Paper ref: TB (06/20) 007

Sandwell and West Birmingham Hospitals NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: WebEx Meetings **Date:** 24th April 2020, 11:00-12:30

Members:			**In Attendance:**		
Mr H Kang	(HK)	Chair, Non-Executive Director	Mr T Lewis	(TL)	Chief Executive *(for item 6)*
Mr R Samuda	(RS)	Non-Executive Director/ Chairman	Mr D Baker	(DB)	Director of Partnerships & Innovation
Ms M Perry	(MP)	Non-Executive Director	Ms P Marok	(PM)	GP West B'ham Med Centre
Prof K Thomas	(KT)	Non-Executive Director			
Ms L Writtle	(LW)	Non-Executive Director			
Mr D Carruthers	(DC)	Medical Director			
Ms P Gardner	(PG)	Chief Nurse	**Apologies:**		
Mr L Kennedy	(LK)	Chief Operating Officer	R. Biran	(RBi)	Assoc. Director of Corporate Governance
Ms K Dhami	(KD)	Director of Governance			

Minutes	**Reference**
1. Introductions [for the purpose of the audio recording]	**Verbal**
Committee members provided an introduction for the purpose of the recording. The meeting was conducted via WebEx Meetings to comply with COVID-19 lockdown restrictions.	
2. Apologies for absence	**Verbal**
R Biran	
3. Minutes from the meeting held on 27th March 2020	**QS (04/20) 001**
The minutes of the meeting held on 27th March 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 (04/20) 002**
KD provided an update on the action log: • *QS (08/19) 004 – Review progress made on results acknowledgement 3 months after the Unity Go Live date.* Completed and removed from the action log. • *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.* To be presented at the July Board. • *QS (02/20) 003 – The Safety Plan to be put on the March Q&S Committee agenda for discussion and assurance.*	

For discussion at agenda item 8.

- *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.*
  To be discussed at the July Q&S Committee meeting – work ongoing in the meantime.
- *QS (03/20) 003 – Forward feedback about the COVID-19 governance and considerations for the Board (listed in the paper) to TL.*
  Completed and removed from the action log.

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

PG advised that the patient story was in regard to a gentleman who had sadly passed away in their care. She noted that there were many lessons learnt and it was pertinent to bring the story to the May Board as Dying Matters [Awareness Week] would commence on 11 May. The death was not COVID-19 related. The main negative issues were communication, lack of information, and contradictory information provided to relatives. There were some positives around the health care assistants and the palliative care team.

DISCUSSION ITEMS

6. Gold update on COVID–19 position to 20-04-20	**QS (04/20) 003**

TL tabled the Paper and provided a summary of the included annexes:

- Annex A – The COVID-19 Tactical Command Response – progress update on the deployment of the Plan.
- Annex B – Mortality Report on COVID-19 positive patients who had passed away in March 2020.
- Annex C – Secondary care preparedness – for the Committee's reference.

TL noted that the emphasis for leaders had been on the quantity of the supply, the emphasis was now moving towards quality of care. He tabled a paper which had been presented to the Birmingham Health and Wellbeing Board which identified that:

- Hypertension was the most associated comorbidity for patients that had passed away.
- The over 85-year-old age group was an extremely high-risk category.
- Whilst ethnic origin was material to their data disproportionately in March, it appeared that the number of deaths of Black British and Black African patients in March at City Hospital, was not maintained in April. The precise geographical information was not known – residential addresses were known leading to the primary hypothesis (supported by anecdotal evidence) that there was inadequate social distancing in particular areas of their community in March.
- The CMO had rightly called for focus on all cause of mortality across the period of the Pandemic as outside of hospitals, the labelling of COVID-19 was poor; therefore, it was more beneficial to look at the overall mortality position.

