Minutes of the Safety & Quality Committee
Held on Wednesday 14th September 2011
2.30 – 4.30pm AD77 Maple House, ESH

Present:		
Yvette Robbins	YR	Non Executive Director (Chair)
Des Holden	DH	Medical Director
Martin Holland	MH	LINK, Surrey
Fionnula Robinson	FR	Director of Communications
Valerie Newman	VN	Clinical Lead for Patient Safety
Jo Thomas	JT	Chief Nurse, SASH
Bruce Stewart	BS	Chief of CSS
Bill Kilvington	CW	Assistant Director Clinical Services WaCH
Alan McCarthy	AMc	Chairman
Virach Phongsathorn	VP	Chief of Medicine
Jonathan Parr	JP	Quality & Standards Lead
Paul Simpson	PS	Chief Finance Officer
Vikki Carruth	VC	Deputy Chief Nurse
David Heller	DHE	Chief Pharmacist
Lisa Bangs	LB	Patients Council (Chair)
Richard Durban	RD	Non Executive Director
Norma Christenson	NC	Non Executive Director
Bernie Bluhm	BBl	Chief Operating Officer
Sharon Gardner Blatch	SGB	Head of Integrated Governance & Quality

Item		**Action**
	WELCOME AND APOLOGIES FOR ABSENCE Apologies noted from: Derek Cooper, Debbie Pullen.	
	APPROVAL OF MINUTES OF LAST MEETING & ACTIONS The minutes were agreed as an accurate record. Noted that due to lapse in time since last meeting actions arising would not be examined here and time would be focussed on the current agenda instead. Let SGB know any necessary updates and changes outside the meeting.	**All**
1	**Safety & Quality Strategy** Paper presented by SGB. The strategy has been developed in the light of a considerable number of internal audits, inspections and changes last year. It provides a framework within the Trust for coordinating and distinguishing between quality management and quality governance; it also clarifies roles and responsibilities and provides checks and balances	

	in the system. Whilst all staff would have access to this document, the information within it may be disseminated via different routes. Appendix 1 provides an overview of the quality strategy and appendix 2 comprises a work plan. It was widely concluded that the strategy provides a very useful framework for work within the Divisions and is helpful in providing a robust definition of quality. The range of issues discussed included communication, grammatical tightening and lack of detail around the plans to achieve objectives. Communication is a key issue for the Trust - capturing existing activities as well as cascading plans to the wards so that everyone understands their responsibilities and accountabilities. **The Committee ratified the Quality Management and Governance Policy and its overall approach subject to the minor amendments discussed.** **ACTIONS:** **1.1 The Quality Strategy was referred to the Executive / Management Board for clarity of objectives and key initiatives and implementation plans.**	**JT/DH/ SGB**
2	**Safety & Quality Dashboard** The dashboard provides a very useful device for monitoring progress on key issues. A 'traffic light system of red, amber and green is used, with green showing issues and projects that are on track to meet their targets red indicating areas of concern. Des Holden explained that some items were process focussed whilst others were outcome focussed. The dashboard helps to ensure that those metrics that are currently green remain so and others that are not start to move in the right direction in the coming months. It was recognised that the dashboard represents a starting point and metrics may change over time as SQC's seeks assurance in different areas. Discussion revolved around usefulness of the dashboard as a tool and suggested ways that it could be improved. Its' value is dependant upon sourcing reliable data. More work needed to be done to ascertain at ward level what patient comments really mean. It would be useful to identify on the dashboard the source of data used as evidence. Patient complaints and SUIs should be included within the dashboard. The range of issues discussed included mortality rates for fractured neck of femur and stroke care. These two metrics	

	were chosen as indicators because they were two of the highest mortality rates at ESH. For fractured neck of femur the reasons seem to relate to delay in prompt access to theatre and nursing patients on the correct wards. Limited access to the stroke ward may contribute to death related stroke. It was noted at the meeting that telemedicine which SASH is a member of has now gone live extended the service to 24/7. However it was noted that the decision-making pathway and the way that ESH practices in relation to these two issues is in line with the rest of the UK. The first three quality outcomes on the dashboard were discussed. It was concluded that whilst it was acceptable for ESH to be located within the middle 60% for some quality indicators the aspiration for dignity should be set higher. Discussion in relation to VTE included the need to correlate 'never' and other events with outcomes on the dashboard. **VTE**: Des Holden stated that data capture is a current concern because assessment results are not always recorded on Cerner. In addition, some patients are not having adequate VTE assessments. The Division is looking into how it can better collect information from maternity, for example. **ACTIONS:** **2.1. Amend dashboard format as discussed e.g. complaints, SUIs, cleaning stats, etc.** **2.2. Provide a glossary of terms, rationale for targets and sources of data for the dashboard.** **2.3 Presentation from both the Medical and Surgical Division representatives on their respective mortalities.** **2.4 CQC non-compliance: SGB to clarify key issues, action undertaken and ensure that related data is transferred to the dashboard.**	**BBL/JT** **DH/JT BBL** **VP / BBl** **SGB**
3	**Medical Division (ED presentation by VP)** VP presented some of the risks currently experienced in ED and what is being done to mitigate them. ED is not big enough for the volume of patients. This is being addressed through new rotas for the junior and middle grades, which are in place and increasing doctor numbers at high pressure times to improve throughput. An improvement programme to increase the physical space in ED had already started and internal working has been changed and streamlined. Main areas of concern included successful recruitment of	

