Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: Meeting held via WebEx **Date:** 25th September 2020, 11:00-12:30

Members:			**In Attendance:**		
Mr H Kang	(HK)	Non-Executive Director (Chair)	Ms S Rudd	(SR)	Associate Director of Corporate Governance
Mr R Samuda	(RS)	Non-Executive Director (Chairman)	Ms P Marok	(PM)	GP Rotton Park Medical Centre
Ms L Writtle	(LW)	Assoc. Non-Executive Director	Ms C Agwu	(CA)	Deputy Medical Director
Mr D Carruthers	(DC)	Medical Director	Ms V Kumar	(VK)	Specialist Registrar (Observing)
Ms K French	(KF)	Interim Chief Nurse			
Mr L Kennedy	(LK)	Chief Operating Officer	**Apologies:**		
Mr D Baker	(DB)	Director of Partnerships & Innovation	Prof K Thomas	(KT)	Non-Executive Director
			Ms K Dhami	(KD)	Director of Corporate Governance

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**
Apologies were received from Kate Thomas and Kam Dhami.	
3. Minutes from the meeting held on 28th August, 2020	**QS (09/20) 001**
The minutes of the meeting held on 28th August 2020 were reviewed and the following comments made: • QS (08/20) 004 (Item 7) – following a query by RS, LK clarified that 87% referred to the total waiting list for each of the specialities in terms stratification of the degree of risk to the patient. • QS (08/20) 005 (Item 8) – It was clarified that CA referred to Chizo Agwu. The minutes were **ACCEPTED** as a true and accurate record of the meeting, following the above clarifications.	
4. Matters and actions arising from previous meetings	**QS (09/20) 002**
The action log was reviewed. 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.* KF confirmed that the audit had been completed and that she would circulate any actions from the	

audit. HK queried whether it would need to be presented to the Trust Board. KF to clarify the action with respect with exactly how LK proposed it and update the Board. The decision can then be made whether it needs to go to the Trust Board.

- *QS (05/20) 004 - 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 QS Committee.*
  DC reported that he was still waiting for a reply from the Unity team. DC to chase for a response.

- *QS (07/20) 004 - Seek advice and input from LW on reviewing the content of the Safety Report.*
  LK reported that a meeting was to be set up to look at the safety report and it would take a few weeks to go through it. Ongoing.

- *QS (07/20) 006 - Check whether the safety metrics have been added to the risk register.*
  KF confirmed that safety metrics had been added to the risk register and that the risk register was being reviewed with SR. LK queried what the risk number was. KF to check and confirm. Completed.

- *QS (07/20) 008 - Meet with the relevant GDONs regarding the fall and grade 4 pressure ulcer cases and provide an update at the August meeting.*
  KF confirmed that this had been discussed and reviewed. Completed.

- *QS (07/20) 007 - DC to include an update of the perinatal paper within his Private Board Report.*
  Completed.

- *QS (07/20) 008 - Review the Mixed Sex Accommodation data and provide an updated report at the August meeting & QS (07/20) 008 - KF to work with DB and LK to review the format of Integrated Quality and Performance Report: Exceptions.*
  DB confirmed that he had a call with KF and Kim Cross to discuss whether the process was working. It was agreed at CLE that nursing and ops would look that. KF has the historic process up and running for September. DB reported that they are starting to get on top of MSA, but the process is taking too long, and the Unity-led process needs fixing. Ongoing.

- *QS (08/20) 004 - Response to DNA patient to be on the agenda of the September meeting for discussion.*
  LK gave an update in terms of general DNA for patients. The general DNA approach taken is the same as has been done previously. It is a clinical review process and the patient is referred back to the GP with advice that the patient has not engaged with us.

- *QS (08/20) 008 - SBAF discussion to be prominently listed on the agenda for the September meeting.*
  Agenda item – see below.

Action: KF to circulate any actions from the audit and clarify the action with respect with exactly how LK proposed it as well and update the Board. The decision can then be made whether it needs to go to the Trust Board.

Action: DC to chase for a response from the Unity team.

Action: KF to confirm risk number with LK for safety metrics.

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

KF gave the highlights from what went to the EQC.

