Paper ref:	PB (07/20) 006

Sandwell and West Birmingham Hospitals NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: Meeting via Webex **Date:** 29th May, 2020, 11:00-12:30

Members			**In Attendance**		
Mr H Kang	Non-Executive Director, (Chair)	(HK)	Mr D Baker	Director of Partnerships & Innovation)	(DB
Mr R Samuda	Trust Chairman)	(RS)	Ms R Biran	Assoc. Director of Corporate Governance	(RBi)
Ms M Perry	Non-Executive Director	(MP)	Ms Parmjit Marok	GP Rotton Park Medical Centre	(PM)
Mr L Kennedy	Chief Operating Officer	(LK)	Ms Chizo Agwu	Deputy Medical Director	(CA)
Mr T Lewis	Chief Executive	(TL)			
Mr D Carruthers	Medical Director	(DC)			
Prof K Thomas	Non-Executive Director	(KT)			
Ms P Gardner	Chief Nurse	(PG)			
Mrs L Writtle	Assoc. Non-Executive Director	(LW)			
Ms K Dhami	Director of Governance	(KD)			

Minutes	**Reference**
1. Introductions for the purpose of the audio recorder	**Verbal**
Committee Members provided an introduction for the purpose of the recording.	
2. Apologies for absence	**Verbal**
There were no apologies.	
3. Minutes from the meeting held on 24th April, 2020	**QS (05/20) 001**
The minutes of the meeting held on 24th April 2020 were reviewed. The minutes of the meeting held on 24 April 2020 were **ACCEPTED** as a true and accurate record of the meeting.	
4. Matters and actions arising from previous meetings	**QS (05/20) 002**
KD reviewed the action log which was updated as follows: • *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.* KD reported this would be presented to the July Trust Board.	

- *QS (02/20) 004 - Identify a list of the top 3-5 areas for services marketing and report back to the March Q&S Committee.*
  KD reported that a paper would be presented to the July QS Committee. Additions to the paper were invited. KD confirmed there would be Primary Care input into the paper.

5. Patient story for the June Public Trust Board	**Verbal**

PG reported that the patient story would be about supporting good deaths in an integrated organisation. The paper was ready for the Trust Board discussion and would cover:

- What a good death looked like, addressing the uniqueness to every individual which could only be achieved through communication with patients and carers to ascertain their wishes.
- The Trust's vision.
- Audit of the National Audit of Care at the end of life.
- Barriers to achieving a good death – communication and DNACPR
- Lessons learned from COVID-19.
- Recommendations from future practice and the utilisation of treatment escalation plans

RS queried the use of technology in Critical Care/COVID-19 treatment. PG reported that in Critical Care video phones were used and one relative was permitted to attend the patient, especially if a patient was being withdrawn from intubation. Next of kin were offered the choice to watch the video as reassurance this was a peaceful death.

PG reported that this approach had worked well in Critical Care and had received positive feedback.

PG reported that next of kin were permitted access onto wards for 15 minutes (wearing full PPE if it were a 'red' COVID-19 area) to enable them to be with a dying patient. The 15 minutes timing was open to interpretation should it be required.

DISCUSSION ITEMS

6. Gold update on COVID-19 position to 20-5-20	**QS (05/20) 003**

TL referred Committee members to the paper and commented that it recognised that COVID-19 would be around for some time. He cautioned against the risk of management complacency and/or losing sight of the knock-on effects of the pandemic.

TL commented that the Trust needed to establish the metrics to govern the quality of care the Trust was able to offer COVID-19 and non-COVID-19 patients.

TL advised that a session had been run, with BAME (Black and Minority Ethnic) staff, regarding specific risk assessments which would soon go live. This would involve individual assessments being carried out against a much broader spectrum of risk factors than existed currently. Antibody testing would also be launched on Monday 1st June 2020, however, TL commented that the limitations and/or benefits of the tests were

not entirely understood. TL stated that these would not be used (unless indicated by science) to drive staffing allocations.

TL commented that the BAME meeting has revealed that a lot of the residual anxiety was found in non-COVID-19 'blue' areas. TL commented that research that had appeared in the Health Service Journal had shown that care workers who had died of COVID-19 infection had often not worked in the most high-risk or highly clinical areas.

In response to a query from HK about the use of risk assessments in staff allocations, TL commented that the topic would need to be dealt with sensitively to avoid the risk of stigma.

