Safety & Quality Committee

Thursday 5th June 2014 11.00-13.00
AD77 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Attendees:		
Richard Shaw (Chair)	RS	Non Executive Director
Yvette Robbins	YR	Deputy Chair, Non-Executive Director
Richard Durban	RD	Non Executive Director
Paul Simpson	PS	Chief Financial Officer
Des Holden	DH	Medical Director
Bruce Stewart	BS	Chief of CSS
Virach Phongsathorn	VP	Chief of Medicine
Michelle Cudjoe	MC	Deputising for Chief of WaCH , Debbie Pullen and Chief Nurse, Fiona Allsop
Colin Pink	CP	Corporate Governance Manager
Kim Rayment	KR	Interim Patient Safety & Risk Lead (Note taking)
Jonathan Parr	JP	Clinical Governance Compliance Manager
Denise Newman	DN	Divisional Risk Matron, WaCH
Sue Jenkins	SJ	Director of Strategy
Steven Adams	SA	Nurse Consultant for Older People and Dementia

			Action by
GENERAL BUSINESS			
	1.1	**Welcome, introductions and apologies for absence** Apologies noted from Fiona Allsop, Sally Brittain, Paul Bostock, Ben Emly, and Debbie Pullen.	
	1.2	**Minutes** **Amendment to page 3.** Paragraph 8, last line, need to add “within 1 hour” so the sentence will read; “He stated that caution needed to be taken when interpreting the data as it is not appropriate or an expectation that all patients suspected to have had a stroke are scanned within 1 hour”. With above amendments noted the minutes of the meeting were recorded as an accurate record and approved.	
	1.3	**Actions and matters arising** **Actions carried forward** Action 1: Risk 1545 is being monitored via Patient Safety and Clinical Risk Sub-Committee and Executive Committee for Quality, Risk and Clinical Care.	

		Action Completed Action 2: Additions were made to the Patient Experience Strategy as suggested. The Strategy was submitted to the Board and was approved. **Action Completed** Learning from mistakes. FA to bring paper to SQC in November Report from Data Assurance Committee being set up to oversee the implementation of the revised policy and work plans. BE – report for AAC in July and update to SQC in Oct / Nov Effectiveness of SQC. Discussions held outside the meeting, item to be carried forward by RS. This action was carried forward to the July agenda. FA to provide a review of themes and trends in complaints linking clinical diagnosis and care implementation. JP to present the 2014/15 annual audit plan. This was an agenda item at the June SQC meeting. **Action Completed** FA to bring falls update report in Nov Indications of lessons learnt and improvements made from Divisional M&M meetings. Update paper from all Divisional Chiefs to SQC in July \ BS to provide an update / progress paper regarding the Outpatient 5 year Strategy in July KR feedback the information from the Safeguarding leads to clarify the scorecard data. **Action Completed** PB to review the emergency re-admission rates, not including maternity that had increased during March and provide the reason and detail at the next meeting as to why. All committee members to feedback any comments / amendments about the draft Quality Account 2013-14 to Eloise and Des by the end of May. **Action Completed** SJ to look at the detail of the waiting times from the deep dives and add it as a risk to the risk register. SJ confirmed that the risk issues had been reviewed and waiting times risks are on the risk register for cardiology, diabetes and ophthalmology. Plans are in place such as extra clinics. **Action Completed** SJ to present the Deep Dive improvement plan at the next SQC. **Action Completed**	Nov agenda Oct / Nov agenda July agenda July agenda Nov agenda July agenda July agenda Carry forward to July agenda

COMMITTEE BUSINESS			
	1.1	**Highlights from Executive Committee for Quality, Risk & Clinical Care** A summary report covering the key points from the ECQRCC meeting held on 14th and 28th May was presented for assurance. The report covered a variety of topics including; the Quality Account Review; QGAF; an SI report; Lessons Learnt from SI investigations; Significant Risk Register; Speciality Deep Dive Feedback and reports from the 5 sub-committees. YR raised concerns that there is some duplication with the information in this summary of the minutes report and the quality report information. DH stated that these agenda items had been agreed when the new committee structure was put in place to provide SQC with adequate information for assurance. RS felt that the summary paper was useful as it is SQC's opportunity to see that the Executive Committee are challenging appropriately and following the new Quality and Governance Committee Structure. He stated that he felt the committee needed to see the other documents too in order to get a handle on the wider picture. DH explained that SQC need to see that the Executive Committee are discussing the right things and be able to build confidence that the Executive Committee and Sub-Committees are managing the issues. It was agreed that the committee should continue to receive all the agenda items including the Executive Committee summary report, as it enables a 'global' picture and provides more confidence in the processes and assurance. RS stated that the discussion about the SI report highlighted the risk about medical notes availability. DH replied that this was an interesting incident for the Trust, an external company were bought in to complete the investigation and write the report due to resourcing issues. Two key things were highlighted. First of all there needs to be a change in culture and expectations of accessing medical notes 24/7. Secondly, Cerner has the functionality to provide allergy information but as an organisation we don't use it in the way we could and to its full potential and functionality. As a result from the discussion at the Executive Committee, 2 working groups have been established. The first programme of work is to look into case notes / medical records availability. Ian McKenzie is bringing an update report on this work back to the Executive Committee in 2 weeks. The second working group is looking at the Cerner issues and has a timeframe of 4-6 weeks before reporting back to the Executive Committee. YR stated that at the IPCAS meeting on Monday there was discussion about how the Trust can identify patients with CPE. She asked whether	

