Sandwell and West Birmingham Hospitals NHS
NHS Trust

# QUALITY & SAFETY COMMITTEE – MINUTES

**Venue:** Meeting held via WebEx **Date:** 29th January 2021, 11:00-12:30

| **Members:** | | | **In Attendance:** | | |
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| Harjinder Kang | (HK) | Non-Executive Director, Chair *(until 11.52am)* | Dave Baker | (DB) | Director of Partnerships & Innovation |
| Richard Samuda | (RS) | Non-Executive Director/Trust Chairman *(Chair, from 11.52am)* | Chizo Agwu | (CA) | Deputy Medical Director |
| Kate Thomas | (KT) | Non-Executive Director | Parmjit Marok | (PM) | GP Rotton Park Medical Centre |
| David Carruthers | (DC) | Medical Director/Acting CEO | Helen Hurst | (HH) | Director of Midwifery |
| Liam Kennedy | (LK) | Chief Operating Officer *(joined at 11.10am)* | Susan Rudd | (SR) | Associate Director of Corporate Governance |
| Melanie Roberts | (MR) | Acting Chief Nurse | Lesley Writtle | (LW) | Non-Executive Director |
| Kam Dhami | (KD) | Director of Governance | | | |

| **Minutes** | **Reference** |
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| **1. Introductions** [for the purpose of the audio recorder] | **Verbal** |
| Committee members provided an introduction for the purpose of the recording. The Committee Chair advised that he may need to leave early to attend another meeting. | |
| **2. Apologies for absence** | **Verbal** |
| There were no apologies. | |
| **3. Minutes from the meeting held on 8th January 2021** | **QS (01/21) 001** |
| The minutes of the meeting held on 8th January 2021 were reviewed and **ACCEPTED** as a true and accurate record of the meeting. | |
| **4. Matters and actions arising from previous meetings** | **QS (01/21) 002** |
| The Committee reviewed and updated the action list, as follows:<br>• *QS (07/20) 004 – Seek advice and input from LW on reviewing the content of the Safety Report* MR advised that she had met with LW; discussion outcome was that the 'Perfect Ward' would be introduced which would effectively replace the Safety Plan. The first implementation meeting would be held next week. Approval from the QS Committee was sought for LW to continue to collaborate on the matter; approval was granted.<br>• *QS (11/20) 004 – Present the Community Mortality Review findings to the January 2021 Q&S* | |

*Committee meeting*

Addressed at agenda item 11.

| **4.1 Feedback from the Executive Quality Committee and RMC** | **Verbal** |
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**Executive Quality Committee (EQC)**

KD advised that the EQC had discussed the following matters:

- The EQC received a presentation from Tammy Davies in regard to discharge information sent to GPs and an action plan to improve the quality of discharge information.
- The Ockenden Report and the governance around that was discussed; to become a regular item for the QS Committee and Trust Board. There was wider learning arising from the Report for the whole organisation.
- Further discussion around the Never Event that was presented to the Trust Board; investigation to occur ASAP.
- Duty of Candour – more work to be done to ensure the three steps in the Duty of Candour process occur.
- Reviewed the Committee's Terms of Reference and governance arrangements, reporting schedule and membership.

**Risk Management Committee (RMC)**

KD advised that the RMC had addressed the following matters:

- Reviewed each Groups' current red risks. Groups to do more work to re-present at the February RMC meeting.
- Health and Safety Executive Notice to provide safe working environments – DC advised that he had informed the Health and Safety Executive that the Trust had implemented corrective measures.
- Received the internal audit report that advised that the Trust's risk management arrangements were reasonably assured; there were some low-level actions arising from the Audit.

| **5. Patient story for the Public Trust Board** | **Verbal** |
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MR provided a summary of the patient story to be presented to the Trust Board:

- Patient that had attended the A&E with an amputation of the top of a finger.
- The patient's initial experience was good; however, was subsequently followed by issues with communication, pain relief/medication and discharge information.
- Main story discussion points would focus on the positives and negatives of his experience.

