Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: Meeting held via WebEx **Date:** 28th May 2021, 11:30-13:00

Members:			**In Attendance:**		
Harjinder Kang	(HK)	Non-Executive Director (Chair)	Dave Baker	(DB)	Director of Partnerships & Innovation
Kate Thomas	(KT)	Non-Executive Director (Chair for second half of meeting)	Parmjit Marok	(PM)	GP Rotton Park Medical Centre
Lesley Writtle	(LW)	Non-Executive Director			
David Carruthers	(DC)	Medical Director	Helen Hurst	(HH)	Director of Midwifery
Liam Kennedy	(LK)	Chief Operating Officer	Susan Rudd	(SR)	Associate Director of Corporate Governance
Mel Roberts	(MR)	Acting Chief Nurse			
Kam Dhami	(KD)	Director of Governance	**Apologies:**		
			Chizo Agwu	(CA)	Deputy Medical Director

Minutes	**Reference**
1. Introductions [for the purpose of the audio recorder]	**Verbal**
Chair Harjinder Kang (HK) welcomed Committee members to the meeting.	
2. Apologies for absence	**Verbal**
Apologies were received from Chizo Agwu.	
3. Minutes from the meeting held on 30th April, 2021	**QS (05/21) 001**
The minutes of the meeting held on 30th April 2021 were reviewed. The minutes were **ACCEPTED** as a true and accurate record of the meeting.	
4. Matters and actions arising from previous meetings	**QS (05/21) 002**
The action log was reviewed and the following update was made: • *QS (04/21) 004 - Add patient satisfaction indicators to the Maternity dashboard.* HH reported that it was in with the paper but having this included in the dashboard per se would take a while. **Closed.**	
4.1 Feedback from the Executive Quality Committee and RMC	**Verbal**
Executive Quality Committee (EQC) KD reported that the EQC had met on 11th May. She highlighted the following points. • **Clinical Audit Plan:** It was confirmed that 57 nationally mandated audits would be done with	

updates to be given at the Audit Committee. Another 97 Group priority and locally selected audits would also be focused on this year. Other audits could be undertaken but only the list of 97 would be reported on quarterly.

- **Medicines Management and Safety Dashboard:** Some areas were below the 85% standards in two of the recent Pharmacy audits:
    1. Safe and secure handling of medicines
    2. Controlled drugs.

  The Groups involved committed to do improvement work before a follow up audit in May.

- **Unity:** System development work was planned to address issues in medication prescribing. A Unity Steering Group had been set up to focus on this.
- **Ockenden Report:** Wider learning for the organisation was being shared.

Risk Management Committee (RMC)

The Groups' current 'red' rated risks had been discussed. The low likelihood, high severity risks were also reviewed. People and OD risks were presented with further work planned on this with FM. Response to a patient safety alert was nationally overdue due to issues in the practicalities of implementing it.

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

MR reported that this month's story would concern a lady who had been quite anxious during her pregnancy. This was quite a positive story of her journey, showing the flexibility of the maternity services throughout her pregnancy. Even services like reflexology were set up to help to manage her anxiety. Despite the fact that she felt anxious about presenting to the Board, she still wanted to describe her story and give feedback about her journey.

DC commented that this would be a great story to have to show the pathway through Maternity.

DISCUSSION ITEMS

6. Gold update on COVID-19 position, including vaccine update	**QS (05/21) 003**

LK reported that COVID numbers had remained stable over the past five weeks with only about 20 in-patients and a fluctuation between 0, 1, and 2 Critical Care patients over the last four weeks. Community infection rates had remained low and stable.

Due to regular monitoring, community infection rates remaining low, concerns about a spike like the one seen in areas like Bolton were currently minimised because there was normally a 10-day lag between infection rate rises and hospital admissions. In the Bolton region, they had seen a rise in infection rates 2 ½ weeks before admissions. Bolton only had 41 COVID in-patients, compared to the 480 the Trust had seen at their peak. Close monitoring continued, with plans in place in the event of seeing a three-day increase in community infection rates, which would trigger preparations for surge plans.

