Surrey and Sussex NHS
Healthcare NHS Trust

**Minutes of Safety & Quality Committee Meeting**
**25th September 2012 2pm-5pm**
**Room 1, PGEC, Trust Headquarters, East Surrey Hospital**

Members Present:

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| Yvette Robbins (Chair) | Deputy Chairman |
| Richard Durban | Non-Executive Director |
| Richard Shaw | Non-Executive Director |
| Barbara Bray | Chief of Service-Surgery |
| Bernie Bluhm | Chief Operating Officer |
| Debbie Pullen | Chief of Service-WaCH |
| Sally Brittain | Deputy Chief Nurse |
| Lorraine Clegg | Deputy Chief Finance Officer |
| Colin Pink | Acting Head of Integrated Governance and Quality |
| Fionnula Robinson | Director of Communications |

In attendance

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| Karen Knox | Consultant Microbiologist - CSS |
| Sara Cumming | Clinical Audit Facilitator, WACH |
| Adaline Smith | Matron – WaCH |
| Amanda Curnow | Note Taker |

Apologies

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| Bruce Stewart | Chief of Service- CSS |
| Des Holden | Chief Medical Director |
| Virach Phongsathorn | Chief of Service-Medicine |
| David Heller | Chief Pharmacist |
| Paul Simpson | Chief Financial Officer |
| Jamie Moore | Divisional Chief Nurse (Surgical) |

| 1 | GENERAL BUSINESS | | ACTION |
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| | 1.1 | **Welcome and apologies for absence**<br>Y Robbins welcomed members of the Committee and apologies were noted. | |
| | 1.2 | **Minutes of the last meeting**<br>The minutes of the last meeting in August were approved as a true record, with the following corrections:-<br>Page 2, line 3: replace 'to drive out efficiency' with 'to drive up efficiency'<br>Page 3 -, 2nd pgh, final sentence - replace 'no holes in middle grades' with 'no gaps in the middle grade rota'.<br>Page 3, pgh 6, 2nd line – delete the word only, i.e. replace 'through the Trust's only welcome programme' with 'through the Trust's welcome programme'. | |
| | **1.3** | **Actions and matters arising**<br>1.3 Scheduling of clinical audit training programme for clinical audits leads in Divisions<br><br>**Following Actions Closed:-**<br>Old 3.1: Co-production unlikely to be received.<br>7.1: Y Robbins confirmed distribution of Quality Account to AAC | **D Holden/ J Parr** |

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| | | Members.<br>2.1: EWTD for nurses: All SASH rotas are EWTD compliant and onus on managers to ensure EWTD compliance as E-rostering system highlights those doing too many hours. Individuals sign to take responsibility, managers monitor health & wellbeing and escalation process in place.<br>3.1: Statutory and Mandatory training: YP reviewed provision - additional courses now available as part of pre-start induction.<br>4.1 Action 4: Y Parker has arranged more refresher training slots for existing staff on manual handling to improve compliance. (SB stated training required upgrading by H&S team).<br>5.1 A Flores to report % staff uptake of HCAI prevention training in next plan.<br>5.1 Action 6 Chairman has ongoing discussions with CEO re promotion and uptake of flu vaccination amongst SASH staff<br>6.1 Action 7: CP has benchmarked SASH's staff incidents against other Trusts in H&S report<br>6.1 Action 8: Execs have communicated to managers the importance of cascading actions and lessons from staff incidents. | |
| **2** | **12/13 Integrated Business Plan** | | |
| | 2.1 | Postponed | |
| **3** | **Infection Prevention & Control Annual Report** | | |
| | **3.1** | K Knox reminded Committee that trust failed Clostridium *difficile* and MRSA targets for last year, however, this year's actions included launch and audit of new antibiotic policy and new drug charts as well as other control measures and Trust was on track for achieving targets.<br><br>R Durban acknowledged good progress had and asked about remaining areas of concerns. S Brittain said that there was a current drive to improve IV line care, which is being audited more frequently. D Pullen stated that the new drug charts which forced reviews of antibiotic prescribed would help, however, the neo-natal unit has experienced a multi-resistant strain of Klebsiella, for which all babies are now regularly screened. B Bluhm stated that the significant positive improvements in Clostridium *difficile* and MRSA infection rates were closely aligned with the introduction of the drug charts and change in use of antibiotics, so feel confident about continued improvement, however some concerns remain regarding surgical site infections (update to Sept SQC) and planning for flu.<br><br>Y Robbins noted that there had been a particular increase in surgical site infections between January and March. Also need further reassurance about additional steps undertaken to improve yearly self-assessment scores in antibiotic education and training. K Knox confirmed that the orthopaedic prophylaxis audit was on track. S Brittain confirmed that the Houdini protocol trial is not yet complete but that it had coincided with a significant drop in the use of catheters.<br><br>R Shaw queried whether Norovirus was likely to pose particular concerns this winter on closed beds/wards. B Bluhm explained that the frail and elderly can be very significantly affected and that SASH could learn from some hospitals such as Frimley Park that appear to be little affected due to the cleaning products that they use. This year SASH will have significantly more space in which to actively manage isolation areas and the associated reduction in overcrowding in ED should help reduce infection rates. | |

