Surrey and Sussex NHS
Healthcare NHS Trust

Minutes on Safety and Quality Committee Meeting

25 January 2012 in AD 77, Maple House, East Surrey Hospital

Present	
Yvette Robbins (Chair)	Deputy Chairman
Bernie Bluhm	Chief Operating Officer
Norma Christison	Non-executive Director
Richard Durban	Non-executive Director
Martin Holland	Surrey LiNks
Des Holden	Medical Director
Pip Kemp	Divisional Chief Nurse, Surgery deputising for Barbara Bray, Chief
Chris Mullins	West Sussex LINks
Jonathan Parr	Quality Lead
Debbie Pullen	Chief of Service, WACH
Fionnula Robinson	Director of Communications
Paul Simpson	Chief Finance Officer
Bruce Stewart	Chief of Service, CSS,
Michael Wilson	Chief Executive

1	GENERAL BUSINESS		Action
	1.1	**Apologies for absence** Received from Alan McCarthy, David Heller, Lisa Bangs, Jo Thomas, Sharon Gardner-Blach, Jamie Moore	
	1.2	**Minutes of last meeting** Latest version of December minutes was not attached to embedded Agenda – to be re-issued with following corrections:- Attendance List:- • Sue Chapman deputised for Debbie Pullen • Caroline Francis Gould deputised for Bruce Stewart **The correct version of minutes with above corrections now approved as a true record.** **Actions carried forward:-** **2: RIDDOR metrics to be added to Board and SQC Dashboard** **5: Report on evaluation of Monitor's CQC Tool** **8: Demonstrate that key complaint themes are being addressed by Quality Strategy** **1.3.1. Peer review report not yet distributed** **7: Review Committee's appetite for E Midlands Quality Observatory Summary Dashboard for Aspiring FTs** While additional metrics have been added ad hoc as the need arises, following the meeting Des Holden has since suggested we need a more comprehensive review of the dashboard to provide better assurance as well as to meet our governance requirements for FT.	111207 Safety & Quality Minutes 7 Dec **BE** **JT** **JT** **JT**

		Action: Organise a review of metrics for implementation 12/13 Remaining actions are addressed in January's meeting agenda.	**DH**
2	**QUALITY STRATEGY**		
	2.1	**Quality Strategy Progress Update** - *Divisional Governance Framework* Paper was discussed in absence of any representative of the Governance team. Safety walk-rounds implemented at ESH and Crawley to give the Executive and Non-Executives visibility throughout the hospital and a better understanding of current issues and safety concerns are well received by staff. BE affirmed their value and that issues were addressed. Chair asked whether we should measure success from the number of walks or the outputs. **Action: JT to agree how issues addressed and actions implemented across different wards could be collated to provide assurance that walk-rounds have improved safety.** In response to Norma Christison's question re generation of alerts from Dr Foster, Jonathan Parr confirmed that alerts were generated from information that SaSH had provided and in turn any alert is cascaded to responsible manager for action. *(FNOF presentation later in agenda).* Paul Simpson confirmed that 10% CQUIN funding was granted on delivery of EQ programme and that SaSH will meet all EQ delivery targets. As a result of Essential Nursing Care, complaints about nursing had dropped out of top 5 complaints. Chair welcomed the news and asked that statements such as "decreases/increases" were backed up with evidence. Pip Kemp confirmed that the End of Life Strategy had been implemented since September and that strategy was more than just training. Chair welcomed the standardisation of the governance agendas for Divisions and received confirmation that response times were included in their review, given her concern about late incidence reporting and protracted resolution of complaints. Richard Durban suggested that report underplayed our achievements in some areas e.g. leadership. **Chair has asked that activities reports are formatted in context of all the strategic imperatives and objectives defined in the Quality Strategy. This will provide demonstrable assurance that the varied actions/activities align with the strategies and are implemented as intended and are achieving the objectives which may well involve triangulation of performance indicators.**	**JT/BE/ JM** **SGB/ Authors**