- VTE Annual Report, which looked at the Trust position on VTE and hospital acquired VTEs. It showed a number of issues that some of the incidents are not being raised, missed doses and delays in administration. They were looking at how they could address that and how to work with the pharmacist to ensure missed doses were picked up. It was asked whether there were any retrospective checks to see whether any harm has been caused to patients. DC confirmed that the report was based on the hospital acquired VTEs, meaning that the VTE occurs during the admission or within 90 days of a previous admission. The themes were that the assessments were generally done, but a proportion of those were from delayed administration or delayed prescription. KF confirmed that there would be reporting back to the committee in November.
- Serious Incident Report, which was a delayed diagnosis of cancer. There has been an action plan to agree on the process to ensure that it doesn't happen again. A systematic review will be undertaken to investigate whether there are any other cases.
- HTA – Human Tissue Act Action Plan was brought to the Committee. It had some shortfalls, but a lot of work has subsequently been done to address these. Currently, they are on track with their actions and the majority of them have been closed. A further inspection is expected in 2021, although there is no date yet for when that will be.

There was a good news story from maternity. The stillbirth rate had reduced to two, which was an improvement on the previous month.

Other things discussed were the Freedom to Speak Up (FTSU) month in October, feedback from the Speak Up day on 9th September and the NHS [SEFT 17:55] analysis was looked at and some further work around that.

KF confirmed that 19 new risks were added to the Risk Register. One thing raised was the fact there is no COVID risk on BAF, but that is being addressed at present. KF updated that she had had a call with RMC, who wanted to give some support around risks because they felt there were a lot of issues on the register. RMC is going to do a review of how risk is managed in the organisation.

5. Patient story for the September Public Trust Board	Verbal

KF clarified that they had been looking for a story that wasn't just a good news story and gave a bit more depth. KF confirmed that they had worked with the PALS team to find a patient who was willing to share their story. The patient raised a concern regarding a delay in receiving CT scan results. Following his most recent scan, they had to wait two weeks for feedback and learning has been taken from that which is being worked on at present. KF reported that the outcome was positive, but it highlighted that sometimes they don't get it right all the time.

DISCUSSION ITEMS

6. Gold update on COVID–19 position	QS (09/20) 003

DC confirmed that they were utilising links out into the community to warn when hospital infection rates might be increasing through the STP calls on what's happening with community rates as well as through national press as well.

There has been an increase community rates in Birmingham, Sandwell and more so in Wolverhampton and that has led to a change in the local lockdown rules, but the knock-on effect has been an increase in admissions with COVID. They are still trying to admit patients who are COVID positive to City hospital so expert care is focussed on the respiratory hub.

DC reported that there about 20 COVID patients on non ITU beds and seven or eight in ITU beds. There are still a lot of outstanding swab results because of the high volume of work going through to Black Country Pathology. This has led to additional pressure on ITU which is busy anyway, but some of the non-COVID patients have been transferred to other ITU.

DC said it was important to pick up on the learning from mortality reviews around identification of higher risk patients or with clinical associations.

DC summarised the new IPC guidance. There are new categories introduced and new colour coding:

- Green/Low Risk: those patients who are now admitting for routine surgery and who have been social distancing, swabbed and then self-isolating before admission.
- Amber/Medium Risk: everybody who would have been categorised as being on a blue ward. This reflects a colour change, without any change in process and a communication strategy for colleagues is being finalised.

DC confirmed that swabbing continued to be a bit of a challenge because there is a lot more being done and there is a backlog at Black Country Pathology. There is still a low number of urgent swabs and a new process for the multiplex system that can assess for multiple different viruses. Again, there is only a limited number and they are focussed on patients from paediatric, ITU and haematology initially.

DC reported that wellbeing support still continues and has been very well received by medical and nursing staff and that needs to continue. Phase 3 submission will be likely be discussed at the Private Trust Board

next week.

HK queried the availability of remdesivir and whether stocks are arriving in a timely fashion. It was confirmed that all of the supply had been used up, but another supply had been sourced, which should last 10 or 12 days on the current run rate. It is slightly more challenging to source from national stocks. HK asked how it was decided who gets what drug. Is there a standardised process? DC clarified the outcome of the trial and gave clear guidance on who should be getting what and when and that was incorporated into the Trust guidance on using remdesivir and dexamethasone.