*LK joined the meeting.*

| DISCUSSION ITEMS | |
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| **6. Gold update on COVID-19 position** | **QS (01/21) 003** |

DC reported the following:

**Community Rates and Hospital Admissions**

- It had been a difficult month with a 4-5-fold increase in community rates and a significant increase in hospital inpatients peaking at around 430 (60% of general patient intake).
- 2/3 of admissions were COVID-19 positive patients and 1/3 non-COVID-19 patients – seemed to be reducing to a balanced 50/50.
- ICU had been intense with over 220% of baseline capacity. There was the option to transfer to other hospitals. Bed space was being maximised with ICU use of D16 and N1. NIV capacity at City had been increased in order to improve patient transfer between Sandwell to the Respiratory Hub and a pathway through the hospital for ICU step-downs.
- Appears that infection rates may be stabilising.

**Staffing**

- Increase in bed-base and staff illness (increase of 4-fold over three weeks due to COVID-19 related illness). Staffing levels had been reduced in all areas, particularly on the general wards. A lot of staff had to be pulled into ITU and had to train reservists in theatre, ward and corporate nursing. Other medical staff and services were redirected to support ITU.
- Mitigations in place to try and balance the risk of reduced staff on the wards, as detailed on page 3 of the Report.
- Using alternative work forces, such as paramedics, medical students and military personnel, and medical rota changes were made to provide additional support to GIM.

**Swabbing**

- Continue to focus on perfecting swabbing processes to ensure timely results for inpatients.

**PPE**

- The PPE requirement for inpatient staff had been increased due to high community rates, high staff illness, poor ward ventilation and high number of COVID-19 positive patients in non-COVID-19 streams. A risk assessment had been done on the latter and Infection Control had recommended the use of FFP3 masks in those environments. The matter would be continually monitored.

**Vaccination**

- To be addressed at agenda item 6.1.

The Chair questioned when reduced infection rates would impact on hospital admission rates. DC noted that over the last ten days infection rates were reducing in the community within all boroughs

(Birmingham, Sandwell, Wolverhampton, Walsall); however, infection rates were not reducing as quickly as they had increased. In 1-2 weeks, it was expected that there would be reduction in hospital admissions and a week after, reduction in ITU pressure. Acute pressures were expected to ease mid-February.

DC reported that there had been a slight increase in the mean-age of patients admitted to hospital and the mean-age of those dying. Despite this, a 24-year-old patient had died with no underlying medical conditions. Unfortunately, last weekend a staff member had passed away after a short period of ITU COVID-19 related illness – the Trust's first staff death to COVID-19. The 24-year patient death was an eye-opener for the Community and reiterates the importance of infection control within the hospital and community restrictions.

LW questioned if there was more that could be done to support staff and staff wellbeing whilst recognising the need for support after the Pandemic. DC noted the following support mechanisms in place:

- Short-term staff support:
    - Ensuring that staff take breaks and have access to refreshments
    - Allocation of opportunities to all clinical inpatient areas to visit and talk to staff (physically or remotely) to reinforce that the Trust understands and to make change where possible.
- Long-term staff support:
    - Consider untaken annual leave and its management over the coming 12–24-month period.
    - MR noted that she had been working with Mental Health to implement psychology support now and post-COVID-19. A senior psychologist had been onsite at ITU this week to offer immediate support due to the loss of the staff member and the 24-year-old patient.
    - Mental health had returned with a full package across the organisation (during and post-COVID-19) in which would be reviewed and shared. Mental Health had been very helpful in providing the support.

DC advised that a meeting would be held during the week between the Trust's ICU and external units (UCL), via the Regional Medical Director, to compare best practice. MR advised that there had been a positive report from the NHSE/I which congratulated the management of capacity and provision of good patient care despite being a split site. LK noted that the report also called out positive reflections on the Trust's reservists' strategy and maintaining the strategy post-Wave 1 in preparation for Wave 2. It was a strategy that the NHSE/I would take to other units as good practice. MR noted that the Trust's Wave 1 learnings workshop had also strengthened their strategy.

LK noted that discharges had recently improved significantly, due to:

- The Clinical Advisory Group's review and alignment of the Trust's discharge criteria to the national pandemic criteria documentation.
- The Trust's Information Team's approach to highlight patients that require a more targeted clinical discussion and approach.

RS questioned the PTSD concern, how to improve the patient discharge issue and the respiratory consultants' matter.

