Minutes of Safety & Quality Committee Meeting
Tuesday 24th April 2012, 14.00 to 17.00hrs
AD 77, Maple House, East Surrey Hospital

Present:

Yvette Robbins (Chair)	**Deputy Chairman**
Norma Christison	**Non-executive Director**
Bernie Bluhm	**Chief Operating Officer**
Lorraine Clegg	**Deputy Finance Officer**
Jo Thomas	**Chief Nurse**
Bruce Stewart	**Chief of Service-CSS**
Barbara Bray	**Chief of Service-Surgery**
Virach Phongsathorn	**Chief of Service-Medicine**
Jonathan Parr	**Quality Lead**

Apologies

Richard Durban	**Non-executive Director**
Des Holden	**Medical Director**
David Heller	**Head of Pharmacy**
Jamie Moore	**Lead Nurse**
Paul Simpson	**Chief Finance Officer**
Colin Pink	
Lisa Bangs	**Chairman, Patients Council**
Joanne Farell	**Matron, Paediatrics**
John Gooderham	**LINks**

In attendance:

Sacha Beeby	**Taking notes**

1	**GENERAL BUSINESS**		
	1.1	**Welcome and apologies for absence** Y Robbins welcomed members of the Committee and thanked everyone for their attendance. Future meetings would continue to take place on a Tuesday afternoon, as confirmed the most suitable time for clinicians. Apologies were noted as above.	
	1.2	**Minutes of the last meeting** **6.1 Action 9: Correction to wording:** Ensure that quality improvement priorities 12/13 align with 12/13 corporate objectives and patient experience objectives. The minutes of the last meeting were approved as a true record.	
	1.3	**Actions and matters arising** **2.1 Schedule review of Governance bodies in May agenda** Carry forward to May meeting	

		2.2 Dashboard to show measure of patient discharge BB confirmed that the current discharge policy will be placed under review following the recent media attention to patients being discharged late at night. BB confirmed that the metrics would be highlighted for May's report. **4.1 Review how national and college guidance is responded to, how and when it is mandated by commissioners into contracts and how SQC gets assurance around implementation and audit against best practice** The committee agreed that guidance received from NCPOD, NICE and RCP would be considered by relevant specialties and listed as a standing item for governance templates. An informed decision could then be made as to the implementation of the guidance. J Thomas and C Pink would audit this process. **6.2 KPI's in dashboard are clearly aligned with objectives in PE strategy in future PE reports** Carry forward to May report	
2	**QUALITY STRATEGY**		
	2.1	**Quality Account Timeline** J Thomas presented a paper which sets out the timeline for the production of the 2011/12 Quality Account. F Robinson was thanked for the report. Feedback to Trust Objectives has now been received by HOSC and LINks members. **Action 1: Chiefs of Service to feedback on Trust Objectives to FR/JT/DH/YR as set out in the QA timeline** **Action 2: FR to circulate Quality Report with SQC minutes**	
	2.2	**Dashboard & Exception Report** Y Robbins highlighted that the dashboard did not reflect some of the additional measurements agreed by the Committee in previous meetings. **Action 3: C Pink to ensure dashboard is consistent in its reporting to various committees/meetings.** Clinical Effectiveness # 27 – measured 6 monthly, which will mean that metrics are not available on a monthly basis. B Bray confirmed that March results will be available for reporting in May's meeting. Clinical Effectiveness #33/34 – B Bray confirmed that a delay in the Dr Foster reporting meant that the metrics within the dashboard would not reflect the improved mortality rate for FNoF and Stroke patients.	

		Clinical Effectiveness # 36b – B Bluhm confirmed that the metric should read 90.5%. Concerns raised for the high number of red-rated indicators relating to Patient Experience. It was noted that there appeared to be no significant improvement since June/July of 2011 which has been due to a discrepancy in the methodology used to calculate the RTM values. **Action: This will be refreshed for next month with the correct values**. **CP to action this**. B Bluhm confirmed that, when comparing the RTM data to that of July 2011 there has been improvement and when compared to March 2011, this improvement is more significant. This gradual improvement continues despite challenges in E.D and delays in discharge. B Bluhm reported that the discharge process was under review and that 6 wards were currently trialling a criteria-led, one-stop wardround discharge process which was less dependent on Consultants. The new format had received positive interest from medical staff. It was also reported that two workstreams were now in place to focus on discharges and looking at complicated cases and actively manage patients reaching their 40-day stay. Safety # 18 – B Bray clarified that the metric related to blood pressure. The issue is widely recognised and is detail at ward-level. Observations documented in patient notes. Feedback session for Consultants and HCA's. Put in place education and training opportunity at induction. Safety # 20 – J Thomas clarified the total number of falls reported had in fact decreased, as had the number resulting in harm. However the number of falls resulting in fracture had remained approximately the same. When studying these results, the trend suggests that the patients tend to be of elderly or dementia nature, often wearing inappropriate footwear and the location of the patient in the ward. Measures now in place to provide alternative footwear and to educate ward staff. Clinical Effectiveness # 29 – The committee was questioned as to why this particular metric was showing considerable decline. J Thomas confirmed that, amongst other initiatives, additional help from staff is now in place to assist patients at mealtimes.	
	2.3	**Executives Quality Report (MBQR / Deep Dives) Summary of Meeting (Feb/Mar)** A summary of the Management Board for Quality & Risk during February and March was circulated in advance of the meeting.	
3	**SAFETY**		
	3.1	**FNoF Action Plan Update** Extensive work by T&O and theatres teams to achieve the target.	