Both 'red' AMU sites were now rated 'amber'. COVID patients for AMU were being managed through

side rooms due to low numbers. D17 remained the one COVID ward, with discussions being held about reducing it further to use only side rooms and bay rooms to manage COVID patients to ensure that they had the right sub-specialisms looking after them. The COVID ward had been in place for 14 or 15 months. Plans to progress away from that would likely be in place in the next two weeks.

DC commented that the Bolton and Blackburn cases were people mainly in their 60s with very few in the older age group. He recommended that they watched what was happening elsewhere to be able to plan effectively for things like a different age mix seen in other areas like Bolton, Blackburn, and Bedford. HK commented on the change in the infection rate link to admissions and DC speculated that it could be age-related and due to doing more swabbing. He reported two known cases of the Indian variant. MR reported that until now, it had taken 10 days to get the genomic testing back.

HK and KT queried whether the point of care testing analysers had been repaired or if they were still not working. It was reported that they were working again and more had been ordered.

MR reported the following:

- **Indian variant:** The Trust had put the new guidance into effect for the ED to isolate COVID patients who have had recent travel to India or to affected northern areas or Bedford.
- **Staff testing**: Letters would be received by all staff next week to encourage LAMP testing. Currently 39% staff were registered to do it but the numbers were closer to 30%. A letter had been written by MR, DC and RBe was sent last week to encourage staff to have LAMP tests and vaccinations. On 21st June there would be further guidance from the Prime Minister around social distancing and mask wearing in public, with separate guidance coming out for within NHS hospitals. New infection control guidance would be received next week.
- **Vaccinations:** Trust vaccination rates were at 70% and were continuing to be encouraged. Pfizer would arrive on site at Tipton from next week, allowing under 40s to be vaccinated. The Trust was working with Sandwell Council to do pop-up clinics for Pfizer once they got a standard operating procedure in place regarding the transport element of Pfizer. Community pharmacists were currently doing pop-up clinics in Sandwell with Astra Zeneca. Vaccines were being brought forward as much as possible, working with the national booking system.

DC commented on the risk if people were to let down their guards with regards to regular LAMP testing, PPE, and social distancing. The wording of the letter to staff made it clear that testing was expected.

HK agreed that messages needed to be clear. He asked if LAMP testing was done in collaboration with Wolverhampton. DC confirmed that all four organisations together received weekly numbers for each of them. The Trust was second on that league table for numbers of staff being tested. There was a national debate around which test was better, LAMP or LFT, so it was important that staff had clear guidance.

LW asked DC and MR what the reasons were for non-compliance, for example if it was time-consuming or if there were reasons that could be overcome with help. MR reported that when she had asked about testing during a night shift, the term LAMP was unknown, which was why they adopted the term saliva test. For some staff it was a question of getting access, so tests were being made available at the evening crossover time to encourage registration. The test was fairly quick to perform. Some school

children's parents were being sent lateral flow testing to do, so staff doing lateral flow tests were asked to register results. DC added that reasons for not doing tests could be overcome with help and support.

PM was asked for views in terms of the COVID guidance letter encouraging face-to-face Primary Care. She commented that given the BMA guidance, the letter sent out to doctors had been seen as contentious. When COVID started, the CCG had asked them to work in a different way, to move face-to-face consultations to be grouped together on different sites. To avoid outbreaks and the effects of closing primary care, the PCNs were supporting this. Recently, activity was being brought back into individual practices. The majority were doing triage first due to the risk of the Indian variant, with face-to-face as necessary as a bit of a halfway house.

Some referrals had been coming to the Trust where people had not been seen first by Primary Care, otherwise they would never have gone to the hospital. Some patients were now expected to be seen by GPs first, such as for the two-week wait dermatology referrals. Letters were being sent to say that GPs were expected to have examined the patient or to have seen a photo first.

7. COVID-19: Mortality – September 2020 to March 2021	**QS (05/21) 004**

DC referred Committee members to the paper and highlighted the following points:

- Mortality data had been taken from September 2020 until the end of March 2021.
- Two main sets of data had been examined, for patients who:
    1. had COVID and died in hospital, and
    2. had COVID, were admitted to hospital and died there or up to 30 days after discharge.
- Another subset of data was based on ICU outcomes, for deaths following hospital-acquired COVID, to look at the potential impact on the HSMR rate.
- The September 2020 to end March 2021 data showed 1383 deaths in hospital, of which over 56% were COVID-related during that period. A table showed monthly changes over time.
- That showed a mortality rate of 16%. Adding COVID deaths within 30 days of discharge to this showed an increase in in-patient mortality rate from 16% to 20%, compared to 33% in wave 1.
- The breakdown by age band and ethnic group with COVID showed that mortality increased with age. Higher percentages of older age bands were white and more younger patients were Asian.

