Minutes of the Safety and Quality Committee Meeting held on 12th October 2011 from 14.00 to 16.30hrs AD 77, Maple House, East Surrey Hospital

Present:

Yvette Robbins (Chair)	**Trust Deputy Chairman and Non-Executive Director**
Bernie Bluhm	**Chief Operating Officer**
Norma Christison	**Non-Executive Director**
Derek Cooper	**Retiring Chairman of the Patients' Council**
Richard Durban	**Non-Executive Director**
Sharon Gardner-Blatch	**Head of Integrated Governance**
Dr Des Holden	**Chief Medical Officer**
Martin Holland	**Surrey LINKs**
Dr Donald Lyon	**Microbiologist, representing Chief of CSS**
Alan McCarthy	**Trust Chairman**
Jamie Moore	**Lead Nurse, Patient Safety**
Dr Valerie Newman	**Patient Safety Lead**
Jonathan Parr	**Quality and Standards Lead**
Dr Virach Phongsathorn	**Chief of Medicine**
Dr Debbie Pullen	**Chief of Women & Children's Health**
Fionnula Robinson	**Director of Communications**
Paul Simpson	**Chief Financial Officer**

In attendance:

Dr Youssif Absouleiman	**Consultant Physician – Medicine for the Elderly**
Dr Laura Ferrigan	**Consultant Physician – Medicine for the Elderly & Falls Lead**
Philip Kemp	**Divisional Chief Nurse, Surgery**
Jamie McFetters	**Service Manager, Surgery**
Mr Praveen Panose	**Orthopaedic Consultant**
Hamish Wallis	**Assistant Director for Surgery**
Anne van Vliet	**Taking notes**

1	**GENERAL BUSINESS**			**Actions**
	1.1	**Welcome and apologies for absence** Apologies for absence were received from David Heller, Head of Pharmacy; Lisa Bangs, Chairman, Patients' Council' Bruce Stewart, Chief of Services, CSS; Jo Thomas, Chief Nurse; Michael Wilson, CEO.		
	1.2	**Minutes of last meeting** The minutes were accepted as an accurate record.		
	1.3	**Actions and matters arising**		
		1.3.1	**Quality Strategy -** Agenda item 2– action closed.	
		1.3.2	**Glossary of terms, rationale for targets and sources of data for the dashboard -** Agenda item 2 – action closed.	

		1.3.3	**Presentation from Medical and Surgical Divisions on respective mortalities-** Agenda item 4.3 – action closed.	
		1.3.4	**CQC non-compliance: SGB to clarify key issues, action undertaken and ensure that related data is transferred to the dashboard** Agenda item 2.2 – It was confirmed that the descriptors requested at the last meeting had been added to the dashboard (tab 2) action closed.	
		1.3.5	**Executives to finalise the ED dashboard and link with SQC dashboard** The committee confirmed that the ED indicators had been subject to further adjustment since the last meeting. Currently the information team were finalising that ED dashboard. **ACTION 1** **The updated dashboard including the final ED indicators will be presented at the next meeting.**	**1) B Bluhm**
		1.3.6	**Never Event preventative planning** An update of the managerial actions to improve the day to day management of the WHO checklist in practice is being received at the MBQR in October. This will be reported to the next SQC alongside the standing key performance indicators in the dashboard. **ACTION 2** **Report from MBQR at next SQC.**	**2) D Holden**
		1.3.6	**Sharing internal clinical audit** The Quality and Standards Lead is systematically attending all divisional quality and risk meetings to share the internal audit findings – action closed.	
		1.3.7	**Clinical Audit resources for CSS** Des Holden reported that he has reviewed the issue of CSS not having a dedicated data facilitator. This will not be resolved by simply enlarging the central data team. Des is continuing to work with Jonathan Parr to identify the best solution and the committee's assurance will be provided by delivery of the CSS data programme – action closed.	
		1.3.8	**Clinical Audit Pie Chart -** Agenda item 4.1 – action closed.	
		1.3.9	**Clinical Audit Report -** Agenda item 4.1 – action closed.	
2	**QUALITY STRATEGY**			
	2.1		**Quality Strategy Update and Implementation Report** The updated Quality Strategy was presented. Following feedback from the committee at its previous meeting, the quality strategy now described objectives and key priorities for the implementation planning by the teams for Clinical Effectiveness, Patient Safety and Patient Experience. Martin Holland thanked Sharon for the clarity of the document. Norma Christenson asked for the reference number of the new document to be amended to represent the correct version control which was agreed.	