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| | | The Infection Prevention & Control Annual Report was accepted. | |
| **4** | **Review compliance with CQC registration standards** | | |
| | **4.1** | CQC monitors trusts against 16 key outcomes – SQC is monitoring progress around 4 outcomes per quarter. CQC recently inspected Crawley against 4 outcomes, resulting in a very positive review. Discussion focussed on our ability to easily collate and signpost evidence and CP referred to need for software to manage this data challenge, especially within ESH. R Durban said that the Quality and Safety Strategy should show how its actions support CQC outcomes.<br><br>Y Robbins summarised need for a process, plan and timetable for delivery of SaSH's assurance methodology around our evidence for CQC outcomes. SaSH needs a clear process, to enable a collective view of assurance (as opposed to individuals'), agreed escalation process (e.g. where changes are adverse), signposting of evidence and acknowledgement of new process & buy-in.<br><br>**Action 1:** CP to develop a CQC Policy will effectively map out the process and produce a timetable for collation and signposting of evidence to support our ongoing CQC registration. | **C Pink** |
| **5** | **CQUINS update** | | |
| | **5.1** | L Clegg tabled a paper which showed the total contract value of CQUIN to SaSH is £4 million. CQUIN targets are set nationally and others locally and they tend to be based around best practice. SASH is achieving 6 (out of a total of 7) CQUIN targets, representing 2.5% of Trust income. Delivery of the 7th target, 'Audacious Goals', a Surrey and Sussex-wide CQUIN, continues to be a concern and represents a £1.8 million loss to SASH because we are not able to meet this target due to over-performance arising from increased A&E attendance and no reduction in referrals. | |
| **6** | **Review Risk Management Performance (Surgery)** | | |
| | **6.1** | B Bray confirmed that risks are reviewed monthly at Divisional meetings and relate to the working environment, equipment needed but unable to purchase, and to services not yet in place. B Bluhm stated that more scrutiny is required regarding how risks are placed onto the risk register and B Bray explained that their risk governance lead had been off sick which had not helped with appropriate risk registration/management.<br><br>R Durban stated that would like to be informed of significant concerns rather than getting tied down in the detail. It was agreed that presentation of Divisional risk registers at SQC should focus on key red risks and their management, once they had been approved at Management Board for Quality and Risk.<br><br>**Action 2: Scheduling of Divisional Risk register at MBQR prior to SQC review** | **C Pink** |
| **7** | **Consider recommendations from NICE, NCEPOD, National Service Frameworks and NPSA Safety Alerts - WACH** | | |

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| | **7.1** | The SQC have requested six monthly updates from each division for assurance around timely management of directives from the various regulatory bodies. D Pullen and S Cumming demonstrated WACH's process following receipt of the directive, allocation to an appropriate person, management of statement on whether it applied or not to WACH (or trust) and subsequent statement of compliance (full or partial) with audits to evidence full compliance when claimed. D Pullen confirmed that over the past 12 months response times had improved significantly<br><br>B Bluhm said SASH needs to make sure that it has a corporate process in place to clarify owners of cross-divisional guidelines which C Pink confirmed. Committee concluded it was fully assured. | |
| **8** | **Annual Health and Safety Report** | | |
| **8.1** | Further work has been undertaken since the last meeting to provide greater assurance that SASH is meeting H&S regulations, fewer objectives and benchmarking with other hospitals.<br><br>Reporting cultures differ widely between different hospitals. E.g. many hospitals still don't report as many RIDDORs, despite national requirements to proactively do so. SASH is ahead of most Trusts in reporting Serious Incidents, but is behind at reporting minor incidents. DATIX Web will speed up reporting rates and should have a positive effect on levels of minor incident reporting.<br><br>R Shaw queried SASH's performance on responding to incident reporting. CP replied that most RIDDORS result in generation of Risk Assessments and action plans. Divisions are slow in implementing actions to comply with H&S requirements, with CP adding this was not helped by lack of H&S officers within divisions and fall off in training. It was agreed that it was important to be able to differentiate between all actions and high priority improvements. Y Robbins requested rag-rating those high priority actions and rationalising action lists, to assist with prioritising workload and managing expectations.<br><br>Y Robbins summarised Committee's understanding that SASH is fulfilling its legal requirements but that further work is needed in some areas to address key issues and to provide assurance of implementation of high priority actions. The S&Q Committee formally accepted the report, thanked the contributors and requested an update of progress on key issues in four months' time.<br><br>**Action 3: CP to liaise with H&S and Governance team re rag-rating action plans**.<br><br>**Action 4: CP to provide an update against key issues in four months' time.** | **C Pink**<br><br>**C Pink** |
| **9** | **SQC Dashboard** | | |
| | **9.1** | **C Pink** presented the scorecard with the same measures as the Board scorecard, and confirmed that all data sources were now consistent for Trust scorecards and reports. Work remained outstanding on ensuring scorecard reflected measures agreed in Quality Account and in previous discussions between Chair, Medical Director and C Pink regarding greater focus on outcomes.<br><br>**Action 5 : C Pink to ensure dashboard is updated/customised for SQC** | **C Pink** |

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| **10** | **Safety and Quality Strategy Review** | | |
| | **10.1** | Some preliminary work had been carried out but C Pink apologised for not completing the update in time for the meeting, due to competing work pressures.<br><br>R Durban commented that there were no updates on progress on high priority areas and queried how this affects the Integrated Business Report. He also commented that it is now 18 months since the strategy was launched and 2 sub-groups (Patient Safety and Patient Experience) have not yet met.<br><br>C Pink agreed to feed back on progress and way forward at the next meeting.<br><br>**Action 6: CP to provide an update on Safety and Quality Strategy** | **C Pink/ D Holden** |
| | **Any other business**<br>None | | |
| | **Date of next meeting**<br>23rd October 2012 2-5pm, AD77 | | |



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