		our systems are able to flag these up. DH confirmed that there is a better culture for using the system and flagging infection risks. RS stated that the committee can take assurance that the risk relating to availability of medical notes is being addressed. RS then went on to raise concerns that delay in the closure of SIs has been discussed at a variety of committee meetings for a long time and different promises and timeframes keep being set and yet the problem continues. He asked for assurance that this will be addressed. DH agreed that the SI figures have never reached the single figures agreed and that the majority of the SIs have been closed internally but have not been closed completely by the CCG on STEIS. There are also a number of SI investigations that have not been completed and closed internally and some have breached the investigation deadline. PS stated that this issue needs to be drawn to a conclusion. DH stated that he will be attending the monthly SI meetings held between the CCG and KR in future. PS explained there is an improvement in the closure of SIs in the Medical Division as they have a person coming in to specifically facilitate the completion of the SI investigations. VP confirmed that this is a temporary solution but seems to be working at present. The committee agreed that a meeting should be set up with the CCG preferably before the next CQRM on the 17th June to agree closure of the SIs that remain open on STEIS but have been closed within the Trust. **Action: KR to set up a meeting with the CCG to agree closure of the SIs that remain open on STEIS**	**KR**
	1.2	**Highlight from CQRM** PS confirmed that CQRM had not met due to the CQC visit. There had been a single performance conversation on Tuesday but nothing had been escalated. The same issues had been discussed which included; emergency c/section; stroke, setting up stroke rehabilitation services and appropriate pathways of care; and the urology review. PS stated that the Clinical Effectiveness Sub-Committee are due to receive an audit report from obstetrics regarding c/sections. CQRM will report back the output from Clinical Effectiveness.	
QUALITY PERFORMANCE			
	The information presented related to the information and data from April 2014.		

	Quality Report The report is a brief high level summary of the key points and any areas of risk or escalation from the Executive Committee for Quality, Risk and Clinical Care. It includes a high level summary report from each of the 5 sub-committees. DH stated that several of the sub-committees have large agenda and are finding that they are not discussing or giving some agenda items as much justice as they should. There is also a question as to whether the right people are at the meetings and the need to have all Divisions equally represented at all 5 of the Sub-Committees. There is a challenge in how the Divisions feed into the Sub-Committees. RS stated that SQC are relying on the Executive Committee and the 5 Sub-Committees to be effective in order to provide assurance and that it is interesting that there are teething problems. DH confirmed that they are not teething problems as such but more the actual realisation of the enormity of the work for the committees. The new arrangement of the committees has been a significant positive way forward and although there are some issues the Trust is in a healthier place than it was at. SQC should have confidence that the work can be done and they should be assured that the new groups are working. PS agreed that there has been a huge step forward but the reports at present don't have the depth required for assurance purposes. He suggested that there should be a retrospective page that allows more assurance about what has been done. YR said that it was an excellent report and she was heartened by the depth. She noted that the common thread that comes through is VTE. The score card identifies it as 95% every month but what does this mean. DH stated that the metric is made up of a number of strands. The deep dives explored VTE assessment by questioning re-assessment after 24 hours or as the clinical condition changes; these are areas that the Trust is not so good at. Initial assessment is better and reflected by the 95% metric. As discussed at the patient safety committee, the VTE nurse has identified poor discharge information is also a problem area and the VTE information counts all embolisms that occur whilst in our care and within 90 days of discharge from our care. YR asked whether the number of incidents is being tracked. DH confirmed that they are and the Clinical Effectiveness sub-committee has oversight of this. RS highlighted that the Patient Experience sub-committee have identified problems with bank and agency staff. RD stated that this is another driver for a move from bank / agency staff to permanent employed staff. RS acknowledged that there is a lot of work being done to address this as there is both a quality and financial need to use less agency staff.	