	2.2	**Dashboard & Exception Report** Dashboard was printed in portrait not landscape which meant it was difficult to understand trends as tables were incomplete on each page. There were also concerns about missing data (e.g. WHO compliance) and incorrect colour coding and the value of targets based on absolute goals where numbers were low. **Action: Secretary to ensure that hard copies of dashboard are landscape and readable.** **Action: Bernie B to review anomalies on missing data entry, scoring and accuracies in colour coding.** Concerns were raised over reported increase in SUIs for Nov and Dec. Des Holden said that we were now identifying some SUIs via different methods. PCTs have instructed us to count more categories of incidents as a SI e.g. falls resulting in Fracture Neck of Femur. The dashboard has yet to be enhanced for additional performance metrics agreed. Run dates and version numbers need to be added. **Action : Update SQC dashboard as planned with additional metrics from Committee** Despite increased focus on pressure ulcers by nursing staff, noting the data refers to the number of ulcers (*and not the number of patients as some patients may have more than one*), the trend shows fluctuating performance of the number of ulcers reported. Ward Managers reporting daily on Pressure Ulcer care. SHA is interested in comparing Acute Trusts which would enable SaSH to benchmark its management of ulcers and Committee would seek assurance from Chief Nurse as to whether this reflected increased reporting and not increased incidence. **Action: Commentary on pressure ulcer trends and consideration of trust's participation in SHA survey**	**SB** **BE** **JT/BE** **JT/BE**
	2.3	**Executives Quality Report (MBQR / Deep Dive)** Chair observed that MBQR meeting had been cancelled and that December minutes indicated several deferrals of agenda items and that some actions were outstanding such as consent training, lack of which was a risk to compliance with the CQC outcomes. Des responded that e- training has been piloted successfully and will take a month to train all doctors when rolled out. **Action: Update on timetable for consent e-training rollout** Richard D asked how well the MBQR was working. Paul S responded that the last meeting was cancelled due to attendance which is an issue currently being address by the Executive team. General consensus was that the agenda was too comprehensive and will be reviewed for a more achievable one. Michael Wilson confirmed that by the next SQC meeting, issues in MBQR will have been addressed.	**DH**

		Action: Provide assurance on MBQR new ways of working	**JT/DH**
3	**SAFETY**		
	3.1	**SUI Themes** - *analysis of SUIs over two years* Paper was discussed in absence of any representative of the Governance team. While the report provide a good basis for discussion, some further questions/issues arose for assurance, • Need to bring up to date - timeframe to Dec 2011 • Peaks in graphs (Mar 11, Jun 11) and peaks in number of incidents by division and type (e.g. surgical, falls) need explanation *(Pip Kemp said Never events and FNOF included as SI's would have contributed to peaks)* • Checking of chronology of dates for 46 SUIs (*understanding that incident date is date the incident is declared, not necessarily the date of occurrence)* • Does number or value of claims affect NHSLA premiums? • Update fall rates to Dec 11 • Expand reference to need for a more rigorous approach to implementing best practice NICE guidelines – issues and recommendations • No reference to number of outstanding actions and incomplete SUI action plans - issues and recommendations **Action: Paper with amendments to be re-submitted to February meeting.**	**JT/SGB**
	3.2	**Mortality Review** - *Fractured Neck of Femur* Des Holden presented the paper reviewing FNOF mortality rates Mortality rates of patient groups were in line with national average and that our largest mortality group remains the "elderly and frail". In order to reduce mortality rates, we need to operate on more patients with less delay and to identify diagnosis earlier. We have an older population and scores will worsen if we delay access to theatre. SaSH remains an outlier on stroke mortality (120; 116). Wards will be reconfigured and pathways revised as additional capacity comes on line so that beds are ring-fenced to push patients through right pathway. We hit 1-hour CT scan and achieved 90% VTE for month 9. Richard Durban reported that against EQ scores, SASH compared favourably amongst its peers. Des Holden reported that Surgical Governance meeting well attended by Doctors and Nurses etc. Bernie Edwards highlighted the issues surrounding theatre capacity. She confirmed that Trauma and Children take priority and that we do not use Cerner yet for theatre management. Some questions over order of FNOF cases on the list and their prominence for bumping when greater clinical needs arises. Michael Wilson said the issues were wider and related to have enough orthopaedic capacity to deliver more theatre work.	

