning across the STP.

TL highlighted that the emotional burden of the pandemic continued to be extremely challenging for staff. HK suggested that an overview of what was happening 'on the ground' with respect to the COVID-19 response would be a helpful presentation for the Board. TL strongly expressed the view that discussion of the welearn Programme and its progress was timely because innovation and transformation was continuing apace in response to the COVID-19 effort.

HK thanked the executive for their candour in presenting the position and noted that this would be the focus of the Board's meeting.

TL left the meeting at 12:09pm. HK left the meeting at 12:12pm, handing over control of the Chair to RS.

Action: Committee members to forward feedback about the COVID-19 governance and considerations for the Board (listed in the paper) to TL.

7. welearn: Programme Update	**QS (03/20) 004**

CH presented a paper on the welearn Programme. In introduction, CH supported TL's view that the timing of the welearn Programme was apposite and stated that learning and rapid change had been implemented in a short space of time in response to the Coronavirus outbreak.

CH reported that the Trust had implemented many of the welearn Programme aims but capacity and visibility could still be improved.

One of the key areas recently launched was the Welearn 'GEMS' and CH reported that staff feedback had been that the project was a welcome distraction from the COVID-19 crisis and would be a positive opportunity to reflect the good work being done in many areas.

CH also reported that work had also been carried out in partnership with universities and private industry, focusing on the utilisation of learning environments. CH reported that a suitable learning space had already been identified, away from clinical areas.

The Welearn from excellence project was still due to be launched on 20th April (circumstances allowing). CH expressed the view that the current health crisis would be a critical time for staff to demonstrate what they were doing well and express appreciation and recognition for others.

CH reported that assurance on sharing and the spread of education and learning would be presented to the Board.

Initial feedback on the programme had been positive and CH invited Committee members to offer further comments around a proposed scorecard idea, which would help evidence progress.

In response to a query from RS, CH reported that the timing of the learning space's development would likely be impacted by the COVID-19 crisis, but it was likely that some progress could be made virtually. CH reported that the GEMS store had been officially opened and staff now had access to submit learning for certification.

CH confirmed there were already some willing volunteers who were prepared to go early on the project.

In response to a query from KT, CH explained the process behind the scorecard that would demonstrate the learning that had taken place, its sharing, resulting actions and positive change to outcomes. CH commented that the COVID-19 response had created exceptional learning circumstances and had already been a catalyst for an unprecedented pace of change.

MP expressed the view that the scorecard would probably be an evolving project. CH agreed and commented that it represented a cultural shift which over time, could reflect staff experiences/stories.

CH reported that the scorecard had taken the spread and relevancy of learning in different specialties into consideration.

RS commented that the scorecard appeared to be well supported and encompassed a comprehensive list

but expressed the view that it would need to be populated before a firm judgement could be formed.

8. Mortality Data Update	QS (03/20) 005

DC introduced the paper and pointed to the current inflation of mortality data.

DC reported that the latest Summary Hospital-level Mortality Indicator (SHMI) was 1.03, which represented a stable improvement. An improvement had also been seen in the depth of coding, but there had been no improvement in palliative care. There had been a recurrence of weekend/weekday difference which was being monitored closely. Quality Plan indices were also being monitored closely with early warning signs being identified and reviewed, with a focus on urinary tract infections, bronchitis and frailty-related issues.

DC reported that there were currently no major warnings issues to be aware of.

In response to a query from RS, DC reported that palliative care coding remained at around 21% and there were more patients – not included in this figure – who had been receiving palliative care (not specialist) and end of life care. Work had been carried out to identify these cases from the data available.

DC further commented that cases were being closely monitored in the COVID-19 environment.

- **LK, MP and PM left the meeting at 12:30pm. With few Committee members remaining, RS confirmed the meeting was inquorate at this point and unable to make decisions.**

9. The Safety Plan	QS (03/20) 006

PG reported that the Safety Plan target, of being 100% compliant on checks by the end of March would not be reached. The demands of the COVID-19 response were the reason behind the missed target in some areas.

PG further reported that Rowley's COVID-19 'cold' areas had been achieving between 75 and 80% compliance, but EDs were struggling as patients typically did not stay for 24 or 48 hours and therefore, reporting needed to be reconsidered in this area. PG reported that this would be a topic for discussion between Tl and Nick Sherwood.

PG reported that monitoring of checks was ongoing and there had been regular communication of mis-checks to staff who were continuing to be supported in their improvement efforts. PG commented that COVID-19 was presenting particular challenges; however, the current compliance rate had improved slightly to around 52-55%.

KT expressed the view that it was important to maintain emphasis on the issue, despite the crisis.

10. Integrated Quality and Performance Report: Exceptions	QS (03/20) 007

DB reported that the cancer [62-day delivery] target would likely be missed in Q4, with a figure of around

82% predicted.

DB further reported that the long-term sickness rate fell to 114 [against the target of 140], with the Women and Children's Group recording below 4% for the first time.

11. Referral patterns: Services for marketing	**QS (03/20) 008**
DB commented that work would continue on the progress report. A broader scope had been decided.	
12. SBAF: Update on limited assurance risks	**Verbal**
CH updated Committee members on 3 risks which had been identified at the February meeting. CH reported that the third risk related to local care homes and the matter would be deferred to nest time. CH reported that the second risk related to service delivery. DB reported that there was no update on this issue in the current circumstances. RS expressed the view that the first risk, relating to welearn's potential impact, had been covered earlier in the agenda.	
MATTERS FOR INFORMATION/NOTING	
13. Matters to raise to the Trust Board	**Verbal**
RS suggested that he would consider this and issue given time.	
14. Meeting effectiveness	**Verbal**
No issues noted.	
15. Any other business	**Verbal**
None raised.	
16. Details of next meeting	
The next meeting will be held on Friday **24th April 2020**, from 11:00 to 12:30, via WebEx	

Signed ………………………………………………………………………………

Print ………………………………………………………………………………

Date ………………………………………………………………………………