	RD raised a question about the effective use of theatres. DH confirmed that utilization needs to be better and that the operations team is making improvements in being able to fill the theatre slots. RS queried whether the right questions are being asked and feels SQC should see a plan. RD asked whether this falls under the plan of work PB is leading. PS confirmed it is and that there are a number of aspects to this issue with different interconnecting drivers. YR added that there seems to be a lot of time wasted waiting around to receive patients in theatres and send patients back to the wards DH agreed that portering was part of the issue but high bed occupancy and patient flow were also key factors. PS added that PB has spent time in theatres and undertaken observations of the current process flows. As a result he has identified a number of key issues regarding better use of time, staff and resources. Staff engagement in the processes and improving them will be important. RD highlighted that outpatients is another problem area that requires a review of the current processes and patient flows.	
	SQC Dashboard YR raised concerns about the 4 deaths of babies and the emergency readmission data. She will also speak to BE as the data has changed and she has concerns over the data quality. DN replied that a big audit is underway and there is a lot of work on-going around key risk factors such as poor weight; jaundice; discharge and many others. YR expressed that she feels assured that the work is going on to address some of the issues. RS asked of there are any more C.diffs. DH confirmed no. YR questioned why the Trust are discharging 230 patients after 10 pm and wanted assurance that these are not elderly or vulnerable patients. VP stated he was surprised at the number and offered assurance that they don't discharge patients during these times. He wondered whether delays in transport may be a factor but those cases would not account for the high numbers. DH agreed to look into the details of the data and feedback at the next meeting. **Action: DH to review the details of the discharge data and feedback to the next meeting.**	**DH**

	YR requested an update on the data quality strategy as she would like some peace of mind that the information is accurate she concedes that some indicators will vary but is concerned about the number of indicators that vary and the range of variation. She requested if it is possible to add a column regarding the confidence in the data and the significance. DH replied that a range of work is being undertaken into data quality and an overall data quality strategy and policy is being developed. **Action: BE to look into the possibility of adding a column regarding confidence in the data and the significance and provide some assurance about the data quality**	**BE**
	Ratification of Quality Account 2013/14 DH confirmed that the document had been circulated for comments from committee members after the last meeting. He stated that feedback had been received from all stakeholders and more content added. Data from particular National sites also needs to be included. The report will then go to the publishers with regards to putting it into a similar format to the Quality Account published last year. RS asked what the timetable is for completion. DH stated that it has to be published by the end of the month. RS said that he found the comments from the stakeholders more supportive. DH agreed that it demonstrates a better working relationship. BS highlighted that page 17 needs to be re-checked as part of the final process. YR highlighted that page 24 needs a line of commentary and page 29 needs re-wording, as it doesn't read well currently. RS concluded that any further comments should go directly to Des but on behalf of SQC the report is approved to go onto the Board for final ratification prior to publication.	
SAFETY		
	Deep Dives Integrated Improvement Plan All services were reviewed with a total of 30 reviews completed. The 4 strongest teams were maternity, clinical haematology, respiratory and therapies. The 3 areas of greatest concern were; - Opthalmology – waiting times, capacity, vacancy and recruitment challenges. The clinical leads are completing a review and will develop short, medium and long term solutions. - Breast service – were unable to demonstrate wider working relationships. They have been asked to re-do their deep dive and that is scheduled for 25th June. - Vascular team – personalities, clinical teams from St. Georges and Brighton	

	have been invited in to advise and develop action plans with the team. Going forward there are monthly divisional meetings to monitor the improvement plan. There will be an annual deep dive for each specialty prior to the business planning process. PS asked whether there were any safety and quality risks as a result. SJ confirmed the waiting times risks that have been added to the risk register. DH reflected that it was a surprise to hear that middle grades were not being supported and could push back as there was no consequence; the consultants are following this up. He found it useful to have a forum whereby opinions could be challenged supportively. Lack of embedded audit was also a safety and quality issue identified. A matrix has been developed that runs to 300 actions which will not be brought to SQC but exceptions reports against the deep dive action matrix could come quarterly. The Divisions are leading on their own actions. RS asked if there is a corporate overview of the plan. DH confirmed that there is a paper going to the Executive Committee. RD asked if it was a surprise to the Executives and senior managers with regards to who the best and not so good services were and asked whether there were any themes and generic Divisional / Trust wide issues uncovered. SJ confirmed that there hadn't been any surprises and that all the services were able to demonstrate areas of good practice. The themes were presented in the paper discussed in the previous SQC. DH stated that a key theme was how incidents are fed into the audit planning process, even the best services had to think about this when asked. He added that the process was helpful for the services to have an appreciation about the information held and known about them. YR asked whether this says something about how the Dr. Foster information is feedback to and discussed with the Divisions. DH confirmed this could be the case and is something that is being addressed through the Clinical Effectiveness group. RS asked what the proposed way forward is from here. SJ confirmed that the integrated improvement plan is being signed off at the Executive meeting next week. RS questioned whether the services involved have fed back into the improvement plan and been engaged in its development. SJ confirmed that the majority have commented and for those that have not she has taken silence to mean acceptance. The process of annual deep dives prior to business planning will not happen this year but will be in place from June – September 2015.	

