Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Safety & Quality Committee Meeting
20th August 2013 2pm-5pm
AD77, Trust Headquarters, East Surrey Hospital

Members Present:

Yvette Robbins (Chair)	Deputy Chairman
Sally Brittain	Deputy Chief Nurse
Richard Durban	Non-Executive Director
Richard Shaw	Non-Executive Director
Lisa Cheek	Divisional Chief Nurse Medicine
Jamie Moore	Divisional Chief Nurse Surgery
Des Holden	Medical Director
Colin Pink	Corporate Governance Manager
Jonathan Parr	Clinical Governance Compliance Manager
Virach Phongsathorn	Chief of Service Medicine
Barbara Bray	Chief of Surgery
David Heller	Chief of Pharmacy
Paul Bostock	Chief Operating Officer
Paul Simpson	Chief Finance Officer
Michelle Cudjoe	Divisional Chief Nurse, WaCH

In attendance

Michael Wilson	Chief Executive
Ian Mackenzie	Director of Information and Facilities
Alan McCarthy	Chairman
Angela Stevenson	AD Medicine
Pravitha Rajendraprasadh	Clinical Governance Consultant
Sue Heatherington	Foresight Partnership-Observing
Patrick Morgan	Consultant Anaesthetist
Natalie Powell	Consultant in Acute and Stroke Medicine
Lucy Burford	Executive Assistant to Chief Nurse and Medical Director- Note taker

Apologies

Debbie Pullen	Chief of Service-WaCH
Gillian Francis-Musanu	Director of Corporate Affairs
Bruce Stewart	Chief of Service- CSS
Sally Dando	Head of Therapies

1	**GENERAL BUSINESS**		**ACTION**
	1.1	**Welcome and apologies for absence** Y Robbins welcomed Paul Bostock as the new Chief Operating Officer and Sue Heatherington from Foresight Partnership who is helping the board prepare for Foundation Trust status and was observing the meeting.	
	1.2	**Minutes of the last meeting** The minutes of the last meeting in June were approved as a true record.	

	1.3	**Actions and matters arising** **Item 2: Discharge processes** **Update-** Work is in progress and plan is to put extra community beds in place. **Item 4: Patient Feedback** **Update-** S Brittain and H Hardwick are revising patient experience strategy and will share draft with colleagues. The strategy is to be linked with clinical effectiveness and safety strategies and update to be provided at next SQC meeting in October. **Item 5: Clinical Audit** **Update-** The winner of 12/13 audit prize was awarded to the Orthogeriatric team for ED timeliness of requirements for #nof. **Item 8: Quality Account** **Update-** Quality Account is now complete and hard copies are available from the Communication office. **Item 9: TDA Requirements** **Update-** C Pink is sharing QGAF with members of the Management Board and then this will be shared with the Non-executive Directors.	**SB/HH**
2	**Patient Experience** **Triangulating Complaints and YCM data** P Rajendraprasadh presented an analysis of the complaints received, by the key seven themes and trends and briefed committee on developments in the policy, process and team structure. For the period of 2012-2013 the Trust received 450 complaints in total and issues that accounted for 80% of complaints were medical treatment, (32%) followed by diagnosis (13%) nursing /midwifery(10%) , communication (10%) , missed diagnosis, attitude/courtesy (10%) and appointments (5%). All 450 complaints have been closed. Analysis of complaints YTD to June 2013 shows a reduction in the number of complaints arising from medical treatment, courtesy and communications but that complaints relating to clinical diagnosis, care and appointments had increased. New coding has been developed to categorise complaints in more detail and is also being applied to categorisation of complaints handled by PALS enabling their alignment in future reports and in depth analysis of themes, trends and potential risks. Action plans developed to address causes of complaints will be recorded in Datix with target times for completion, enabling lessons to be collated. Committee was informed that the new complaints policy was due for sign off by Execs and then training would be rolled out from September . There are currently 3 cases open with the ombudsman. One case is for the medical division and the other 2 for surgical. The 3 themes represented are rudeness, delay in treatment and poor outcome.	