LK noted that the timing of discharges remained an issue; 30 plus discharges remaining at 5/6pm. An audit of all late discharge patients during the last week would be conducted to identify 2-3 key themes and actions to mitigate would be implemented. In response to the question regarding the Respiratory Consultant – Respiratory numbers had increased again prior to the last QS Committee meeting; NIV expansion now up to 22, noting that the baseline NIV is 4. It was a considerable increase in NIV, ratio of staffing and medical support required to care for patients. The respiratory consultants and registrars had been pulled off the GIM rota to create a 24/7 support rota for D15 and D17 and outreach into Sandwell. GIM had subsequently been filled from other specialities which was problematic due to staffing issues. We managed to do it so that they had the cover in the Respiratory Hub, a signed-off ceiling of care for the CPAP pathway and a SOP for non-COVID-19 NIV patients. A few challenges remained to work through.

KT congratulated the staff and the Leadership Team on their hard work, which resulted in a positive report. She questioned if the patient care in which the Trust was offering was safe. MR advised that the care was safe. Staffing was challenging and had been discussed at the EQC; each Group had completed a Quality Impact Assessment on staffing during COVID-19. LK advised that the Trust's ICU was the best regionally, the staff felt that they had everything that they could possibly ask for – there was nothing more at this time that could be provided to support them more.

DC noted provisional data on the outcome of patients from ITU showed outcomes had improved on Wave 1. Treatment approaches had led to the benefit, also a younger patient cohort attributed to improved outcomes.

PM provided reassurance that the Trust was safe by informing that trainees and staff deployed to the Trust had reported that the Trust was safe and was a stand-out compared to other organisations in which they had been deployed. She questioned if the new COVID-19 variant had an impact on the severity of the illness and the number of patients admitted. DC noted the following:

- In the current wave, the patients were younger with a lot more younger patients requiring ITU placement.
- Approximately 70% of positive swabs were the new variant.
- Admissions to hospitals were from the younger age group (below 65-years of age) than they were in Wave 1.
- Mortality was 14% in September, compared to 30% in Wave 1; could be due to treatment approaches or simply that the patient age was younger and had the physiological resolve to recover.
- Mean age of death in Wave 1 was 80-years of age; mean age was now 78-years of age. Noting that in the first couple of months in Wave 2 the mean age was 74-years of age – the age was increasing month-by-month.

LW stated the importance of the Safe Staffing Report and noted that there was more work to be done. She queried if the Safe Staffing Report should be included as part of the Perfect Ward work. MR noted that she had an example which she had written for a past organisation and was collecting staffing information/data to enter into it. KD advised that it was a monthly annex to the CEO's Report (Safe Staffing Report); however, it would be helpful to have a narrative rather than data only.

| 6.1 COVID-19 Vaccine Monthly Report | QS (01/21) 004 |
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MR noted that there had been changes since circulating the Report. The following was reported:

- The Trust had vaccinated 7,000 (staff and patients) up to the end of last week.
- Changes to vaccine supplies over the past few days; hospital hubs (except for Walsall) would be stepping down from 1 February for a period time. The Trust had 1000 vaccines for the week of 8 February and would therefore step down on 11 February. Would push for staff in hot spot areas to be vaccinated. MR had an upcoming conversation with the STP in regard to possible additional vaccine supply.
- The Trust had clinical and operational responsibility for the Tipton Sports Academy Vaccine Centre due to go live on 1 February. However, due to vaccine supply the centre may not go live until late-February/early-March.

The Chair questioned whether staff were reluctant to receive the vaccination. MR reported that there were staff concerns in specific groups; trying to identify and understand the gaps. The staff concerns were also replicated within the Community. The work to encourage vaccination internally would also be used externally to inform individuals. The following vaccine-positive promotional activities had been implemented:

- Chizo Agwu had created an information video.
- The Trust had provided an information webinar that discussed the vaccine, side effects and mortality data.

PM questioned if the decision to delay the vaccine from 21-days to 12-weeks (Pfizer) had resulted in any issues and if there was any work being done to reassure the Community of the effectiveness of the strategy. DC noted that they were identifying and studying patients admitted with COVID-19 that had previously been vaccinated, to collect serological, body and clinical data. The timeline was a bit short to identify patterns. It was also being investigated at a national level and the Trust would need to consider how to contribute to that.

