Paper ref:	TB (09/21) 016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

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

Members:

Harjinder Kang	(HK)	Non-Executive Director (Chair)
Kate Thomas	(RS)	Non-Executive Director
Lesley Writtle	(LW)	Non-Executive Director
David Carruthers	(DC)	Medical Director
Mel Roberts	(MR)	Acting Chief Nurse
Kam Dhami	(KD)	Director of Governance
Helen Hurst	(HH)	Director of Midwifery
Chizo Agwu	(CA)	Deputy Medical Director
Sarah Carr-Cave	(SCC)	Deputy Chief Nurse
Dave Baker	(DB)	Director of Partnerships & Innovation
Liam Kennedy	(LK)	Chief Operating Officer

Apologies:

Parmjit Marok	(PM)	GP Rotton Park Medical Centre

Minutes	Reference
1. Introductions [for the purpose of the audio recorder]	**Verbal**
Chair HK welcomed Committee members to the meeting.	
2. Apologies for absence	**Verbal**
Apologies were received from Parmjit Marok.	
3. Minutes from the meeting held on 25th June, 2021	**QS (07/21) 001**
The minutes of the meeting held on 25th June 2021 were reviewed and **ACCEPTED** as a true and accurate record of the meeting.	
4. Matters and actions arising from previous meetings	**QS (07/21) 002**
There were no actions to update.	

4.1 Feedback from the Executive Quality Committee and RMC	Verbal

Executive Quality Committee (EQC)

KD reported that the eight national metrics for end-of-life care had been discussed. The Trust was currently sub-standard in all and an improvement/action plan had been presented. It had been suggested that end-of -life care be included as part of the mandatory training programme. The plan would be revisited in six months-time.

The Committee had also been updated on the safety huddles which had been taking place daily in 30 wards. KD advised that in organisations where safety huddles were in place, these had been rated much better by the CQC.

Four Never Events had been discussed. These had occurred in February and April 2021 and related to patients being attached to air instead of oxygen. KD reported that many actions had already been taken including the removal of many of the airflow meters. Around 108 similar incidents had taken place around the country in the last three years, demonstrating that the issue was not peculiar to SWBH.

Serious incidents (SIs) had also been reviewed.

Risk Management Committee (RMC)

The Estates team presented to the Committee; and the department's risks had been reviewed along with MMUH risks. Discussion had focused on mitigations and risk assessments.

DB commented that if end-of-life patients could be identified earlier, then more work could be done to keep them out of the hospital setting which would have a positive impact on their experience and other metrics.

KT queried whether the Palliative Care team was large enough to reach all the patients who might benefit from its input. DC commented that the team was not large enough, but the aim of the Quality Plan was to better train clinicians, so they would not need the Palliative Care consultants to be involved. Discussions were ongoing about relaunching initiatives (post COVID-19) to encourage clinicians to have more ownership in this area and to embed end-of-life in the governance structure of the medical teams.

DISCUSSION ITEMS

5. Gold update on COVID-19 position, including vaccine update	QS (07/21) 003

LK reported that recently, there had been a significant increase in COVID-19 positive patients. At the time the report was written, the community infection rate had been equal to the high rate seen in the middle of January 2021.

The Trust was currently treating more than 80 COVID-19 positive patients compared to 60 at the time the report was written, demonstrating the rising trend. The ICU department was currently full. Similar pressure

was being felt regionally and nationally, however Sandwell and West Birmingham was facing the highest numbers in the region.

A high proportion of admitted patients were unvaccinated. LK commented that public health data showed there was still a lot of work to do to improve vaccination uptake amongst the 30-60-year-olds age group. A concern was that community testing rates appeared to be in decline, posing a problem for hospital admission modelling which had historically used this data to plan services.

Support for additional Point of Care testing analysers and kits for the Emergency Departments (ED) had been requested from Black Country Pathology and region. A lack of testing capacity had caused significant flow problems in identifying COVID/Non-COVID patients, to the extent there had been some 12-hour EDA breaches.