HK commented on the sad but illuminating examination of data. He queried the reason for the reduction in crude mortality rates falling from 33% in the first wave to 20% in the second wave, and whether it was from things like starting patients on dexamethasone as soon as they arrived. DC described three factors:

1. Therapeutic changes such as the use of dexamethasone and immunosuppression and more effective use of thromboprophylaxis
2. Home monitoring allowed patients to be alerted to come back into hospital as required.
3. It may have been a younger group, or one more physiologically able to deal with COVID, although

data had not yet been compared across the two waves.

- The mortality rate in wave 2 for patients admitted to ICU was 35% compared to 39% nationally.
- The patients worse off were males, and patients who were ventilated or had renal failure.
- 46 out of 60 patients who were transferred had known outcome data. Their mortality rate was 50%. This was similar to rates for patients at the Trust who were ventilated.
- A graph showed over 257 patients whose first coding of COVID was after their first two in-patient consultant episodes. 60 had died, so there was 23% mortality for that group. Because COVID wasn't listed in the first two episodes, this would have had a negative impact on the HSMR.
- In January, 20 out of 85 patients had died who either had hospital-acquired COVID or had COVID coded after their first two episodes. This would increase the HSMR over the next few months on the basis of this data because these deaths were not excluded from HSMR.
- SJR and Medical Examiner work had also been analysed. Support from the Infection Control Team had been sought regarding the final Medical Examiner findings and how to pull together information from three data sets that would be required to be consolidated in order to fully report on hospital-acquired COVID deaths.

LK noted that it was clear to see that the HSMR rate increase was linked to the initial influx of COVID but it did seem to rise just before the pandemic hit in January and February 2020. It helped to understand that a large proportion of the variance was related to COVID-19 due to the coding element.

DC added that the depth of coding, the symptoms instead of actual diagnosis, the prefix that was used, and how same day emergency care was recorded were all issues brought out more by COVID. They planned to review case notes of anyone who died to see if they had the correct diagnosis recorded, the correct recorded palliative care, and then in parallel with Unity optimisation, to look at the recording of complexities and comorbidities documentation and the impact of same day emergency care data to see how other organisations included that and the impact. Grant Thornton, external auditors, were being asked for advice and guidance about this, based on their work with other organisations.

KT queried whether with the coding of COVID in patients coming in was because it was unclear or if they hadn't got around to coding it. DC explained that SHMI data excluded COVID deaths but the HSMR didn't if COVID wasn't identified in the first two finished consultant episodes. If those episodes changed very quickly, so for example, if the patient changed consultant twice in AMU within the first 12 hours, COVID recorded after that would not be included. So, if a patient came in and COVID was picked up in the swabbing or if they came in with something else and acquired COVID in hospital, what they came in with would be shown as their risk of death coding even though COVID would have raised the chance of mortality. The issue involved the depth of coding and the timing as to what was included.

DC explained that ECMO stood for Extracorporeal Membrane Oxygenation and it acted like a cardiorespiratory bypass, available in Leicester. Patients needing this had been transferred out.

The next steps were as follows:

- to clarify what to do next about HSMR
- to identify all the risk factors for hospital-acquired COVID to be able to address those next time.

MR queried whether it would be helpful if they wrote a separate paper on the latter step, given the public enquiry about hospital-acquired COVID. HK added that this would also help to prepare for the media storm and to reassure themselves that they had done all they could do.

LK suggested a Board discussion ahead of the enquiry to assure the Board about what had been done and why certain decisions had been made, to allow an internal challenge and reflection on learnings.

KD added that as part of internal audit, they would put some time in to look at decisions made by the Executives and the Board versus what came out nationally.