*The Chair advised that he was required at another meeting and requested that RS accept the role of meeting Chair. HK left the meeting. RS assumed responsibility as Chair.*

| 7. Planned Care and Recovery Report | QS (01/21) 005 |
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LK reported the following:

- The Trust was tracking well against activity recovery plans and ensuring that patients were being brought in in a timely fashion.
- Diagnostics had returned to pre-pandemic results.
- Progress had been made with the inpatient backlog; however, there was still a long way to go and December/January had taken a hit due to stepdown of non-urgent cancer work and some theatres. There would be difficulty in delivering the standards of cancer care of non-emergency care and so forth. It was a challenge and they would need to work out recovery plans that involve support from

other providers to return the Trust to where they needed to be. That support had not yet been quantified but was being worked through. All resources were being used to support the Pandemic.

- Noted that section 6 of the paper highlights the clinical prioritisation work completed. There were still 174 patients yet to be prioritised out of 7000; had made good inroads in prioritising all patients in the inpatient waiting list.
- The implementation of the harm review process; almost there with a standardised harm review form that goes into the patient's record. The form would review harm of patients that were over 52-weeks and those that go beyond their clinically prioritised allocation. Reporting on that would commence shortly.

DC questioned how advanced other Black Country organisations were in the process, whereby in the future, system-based working could be conducted. LK advised that UHB were as advanced as the Trust; the remainder of the Black Country organisations were not; some had not yet started. The Trust's work had been shared with regional colleagues.

The Chair questioned whether the Trust was in the same position as other organisations in regard to cancer. LK noted that, in Wave 1, there had been a national mandate to authorise peak capacity to organisations in order to deliver elective care and cancer care; the Trust had upwards of 25 sessions per week allocated. In Wave 2, that had been reduced to just over 20 sessions. At the beginning of January (when they hadn't classified it as a national mandate or regional surge), the Trust had just over 12 ISP sessions to deliver cancer. Even at Wave 1 standards, it was difficult to get all of the Trust's cancer care through whilst balancing the lack of HDU facility across the ISPs and the limitation of what some independent sector providers would accept (as they couldn't do complex cases, no registrar or consultant cover on the wards). It had been agreed regionally to surge, and the number of ISPs had increased to around 20. All other Black Country organisations were in the same position as the Trust, with the exception of Wolverhampton as they had access to Nuffield.

| **8. Maternity Services Report** | **QS (01/21) 006** |
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HH thanked the QS Committee for incorporating Maternity Services into the agenda and including the Director of Midwifery role into the Committee.

She noted that the paper covered governance and assurance for transparency of Maternity Services throughout the Trust; from the Directorate through to Trust Board. She had worked with KD to ensure that the right governance framework was in place and the sequences were correct. HH provided a summary of the Paper:

- They were very much aware that the lack of transparency and strong Board oversight and leadership within the Ockenden Report led to institutionalised failings; and therefore, poor outcomes for the women and babies served by Shrewsbury and Telford Hospital. In order for the Trust to meet part of the requirement of the Ockenden Report, a framework had been drafted which shows a clear structure on how reports would work through from the Directorate to the Trust Board.
- At the LMNS meeting held on 12 January 2021, the paper was agreed by the Maternity Network and would pass forward to the NHSE/I for submission.
- The Trust was in-line with other Black Country maternity services; in some ways was further ahead

but still had more work to do.

KT questioned whether work had commenced on the 12 recommended actions. HH advised that the following had been done:

- Completed the recommendation for the involvement of the Director of Midwifery role to attend Committees and Trust Board.
- Oversight of perinatal safety and review of mortality of perinatal occurrence; were moving through the financial approvals for external review – making headway.
- We Had previously done a lot of work around Saving Babies' Lives and embedded that within the Maternity Governance Framework; there was still work to do and would require additional funding.
- We had in place for some time, Executive support from DC which had subsequently been strengthened by the non-exec support from HK. Currently were working though role expectations of workload share.

| **9. CQC Inspection Preparedness Update** | **QS (01/21) 007** |
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KD advised that the Paper would be presented at the upcoming Trust Board and noted the following highlights:

- In-house unannounced inspection visits: an important inspection preparedness activity. Eight wards had been completed and the action plans were in practice. It was hoped that the activity could be resumed in May. The 115 'Must do and Should Dos' had been implemented and closed but were still part of the continuous monitoring process.
- Developed a ward/clinical team self-assessment programme: all areas were required to self-assess against the toolkit by the end of February.
- Staff engagement: more work to be done on work force and staff morale at a local level.
- CQC not expected to visit anytime soon unless they identify the Trust as a safety risk; which was where the safety discussion at agenda item 6 was important.
- The CQC's new dynamic, proportionate and flexible approach, Transitional Monitoring Activity (TMA), was out for consultation.
- The CQC Insight Report was flagged for Trust action to identify what data the CQC had on the Trust.
- The current CQC ratings (April 2019) at Annex 1 of the paper were noted and showed that 73% of rated domains are Good or Outstanding