TL noted that the Trust was emphasising that it was open for business as there was an extremely troubling

under-presentation of patients. Regionally, it was suggested that up to a third of strokes and heart attack patients were not presenting at GPs – the Trust's data was worse. The ambulance service reported that it was apparent that patients were refusing to be conveyed after professional recommendation that they should be. To improve the under-presentation, the Trust had offered to provide a telephone follow up service – which would 'go live' next week. Over the next month, the Trust would need to take a view across their COVID-19 mortality and a broader view across all cause of mortality to investigate the under-presenting patients and the accumulated backlog/waiting list of patients.

The organisation's emphasis was now what could be done in the next four weeks to save lives – to look at assessments, triage, oxygen prescription, NIV and so forth to give patients an improved survival outcome. He noted the following three exam questions for consideration:

1. How are our care pathways compared to best practice?
2. How are our communications compared to neighbours?
3. How well a population served by the Trust be treated?

It was anticipated to use Unity to confirm the consistency of clinical practice – need confidence that 7-days a week across both acute sites, that patients were getting best practice in a timely way. The absolute emphasis for the leadership team would be on the quality of care, without neglecting the patient experience.

TL reported that the following activities had been implemented:

- Up-scaled the critical care units to surge level.
- The Trust had been sent a series of national stockpile of ventilators, in which were tested and the Trust adamantly declined their use even though there was extreme pressure to use the ventilators. The basis of the working model should be that it cannot be assumed that anything sent from national bodies had been in any way quality assessed. He noted the working example of that was the issues experienced with some of the NIV machines – a case for a future inquiry.
- Staff wellbeing – he noted that papers presented to the Board in regard to psychological wellbeing and sickness management. There was a sense that they were doing better; however, it needed consistent focus and management, otherwise it would escalate. Evidence from other organisations indicated that the point where a staff member passes away, was when the organisation experiences a psychological decline. It was a challenging situation; however, TL thought that the Trust had the impact of harm boxed-off and had the ability to manage it well.

MP joined the meeting.

The Chair noted that the mortality data from City and Sandwell were polar opposites month-by-month and questioned the rationale. DC advised that as the outbreak spread from western Birmingham to the northwest to encompass Sandwell, resulting in increased cases at Sandwell. He provided a breakdown, by ethnicity, of deaths at Sandwell and City in March and April:

- Sandwell – In March and April, there was no difference to the relative proportion of Black (approx.

12%), Asian (approx. 12%) or White (75%).

- City – reflecting the relevant percentage of population in West Birmingham that passed away at City:
    - Black 39% March, 19% April
    - White 20% March, 33% April
    - Asian 24% March, 31% April.

He noted that the above data suggested to him that in March, the initial part of the outbreak, people were being slowly infected that were in a specific group of the community. However, in April when the population was behaving the same, that had changed that data. They need to look at not only the percentage of deaths in different groups of people, but also those who are tested and return a positive test.

TL noted that there was a risk that the Chair's question of if the level of deaths at City or Sandwell was in any way red flagged against their anticipated levels, could not yet be answered. There was no frame of reference for actual versus expected. Quantitively, they didn't have the data, but instinctively there was a feeling that if a patient was of Black descent, elderly and had a comorbidity of hypertension – that the risk of death was higher.

It was questioned whether anything different was being done with those patients that ticked those boxes when presenting at the Trust. DC advised that those patients were not being managed any differently, they were getting the interventional treatment as appropriate to the escalation plan. TL noted that it was unknown where there was an association with a comorbidity, which of those patients had relatively unmanaged conditions and those that had managed conditions. He suggested that it would be worth collecting that data and investigating further to assist the community with a forward plan.

The Chair left the meeting and RS took the role of Chair.

KT suggested investigating deprivation and poverty geographically after the situation calms. TL advised that that data was being collected for future analysis and was also being collected at a national level, in which Birmingham was emerging in the data.

KT stated that she was proud to be associated with an organisation that refused to use defective equipment.