7.1. Monthly mortality dashboard	**QS (04/21) 005**

DC outlined key points from the dashboard report as follows:

- A graph of SHMI data that excluded COVID showed that in-patient deaths and deaths after discharge had fallen over time. Another graph that included COVID showed peaks in January and March when they had had a high number of admissions.
- The table of elective and non-elective in-patient spells showed that these had stabilised at around 6000 or 7000, whereas these had risen higher during wave 1.
- Monthly SHMI and HSMR rates were higher than the national rates.
- A slight discrepancy between weekend and weekday mortality rates was being investigated.
- The Quality Plan showed challenges with sepsis and pneumonia, being managed with safety huddles and the audit tool, but myocardial infarction and neck of femur fractures were fine.
- The clinical areas that were alerting were shown. These were being reviewed and reflected on by the Learning from Deaths Committee. There was a focus on the clinical outcomes side.

HK queried their progress on plans to address the issues. DC outlined three steps.

1) Part 1 was a focus on the coders looking at notes and records of patients who had passed away. Looking at this with the Specialty mortality leads would make the link between coding and the groups and the mortality.
2) Part 2 would be having support with proper day-to-day coding in admitting areas.
3) Part 3 would be looking into same day emergency care.

Since discussing this with the Board, they had had discussions with Grant Thornton to get experience from elsewhere, they had got the COVID mortality data, and now they needed to engage with coding and mortality leagues to complete phase 1.

HK queried whether the interventions were expected to make a substantial impact. DC reported that they needed to work out the relative contribution of each of those different parts. Grant Thornton had

suggested that the greatest impact would be taken from applying the learning made from the first part. There was also work to be done around changing the consultant episodes to be by area so that if, for example, a patient was seen by three different consultants in AMU, that would constitute the first consultant episode. Team based work was the way medicine was practiced these days for handovers with consultant change so this made sense.

- **KT took over the Chair role from HK at this point.**

8. Maternity dashboard and neonatal data report	**QS (05/21) 006**

MR took the report as read and highlighted the following areas.

- Perinatal mortality rates were 5.3/1000 in April. Rates for 2020/21 were higher than in 2018/19. They had seen a reduction of between 30% to 50% from 2015 in line with government requirements. Some good work had been done there but they were aiming to continue a sustained drive to reduce mortality rates. [Booking] numbers remained static while delivery numbers had fallen.
- From a quality, safety and patient experience perspective in April 2021, there were no SIs or HSIB referrals, and no complaints were received by the Directorate. A smaller number of patients had provided feedback in April. Their experiences were rated good to extremely good.
- High performance had been sustained against the Neonatal Audit Programme measurements, where the Trust had previously been an outlier. In April term admissions, only 28 babies were admitted with respiratory distress, compared to 40 seen in March. They hoped that they were reaping the rewards from some of the work being done by the ATAIN group.
- The CQC sent a letter following their visit. Highlights from their feedback were in the report.

LW expressed concern about the last two bullet points from the CQC letter and asked for assurance about what was being done about the lack of midwives and their perceived lack of support. MR stated that nothing came from the CQC report that wasn't already in the improvement plan they were working on, which they had shown the CQC. This plan would go to Board on 9th June, showing where the discrepancies were and what was being done about them. The first part of Debbie Graham's work had been received last week, which provided helpful detail behind some of the issues.

LK queried whether it was a concern that the Induction of Labour (IoL) rate of 25% was below the lower limit, compared to a national average of 31%. MR clarified that they had seen this as a positive because national rates had been rising, as were national Caesarean section rates. Induction was often driven by reduced fetal movement. They could demonstrate how their clear pathways for these cases had worked. They were working within current NICE guidance on IoL.

If the new NICE proposals were adopted to advise more women to be induced at 41 weeks, this would have a large national impact, with capacity issues to resolve for the extra women coming in earlier.

LK queried how they could evidence that lower IoL rates were good, such as by showing that they had lower comorbidities when babies were born or less admissions to the neonatal unit. MR explained that it

was difficult to judge whether less inductions would reduce babies going to the neonatal unit. The earlier the induction, the greater the incidence of Caesarean section and the corresponding risks. Inductions needed to follow guidelines and women needed to be counselled correctly. Inductions weren't a very pleasant experience for ladies. MR undertook to think about how they captured and showed their data, including patient experiences.