LK advised that the Trust was currently on the cusp of cancelling elective work. This was a problem as the elective work was part of the restoration and recovery programme and was high priority, rather than routine focusing on P2 and cancer cases.

MR reported that staff at Sandwell and City were being registered for LAMP testing and the Trust was currently highest in the STP for LAMP usage. There were still two vaccination sites open and a workshop was due to be held to target new groups. Two large vaccination weekends had been staged to promote uptake of the vaccine and there were 28 pop-up vaccination clinics in operation.

A 10% increase in vaccine uptake in Sandwell and West Birmingham had been observed but progress was slow. West Birmingham rates had moved up to just under 70% and Sandwell's rate had improved to just under 80%.

MR reported that further pop-up clinics would be appearing in the Emergency Department (ED), Surgical wards and Maternity (for pregnant women and staff).

In terms of infection control, swabbing on admission had been updated but more machines and tests would be welcomed.

MR reported that staffing was currently challenged. Staff were very tired after working through two waves of COVID-19

HK commended staff who had appeared on media in support of the vaccination programme. HK queried why the Trust's population infection rate did not reflect plummeting national rates. LK hypothesised that national testing rates had been reducing, vaccination compliance was much lower in the Trust's area and outbreaks in the local area were more severe because of factory environments.

LW expressed concern on the impact of the situation on the urgent elective work and queried the response plans in place. LK highlighted the gynae-oncology tertiary work which was undertaken at the City site. There had been no ICU capacity at City for a couple of weeks and therefore, the Trust had not been able to perform a range of gynae-oncology operations involving some aggressive cancers which needed urgent surgery. Solutions were being sought. Pressure of nursing resource was a limiting factor. Discussions had taken place with other Black Country providers regarding elective work.

One of the biggest problems – raised with the local and regional Cancer Alliance - was that previous access

to 48 independent sector theatre sessions had been reduced to just two. A request had been made to increase access. University Hospital Birmingham (UHB) had priority because it was a tertiary centre. LK stated that it was a difficult balance to strike.

6. Maternity dashboard and Neonatal Data Report	QS (07/21) 004

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

The Caesarean section rate remained slightly above the national average. Elective caesareans had increased during the month, whilst emergency procedures had decreased. They would all be reviewed.

There was one stillbirth case in June 2021 involving a 25-week foetus. The mother presented at hospital with no foetal movement. In terms of ethnicity, the mother was black African. HH reported that the piece of work recently carried out by the Equality Diversity and Inclusion (EDI) team, had shown it was the area's black Afro-Caribbean women who suffered a higher incidence of perinatal morbidity, closely followed by Indian and Pakistani mothers.

Three neo-natal deaths had been excluded from the report because these were due to extreme prematurity. No serious incidents had been escalated to Moderate Harm group or HSIB in June which was a positive.

HH referred Committee members to the breakdown of births by ethnicity in the paper.

HH reported that in terms of National Neonatal Audit Programme (NNAP) data in comparison to other Neonatal units, the Trust had been performing very well against two previous outliers – temperature on admission and consultation within 24 hours with parents. However, the Trust was a high user of antibiotics in comparison with others, however a piece of work continued in this area.

KT welcomed the inclusion of the ethnicity data which had shown inequity of outcomes. She queried whether any training was taking place with obstetricians and midwives. HH advised that two EDI leads had undertaken a piece of work with the local communities and the workforce.

In response to a query from HK about service provision, HH commented that the Trust had been forced to alter the way it provided services during the pandemic (virtual appointments etc.) This had impacted staffing.

MR reported that the second part of Debbie Graham's report had been received which would enable the Trust to deliver what local women wanted in terms of service provision.

CA queried the reaction to the new NICE guideline around induction of labour. HH responded that the NICE guideline was currently in draft, but discussions about the issues raised had commenced.

LK raised the issue of staffing and commented that it would be useful to have visibility of the Trust's Maternity staffing position and any risks or concerns associated with it, for monitoring purposes. HH acknowledged that staffing was a struggle. Matrons had offered to work night shifts to ensure there were safe staffing levels in place. COVID-19 isolating protocols following contact 'pings' had badly impacted staffing levels at the Trust and the NHS more widely.

