Surrey and Sussex NHS
Healthcare NHS Trust

# Minutes of the Safety & Quality Committee
# Held on Tuesday 22 March 2011
# 09.00 – 11.00 AD77 Maple House, ESH

| **Present:** | | |
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| Yvette Robbins | YR | Chair |
| Michael Wilson | MW | Chief Executive |
| Richard Durban | RB | Non Executive Director |
| Bernie Bluhm | BB | Chief Operating Officer |
| Dr Barbara Bray | BBR | Consultant Anaesthetist |
| David Heller | DHE | Chief Pharmacist |
| Joe Chadwick Bell | JCB | Director of Strategy and Transformation |
| Sharon Gardner-Blatch | SGB | Head of Integrated Governance and Quality |
| Fionnula Robinson | FR | Director of Communications |
| Jo Thomas | JT | Chief Nurse |
| Vikki Carruth | VC | Deputy Director of Nursing |
| Des Holden | DH | Medical Director |
| Valerie Newman | VN | Clinical Lead for Patient Safety |
| Dr Bruce Stewart | BS | Consultant Microbiologist |
| Aine Killeen | AK | Minutes |

| **Item** | | |
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| | **WELCOME AND APOLOGIES FOR ABSENCE**<br><br>Apologies noted from: Rob Haigh, Virach Phongsathorn, Debbie Pullen, Norma Christison. | |
| **1** | **PURPOSE OF NEW COMMITTEE**<br><br>Chair opened the meeting with an overview of the purpose of the Committee: to focus on safety and quality which is consistent with national agenda and SaSH's needs. Previously, the Performance Committee, attended by both Executive and non Executive Directors, looked at performance across the whole of the Trust including financial performance, investment performance and workforce issues diluting time and focus on safety and quality.<br><br>The new Safety and Quality Committee is a dedicated committee which will be attended by some but not all Executive Directors and senior Clinicians to ensure that Safety and Quality is represented across the new clinical organisations and other governance personnel with pivotal roles in Quality and Safety. | |

Aim of meeting is to review Terms of Reference and to agree how we will work in committee meetings.
The Committee will focus its priority around seeking assurance in the Trust's management of clinical and safety issues and does not wish to repeat activity conducted in other parts of the organisation. As a sub-Committee of the Board, the assurance will then be passed to the full Board.

The Committee provides a layer of scrutiny between Board performance review and Divisional monthly reviews and quarterly deep dives, in terms of the safety and quality agenda.

As a new committee, the Chair stated that it may take several meetings for the Committee to properly establish itself e.g. fixing the agenda and finalising who sits on the Committee. However, the experience of two new directors, Des Holden and Jo Thomas, from the S&Q Committee at BSUH will help to expedite the set up and functioning of the S&Q Committee at SASH.

DH acts is lead Executive Director for the committee. He added that the committee functions around having assurance internally and promoting assurance externally. DH referred briefly to improvements made by the Safety and Quality committee that has been established in Brighton and Hove NHS Trust in the past 6-7 months.

JT referred to a shift in culture at Brighton and Hove in how people perceive safety and quality and the enhanced priority given to safety and quality, evidenced by a division led shift in behaviour. This included individual accountability to ensure clinical services are meeting safety and quality objectives.

VC stated that action plans need to be understandable to the staff charged with implementing safety and quality actions (e.g. band 5 staff) e.g. staff following pressure ulcer action plan can easily comprehend actions.

JCB explained that all ToRs from the new committees would be presented at a Board seminar on 28th April to ensure that the Trust doesn't duplicate work being done across committees and to identify any shortfalls. The Audit and Assurance Committee will continue to have an overarching assurance role over the other committees.

BE stressed the need to 'marry up' quality and safety alongside operations.