RS raised the issue of the care home position. TL commented that low occupancy rates were currently the biggest challenge in the care home sector and financial support from Council would be finite. TL expressed confidence that the Trust was not seeing more admissions or readmissions from care homes compared to the same time in 2019 and the length of stay had been going reasonably well. PPE was continuing to be provided. TL further commented that the move to 'Test, Trace and Isolate' had the potential to have a big impact on care homes.

In response to a query from RS, about the numbers of home deaths, DC commented that he would shortly take part in a call with Medical Directors to discuss this topic and the Trust had been working closely with Primary Care in reviewing deaths through the Learning from Deaths agenda. (DC commented this had not been mentioned in the paper).

TL reminded Committee members that the Trust had been instructed to include people whose clinical record indicated some suspicion of COVID-19 in the COVID-19 death statistics. DC reported these deaths had been included from 1st May 2020.

KD reported that Sandra Kennelly, who had organised the Freedom to Speak Up Guardians, had given feedback that the Trust's support for local care homes and their staff had been viewed very positively by the sector regionally.

KT queried whether any metrics would need to be shelved. TL reported that there were some things that were not currently monitored but suggested that tracing against pre-COVID-19 metrics would be more valuable. TL reported that the topic of how to present quality and safety metrics in a more integrated manner was already being considered. It was likely that more diagnoses of COVID-19 would be made in a Primary Care rather than a hospital setting in the future.

PM queried how the case finder (for at risk patients) and partnership with Primary Care would work. TL stated that discussions would take place later in June. He commented that the latest national guidance in relation to shielded individuals was expected in June and would be helpful.

7. COVID-19: Mortality – March and April review	**QS (05/20) 004**

DC reported that the paper reflected the reviews of mortality from COVID-19 in March and April 2020. DC clarified that the figures represented patients who had died after testing positive for the virus.

DC stated that it included how care pathways had compared to best practice and how outcomes had

compared with neighbouring Trusts and their different populations. Information had been taken from reviews undertaken through the Medical Examiner's Office. Included were patients who had died of non-COVID-19 related illness, patients who had been managed in ITU, in the respiratory hub, ward-based mortality and hospital acquired COVID-19 infections and mortality.

A review had also been done of the approach taken to ensure the Trust was compliant with best guidance through the treatment pathways by specialities and in response to information from NHSE and NICE.

DC highlighted the following key mortality data:

- The majority of 293 COVID-19 (swabbed positive) deaths in March and April had been given a first-tier mortality review.
- 32 cases were escalated to structured judgement review and a further 10 were scrutinised by the Palliative Care team.
- The number of elective and non-elective inpatient spells was less compared to usual levels. In relation to the non-COVID-19 deaths, DC reminded Committee members that there were probably non-COVID-19 patients, who had COVID related illness but had been swabbed negative. Non-COVID-19 deaths in March and April totalled 138, and 107 respectively and 64% had been reviewed by medical Examiners.
- Around 33% of all March deaths and 67.7% in April were due to COVID-19 illness.
- DC reported that crude mortality across the region was similar to some of the other neighbouring Trusts.
- Mortality risks factors included ethnicity, hypertension and diabetes and the median age of those who died was 80 years. Many of the deaths had complex medical histories as would be expected in patients of this age.
- Trust data was compared with ICU and NIV (non-invasive ventilation) figures which showed an overall SWBH ICU survival rate of 46.6% which was better than national data. There had been no published data for NIV unit outcomes. Mortality was high but there was no comparative data because it had been the first time that units had been used in this way.
- Medical Examiners obtained feedback from 96 next of kin.
- In relation to nosocomial (hospital acquired) COVID-19 infection, the definition of definite transmission was no clinical suspicion of COVID-19 infection on admission to hospital, but the patient had tested positive 14 days later. The probable transmission definition was testing positive 7-14 days following admission. DC reported that within this group there were 97 patients who had tested positive. The mortality rate of patients within the group was 27%.

DC thanked Dr Chizo Agwu for her hard work in the analysis of the data which had already proved beneficial to treatment learnings and improvements.

KT queried how the lessons learned were being communicated to relevant individuals throughout the organisation. DC commented that there was an established process through the Learning from Deaths

Committee to ensure discussion took place and was calibrated down through the specialties. Learning bulletins were issued from the Learning from Deaths Committee and from within the specialist groups. DC reported that **we**learn and Webex were being used to collate and further discuss information in a multi-faceted approach. DC reported that nosocomial infections were front of mind through the tactical meetings to direct patient flow and avoid infection. The groups also disseminated information through their group teams.