LW raised the issue of service user and staff feedback as a powerful tool for improvement and queried whether more resource might be needed. HH commented that the CQC report and the Debbie Graham report containing staff and patient feedback, would be helpful in deciding this question.

7. CQC maternity inspection: published report and response	**QS (07/21) 005**

HK introduced the topic by congratulating the Maternity department for the positive outcome of the CQC inspection. MR acknowledged the result and commented that the department had been assessed as 'good' because of the knowledge of the issues demonstrated by the leadership team. MR added that it would be important to be very transparent with staff.

HH commented that Maternity was extremely pleased with the result which had been achieved as a result of being able to effectively evidence its efforts. There had been some outstanding practice with midwifery and obstetric teams working well together and putting women and families at the centre of care.

HH expressed the view that the investment into the governance team had been worthwhile.

Areas identified for improvement were:

- Staffing levels - HH commented that recruitment had improved.
- Low morale - This was being tackled with culture workshops and other culture support.
- Mandatory training - The '100 club' training required improvement however, HH expressed the view that it was pleasing that professional training had been maintained throughout the COVID-19 peaks.
- One to one care in labour – This was currently being provided with some procedural waits accepted. This was likely to improve following the move to MMUH.

HH expressed the view that greater staff engagement with the initiatives currently in place would be required in terms of next steps.

HK welcomed a reference to international recruitment. HH commented that the Trust had previously struggled to recruit international midwives because most other countries had a different midwifery approach.

8. Mortality	**QS (07/21) 006**
a) Nosocomial infection	**QS (07/21) 007**
b) Improving Hospital Standardised Mortality Ratio (HMSR)	**QS (07/21) 008**
c) Mortality Dashboard	

DC referred Committee members to three papers:

- Nosocomial rates, numbers from this group and infection control processes.
- The improvement plan for the HSMR/SHMI work

- The mortality dashboard

Nosocomial Infection

KT noted that some wards were more likely to have higher nosocomial rates than others and queried whether any targeted education had been done with these wards. DC commented that it was the smaller, less ventilated wards within Sandwell that had more problems and this meant that infrastructure was a bigger issue than infection control training. MR commented that removing some beds and creating contact bay areas had helped keep cases under control. Maintaining regular swabbing of patients was also a focus.

HK queried how the Trust compared with others in terms of nosocomial infection. It was reported that the Trust had median rates of infection. MR confirmed that the Trust was not an outlier compared to others. CA reported that around 4.5% of deaths were due to definite, hospital acquired infection which rose to 10% if probable cases were included.

MR advised that one of the biggest challenges was caused by asymptomatic patients who presented at the hospital for other reasons. CA highlighted the importance of Point of Care testing.

HK queried why all COVID-19 patients were not all being treated at the City site, given Sandwell's ventilation issues caused by its infrastructure. MR reported that the Trust was trying to do this. It was also a challenge for the ambulance service to be transporting patients between sites.

Improving Hospital Standardised Mortality Ratio (HSMR)

CA expressed the view that the improvement work would need a project lead from the improvement team with formal reporting processes and administration staff. Activity was not happening as the Trust would want despite dedicated training and resources. CA expressed the view that change would only be delivered by formalising the process.

The Mortality leads had been meeting with the Coding team, but agreement was required to enable them to make necessary amendments to the prefix etc.

CA commented that September would be Sepsis month to draw attention to this issue.

HK commented that it was important to understand the issues and how improvements could be made.

9. The Perfect Ward implementation	**QS (07/21) 009**

The paper was taken as read. SCC highlighted that the Perfect Ward, SMART, quality inspection application had been piloted in the organisation since April 2021 and the wider rollout had commenced from June/July 2021.

The aim was to provide easily visible data around the fundamentals of care for patients, relatives, carers and external bodies.

So far, feedback from the areas piloted had been positive. The ease of use and real time data had been welcomed. The data can be analysed by individual area, directorate, group or CQC regulatory theme.