	The process has provided assurance across the 5 domains but she is also going to add financial and environmental elements in the future. BS commented that one omission was the outpatient's service. DH replied that outpatients were included in the majority of service deep dives. BS agreed that was the case but felt it should be have its own stand-alone deep dive. RS concluded on behalf of the committee that it was a very good process and welcomed the arrangements for taking the process forward in order to build in the cycle of learning and business planning. The committee would like quarterly exception reports against the improvement plan as suggested by DH. **Action: KR to plan into the SQC annual agenda planner quarterly exception reports on the deep dive integrated improvement plan**	**KR**
STRATEGY		
	Dementia Strategy / Plan SA presented a report that consolidates the work completed in the past 6 months. He explained that the original plan was to develop a strategy for dementia care but the work turned into a scoping exercise of practice and the end result is the standard operating procedure. He described how he has tried to develop something that is practical and also aspirational. RD stated that the work is very interesting and asked how the Trust is going to make this happen, who is sponsoring the work to ensure that SA is supported in facilitating the roll out of the procedure. VP replied that SA reports to the Chief Nurse but the Medical Division feel the main aspects of the work fall to them and so are taking a lead in supporting SA as he moves forward with the work. He stated that the Division recognises that there are other adult wards and areas across the organisation that this work is relevant to. RD asked what the weight behind this is and the driving force. DH replied that the weight behind the work is significant. Everyone within the Trust wants to meet the challenge and it is part of the Estates strategy in terms of considering dementia care when new buildings, particularly inpatient ward areas, are being designed. SA added that dementia care needs to be at the heart of everything we do, if all services are accessible to one of the most challenging groups of patients, those with dementia, then they will be accessible to everyone. RS commented that it is an excellent piece of work but the key to its success will be the engagement of everyone within the organisation. He asked if there is Executive Board ownership of this. SA answered that there is Board ownership and that the uptake of training is an	

	encouraging sign that there is buy in from all staff and the fact that staff have identified themselves in need of training reflects the importance that all wards and areas are putting on this aspect of care. VP added that the Consultant Geriatrician and team and the Psychiatric team are actively involved and supporting the work and there is also the driving in terms of participation in the CQUIN. SA confirmed that the Trust is a lot further on in achieving the CQUIN already this year in comparison to last year. PS added that the leads are being resourced, it remains on the radar at the Executive meeting but is not talked about every week as it is not felt necessary to action plan every aspect of the project. However, it is seen as a huge priority for the Trust. RD agreed that it was best to be driven at 'ground level' rather than totally through the Executive. DH stated that the Director sponsor could be FA or PS. YR expressed that it is very interesting what we've started to do in identifying needs of specific patients. She agreed that the paper was excellent and agreed that by meeting the needs of patients' with dementia we will also meet the needs of a lot of other groups of patients. YR felt we should be taking this approach for more of our work for example looking at the needs of elderly patients particularly at discharge and also signage and information. She would like to see a lot more patient facing strategies although recognises there has to be a balance as we are a provider of services. DH commented that he felt that is the journey the Trust is on. RS asked if the training is deliverable and whether there is the resource to continue to support the uptake. SA conceded that it is always difficult to sustain uptake on training but feels it is about flexibility of the training and being able to deliver it at times the staff can attend for example at lunchtime, offer the training at the ward / department they work in and also develop some bespoke training. CP asked whether cascade training will be an option after the initial 500 people have been trained. SA confirmed that he is looking to establish dementia champions and cascade training could be something they could take forward. CP advised SA that he should look into joining the training group that meets regularly to discuss all aspects of training needs and development of new training. SA stated that the dementia group needs to feed into the Quality and Governance structure and strategy but needs to establish more clearly what the dementia group will look like. DH asked for it to be put on the agenda for the 2nd Executive Committee for Quality, Risk and Clinical Care in week 4 of the month.	