In response to a query from PG, DC commented that treatment escalation decision making had been better. PG commented that the pandemic had made a positive impact in this area.

TL commented that 70% of people who had died had been placed on a supported care pathway and suggested they be reviewed to establish how many of these patients could have been put on the pathway before they arrived at the hospital. TL suggested that this exercise might identify missed opportunities.

DC reported that one of the issues was that patients who had been either admitted through Primary Care with a treatment escalation plan or who had decisions made for them in hospital – their historical records had not easily been found through Unity because they had not been pulled through. Staff had needed to look and identify. TL commented that the Executive team should work on a way to make the information available as a priority.

RS queried the location of patients who had contracted COVID-19 within the hospital. DC commented that infection control within the environment including the PPE component would be the key focus. RS also raised the issue of the impact of Winter flu. PG advised that this topic and had been discussed and expressed the view there would be a strongly targeted vaccination campaign in 2020.

TL raised the issue of the cross-infection rate being similar in 'Blue' and 'Red' wards and queried whether this inferred that cross infection had been caused by staff. DC acknowledged this was a possible inference, however, the problem was multi-faceted and could include patients who had been admitted to 'Blue' wards who subsequently turned out to have COVID-19.

Action: DC to arrange a meeting with the team to find a solution to the lack of visibility of patient historic records through Unity. A report to be brought back to the July Q&S Committee.

8. COVID-19: Clinical care risks and mitigation	**QS (05/20) 005**

KD reminded the Committee of the surge plan risks which would be mitigated to a likelihood level of 'rare' or 'unlikely' by the end of June. Work had been ongoing.

KD reported that Recovery and Restoration risks were currently being worked on, covering workforce, equipping, assets and clinical care risks. Nine clinical care risks would be presented in a paper to the Board:

1. New patients
2. Patients with chronic disease
3. Impact of investigations changes
4. Changes in pathways and process

5. Acute admissions
6. Medical staff being engaged with the approach to consultations
7. Acute services
8. Impact of the change in services and how it might change the approach to clinical assessment
9. Prolonged waiting times

DC reported that clinical risks had been considered by specialty and whilst many of the risks were similar, they had differing risk ratings depending on the underlying specialties. The risks were reviewed in relation to inpatients, outpatients and follow-up patients and a generic risk would be considered for each risk identified.

Within each risk would be Trust based risks in relation to the environment, processes, use of technology, communication etc.

LW queried what the integrated approach might mean for Community and Primary Care. DC acknowledged that these would need to be considered and would likely affect the risk.

HK queried whether the delay in endoscopy had been covered in the risks. DC reported that risks 1, 2 and 9 would be relevant.

TL commented that the Trust needed to be very clear about what the consequences and harm of the risks were likely to be.

9. Safety Plan Update	**QS (05/20) 006**

PG reported that Trust performance had been improving slowly, with compliance at 66.7% from 64.71% the previous week. Paediatric checks had been built and reports were now available. Learning materials including videos and action plans had been arranged for paediatric staff.

PG reported that there were still issues with the handling of home medications. It was expected that the reconciliation of medications was correctly documented through Unity by medical staff. PG reported that numbers were too low despite interventions.

PG also reported issues and anomalies with the falls' assessments and the Mental Capacity Act assessments not pulling through from Unity as required. PG expressed the view that compliance would be better if these problems could be addressed.

Medicine and Emergency Care had now introduced a Link Matron to support the wards that were getting more missed checks than desired. PG reported that the department was showing commitment to improvements and ensuring the checks were not being missed in 48 hours. A meeting had also taken place in Maternity to confirm safety priorities.

PG assured the Committee that there had been no let up on pressure to progress the Safety Plan but acknowledged there had been a slow trajectory of improvement.

HK queried whether staff were running both manual and Unity checks in parallel. PG reported that manual

checks had ceased in favour of using Unity. PG commented that Unity presented a much more accurate picture.

PG commented that the Trust should perhaps analyse whether missed 48-hour checks had caused any harm. This might create another way of motivating staff to ensure the checks were not missed.

DC reported that new Foundation doctors would soon be starting with the Trust and expressed the view that knowledge of the safety plan and its interactivity would be helpful. PG suggested asking Debbie Talbot (Assoc. Chief Nurse) to arrange an educational Webex meeting on this topic for the doctors.