		Between 40-50 patients per month. Concentrating on 2 key factors; • The way work is escalated during peaks and how volume of work is managed • Ensuring medical fitness of the patients We were 79.23% compliant with 36 hour target in March. This meant that a total of six patients were not operated on within 36 hours due to further interventions needed. This is the only item remaining regarding the obtaining of the Best Practice Tariff. Concentrating on balancing the risk taken with this elderly group of patients and needing a shift in thinking to ensure early operation. However some patients (approx 10%) will remain unfit. Improvement in number of patients sent to ward within 4 hours but this is dependent on the situation of the hospital. Peaks of admission require cancellation of elective work and working additional hours. T&O are working on a protocol for this. Dr Foster statistics reflect the reduction in mortality with relative risk of 109 in December – last month available. This is following work done by T&O and Orthogeriatricians to ensure accurate coding and documentation. The overall figures from Dr Foster reflect the information submitted in the12 months to December 2011 and will slowly reduce. No risk tool currently in place.	
4	**RISK**		
	4.1	**Datix Reporting – Update on Project Plan** The team's workload is under review to accommodate the additional support needed to this project. It has highlighted the need for additional resource and J Thomas will approach the TDG (Transformation Delivery Group) to make the request. **Action 4: J Thomas to discuss additional resource with M Wilson / P Simpson to expedite the approval process.**	
	4.2	**CQC Compliance** A report which provides an update on the monitoring of the Trust's compliance with the Health and Social Care Act 2008 Regulations 2010 and the Health and Social Care Act 2008 Regulations 2009. The report highlights 3 Amber risks (#1, #5, #9) all due to the out-patient survey results. **Action 5: The committee requested that the Outcomes defined by a negative or positive dial are split clearly within the table. J Parr to action this.**	

		A breakdown of complaints-by-outcome was presented in the report. A process which involved reviewing the content of each complaint and allocating them to a specific outcome. Many letters relate to more than one outcome so the metrics within the table do not reflect the number of individual letters received. The reporting enables the team to address key areas of concern and to make a comparison of the ratio of complaints to patients. The peak in complaints relating to CQC Outcome #1 was related to staff attitude, including abruptness, patients feeling rushed and not understanding the consultation. The peak in complaints relating to CQC Outcome #4 was related to the cancellation and waiting time to operation/clinic appointments. The Trust has looked at offering outsourced appointments to those patients concerned but often this offer was refused in favour to wait for the next available appointment at SaSH. A similar process will take place to monitor compliments received. **Action 6: Update on source of complaints and action trackers**	
	4.3	**CNST Update** The Trust has been advised that it would be better placed to apply for Level 1 in light of the recent meeting with the CNST external assessor. This assessment would be in February 2013 with a proposed fast-track application for Level 2 six months later.	
5	**CLINICAL EFFECTIVENESS**		
	5.1	**Clinical Audit Report** A paper was presented to provide an overview on progress of the Clinical Audit Programme, progress on the internal audit recommendations for Clinical Audit and issues relating to Clinical Effectiveness including NICE guidelines. J Parr confirmed that 82% of the audit programme had been completed with a 10% improvement on previous achievements. Progress was being made in CSS (84), WACH (84), Surgery (76) and Medicine (85) and this was demonstrated in the report. Audit recommendation #1 – admin support now in place to support this. Audit recommendation #2 – agreed that the workload should be shared amongst the clinical leads Audit recommendation #5 – Due for sign-off. Amend colour coding to AMBER Audit recommendation #6 – Monthly KPI's to be inserted into Dashboard. Audit recommendation #8 – Medicine/Surgery to present red risks and identify/rationale (BAF) Audit recommendation #11 – Bring forward	

6	**PATIENT EXPERIENCE**		
	6.1	**Patient Experience Age UK Focus Group: Dignity & Respect** A paper was presented to the committee, summarising the comments received from approximately 40 older people who are in the community served by SaSH. The questions were developed from the five key questions within the patient survey and supplemented with questions relating to equality, dignity and respect. Feedback received from each of the focus groups was mixed. Some of the participants were engaging and were appreciative of the contact made. Others were not so engaging and seemed not to appreciate our presence.	
7	**The Way Forward** Y Robbins shared with the Committee the plan for future Safety & Quality Committee meetings. In order to accommodate clinical commitments, future meetings will take place on the fourth Tuesday of each month. Times will remain the same. A rolling 12 month planner will highlight items/reports for future SQC agenda's and a new format of Agenda will commence in June. **Action 7: S Beeby to circulate confirmed dates for 2012.**		
8	**Meeting Review/Close**		