	consultants, paediatric training of medical staff and number of hours being worked by doctors in ED. BBl confirmed that performance and patient experience in ED was a key focus and that it is necessary to view the problems in ED as a 'whole process' issue. Thus, ED is looking to improve those aspects owned by the department and is also working with others to change those aspects for which they are responsible. BBL tabled an ED Quality & performance dashboard and gave an indication of the indicators to measure the impact of the actions being taken. DH reported that he was very pleased with progress on recruitment and patient care in ED **ACTION:** **Executives to finalise the ED dashboard and link with SQC dashboard.**	**BBl**
4 **4.1**	**Clinical Audit** **Never Events SUI Analysis Update** VN reported back on recent 5 'never' event occurrences in theatres, three of which occurred within the last six months. ('Never' events, is a national term and refers to events that should never happen). The range of issues discussed included identifying accountability and sharing responsibility for never events. It was noted that the staff groups involved in these 'never' events were not always the same. The Trust has a process where those involved are dealt with individually. There is evidence to show that 'never' events are more likely to occur where the team ethos is more hierarchical, and that excellent teamwork is the key to making operating theatres safer. Focus on the WHO checklist and 'sign in' and 'sign out' has increased with daily reporting and challenge and has reached 97% against 100% compliance. PS reiterated that it was important that this Committee is reassured about action undertaken to resolve 'never' events. BBL confirmed that the surgical division report on 'never' events at their Deep Dive meeting and must report back to this Committee on key actions. DH reported that it had been previously agreed that safety themes would be reported to this Committee, of which 'never' events in theatres was one theme. It was widely concluded that 'never' events should continue to be monitored but that	

	the existing plan to further address the issue of 'never' events should be brought to the Management Board. **ACTION:** **4.1.1 Never Event preventative planning referred to Management Board for further discussion and action and report back to this Committee.**	**JT/DH**
4.2	**2010/11 Clinical Audit Report** The report highlighted a number of failings in the management and implementation of clinical audit resulting in poor completion rates and minimal value from the majority of completed audits at the opportunity cost of quality improvements It was widely agreed that it was necessary to focus on priority audits in order to ensure delivery in 11/12. Incomplete audits from 2010/11 will not be in the 2011/12 plan for completion unless they are national 'must do's'. Clarity on the reasons for the shortcomings in 10/11 report as well as insight from the internal auditors' report will help to ensure the success of the clinical audit activity. Leadership from Medical Director and Divisional Chiefs is key to successful implementation and better communication and sharing of outcomes will start to provide the basis of positive assurance and quality improvements. Committee requested a regular update on audit activity each month to provide assurance on progress as well as progress on implementation of recommendations listed in internal auditors' report.	
4.3	**2011/12 Clinical Audit Programme & Best Practice Audit Approach** Programme provided greater assurance about delivery based on learning from previous year and stronger emphasis on management and reporting as well as divisional performance management from Medical Director. Committee sought assurance on how adverse audit results would be escalated. The range of issues discussed included how the audit plan helps improve visibility and that considerable progress has been made this year. The Gantt Chart helps to reassure that ESH is succeeding in getting the required systems and processes in place. There is a need to monitor progress. DH reported that considerable progress had been made in tracking the status of the audit plan at two recent Deep Dive	

	meetings. Issue on clinical audit resources to better support CSS and a larger programme of audits this year remains outstanding and is on internal auditors' list of recommendations. Some debate about better harnessing the audit capability within the divisions to address this given resource constraints on the trust. **ACTIONS:** **4.2.1 JP to report back on how to best to share internal audit with Divisions.** **4.2.2 DH to report back on progress to the next meeting.** **4.3.1 JP to produce a pie chart for this Committee showing delivery of audits.** **4.3.2 Monthly clinical audit report is to be used as a mechanism to report matters of concern (i.e. a standing item).**	 **JP** **DH** **JP** **JP/DH**
5	**VTE performance (see under Agenda Item 2, pp3)**	
6-8	**Items 6 to 8** The following items were postponed to the next meeting due to meeting overrun: • Item 6: Press coverage • Item 7: Patient Experience)	
	Next meeting: 12th October <u>2.00</u> – 4.30pm in AD77 **Future meetings:** 9th November 2.30 - 4.30pm in AD77 7th December 2.30 - 4.30pm in AD77	