The roll out plan was in a four-week cycle and the aim was that all of the inpatient areas would be included

by the end of August 2021 and the wider non-patient areas to be included by the end of October 2021.

There was work to do with the specialist areas to develop their bespoke suite of audit questions.

HK queried the staff response to the data. SCC stated there was still work to do in relation to how staff utilised the results. The quality assurance framework around the project had been drafted which took into account all of the Trust's quality measures and some triggers which would support an in-depth review.

LW stated that ownership and developing an element of pride in work was important. Recognising staffing challenges, LW queried whether all the wards had good admin support to input data. SCC responded that engagement was sought from staff in every clinical area – the aim being to get everybody involved.

LK commented there was still work to do to determine what work really needed to be carried out by nursing staff and what could be delegated to senior ward clerks/ward managers. He suggested training could be introduced to support this.

10. weAssure Programme: update on in-house ward inspections	**QS (07/21) 010**

KD updated the Committee on the unannounced, in-house inspections. Since May 2021, a further 12 visits had taken place. Nine of these had been rated by the in-house inspectors as 'good' with three being given a 'requires improvement' rating.

There was now a 'squad' of 70 volunteers taking part as inspectors.

Emerging themes for improvement were:

- Staff knowledge of NCA, DoLS and Duty of Candour
- Learning form incidents and complaints
- Identifying the top three risks
- Understanding of clinical audits
- Access to the staff wellbeing services

Positively, KD reported that staff's knowledge and understanding of safeguarding had been well articulated and staff enjoyed working at the Trust. Visibility of leaders was good and patients felt cared for and welcomed. Freedom to Speak up had made staff feel that they could raise issues, but some were confused about the route. Good team working had been observed on the wards.

KD advised that the programme would continue as part of the weAssure plan.

LW queried the production timeline of the repository dashboard. KD advised this was planned to be ready by the end of September 2021.

11. 2021/22 CIP: Quality and Equality impact assessments	**QS (07/21) 011**

DC introduced the paper explaining that the CIP programme of £13.2m of which about £7m of schemes had been approved and required a quality impact assessment. The paper outlined the process that was followed.

Of those projects (in the paper) that the team had been asked to review, issues had been minor. There had been no QIA or EIA concerns about their delivery.

MATTERS FOR INFORMATION/NOTING

12. Integrated Quality and Performance Report: Exceptions	**QS (04/21) 012**

DB highlighted an error in the paper which appeared to link a high rate of falls and pressure ulcers to the Women and Children's department. This was incorrect and would be removed.

DB reported that the Imaging team would be reporting to the CLE August meeting on the GP five-day turnaround of scans.

There was a 172-minute neutropenic sepsis wait which was deemed to be an incident (correcting an error in the paper suggesting it was not an incident).

There had been 49 late cancellations of which 21 were avoidable.

DB commented that patient satisfaction was missing in the board level metrics. A job description for a lead had already been written and DB suggested that a paper be presented to Q&S Committee in September or October 2021.

MR reported that RMC had agreed that any sepsis wait over 60 minutes would be viewed as an incident with further discussion required for it to be deemed a Serious Incident (SI). Funding to support the introduction of a Sepsis Nurse was being considered.

A lead for the patient experience was being considered. Gap analysis would be undertaken to determine what the organisation needed and this would be reported to a future Q&S Committee for discussion.

LK commented that in relation to late cancellations, there had been issues with patients who did not have their swab results returned in time for them to undergo surgery. Availability of beds, especially in ICU was another problem along with staffing shortages. This situation had made achieving the same level of throughput difficult.

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

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

- Gold update – to include the impact on gynae-oncology
- Maternity update
- CQC Report
- Mortality and hospital-acquired COVID-19

14. Meeting effectiveness	**Verbal**

Not discussed.

14. Any other business	**Verbal**
None.	
Details of next meeting	
The next meeting will be held on 27th August 2021, from 11:30 to 13:00, by WebEx meetings.	

Signed ……

Print ……