RS queried whether the streaming in A&E was working well in terms of COVID risk. DC confirmed that recently, where there had been challenges, it has often been a combination of patient flow and the fact of COVID-related patients spending longer in ED.

RS queried how Visionable was being optimised to streamline getting people back for electives in terms of language barriers. DC highlighted that, at present, there is no clarity on the degree of use, effectiveness of it and functionality to be able to have interpretive family members in. There needs to be a review of where Visionable is at the moment and some work needs to be done with the patient access team in understanding where it is and what the trajectory is.

RS highlighted that the performance with care homes had been distinctive and something to be proud of. RS requested a reassurance that they were ready if another surge were to happen again now. LK confirmed that they were looking to exactly the same this time as in the original surge. The A&E Delivery Board has just commissioned the system to open up to the Sandwell care homes and the West Birmingham ones as well. This means the 20 Sandwell care homes plus the West Birmingham ones are part of the Winter Care Funding Transformation protocol.

HK queried whether the volumes wanted were being reached, with regard to swabbing and testing, or were there any restrictions placed by BCP. Secondly, if there is any restriction or supply points of constriction, is there a backup. DC confirmed that there were no restrictions. Black Country Pathologies did have some delays, but they are now utilising the PHE lab at Heartlands as well. Those requiring urgent swabs are dealt with by the in-house CEPHEID process and also the new multiplex system. HK highlighted that there would be new testing methods coming through. DC raised the issue of communicating results to patients who have been discharged. The process is being put in place currently to make sure patients are informed of the results which may not be happening at present.

LW queried which cohort of patients were being swabbed in the Trust. Regarding staff swabbing, are there any issues with staff who get swabbed and are their family members swabbed also? DC confirmed that everyone admitted to hospital should have had a swab done. Any patient in a blue/amber stream or a lilac stream gets swabbed every five or three days, respectively. Routine admissions are swabbed three days prior and then checked before surgery. Patients not admitted and just seen in ED are generally not swabbed. Staff members who are symptomatic and their symptomatic family members, with whom they live, can access the community swabbing services at either site. That has been extended through to primary care colleagues also. PM asked who in the CCG had been told about the primary care testing to ensure that it was disseminated fully. LK confirmed that Dottie had sent it through and it went out in the

newsletter. PM to link up with Dottie and check who has been informed.

LW asked LK whether they were concerned about any particular areas regarding wellbeing support coming into the autumn/winter season and whether any additional support was required. LK responded that they were concerned about all areas. All ITU reservists have been contacted to invite them for an informal discussion and wellbeing opportunity around the likelihood of a second surge and they might be called up. LK confirmed that the response rate has been high. This will then be rolled out through the areas. DC highlighted that they needed to be mindful of where staff were coming from and that staff were moved without closing down other services again.

Action: PM to link up with Dottie and query who has been informed about the primary care testing.

7. COVID-19: Recovery and Restoration Plan	**QS (09/20) 004**

LK outlined the recovery and restoration plan. The Phase 3 returns where submitted on 21st September. These were mainly focussed on the activity targets against RTT, DMO1 and cancer. An activity plan was submitted that lined with what the Phase 3 letter required, which was up to 90% by the end of October. LK confirmed that the potential second surge did have implications on whether or not that 90% activity level could be maintained.

The plan profiles that by the end of March, 52-week waiting patients will be reduced. The difficulty is that a lot of the patients who are in this category aren't in the clinical priority of Levels 1, 2 or 3. LK confirmed that they are looking to put in place a procedure which will move Level 4 patients who have exceeded the wait limit up into a higher clinical priority group. All 52-week patients have been reviewed and with the exception of ophthalmology, it is thought they could be resolved swiftly by the end of October.

LK reported that, in terms of clinical prioritisation, that is now completed and all patients on waiting lists from each specialty have been reviewed and put into a clinical prioritisation.

DC asked whether patients who are less than 52 weeks but waiting longer than three months should have harm reviews. LK reiterated that that would happen, but the mechanism that captures that needs to be put in place first. DC queried if there was a set proforma for all patients which was used as part of the harm review or was it specialty specific. LK confirmed it is very generic and hence is probably not fit for purpose in the current format, but work is being done on it at the moment. HK queried whether anyone had checked outside of the system. LK responded that UHB has got a clinical prioritisation tool and process, but they haven't asked whether they have got a standardised harm review format. DC confirmed that they are trying to collate from all the BSOL acute care providers, but there was nothing nationally.