	The committee heard that divisions used their governance meetings to discuss and share complaints, lessons learned and that there was now no backlog. It was noted that team structure and training were key dependencies for effective complaint management. The customer care manager, starting shortly, would identify trust wide learnings for sharing. The committee asked for an update on complaints in 3-6 months when the changes to service have been put in place. **Action 1** Chair asked that Board's IPQR included metrics for trust's performance on complaint handling as currently only the number of complaints is reported. **Patient Experience Update** I Mackenzie presented the patient experience update: the inpatient survey went live November 2012, ED February 2013 and Maternity will go live in October 2013. Your Care Matters has now been rolled out further to outpatients, day surgery, chemotherapy and angiography. Inpatient dashboards have been developed whilst ED dashboard is in the process of being developed. In July the national patient survey results were announced and scores reveal that SaSH came the 7th lowest for inpatients. It was acknowledged that surveys of patients during their time in hospital tend to rate services higher than after their discharge; the merits of surveying at point of discharge instead of at home up to 48 hours later were discussed. Nationally there is concern over the system which acknowledges only "highly likely" responses but not "likely to recommend" responses in the calculation of the score; both responses counted together show a total 90% of patients recommending SaSH. The overall response rate was 16% and the NPS score increased significantly from June to July showing that increased participation and ward based response plans collectively improved NPS score. The committee discussed whether patients are being asked too many questions in comparison to other acute Trusts who are scoring better and asking fewer questions. It was felt we needed to do both as YCM analysis provided granularity as to the underlying reasons as well as valuable qualitative feedback. It was also acknowledged that our response to complainants on social media and on patient opinion sites, often within hours of the complaint's posting, would be included by CQC as part of their data gathering intelligence. It was noted that SaSH was a early adopter of patient surveys (previously with Real Time Monitoring) and Patient Opinion, where our active engagement includes circulation of all posted complaints to Execs and senior staff. The Committee was assured that trust, divisional and ward response to complaints had helped to reduce incidence of some types of complaints and that specific issues were being addressed to improve patient experience. The Committee also acknowledged the role of PALs, Your Care Matters and Patient Opinion in collectively take some of the frustration away from potential complainants, reducing the volume of some types of complaints. However, further improvements in patient experience are still required to improve the proportion of "highly likely" recommendations and learnings and action plans	**GFM**

	need to be documented in governance meetings.	
3	**Best practice with evidence at point of care:-** **NICE Compliance: Enhanced Recovery** P Morgan attended the meeting to talk about the Enhanced Recovery Programme 2009-2013 which in summary is a quality pathway for elective patients enhancing their recovery following surgery. It was created to optimise pre-op condition, peri-operative care and post-op rehabilitation resulting in better outcomes, reduced LOS and a better patient experience. . A business case for funding of extra therapists and accessibility to therapists 7 days a week, has been approved but recruitment has not yet taken place. P Morgan asked for executive support to attend the bi-monthly meetings and P Bostock agreed to support ER team. ER has been rolled out within 3 specialities in 2 years and is supported by CQUINN funding and can be applied to most specialties. Audit of results show that ER's LOS has reduced favourably when benchmarked with peer group, but the balance is tempered with risk of increased re-admissions. Committee were informed that better coding and documentation would help to increase the proportion of patients that received the full ER package, currently 60%. It was also noted that the outsourcing of cases reduced the opportunities for inclusion on ER as the complete pathway was not in trust. Committee requested an update on EQ and ER in 6 months.	
4	**Regulatory Update/Status** **Review of Francis Recommendations** **HASC presentation** A Clough and S Brittain attended the Health and Scrutiny Committee meeting in July and reported HaSC were impressed with the Trust's response and action plan, noting that trusts had responded in very different ways. The committee sought assurance that the action plan developed in response to the Francis recommendations was robust and comprehensive. Our Interim Chief Nurse, A Clough provided an independent assessment of the plan and in his absence; S Brittain presented his recommendations to the committee. His recommendations for consideration included:- • some 'tightening up' and that some of the actions lack clear dates of expected completion • the establishment of local thresholds for reporting to professional regulators, poor, unsafe practice that harms or puts patients at risk of harm. This would contribute significantly to providing consistency and clarity in decision making when managers and clinicians at all levels are involved in disciplinary and remedial processes. • An action to commit to exploring a transparent safe staffing framework with commissioners, patient representative organisations and professional bodies. • An action to re-issue Trust Board members with a copy of the Nolan Principles. • a clear action to continually 'market' whistle blowing within the	