		The consistency of not having ED as a separate improvement priority in patient experience was discussed. It was agreed that the priorities apply in all locations / departments. The dashboard is benchmarked to national, regional or local targets for performance and colour coded to reflect the performance level achieved. It was noted that the dashboard is not benchmarked to other providers. It was agreed that where it is possible this will occur whilst noting that the frequency of data to benchmark performance is variable. The chair requested the committee note that the strategy sets out the infrastructure first to support delivery of the objectives. Following discussion it was noted that the executive believe this will be in place by end of year and starting to deliver in quarter 4. ***The document was duly approved by the committee.***	
	2.2	**Quality and Safety Dashboard** **a. Review of indicators** **b. Exception Reports (verbal)** The committee were cautioned against using two data points and any variation between them as either positive or negative assurance. In relation to the improvements ED performance (August 2011) with time to treatment the committee was requested to note that when attendances dropped the systems in place had ensured patients received a much improved service. The capacity and demand issues facing the ED are well understood and documented. SASH score for VTE risk assessment is the worst in the area, but is showing steady improvement. The Chief Executive has written to all staff to ensure there is an increase in assessments, to reach the target of at least 90%. The Trust is requiring all risk assessments to be documented on the electronic system and are 'policing' this through performance management and publication of compliance by Consultant. The three mortality rates reported in the dashboard have all risen since the last meeting. The committee were informed that Dr Foster has rebased the national improvements back to 100 which accounted for the increase. Despite the rebasing the Stroke and Fractured Neck of Femur mortality rates remained significantly above 100. Questions were deferred to the specific agenda items. It was confirmed that there is no 'target' for cardiac arrests / MET calls. These indicators alongside the compliance with physiological monitoring are used together to gain a picture of how well the Trust is identifying and managing patients who are deteriorating. The committee should expect that numbers of cardiac arrest calls to drop and the numbers of MET/ Outreach calls to increase alongside a picture of high compliance with physiological monitoring. The HCAI indicators were given verbally at the meeting as 51 days and 8.5 days respectively for MRSA BSI and C Diff. The committee were informed that whilst the C Diff days between cases had decreased none of the cases were linked, there were no periods of increased incidence.	

		Jamie Moore reported that safety walkarounds were working well and he was forward planning for the coming year. The slippage of action to address the Health and Safety improvement notice is due to staffing recruitment. Both Occupational Health and Manual handling recruitment is progressing. The committee reviewed the validity of the chosen indicators for monitoring obstetrics in order to provide assurance following a number of serious incidents. **ACTION 3** **Neonatal intensive care needs reviewing to ensure figures are correctly recorded. Debbie Pullen and Des Holden will review and bring back their recommendations.** The number of readmissions within 28 days has increased as a direct result of early discharging to create capacity. Derek Cooper was disturbed to hear that patients are discharged early before they are ready to go home. Des Holden agreed that it was a concern and a balance of risks as there are also risks associated with prolonged hospital stays, such as pressure ulcers, falls, infections etc. The Trust is working with its partners to provide ongoing care. When emergency patients are waiting to be admitted, judgements have to be made. Norma Christison said that the dashboard looks bad when viewed by the public. It was noted that the number of complaints alone does not provide the committee with enough detail to understand the concerns. The exception report should contain information about the trends. **ACTION 4** **Review themes of complaints to give an overall view of trends and recurring areas of complaint.**	**3) D Pullen D Holden** **4) S Gardner-Blatch**
	2.3	**Executives Quality Report (MBQR / Deep Dive)** The committee were informed that the format of the Deep Dive has been reviewed. The Deep Dive will be held as an extended divisional quality and risk meeting with the executive attending. There was discussion about the issues in the report from both deep dives and the management board. Assurance was sought that the Trust was not financing initiatives e.g. extending pharmacy opening hours, using Medica to report radiology as a consequence of failing to address staff behaviours. The committee received assurance around the outsourcing of radiological reporting; a tendering exercise was being undertaken and ED clinicians were focusing on radiology in hours. The committee was informed about the extensive work around discharge in the Trust. They were requested to note that a cultural change needs to occur to successfully deliver discharge planning from admission. The committee agreed the content of the report and approved the format for future meetings.	