LW noted that she was pleased to hear about support to staff. She queried the support provided to bereaved relatives that were prohibited from being present at the bedside. TL stated that that was an area with room for improvement across the Trust, not only in regard to COVID-19. PG noted that there were exceptions to visiting (one of which was end of life), and there were platforms throughout the wards (phones, apps) that allowed visual contact with relatives outside of the hospital.

TL noted that:

- There were areas of the Trust where it was working well and those areas should be used as role models to inspire the rest of the organisation.

- There were challenges with working with large families at the end of life – more people increase the chance of communication being misconstrued. The Trust had moved from a one-relative model to a two-relative model – not prepared to go any further.
- Some staff were communicating the new reality thoughtfully and unstressed, whilst others were not as sensitive as they need to be – more work was required.
- The staff's perception of *what it means to be on a red-ward* – the differences in a direct experience versus an indirect experience where a red-ward is perceived as a death sentence. There was a need to develop material for circulation to staff and be referenced for reinforcement purposes.

RS queried the problems with the NIV machines. TL advised that most of the issues had been resolved and that there were no patients on any problematic machines. However, if further growth occurs, they would need to re-address the matter. The more pertinent concern was how many other Trusts had the same problem. In regard to the oxygen position, the identification of a data set was required to convince themselves that they were currently doing best practice and for the Committee to use as a monthly review/comparison process.

DC advised that the following had been implemented over the last few weeks in regard to oxygen therapy:

- Proning – target amendments in the national guidance on oxygen limits.
- Internal Trust documents approved in regard to weaning and reducing oxygen therapy.
- The evolving issue around NIV and the different types of NIV.
- Documents and policies had been collated for reference and identification of the right thresholds to move from one form to another. Unity would be used to monitor oxygen and to provide an opportunity to reflect on oxygen and timings to investigate if:
    - The proning technique made a difference to the patient outcome.
    - The use of NIV was reducing mortality.

RS asked to what extent the Trust needed to be doing pre-work ahead of any central demobilising of COVID-19 dedicated spaces in consideration to the people who were not presenting. TL advised that there was a national and regional system approach, which included establishing clinically lead committees. The Trust was monitoring the approach; however, they had their own place-led approach and in service of that, had commenced internal meetings and building plans. In the second week of May, two integrated place meetings (one for Sandwell and one for West Birmingham) would take place as it was feared that the national/regional processes would come slowly, on a sectoral basis (not an integrated basis) and a waiting list focus (not on people who have unmet need in the community). TL noted that if the Trust appears to have moved on, that would leave a scar in the organisation – there was a need to be very thoughtful with their restoration project and not move on from COVID-19 too quickly. LK noted that self-isolation was still in place; however, the lifting of that restriction would change things to an unknown impact in which the Trust needs to be mindful of.

PM noted that the data presented to the Health and Wellbeing Board did not include COPD as one of the

top underlying conditions. She reported that primary care had been sending shielding care letters to patients; however, there was no clear messaging in which patients to focus those letters too. She questioned whether the data had been shared with the Primary Care Network (PCN) to indicate a local focus. TL advised that the information had been shared with the PCN and that discussions were held regularly with all PCN leads; the next meeting was to be held on Monday.

DC noted that the had investigated the patients whom had tested positive and those that subsequently died, and their underlying conditions. The strongest associated conditions were hypertension and diabetes (which mirrored data from UHB and most national publications). In regard to shielding information, the concern was around the persistent use of steroids (which scored patients highly in the risk assessment). In their findings, there was not a high instance of patients with asthma or COPD who were admitted to hospital, tested positive for COVID-19 or dying to the degree found with hypertension.

7. COVID-19: Awake Prone Ventilation	**QS (04/20) 004**

PG advised that Awake Prone Ventilation had been implemented in Sandwell and West Birmingham. She provided a summary of the Paper.

