TRUST BOARD IN PUBLIC	Date: 26th September 2013 Agenda Item: 2.2
REPORT TITLE:	Safety and Quality Committee Chair Update
EXECUTIVE SPONSOR:	Dr Des Holden
REPORT AUTHOR:	Dr Des Holden
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Safety and quality committee

Purpose of the Report and Action Required:		**(√)**
	Approval	
	Discussion	
	Information/Assurance	*

Summary: (Key Issues)

The committee was observed by a member of the Foresight team as part of the Board development work, and considered a number of presentations and papers under headings agreed at the review of Board committees. Of note there were presentations on themes arising in patient complaints (which showed fewer in relation to medical treatment, courtesy and communication but an increase in relation to appointments and diagnosis) and on the trust's your care matters and friends and family test performance (the trust was ranked 7th worst in England on the FFT).

A report on clinical audit activity in surgery demonstrated many of the drivers and constraints of the program and the committee felt that examples where change had been introduced would have further strengthened the presentation. Surgery presented their work on enhanced recovery which has improved significantly in recent months. The mortality review process was presented as experienced by the medical division and gave assurance to the committee who requested a similar presentation from surgery. the committee received a presentation on the use of Early Warning Scores as a theme within Sis as discussed at MBQR and was assured that appropriate focus and education was in place.

The requested review of progress against Francis recommendations suggested that an explicit timeline and oversight of how whistle blowing and raising concerns in general could be promoted in a positive way through the organization would provide assurance.

Relationship to Trust Corporate Objectives & Assurance Framework:

Underpins the trust objective of delivering safe, high quality and well evaluated services

Corporate Impact Assessment:

Legal and regulatory implications	Relates to CQC compliance
Financial implications	No direct impact
Patient Experience/Engagement	
Risk & Performance Management	Some assurance provided with suggestions of further work
NHS Constitution/Equality & Diversity/Communication	
Attachments:	
Appendix ….	

The meeting was held on 20th August and was well attended.

Patient Experience

The trust's external consultant in risk and governance presented a paper on complaints received by the trust and reported that although themes under which complaints are grouped has changed this year there was evidence that the total number of complaints received had reduced and that key themes in 2012 around courtesy and communication between clinical staff and patients and their relatives had reduced this year. All 450 complaints were closed and the divisions reported how they looked at complaints within divisional governance meetings. The new customer care manager (vacant post since governance consultation) starts in September and will help integrate action plans in relation to complaints onto the Datix system allowing tracking of actions as per SI. PALS contacts will be a categorized under the same heading as formal complaints to aid maximum learning. Three complaints are currently with the Health service Ombudsman. The committee was assured on the handling of complains and the lack of a backlog and asked for a further presentation in 6 months when the new approaches had embedded.

SaSH was ranked as 7th lowest of English acute trusts on the initial publication of the Friends and Family Test despite 89% of patients recommending it as a place to be treated. The committee received a report and had a wide ranging discussion on how this feedback was obtained and what this information meant. There were two significant differences between the SaSH system for administering this survey and practice at other trusts – that the question is asked after patients have left the organisation, rather than at the end of their treatment episode and it is one of a large number of questions asked. Plan s to change how this question is asked were described, to bring comparable information to other providers, but the richness of the additional information sought to inform patient opinion will continue.

Triangulation of patient experience with complaints seems to indicate that where patients have the voice to communicate concerns through Your Care Matters, patient opinion websites or other means, and the trust responds satisfactorily, they are less inclined to complain formally

Best Practice

A presentation for the lead for enhanced recovery explained that a bundle of pre- peri and post-operative interventions applied in particular to elective surgery had been shown to reduce length of stay and accelerate return to full activity. This process was called enhanced recovery and was an agreed CQUIN across Kent Surrey and Sussex. Challenges to delivering high numbers of patients through this pathway included data capture, out-sourcing of patients to other providers, a perceived lack of visibility to the trust Executive and a lack of therapists. All of these constraints were being worked through including recruitment to therapist posts for which funding has been approved. The committee were assured that progress was being made and more patients were benefitting from the pathway and asked for a further update along with other EQ pathways in 6 months.

The committee felt that the surgical division had made significant progress despite the chief of division focussing on problems with overall delivery. While there was room for improvement in aligning the audit programme with the Board Assurance framework, and the risk register, and more audits could have action plans with a commitment to implement and action tracking it was clear that here was a balance between national and locally developed audit and that the latter was built from incidents and local issues. The committee asked for further work through management board to tighten guidelines for setting and conducting programmes of audit.

A comprehensive review of how patients who die in the care of the medical division was presented by Natalie Powell, consultant physician and divisional lead for safety. This reviewed changes in IT capture of details of death and certification, and categories of death requiring further investigation. Case examples where learning arose being presented in governance and team meetings and at the medical grand round were given. The committee commended the work and asked for a similar presentation in relation to surgery to be made at a future meeting.

MBQR had taken a theme from SIs around the calculation and use of the early warning score to identify deteriorating or critically ill patients, and a paper was presented to the SQC in relation to the themes and actions that were being taken in relation to design of the chart, the incorporation of urine output, education to support use and professional standards of response to raised concerns. The committee was assured by the action plan.

<u>Regulation</u>

A review of recommendations made in the Francis report, and a gap analysis between these and the sash action plan was made by Andrew Clough, interim chief nurse. This paper confirmed the action plan was relevant (and built on assurance given when the plan was presented to the HASC). It did however suggest that further work could be done on cultivating an environment that set thresholds for expressing concerns about quality and safety of care, and also recommended that any need for whistle blowing was made as easy as possible. The committee recognised these areas, was assured by both the original and updated reviews and commended the plan to the executive.

Des Holden 19.9.2013