3	**SAFETY**		
	3.1	**SUI Themes – Falls Prevention** Laura Ferrigan tabled her presentation on falls prevention. She said that the majority of patients who suffer falls are elderly, but also surgical and orthopaedic cases. SUIs are investigated and themes have emerged concerning risk assessment of falls, the tool used, staff understanding and completion of the tool. LF acknowledged that a key part of any person's recovery includes rehabilitation and that a falls risk will always be present. The key factors being tackled are the cultural changes and increased awareness amongst staff. Falls Week earlier this year put particular focus on this subject. The falls group has identified 'high risk' areas for falls and targeted their pilot interventions in these areas. Interventions included non-slip slipper socks are being provided, ultra lo beds and risk assessed use of cot sides for beds. The falls risk assessment and care plan have been revised and are being piloted. The group designed and implemented a post falls patient management protocol in response to the NPSA alert. They are revising the Falls Management Policy. The committee were informed of challenges to reducing falls harm to patients; current therapy resources need to improve to ensure that a multi disciplinary approach to falls can be provided, a fracture liaison service is required. Alan McCarthy asked what the biggest frustration was. Laura replied there were insufficient resources and time. The screening plan needs to be more patient-focused and interventions put in place if required. Laura was thanked for her presentation.	
	3.2	**Safety Alerts Report** The report for April to September 2011 was presented. She said that every safety alert this year has closed on time. There are several currently being progressed. Overdue alerts go first to the division then to the management board for quality and risk. A common theme is delay in identifying the correct lead for the alert. Jamie Moore, patient safety lead nurse, is able to identify the lead. Chair raised concern regarding SaSH's legal liability if a safety alert was not responded to in time. DH proposed that benchmarking with other trusts' progress would be taken into consideration. **ACTION 5** **Yvette Robbins asked that the overdue alerts in the safety alerts report be reviewed and assessed by the Management Board for Quality and Risk in order to understand where SASH stands compared to other trusts and to report back to the Safety & Quality Committee if there is an ongoing safety issue.**	**5) J Moore**

4	**CLINICAL EFFECTIVENESS**		
	4.1	**Clinical Audit** Jonathan Parr presented the Clinical Audit Report and invited questions. Audit data intelligence has improved and will be more comprehensive next month. DH acknowledged progress was no as significant as he would have liked. Feedback to be received from a different division each month. If there is no negative feedback, narrative is required to give assurance. Minutes of local Divisional meetings should document detail and actions from audits. There were no exceptions to the implementation of overall clinical audit plan (including Internal Auditors' recommendations). External Guidance on NICE compliance identified lack of governance around assurance where Trust is not or only partially compliant as well as delays in nomination of clinician responsible for compliance review. Divisional reporting will help to address this issue along with timely reminders from Clinical Audit team. .	
	4.2	**CQUINS Report** Paul Simpson reported that this scheme offered potential income of £2.4m if the Trust can deliver on the eight areas of innovation. He said that four of the eight are achievable - VTE assessment, Enhancing Quality Programme, Outpatient Communication and Radiology Diagnostic Report. Ambulatory Care Sensitive Conditions and Inpatient Tracking both require further clarification as they are PCT pathways. There are two risk areas – Patient Experience and Enhanced Recovery. Progress is being monitored closely through the Transformation Delivery Group.	
	4.3	**Mortality Presentations** a) <u>Fractured Neck of Femur</u> Mr Panose reported that the mortality rate had been monitored for six months. Laura Ferrigan reported that the mortality rate was coming down and that recent deaths have not been unexpected due to multiple co-morbidities. There is national opinion that delay to theatre adversely affects the patient. Mr Panose said that delays to #NOF patients can be caused by delay to theatre or block in recovery if no bed is available on the ward. There is lack of clear management regarding prioritising #NOF patients. Best practice tariffs will not be achieved if beds are not ringfenced. Jamie Moore reported that, between January and March 2011 four of the 88 #NOF patients had Surgical Site Infections – a rate of 4.5% against a national average of 1.7% and in each case, patient infection was not unexpected due to co-morbidities. Dr Panose considered data collection for this quarter would not be consistent with subsequent quarters, with annual overall rate within acceptable limits.	