RS queried what the staff incentives meant in section 2.3. LK responded that there were several things being done in terms of staff incentives. For example, the bank rate has been enhanced after so many shifts have been taken up.

RS queried why the figure for outpatients in section 2.4 was low. LK confirmed that part of that is that some specialties aren't seeing the referrals that they used to see so some of it is demand driven. GP referrals are still only at about 66% of what would normally be seen. AC clarified that GPs aren't seeing the

level of activity through to be able to refer on not that they aren't referring patients.

RS queried whether the link with PCNs was now actioned. LK confirmed that that was due to be presented at the next Clinical Director Network about attendances, referrals, wait times et cetera to give them a bit more of an understanding of the issues.

8. Review of Mortality Statistics – HSMR	**QS (09/20) 005**

DC reported that there had been an increase in HSMR mortality rate above a level of that understood from the data. DC handed over to CA for further discussion.

CA reported that HSMR for March to May was high. The analysed data was about 134 so the Trust is higher than this. Looking at NHS England data, it shows that the Trust is still within controlled limits. The HSMR maker excludes COVID deaths, but the Trust data included 67 COVID deaths. This is because HSMR only accepts COVID as a diagnosis if it's coded in the first or second episodes. Committee members referred to the paper and highlighted the excess number of deaths during March, April and May 2020 (compared to recent years) in the SWBCCG area. CA clarified that there a number of things being looked at, including whether data can be resubmitted, although most cases were diagnosed as COVID multiple episodes down the line.

CA reported that Leasowes was re-designated as an end of life facility during COVID, although this was an internal designation, but externally it is still known as intermediate care. Work is ongoing to see whether the end of care beds can be recognised and then to use Leasowes as an end of care facility. This would then affect the mortality indices going forward.

HK queried whether the system had picked up on the rates. CA confirmed that in March and April they were aware that numbers were high, but NHS England showed [TBC]. The reason HMSR results are out is really to do with the coding.

DB highlighted that this is more than a chance to get back to pre-COVID rates, this is a chance to get below that.

DC asked whether other organisations had that same reduction in acute admissions and spells during the period, because that's one thing that's going to more adversely affect the data. CA confirmed that Wolverhampton and Dudley did see a reduction in spells and, as a result, crude mortality was a little bit lower than Sandwell's.

LK asked when the correct figures would be available. CA confirmed that the work trying to improve the multiple episodes of care was going to take some time. CA commented that the HMSR data should have improved by the time the July data is available. It was confirmed that the piece of work done to rectify the clinical coding of COVID deaths would be complete by the end of September.

9. SBAF Review	**QS (09/20) 006**

DC confirmed that all of the SBAF were linked to items on the risk register. DC talked through the following

SBAF:

- SBAF 4 – vulnerable services: the review completed at the beginning of the year was discussed at the Private Board. Due to meeting cancellations, the work needs restarting on vulnerable services internally, but also externally, into the clinical leadership group and clinical reference group of the STP.
- SBAF 14 – amenable mortality: CA had already discussed this under the review of mortality statistics, but DC highlighted that there is now almost a full complement of medical examiners. DC confirmed that it would be good to bring the information that goes to Learning for Deaths to Q&S next month.
- SBAF 15 – research goals: the research director and research manager are both effectively in place. COVID again suspended all normal research projects that were ongoing, and a lot of the research staff were redeployed.

DC confirmed there had been no improvement in the assurance of the two former SBAF.

LK queried whether SBAF 2 could be amended to a six and perhaps no longer needs to be an SBAF following the work that has been done. RS agreed that this should happen.

DC asked HK how often the SBAF should come back to the committee. LK confirmed that every quarter there should be a deep dive on it, but otherwise a quick review for other meetings.

Action: DC to bring the information that goes to Learning for Deaths to Q&S next meeting and then every quarter going forward.