10. Integrated Quality and Performance Report: Exceptions	**QS (05/20) 007**

DB highlighted the cancer performance success in Q4 and updated the Committee on understanding the route to recovery on the following issues:

- Administration errors – DB reported that LK had been working on the issue.
- Stroke, Cardiology – Case volumes were currently low. DB reported that as numbers went up, performance percentages would improve.
- Sepsis – Treatment of Sepsis within 60 minutes was being investigated by DC.
- Closure plans for open referrals – This would be reviewed by OMC in June.
- Friends and Family – PG and DB would do some work in relation to outpatients.

DB drew the Committee's attention to seven, 52-week breaches which had happened in April. They had all been caused by the cancellation of non-elective operations due to COVID-19.

RS queried the 9.7% rate on readmissions. DB reported that it had spiked because patients were being discharged rather than transferred to the Trust's other hospitals, therefore this led to patients re-entering hospital being recorded as readmissions. LK confirmed that it was a data quality issue and commented that the percentage should be lower.

11. Learning from complaints: 19/20 Annual Report	**QS (05/20) 008**

KD referred Committee members to the 2019/20 Annual Complaints report which covered formal complaints registered by patients or relatives, local resolution (issues that could be turned around quickly) and Purple Point (issues raised by inpatients which could be immediately resolved).

KD reported that the Trust wanted to lead the process by triaging complaints as they were received, so that those issues which could be resolved quickly did not go to the 30 working days set target. Another focus was on improving the quality and timeliness of the responses – a target of 97% of complaints being responded to within the agreed time had been set. The Trust also wanted to raise the profile of the complaints process to reach a greater range of people.

KD reported that there had been some good progress in triaging and resolving complaints. Quality improvements had been judged by the level of complaints 'bounce back' i.e. people who were not happy with the response. Last year, the number had been 102 and this year 66 people came back to the Trust out

of around 1,000 complainants. KD reported that often the reason was disputed information or further complaints. KD reported that complainants also had the right to go to the Ombudsman and this was routinely checked. Timeliness of response had been 77% last year, 99% just before the pandemic (February) before slipping back to 98% at the end of the current financial year.

In terms of raising the profile, KD reported that some excellent community outreach work had been undertaken. Complaints had increased which was a positive because it demonstrated the success of the outreach work. However, this work had been suspended because of lockdown restrictions.

KD commented that it had been a positive year overall.

HK raised the possibility of delayed treatment complaints increasing because of the impact of COVID-19 and KD agreed, reporting that she had requested all COVID-19 related complaints to be tagged. KD stated that the situation would be monitored and would show up in the quarterly reports reviewed by the Committee.

MP raised the inclusion of road traffic accident calls in the paper. KD explained that Purple Point received a number of calls enquiring about people who might have been admitted to hospital following a road traffic accident. These had been included for completeness.

RS congratulated the outreach work and queried the CQC view of complaints. KD reported that the CQC would be aware of patient complaints that had been referred directly to the Ombudsman without exhausting other local channels. The CQC also received direct complaints to them and others which were then referred back to the Trust for further investigation.

KD reported that the CQC had been very positive to the Trust's approach to handling complaints.

LW commented that the Trust should be encouraging a greater number of complaints and compliments and suggested that the report more clearly indicate what the Trust was doing in response to issues raised by complaints.

FOR INFORMATION/NOTING

12. COVID-19 special QIHD: 13th May feedback	**QS (05/20) 009**

KD referred the Committee to the paper for information. The number of attendees had risen to 734 which was positive. There had been a total of 47 QIHD teams.

KD reported that feedback had revealed an appreciation of discussion time and a similar exercise would take place in June.

13. Paroseals: Evaluation	**QS (05/20) 010**

PG referred Committee members to the paper and reported that the Paroseals were currently out of action because they posed an infection risk. Unity would be considered to provide a reliable recording method. They were expected to be back in operation when the environment was safer.

14. Matters to raise to the Trust Board	**Verbal**
HK suggested the following matters be raised to the Trust Board: o Mortality o Gold update o Complaints	
15. Meeting effectiveness	**Verbal**
• Not discussed.	
16. Any other business	**Verbal**
Advanced care planning: PM reported that, in relation to advanced care planning (discussed earlier), Primary Care was appointing GP clinical leads for care homes as part of work with the CCG. These would be a useful link in improving advanced care planning.	
16. Details of next meeting	
The next meeting will be held on Friday **26th June 2020**, from 11:00 to 12:30, Room 13, the Education Centre, Sandwell General Hospital.	

Signed ……

Print ……

Date ……