LK suggested having countermeasures around safety or quality or patient experience that could be shown by having less inductions. It was reported as a debatable subject but that inductions could affect fetal wellbeing. More fetal distress and instrumental deliveries were due to forcing the body to what it didn't want to do. This topic would be raised within the Directorate team.

KT suggested as a general point that adding context to reports would be helpful for non-experts. She congratulated the team on the clarity of the paper. MR undertook to feed these comments back.

DC queried the term 'eligible women' in the IoL graph, as the numbers were higher than monthly deliveries. MR undertook to find out for him. She reported that they had had 372 births in April.

9. Ordering tests/results endorsements: Actions to move forward	**QS (05/21) 007**

DC referred Committee members to the paper which summarised where the Trust stood in the aim of ultimately turning off paper results.

- Before that could be done, improvements needed to be made. More results needed to be endorsed, requests needed to be made appropriately and they needed to come back to where they should be, and all requests needed to be coming back to Unity for endorsement.
- The graph in Annex 1 showed the thresholds required to turn off paper results in a phased fashion to reduce the risk of results being missed, particularly in cytology and histology.
- All groups would have had their monthly figures sent out to them on missed results not coming back into message centre.
- 'At the elbow' support at AMU could tie this together into the Unity optimisation project.

DC was asked to define what an unsolicited request was. This was a request that didn't go through the proper process and pathway of ordering through Unity so it didn't arrive in the right place.

KT commented that the elimination of paper would be a good thing because it would concentrate the mind towards looking at the electronic version if it was also on paper, and it would reduce time needed to duplicate work. DC agreed that in their audit, many people reported that they didn't look at the paper results anyway. There were differentiations by specialty in terms of timing and processes.

LK agreed with the switch away from paper and queried what the risks were of switching paper off. DC explained that the risks differed between the in-patient and out-patient environments and across specialties. The biggest risk lay with cytology and histology. He proposed a phased approach.

LK suggested a full communication process with 'elbow support' to unpick problems and FAQs as they happened. On the job training with a definitive switch-off deadline would provide support and emphasis.

DC agreed. He raised the following questions.

- the extent to which this linked into the Unity optimisation work, versus a standalone project
- if there was the requirement for a team of individuals who could do results endorsement and reconciliation, and correct documentation, which linked with the mortality work
- the makeup of the best workforce, such as JSDs who were half clinical, half digital, and/or superusers. They were looking at Unity training with Andy Page.

10. Safe nurse staffing and workforce update report	**QS (05/21) 008**

MR reported that this paper was still in development because she was creating a Nursing and Midwifery Assurance Framework with plans to triangulate Perfect Ward data, quality and safety information and their hotspot areas. She highlighted three key points on the work being done around nursing ratios:

1. Following COVID, staffing ratios had returned to recommended levels. They continued to input daily into Acuity, allowing staff to be moved around as needed. They were working to reduce their bank and agency spend, which they had lowered by about £700,000 in April. A new bank and agency escalation process would go live on 7th June, going back to rostering six weeks before, with specified sign off for bank and agency decisions. They were working to improve focused care and workforce management moving forward. A piece of work was being done across the community Directors of Nursing around community staffing in health visiting, district nursing, and intermediate care teams.
2. Recruitment work was underway over the next six months, where most of their band 5 posts would be filled. International nursing recruitment was on pause due to the Indian variant of COVID but they were looking at ways of keeping in contact such as by sending videos of who they were and what they did at the Trust.
3. MR and LK were leading a piece of work around the number of beds against nursing ratios, looking to rationalise beds against demand. They were also working on staffing for Midland Met, the first part of which was to be signed off by 14th June. Another piece of work was being started nationally around healthcare support workers and ratios to nurses for each of their ward areas, similar to what they were already doing for Midland Met. 37 healthcare support workers had just been recruited.

LW queried retention strategies. MR described two parts to this: (1) the Nursing and Midwifery Assurance Framework launching in July, which involved fundamentals of care and being proud to be a nurse, and (2) putting pastoral support in place. NHSI had given the Trust £7000 per international nurse recruited and the majority of that was going to pastoral support. Cathy Brown was leading a project.