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| | **ACTION** Develop a plan to ensure operational decisions reflect patient safety and quality objectives.<br><br>BS emphasised that quality has a cost attached to it. Undoubtedly will be some aspects where we look at working processes in terms of our clinical commitments but there will be a need for money/resources to back that up in terms of analysing data, reviewing it and allocating appropriate resource.<br><br>For example in relation to radiological reporting errors: How do we look at it, how do we monitor it, what's the framework. In order to meet all the quality criteria we need people dedicated to take these agendas forward within each department. It is a time, focus and energy commitment and it does take people out on a day to day basis from their clinical service delivery.<br><br>JT agreed the need to look at resources that we currently have and ask are they working in the way we want them to work and do we need them to work differently. Having investigated this, we can then look at what additional resources may be needed.<br><br>BS added that an untapped resource is consultant SPA time as there are opportunities to make better use of their time. Other groups have healthcare workers – we need to have time protected in order to do audits. Antibiotic prescribing and pharmacists is a good example.<br><br>DH considering the cultural shift commented on his experience of antibiotic pharmacists spending huge amounts of time auditing; decisions needed to made around priorities and use of resources as junior doctors need to conduct audits, but organisational priorities have to be appropriately managed at that level. DH explained how a review of prescribing patterns and accuracy led to better reduced quinolone prescribing, £22k a month savings from which funded a pharmacist on the wards to reduce other broad spectrum antibiotics and reduce our CDiff rate. NB new money was not required. What it required was looking at the budget, funding work, priming it and being certain that we would get the reward for doing that that would enable us to carry out further work.<br><br>JCB reminded the committee of its assurance role and that it was not about performance management or management of action plans; it was about assuring ourselves that there is an effective plan in place, with dates and responsibilities and that is being delivered. | **JT, VC, BE** |

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| **3** | **TERMS OF REFERENCE**<br><br>It was agreed that Patient Experience was not represented in the Purpose of the Committee, although there was a view it was included in Safety and Quality. However to be explicit it was agreed to add another paragraph which recognised also includes other aspects affecting patient experience i.e. the environment, the way people are spoken to, the empathy, dignity, respect the patient receives.<br><br>Chair reminded Committee that Trust on an FT trajectory and starting its application later this year and therefore Monitor's view of Patient safety need to be acknowledged in the way the Committee sets up and works.<br><br>Compliance with regulatory standards is important – looking at regulatory bodies and internal controls. SGB had an important role in providing Committee with assurance that we are meeting our CQC requirements.<br><br>YR and RS shared frustrations with lack of communications around clinical audit outcomes as they were opportunities for positive assurance as well as flagging up concerns. DH responded that more clarity, structure and regular reporting was required.<br><br>FS informed committee that deadline for the Quality Accounts is 30th June when they are published on NHS Choices website and send to DoH. The quality accounts focus on improvement priorities which the Trust has measured in the last year and will measure for the coming year. The Committee will review trust performance on improvement priorities set last summer and agree priorities for 11/12. Draft quality account to be presented at next meeting.<br><br>The quality account reviews how Board assures itself of the improvement priorities that the Trust has set – clinical effectiveness, patient safety and patient experience in equal measures.<br><br>**ACTIONS /CHANGES**<br><br>**1. Purpose and Authority**<br><br>**ACTION:** Include a paragraph explicitly about the duties of the Committee to optimise the patient experience/deliver a patient experience strategy after 6.1.5. | **VC, JT** |

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| | **2. Authority**<br>Delete 2.3 plus (i) and (ii) for the present time. | |
| | **3. Membership and Attendance**<br>3.1 (v) Add Chief Operating Officer<br>3.1 (vi) Chief Financial Officer /his Deputy to attend as members. Invite to next meeting.<br>3.1 (vii) Add Deputy Chief Nurse | **YR** |
| | 3.4 Add Director of Communications | |
| | Review timing of Safety & Quality Committee meetings to check ability of Chiefs of Service/ clinicians to attend/arrange alternative | **DH/AK** |
| | Inform Divisional Nurses of deputising role at S&Q Committee when Chiefs unable to attend | **Chiefs** |
| | 3.4(iii) Invite Jamie Moore, Lead Nurse for Patient Safety to attend Committee when he joins SaSH<br>3.4 (v) and (vi) delete nominees;<br>3.4 (vii) Patient representatives | **JT** |
| | a. Identify and invite Links reps for Surrey and Sussex. | **FR** |
| | **b.** Derek Cooper from Patient Council to attend next meeting. | **YR** |
| | **c.** Brief new members in advance of next meeting. | **YR/DH** |
| | 3.4 (ix) Add Accountable Officer of Drugs | |
| | 3.4 (xi) Add GP<br>Invite GP (Dr Simon Deen) to next meeting* and brief in advance | **MW/DH** |
| | **4. Quorum**<br>4.1 Quorum shall be three members | |
| | **5. Meetings**<br>5.1 Meetings shall meet monthly for two hours<br>5.2 Aine Killeen shall act as Secretary to the Committee | |
| | **6. Duties**<br>5. (iii) delete paragraph | |
| | 9. "... well understood processes for escalating safety and quality issues and managing performance, including whistleblowing and patient feedback" | |