	organisation if it is going to achieve any change in the culture the NHS aspires to. The committee agreed that Execs need to discuss the recommendations first and asked how whistle blowing values would be reinforced and how staffing levels are calculated for assessing and defining safe staffing levels. The next step will be for the execs to discuss triangulating this piece of work with the Keogh reviews and will take to the newly formed workforce planning group **Action 2** Execs to consider recommendations for take up SB to report back on take up of recommendations and implementation	**Execs** **SB/AC**
5	**SUI Theme** **Early Warning Scores** The early warning scoring (EWS) system is used for the assessment of acutely ill patients and issues around the EWS calculation, escalation and response had featured in SUIs of deteriorating patients. At a multidisciplinary team meeting in July, a report of a working party was used to benchmark the current tool and outputs agreed include:- - A new EWS tool will be developed to circulate to the team for comment by 13th August 2013 to include urine output in addition to the other recommended measures within the national document. - Other local Trust EWS charts would be reviewed for innovations - EWS scores will be included on the electronic whiteboards currently being implemented within the Trust. It is important to get the tool right so it is fit for purpose. Once the tool is agreed, training will rolled out across the Trust early September to all doctors, nurses and. HCA's. An electronic solution is also required by the Trust and those that were identified for review are CERNER, Vital Pac and patient tracker. When the team have decided on the most appropriate solution S Brittain will write a business case to present to the Executive Team. Committee felt assured that that the new design and trust-wide training would help to address issues around EWS and asked the group to report in 6 months time to review evidence.	
6	**Clinical Audit** **Surgery's Clinical Audit 13/14 Programme & 12/13 clinical audit outcomes** The Surgical Division undertook 16 national audits and there was increase of 29% in the number of audits completed with an action plan. The division recognised that the audit objectives and quality of action plans produced need to improve. The objectives of the audit are getting tighter with 73% with good audit design however Division's overall rationale for 13/14 audit programme in line with trust objectives and/or BAF needs continued focus..	

	Of the 42% of 12/13 audits resulted in action plans and of those, only a third had action plans that were judged to be able to influence patient care/experience; in response have developed an action plan template to ensure plans are patient-focused. B Bray reported that the purpose of the audit is to provide assurance of what is being carried out and to make recommendations for improvements. While it is felt that individual audits have been worthwhile, the challenge remains to collate the findings and assess the impact as a Division in terms of improvement to quality, safety and patient experience. Use of the traffic light system had been very helpful The Committee felt that Division had made significant progress and had constructively critiqued its audit performance while missing opportunities to share areas of good performance, evidence for which existed but was not shared as difficult to collate. **Action 3** D Holden, J Parr and Y Robbins will arrange a meeting to look at how clinical audit is set out and agree the way forward.	**DH/JP/YR**
7	**Mortality Group** **Update and Hot Topics (Medical Division)** N Powell reported that the purpose of mortality review within the Trust is to monitor the cause of death, review each death that occurs in the Trust to determine the categorisation of death, detailed clinical reviews of deaths within the Trust (not exclusive to unexpected deaths) and identification of themes surrounding in-patient mortality. There are 4 categories of death and the focus is on preventing unexpected deaths (4.):- 1. Anticipated Death: • Due to terminal illness (anticipated by clinicians and family) • Following cardiac or respiratory arrest before arriving at the hospital 2. Not unexpected death which occurred despite appropriate medical management 3. Unexpected death which was not reasonably preventable with medical intervention 4. Unexpected death requiring detailed review All category 3 and 4 deaths are then subject to a detailed clinical review however any death can be subject to detailed clinical review if a learning point or concern is raised by any of the clinical team. Those cases which have been subject to detailed clinical review are discussed at the departmental mortality meetings. All stroke deaths are given a detailed review and mortality reviews provide assurance that the organisation is learning from in-patient mortality by determining if a death could have been avoided and if different influencing factors need to be addressed i.e. patient factors and organisational factors. **Action 4** Surgical Division invited to present Mortality in 3 months' time and B Bray will	**BB**

8	**Any other business -** none	
9	**Date of next meeting -** 8th October 2pm-5pm AD77	