10. Complaints Q1 Report	**QS (09/20) 007**

KF ran through the highlights from the Q1 report. As a result of COVID there has been a reduction in the number of complaints received in Q1, as well as a reduction in the number of local resolution concerns. There were 12 Purple Point calls for the last quarter. One of the themes which emerged was the fact that there is no single property process in the Trust. This had been raised on another occasion. An audit will take place and that will be reported back through the GDON meeting. KF reported that the Q2 data will likely be brought to the next meeting.

Trust wides themes from received complaints included values, behaviours and communication. KF confirmed that work is being done to look at how the actions are being picked up for learning and ensuring that the action plans in the complaints are being completed and discussed at a governance level.

HK queried whether there were any specific ones which could be pointed to as COVID caused. Has anything increased as a result of COVID-19? KF responded that the data would need to be looked through more closely, but that could be clarified.

RS asked whether the data could be compared to other organisations. KF confirmed it is difficult to compare, but data is submitted centrally on a quarterly basis. RS queried whether the decrease in Purple Point is a result of people on the wards dealing with complaints in real time. KF suggested that they may

not be used at present due to COVID-related fears around cleaning. DC highlighted that there hasn't been visitors in the hospital either and most calls are made by visitors. LW confirmed the Purple Point phones are staffed 9am to 9pm, 365 days of the year.

LK highlighted there had been an increase in July and August in PCCT complaints because of YHP coming on board.

11. Draft Terms of Reference	**QS (09/20) 008**

DC requested that comments on the draft Terms of Reference be returned to SR.

KF confirmed that these were the most up to date Terms of Reference that could be found so they do need a review. It was suggested that the best course of action would be to circulate a draft and then to discuss at the next committee meeting. LW commented that a programme of what might be expected through the years might be useful.

Action: KF to draft and circulate Terms of Reference for comment at the next meeting.

12. Integrated Quality and Performance Report: Exceptions	**QS (09/20) 009**

DB provided an update on the Integrated Quality and Performance Report:

- ED performance is the lowest within the Black Country and the bottom 10% in the country based on the July data. This has been driven primarily by Sandwell ED. RTT has started recovering after bottoming out in July. Cancer continues to improve.
- Stillbirths have decreased to normal levels and there were no neo-natal deaths August.
- Falls have increased, particularly in medicine, with high numbers of non-observed falls in the early morning corresponding with handovers.

RS requested clarification on the 59% on urgent GP tests. DB clarified that 59% is the overall diagnostic standard. It should be 99% and the Trust normally achieves very highly on that. COVID has delayed patients waiting, but backlogs are being worked through.

LW highlighted that, within the report, there are quite a few areas resilient to improvement such as multiple cancellations. It would be useful to be able to understand why and to be sure that we are satisfied that that is okay at the moment. LK agreed and suggested that some review is needed.

KF queried where 10.7 came from regarding qualified nurse turnover. DB confirmed he would clarify where that came from.

Action: DB to clarify where the qualified nurse turnover figure of 10.7 came from and report back.

MATTERS FOR INFORMATION/NOTING

13. CQC Update and Board Development Session	**Verbal**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

KF provided an update on CQC. The CQC unannounced inspection programme has started. This week's inspection was at Lindon 4 and there were some real positives in terms of care and examples of practice. It did identify that there was further work required with mental capacity, deprivation of liberties and restraint. It also highlighted the need for further learning around incidents and complaints and also that staff need to be aware of the Freedom to Speak Up culture that was being built.	
14. Matters to raise to the Trust Board	**Verbal**
HK suggested that the following matters be raised to the Trust Board: o COVID-19 o The Restoration and Recovery Plan o Mortality Review LK queried whether SBAF 2, Care Homes should be mentioned.	
15. Meeting effectiveness	**Verbal**
It was noted that having VK on the call was useful.	
16. Any other business	**Verbal**
RS queried whether there was a target date for either STP or individual Trusts to move to a system-wide sharing of records across the system. It was confirmed that Coventry and Warwick had completed it. The Q&S Board was informed that there had been a 12-hour DTA in ED who was still there and there had been a huge amount of work to get them placed in adolescent/paediatric intensive care psychiatric unit. That's not been possible. Multiple options are being investigated today.	
16. Details of next meeting	
The next meeting will be held on 30th October 2020, from 11:00 to 12:30, by WebEx meetings.	

Signed …….

Print …….

Date …….