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| | 18. ***assuring*** that effective action plans are developed and implemented following reviews or investigations .....<br><br>19. Delete whole paragraph. | |
| **4** | **SAFETY AND QUALITY AGENDA**<br><br>Committee reviewed items and structure for the monthly agenda, deciding on frequency of review and actions were agreed on format and information requirements.<br><br>**ACTIONS/CHANGES**<br>***Insert***<br>**3**. **Strategies & Plans** (after Mins of prev meeting)<br><br>Safety and Patient Strategy<br>Patient Experience Strategy<br>Quality Accounts<br><br>Review plans to develop and monitor implementation plan/receive progress updates<br><br>**4. Safety and Quality**<br><br>**Divisional Safety & Quality Committee Reports (incl SUIs)**<br>**ACTION:** Minutes from monthly divisional meeting and quarterly deep dive meetings and SUI exception reporting and SUI tracker required to give assurance to the Committee<br><br>**ACTION:** BruceStewart/Des Holden to discuss with other Chiefs of Service differences between BSUH and SaSH in terms of Quality & Safety Lead roles to support SUI management – a role that exists in B&H but no equivalent title in clinical support services at SaSH.<br><br>**SaSH Safety and Quality Scorecard**<br><br>ACTION: Creation of dashboard for Safety & Quality Committee using traffic light systems. Agree content.<br><br>**Health and Safety report**<br><br>Annual report that the Trust has a legal requirement to complete goes to Board. The report comes to Management Board, Quality & Risk. **ACTION –** To review quarterly. | **Chiefs**<br><br>**BS/DH**<br><br>**BE/JT/ DH/ Chiefs**<br><br>**All** |

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| | **Clinical audit programme and audit results**<br><br>**ACTION:** Develop report format for quarterly review of audits completed and findings. Contrast with AAC role/ review assurance requirements. | **DH/EC AAC/ Chair** |
| | **IPCAS exception reporting *(remove from agenda)***<br><br>**ACTION:** Monthly IPCAS report presented at MBQR. As CDiff & MRSA KPI targets are standard items on the organisation's dashboard, no report required unless significant exceptions e.g. Saving Lives audit scores seriously dropping, noted rise in CDiff cases etc. | **BS/DH** |
| | **CQC compliance report & Regulatory timetable**<br><br>SGB stated work in progress to produce percentage scores against compliance for each of the Trust's registered activities. CQC Review of compliance report is will be presented at Trust Board on 24/3/2011. **ACTION:** Review format to present to S&Q Committee monthly to provide assurance of progress or highlight risks. | **SGB** |
| | **Incident reporting**<br><br>There had been some delays in incident reporting system – paper based systems causing delays. The organization has now recruited to the Datix Administrator post so this should see an improvement in incident reporting process.<br><br>**ACTION:** Update on new process and develop reporting format for monthly review | **SGB** |
| | **Add Mortality data/alerts**<br><br>**ACTION:** Monthly report required/as issued | **DH** |
| | **Add Accountable Officer reports**<br><br>**ACTION:** Quarterly report, highlighting exceptions | **DHE** |

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| | **5. Patient experience**<br>**ACTION:** Ensure RTM results reflected in scorecard and consider how responses and action plans can be better implemented<br>Complaints and Compliments – add to scorecard; remove here<br>Move "Quality Accounts" from this section to 3.<br>Remove "Stakeholder Engagement"<br>**ACTION:** Consider how the Committee can receive assurance around effectiveness of patient experience action plans at local level.<br>**ACTION:** Review draft Patient Safety policy prior to submission to Committee. | **VC**<br>**YR**<br>**JT**<br>**JT/DH** |
| **5** | **SAFETY AND QUALITY STRATEGY**<br>DH talked about it encompassing a range of actions and initiatives<br>**ACTION:** Circulate sample of draft safety and quality strategy to members of this Committee for review | **DH** |
| **6** | **SAFETY AND QUALITY SCORECARD**<br>It was agreed that a performance Scorecard was needed, structured in a similar way to the performance scorecard used at the Board, but with more detail and divisional evidence – to understand direction of travel and to provide assurance that progress is being made in a timely way. | |
| **7** | **AOB**<br>None | |
| | **DATE OF NEXT MEETING**<br>Provisionally 26 April (to be confirmed with Chiefs)<br>Email confirmation to be sent out as soon as possible | |

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