		Action: Develop programme plan to address issues of job planning, theatre lists management and theatre capacity to reduce FNOF asap *Mortality review of ED carried forward to February meeting*	**DH/BE**
4	**RISK**		
	4.1	**Risk Register – *review of the effectiveness of risk escalation*** Bernie Edwards meeting with divisions to look at the role of the Executives and ADs in actioning risks identified and ensuring wider discussion and circulation. Brenda Kelly produces KPIs on risk performance. Recording percentage of actions closed on time, number of closed actions. Chair said Committee needed to see include risk management metrics in the Dashboard to provide assurance of progress towards effective risk management at all levels in the organisation **Action: Meet with Brenda Kelly to identify metrics**	**YR**
	4.2	**Information Governance – *review of information governance compliance and incidents.*** PS presented on behalf of Ian Mackenzie. Paper assured Committee of good progress and achievement. Richard Durban asked about expectation and level of ambition. *NB. Chair discussed this question with IM after the meeting and SaSH will not progress beyond current levels of IT compliance until Trust invests in corporate record keeping. SaSH is not alone in this position with other trusts also unable to move to the next level of compliance*.	
	4.3	**CQC Compliance – review of risks and their management** 2 SHA / CQC inspections – reported no compliance issues Draft report and action plan put forward following recent CQC inspection. Report concluded we were safe but key areas for improvement were around operational processes and patient experience, particularly in E.D. Michael Wilson told the committee that, following various conversations with the SQC, they do appreciate the Trust's difficult past and the journey we are now on to improve this. They are working with us to implement our goals. Chair was concerned about reliant on CQC reports to inform us of concerns and our compliance and CQC risk dials based on published information. She felt uncomfortable that where there was insufficient data we assumed some comfort. Pip Kemp reminded Committee of internal tool for assessing compliance which reviews evidence throughout the organisation against our requirements under each CQC outcome	

		Committee concluded that in future we need both sets of information to be aware of how we are seen externally based on data in the public domain as well as our own forward looking analysis of where we perceive risks due to lack of evidence of compliance. So in future we will continue to communicate concerns regarding our risks with SQC but the Committee will monitor the data on which we are judged in a possible inspection and look for assurance that we are proactive in preventing risks and responsive in managing risks to compliance before they hit the CQC risk dials. **Action: Two reports required: existing CQC Compliance Risk Dials and a summary of risks to compliance based on internal analysis.**	**JP**
5	**CLINICAL EFFECTIVENESS**		
	5.1	**Clinical Audit Report** - ***progress update*** Progress has been achieved over the year, with continuous improvement on previous years' performance on delivery of the audit programme. However, Des Holden suggested it is unlikely the full programme will be achieved by all Divisions due to over-ambition in setting targets. Aim to achieve 100% next year Chair observed there had been no improvement in assessing compliance with issued NICE guideline since previous meeting, with exception of Technical Appraisals. She asked that month's performance was compared with previous two months to provide assurance of real progress. Debbie Pullen reviewed the clinical audit programme in WACH and acknowledged it had taken some work to get a clear view but that it had helped her understand the true position of the Division in delivering the programme. She tabled some handouts for the basis of discussion and was thanked for her presentation. Chair also noted that Clinical Audit Report had not made any reference to progress on the implementation of recommendations from the Internal Audit report, many of which were key to improving the value and output of clinical audit to the Trust.. **Action: Clinical Audit Report to include update on implementation progress of all Internal Audit Recommendations** **Action: Clinical Audit Report to show three months' data on NICE guidance**	**JP** **JP**
6	**PATIENT EXPERIENCE**		
	6.1	**Patient Experience Report** It was agreed to defer this paper to the next meeting in the absence of any one to present it with the following amendments	

		• Summary page and Executive view that it provides assurance • Clearer alignment of activities with our strategic imperatives e.g Patient Experience Strategy, Quality Improvement Priorities, CQC/other etc to provide assurance that we are delivering our strategy as intended with evidence that patient experience is improving. **Action: re-submit Patient Experience report with amendments at February meeting**	**JT/SGB**
7	**Any Other Business** SaSH has recently been awarded Associated University Status in recognition of work by Des Holden with Brighton and Sussex Medical School. SaSH will take on a greater number of students and we hope this status will attract high calibre of Consultants and doctors. It will also give our staff great opportunities to seek honorary academic titles. Two new experienced consultant appointments for E.D will start between April and August and Medical Director vacancy advertised – interviews 2nd Feb as well as two experience GPs who will join the UTC in April and May.		
8	**Meeting review/Close** It was a difficult meeting in the absence of members of the governance team to talk through their papers, absence of deputies for Nursing and Medicine and an overall lack of effective administration with respect to electronic and hard copy papers. **Action: Chair to seek better assurance of cover for absenteeism and administrative support**		**YR**