11. Joint Children/Adult Safeguarding Report: 2020/21 Q4	**QS (05/21) 009**

MR took the paper as read and highlighted the following key points:

- **Looked after children service**: 888 children were being looked after. The biggest issue was

children placed up to 50 miles outside of Sandwell. 276 children had been placed in Sandwell from outside areas. Two new staff were expected to begin 1st July. They were looking at a resolution regarding the number of children to be looked after and their ability to meet KPIs. They were currently at 77% with their KPIs, normally at 85%.

- **Safeguarding**: Tammy Davies was leading a formal Safeguarding Review of both adults and children, with some support from the CCG. Walsall were sharing their external review from CQC so they could make sure their terms of reference covered off the points raised by the CQC. This report was planned to be presented to Q&S and Executives next month.
- **Training** challenges had been experienced around delivering training to 300 maternity staff. They were working with HH to deliver this by December.
- **Issues with Unity** and its interaction with the Child Protection Information Sharing system were being investigated by Martin Sadler. They were double checking daily to ensure nothing was missed.
- **Mental Capacity Act (MCA) training:** A training programme was being pulled together to improve MCA compliance, starting the rollout where compliance was poorest.
- **Delirium, Dementia, and Distress (DDD):** Focused Care and the DDD service were being reviewed. This linked in with the bank and agency spend.

LW commended the authors of the report and queried where it was being shared in the organisation. MR described shared learning as a focus of the Safeguarding review. They had just reviewed the governance of their Safeguarding Committee. This paper also went to EQC and got shared with the GDONs. They were working on ways to share learnings from the case reviews and Perfect Ward.

MATTERS FOR INFORMATION/NOTING

12. Integrated Quality and Performance Report: Exceptions	**QS (05/21) 010**

DB reported the following key performance results from the IQPR Report.

- ED were improving performance in both percentage and national ranking. They were nearly halfway at 55th out of 109 Trusts. They had been doing better before January, when it had fallen to the bottom quartile, before rising again over the past three months.
- RTT had been signed off at 70.52%. They were in the top quartile.
- They ranked 84th for 62-day cancer, up from 99th in the previous month. Two-week wait cancer rankings had fallen from 115th to 120th in the country.
- HSMR recorded January next month, when it was hit quite hard by wave 2, unlike SHMI data.
- Friends and Family had gone up from 74 to 82. Whilst it was still in the bottom quartile, it had gone up, which was positive.
- DC reported two never events, one in April with ED oxygen in a process they thought had been

resolved and one in May to surgically correct a squint on the correct eye, but they had shortened and lengthened the wrong eye muscles. It had been immediately rectified with a good outcome.

- MR reported two serious falls that had taken place, both of which ended with the patients' deaths. One happened in D47, where the patient had a subarachnoid haemorrhage. The RCA had pulled out the lack of individualised care planning in relation to the patient. The number of beds had been reduced to raise the staffing ratio to help to manage the layout of how the rooms were spread out. The patient in Newton 5 had had complex anti-coagulation issues. As part of the Fundamentals of Care Programme MR was working on, there would be greater ownership and the Falls Team would become more proactive in their approach.

KT queried how often the Falls Group met. MR reported that this was monthly. Any patients at risk of falls were discussed in safety huddles. Perfect Ward also picked up on assurance around falls.

KT queried the timings for Perfect Ward. It was in place in specialist areas like ITU and theatres. The pilot was going well in four areas and they had had positive feedback from the staff. It was hoped to have it adopted in September.

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

It was suggested that the following topics be raised at the Trust Board:

- Gold update including the variant identified in India
- Relatively low levels of LAMP saliva testing for staff
- COVID-related mortality rates including hospital-acquired COVID and how findings fed into the improvement plan for HSMR
- The CQC Maternity inspection report
- Increasing endorsements and the pathway to phasing out paper test results
- Nursing staffing ratios, bank and agency reductions in April, and local management work
- The large number of looked after children in Safeguarding, training in Maternity and the Mental Capacity Act
- IQPR 2 never events and 2 falls.

14. Meeting effectiveness	**Verbal**

Noted.

15. Any other business	**Verbal**

None reported.

Details of next meeting	

The next meeting will be held on **25th June 2021**, from 11:30 to 13:00, by WebEx meetings.

Signed …….

Print ………………………………………………………………………………………………….

Date …………………………………………………………………………………………………