		Issues are: longer surgery time, laminar flow, theatre sharing, surgeon-related. POPPA is also being used as an inpatient area. Mr Panose will report to the management board next week. **ACTION 6** **Orthopaedic team report on SSI to Management Board** b) Stroke SASH stroke mortality rate is higher than average. Dr Youssif Abousleiman, Stroke Physician, presented results from his analysis of nine sets of patient notes were investigated following deaths during September 2011. In summary, all 9 patients who died were dependent, aged, had suffered severe strokes, with multiple co-morbidities and were prone to heart failure. He confirmed that care delivered to these patients met the nine care standards identified as best practice. On average, SASH patients have been more severely ill than the national average, had a higher death rate, but more of our patients were sent home independently than the national average. SASH has more cerebral bleeds than the national average and the men are 7 years older than the national average. Clinicians must validate the cause of death. Dr Abousleiman will be reviewing notes of all patients who die of stroke before submission to Dr Foster to ensure coding is appropriate. Causes for concern are: no ring fencing of beds; too many patients in bays. Early identification of stroke patients in ED is important. A new acute stroke unit with 28 beds has been planned. It is important to have only stroke patients in stroke areas. Stroke outreach and stroke thrombolysis will be available 24/7. A comprehensive mortality audit will take place with review of every stroke. Des Holden said he felt assured that a plan was in place. Data is not reflecting reality. The Trust is following the nine principles of best practice. A clinician is checking coding. Dr Abousleiman was thanked for his excellent presentation.	**6) D Holden / B Bluhm**
	4.4	**External Guidance (NICE / NCEPOD) Report** Covered earlier along with Clinical Audit.	
5.	**PATIENT EXPERIENCE**		
	5.1	**Patient Experience and Staff Engagement Report** Jo Thomas has taken over as chair of the group. With effect from November, the group will alternate between an internal meeting and an open patient forum to which people will be invited to hear a special topic. The first meeting in November will be an internal meeting focusing on Emergency Department.	

		Matters of particular interest to patients are nutrition, privacy and dignity, and communication between inpatients and staff.	
		ACTION 7 **There was concern that use of real time monitoring devices is low. Usage will be monitored and Jamie Moore will ask volunteers to help encourage patients to use RTMs.** Yvette Robbins said that patient issues would be addressed with a view to improvement by the end of the year.	**7) J Moore**
	5.2	**Annual Safeguarding Adults Report** Report issued for information. Any comments to be passed to Vikki Carruth.	
6	**ANY OTHER BUSINESS**		
	6.1	**Emergency Department** Bernie Bluhm reported that today SASH had been challenged for the third day by volume of ED patients and inability to discharge enough patients to free up beds. Communication between SASH and social care providers has been escalated to executive level. The threshold for discharge has been lowered. GP calls have been monitored. SECAmb have proposed a portable cabin to accommodate patients awaiting entry to ED, but this has been strongly opposed by SASH. Additional triage has been provided to the ambulance queue so they can be released but this puts additional pressure on ED. All elective operations were cancelled today which will greatly impact on the 18 weeks situation. Early discharge of patients in order to free up beds has created a risk.	
7	**DATE OF NEXT MEETING** Wednesday 9th November at 14:30 in AD77 Future dates Wednesday 7th December Wednesday 25th January 2012 Wednesday 22nd February Wednesday 28th March Wednesday 25th April Wednesday 23rd May Wednesday 27th June Wednesday 25th July Wednesday 22nd August Wednesday 26th September Wednesday 24th October Wednesday 28th November Wednesday 19th December		