The Trust would need to start making the decision whether patients require proning or NIV prior to intubation. Proning was a simple intervention and a better method for COVID-19 patients – improving perfusion in the lungs as it releases pressure off the heart. ITU was looking at using proning teams with the assistance of orthopaedic teams. Due to the use of pillows in the proning technique, an additional 2,000 pillows had been ordered to be distributed throughout the wards. She noted the Awake Prone Ventilation SOP and the diagram of the proning position for the Committee's information. From an outcome perspective, the process must be auditable; therefore, a power form chart was being implemented in Unity to collect data and to confirm if proning improved outcomes. LK advised that the proning power form was currently on the testing platform, once tested, it would be moved to the live platform.

The evidence of how proning improves outcomes and the implementation of innovation was questioned. PG advised that:

- Other organisations had implemented proning in ITUs, but not wards.
- The Trust's staffing of wave 1 and wave 2, were being recorded by sub-committees and the Board to be used in an innovative way for the future.

8. Safety Plan Update	**QS (04/20) 005**

PG advised that the Safety Plan would be presented to the Q&S Committee monthly. She reminded the Committee that it had been stated at the February Board that they would achieve 100% by the end of March. She advised that the 100% position had not be achieved; however, the outcome of 100% of safety checks in place was still needed. COVID-19 had hindered the Trust and had caused difficulties with the establishment of two teams.

PG noted the following:

- There was a slow improvement in the mis-checks of 48-hours which was being followed up to identify if there had been any material effect of that on other ward areas. The anomalies were throwing them out – the Emergency Department only have three measures which apply during the 1-hour period and they were trying to measure *all* of the safety measures. The Committee's approval was needed to just use the three measures to see what impact that would have on compliance. The shielding members were supporting the AMUs, particularly with man-marking those patients.
- Home meds were required to be recorded by the doctor and subsequently signed by the nurse in charge – there was a disconnect there, which was why the results were reduced. They were not getting the safety culture in place with an MDT; therefore, the shielding nurses were prompting medical staff that they record the home meds.
- The wards had commenced live reports/safety briefings at handover and huddles with the multi-disciplinary team.
- The Paediatric Safety Standards were being reviewed and it was anticipated to be available at the end of April.
- PG man-marks the Safety Plan each morning and visits all wards and departments where a reduction has occurred.

LK questioned to what extent PG thought that all wards and leadership teams felt ownership of the safety metrics and feel accountability to deliver against those. PG advised that some areas do it very well, for example:

- Newton 5 (94%); however, it was a non-bed unit and were able to do deliver in a timely manner.
- ICU D16 had improved to 92% and AMU 1 at City was 86% - a marked improvement in their AMUs.

She advised that any units above 85% were owning the Safety Plan. The shielding staff were assisting to ensure that all questions are answered – if the questions are not answered, it's not compliant.

LK questioned if assistance from administrative functions was required to assist in data input into Unity if the clinical staff can't do it. TL noted that the areas that were performing well with compliance, consistently performed well even through COVID-19, suggesting that COVID-19 was not the variable, Unity was. A matter that needed to be addressed. PG noted that Unity was a good tool and its implementation highlights where compliance was weak.

9. Integrated Quality and Performance Report: Exceptions	**QS (04/20) 006**

DB provided the following key points from his Paper:

- ED was picking up quite strongly and achieving over 90%.
- The backlog for RTT was growing.
- Cancer may be achieved for Q4. LK noted that the cancer position was tricky for Q4 due to the carry forward of HDU cancellations from the winter pressures and the BTC matter. A few treatments had

been pulled forward at the end of the month and had provided alternative treatment to achieve greater numbers. At last look, the quarter performance was 84.9%, 85% was required to achieve.

- The volatility of deaths in the low-risk diagnoses groups related to coding in four areas, in which was being addressed.
- The Sepsis position, in particular around treatment within one-hour, was being addressed. KP noted that the numbers seemed to have dropped significantly. It was advised that there were small patient numbers and the data was therefore skewed. DC advised that another look at Sepsis was required as there was a risk of patients not presenting – need more data.
- Falls seemed to be in three ward hot spots – PG was investigating.
- Primary angioplasty signs had significant reductions:
    - 92% to 71% door to balloon in 90-mins,
    - 91% to 50% call to balloon in less than 150-mins.