RS requested insight into the Trust's primary care CQC element process. KD noted that the CQC had advised that the process would commence with the local CQC talking to the practice manager and lead GP – in effect, it would be a trial run of the process through the Trust's primary care practices.

| **10. Integrated Quality and Performance Report: Exceptions** | **QS (01/21) 008** |
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DB provided the following update:

- The seasonal flu target had been met.
- Harm Reviews – reporting into the IQPR anticipated to be completed in March.
- First time formal patient complaint had been resolved as a data input issue.

- ED had achieved 59th in the country; had done well in regard to benchmarking. This had been reduced during January due to the pandemic.
- Two maternal deaths:
    i. Beginning of December, patient was not in the Trust's care. Had attended the ED with acute fatty liver (high fatality rate). Patient had been referred to the Liver Unit; however, unfortunately deteriorated rapidly on the ITU. Through an in-depth review, it was found that there had been no issues with care.

    ii. Patient had attended ED early in the pregnancy and died of attempted termination of pregnancy; classed as an accidental maternal death. Work was being conducted to align maternity and gynaecology support to the ED. It was advised that the patient had not been flagged on any social services list.
- Never Event – DC advised that it was still being investigated through the SI process. The retained trocar had previously been searched for but could not be found; three-months later appeared having been concealed within the ocular tissue of the patient.
- Patient harm incident – DC advised of an assault by one patient on two staff members and two patients. One patient sustained a bruise and bite mark; the other, a severe head injury. The female assailant was arrested and charged by police. The Assailant had been brought in to the Trust in police custody. The Trust was currently reviewing issues around police involvement, police leaving the Assailant under the Trust's care, assessments undertaken by staff at the time relating to drug and alcohol dependency, and the rapid change in the Assailant's behaviour when moved from A&U to the base ward. Staff members were severely affected with 2-3 staff still on compassionate leave with significant mental health issues.

| **11. Community mortality review findings** | **QS (01/21) 009** |
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PM provided a summary of the Paper:

- Structured Judgement Reviews (SJR) were common place in secondary care; however, within the Community it was not. With the development of COVID-19, it had been decided that it would be appropriate to assure the quality of care across all services by devising a process for mortality reviews for community deaths based on the SJR methodology.
- The patient cohort for review were:
    - Residents in care homes during the pandemic that died.
    - COVID-19 positive patients within the Community that died at home.
    - Any patient with significant mental illness (on the SMI register).
    - Serious patient complaints.
- Resulted in sampling 47% of all deaths that met the criteria for SJR. CA was instrumental in providing training in conducting reviews. The reviews were conducted with the help of the Trust in terms of access to medical records.
- The findings assured quality of care across sectors and there were some recommendations for secondary care learning, including:

- Improvement of the quality of discharge letters.
- End of life care in place prior to discharge.
- Infection control and prevention – swabbing frequency.

PM advised that CA had organised to a joint mortality review with the first meeting to be held next month to embed the learning and make forward improvements.

**MATTERS FOR INFORMATION/NOTING**

| **12. Learning from Deaths Dashboard** | **QS (01/21) 010** |
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DC tabled the Paper. CA noted that:

- The ICU deaths median age was younger at 66-years of age compared to 78-years of age for *Other*. 73% were from Asian origin and would monitor disproportionate impact in any group.

| **13. Matters to raise to the Trust Board** | **Verbal** |
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The following matters were decided to be raised to the Trust Board:

- Maternity
- CQC
- Feedback from ICU visit
- Community Mortality Review

| **14. Meeting effectiveness** | **Verbal** |
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Nil discussion.

| **15. Any other business** | **Verbal** |
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RS questioned the movement flow of paediatrics into the Children's Hospital and if there were any implications of paediatrics returning. LK advised that the paramedics would simply need to be instructed to drop patients at the Trust's ED.

| **16. Details of next meeting** | |
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The next meeting will be held on 26th February 2021, from 11:00 to 12:30, by WebEx meetings.

Signed ……

Print ……

Date ……