  The accuracy of the data had been confirmed and the GM had been requested to explain the data in more detail. DC noted that angioplasty had had a change of presentation pattern. LK noted that the significant reduction in numbers may have skewed the data.

RS questioned the confidence in achieving cancer for Q4 – prospectively given that the cancer services had been reconfigured. LK noted that DC was working with the independent providers to set up pathways for all of their cancer services. All had alternative pathways and alternative places to carry on cancer works – there was always continuous cancer care for patients.

10. GIRFT Reviews: Imaging	**QS (04/20) 007**

DC tabled the Paper. He noted the outcomes of the GIRFT Imaging Review:

- With the outsourcing arrangements, the Trust's position in turnaround time to primary care and within the organisation had improved.
- There was more home reporting by radiologists, and waiting times reduced.
- The IT infrastructure was holding up well with the ability to separate scanners; those for COVID-19 and non-COVID-19 patients. There had been no equipment failures or breakdown.

MATTERS FOR INFORMATION/NOTING

11. COVID-19 special QIHD: 16th April - early feedback	**QS (04/20) 008**

KD noted that the decision had been made to proceed with the QIHD as it was an opportunity for staff to talk about their experiences and their perception of the Trust. That decision had been met with a lot of positivity. She advised that the final data was not yet available; however, the initial outcomes were:

- Over 30 clinical and multi-disciplinary teams and at least 422 staff completed the QIHD.

- First time since launching the QIHD in 2015, that the Trust had taken over the agenda for the teams to include a COVID-19 focus – which was welcomed. Local and regional data were supplied to give staff a position and to ask questions around that – consistent messaging.
- The agenda asked questions as to what issues kept staff awake at night – completing some work on risk mitigation to ensure they were not missing anything.
- No negative feedback was received on the availability of PPE.
- The emotional toll of COVID-19 with staff filling the roles of relatives for dying patients.
- Launched **we**learn from Excellence – was received well with a lot of stories submitted.

The support offer to staff was questioned. KD noted that there was a daily bulletin to inform staff of what support/services were available to them – the staff were engaging with that. The Trust would introduce Mental Health First Aiders – every area/department would have posters to inform of who the Mental Health First Aiders are. The Mental Health First Aiders were currently in training.

PG noted that staff were scared to work in other departments. Recently two surgical matrons had completed ITU training and had worked in ITU. The surgical matrons provided overwhelming positive feedback about how they could take that experience into the ward area and vice versa.

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

- COVID-19 special QIHD to be included in the CEO's Report
- Awake Prone Ventilation
- Safety Plan Update
- Integrated Quality and Performance Report: Exceptions

13. Meeting effectiveness	**Verbal**

Not discussed.

14. Any other business	**Verbal**

RS questioned if the Trust was to move to a situation where non-COVID-19 patients return and a backlog of non-presenters, would they test those patients for COVID-19 before operating on them. LK advised that in regard to cancer, they had different provisos for different providers; some asking for swabs three-hours prior, some were accepting that there was a clinical triage available. The national guidance directs that care homes and elective surgeries should be swabbing. However, if the patient is a-symptomatic, it was pointless to swab them.

RS noted the mention of care homes and called for any additional comments. It was advised that the Trust has two streams:

- Hot stream – positive swab, over 14-days or not over 14-days.

- Cold stream – had not been in contact with COVID-19 and not showing symptoms; therefore, deemed as non-COVID-19 and would attend the care home.

15. Details of next meeting

The next meeting will be held on Friday **29th May 2020**, from 11:00 to 12:30 via WebEx Meetings.

Signed …….

Print …….

Date …….