	Action: CP to add Dementia to the Executive Committee for Quality, Risk and Clinical Care agenda.	**CP**
PATIENT EXPERIENCE		
	Maternity Survey Feedback RS suggested that MC give the headlines from the survey and then the committee could ask questions. MC stated that the survey report is 18-24 months old and in the meantime some actions in response to it have been completed and the service is able to demonstrate improvements. The scores for labour / care were the same as other Trusts and lower in the care and afterbirth data. Work was completed to benchmark against other data and organisations. There is a new person in post now and there have been improvements in 1 to 1 care. At the time of the survey closure of the birthing unit also had an impact on the results. Postnatal care was also problematic but YCM survey results have shown that last month 90% of women felt their care was delivered with respect / dignity. The FFT score is lower than expected and is a mismatch with the YCM results. So, in August the service are holding a listening group for postnatal care to develop a more robust action plan. The service are aware there are some issues around staffing on the postnatal ward, particularly at night but it has been agreed to recruit 5 new staff. They have also implemented a 4 hourly 'check in' round from a compassion perspective. An 11'o clock stop has been introduced where support can be given to all women on the ward in relation to bathing, feeding and changing their baby. RS thanked MC and asked why there seems to be a discrepancy in the YMC and FFT data, are we asking the same questions in the same way. MC confirmed that the same questions are asked but the team are also doing walk arounds and have identified issues regarding food and the fact that the ward is crowded and busy. They hope that the listening group in August will give them more information. YR asked if the service is including the patient opinion data. MC confirmed this is being included. YR acknowledged the good work RS concluded that the committee can take solid assurance that the results from the survey are being acted on and improvements have been made.	
QUALITY		
	Trust Annual Audit Programme / Plan 2014-15 JP explained that this is the first year that the Divisions have managed their own audit plans since the function was de-centralised. The Divisions are still pulling together the learning from the audits completed and this will come back through the Clinical Effectiveness Sub-Committee.	

	A number of audits on the Medical and Surgical Division programme have rolled over from last year, particularly Medicines involvement in the National Programme. There have been less audits completed in the last year but they were of a higher quality however, there has been a drop off in the action plans. RS stated that the committee has raised concerns in the past about non-completion of audits and action plans, and requested assurance that the Clinical Effectiveness Sub-Committee will provide challenge and monitor closely the audit programme this year. YR asked whether the annual audit programme / plan have been to the Clinical Effectiveness Committee yet for approval. DH confirmed that the programme / plan have not been to the Clinical Effectiveness Committee yet. He reiterated that it is the first year that Divisional Chiefs have been asked to develop the audit plans. However, there had been an agreement that if the audit went onto the audit plan there was an expectation that it would be completed. If a junior doctor starts an audit and then moves on this will not be an acceptable excuse for the audit to remain unfinished. He added that it is not always necessary for all completed audits to have an action plan for improvement but there needs to be a clear understanding of the outcome. RS questioned whether there is a process for agreeing the suitability and appropriateness of the audits and whether they are achievable. YR added that there still needs to be the 'so what' factor added to the action plans, we need to be able to demonstrate the value from the audit programme. If a Division participates in a National audit we need to be able to clearly state where we are in comparison to the National findings, against other Trusts and what actions and improvements have been taken forward internally as a result. DH concurred that it is not unreasonable to want to know where we are in terms of benchmarking against other organisations and at a National level but there is usually a 12-18 month delay from the time we took part in the audit to the publication of the results and outcome. RD explained that the committee are looking for the judgment of the lead clinicians in the areas who are undertaking and overseeing the audits to state in the audit report narrative whether or not this is a good result and whether the outcome can provide assurance or not. He suggested that the Clinical Effectiveness Sub-Committee, Executive Committee and AAC need to see the plan, what was completed last year, the value gained from it and why we are doing the audits planned for next year and what we hope will be gained from them. DH agreed that this can be done and he will pick this up at the Chiefs meeting. **Action: DH to pick up the points raised by RD at the Chiefs meeting.**	**DH**
	Any Other Business and Review of Meeting No other business. CP offered to take the minutes in the future.	

	DN commented that she felt it was useful to attend and see how the committee structure works in terms of issues being discussed at Board, Executive and Divisional levels and concerns scrutinised or escalated. YR was concerned that the maternity survey was not seen until 12 months later but otherwise felt the meeting was useful and went well	
	Next Meeting Thursday 10th July 2014, 14.00 – 16.00, AD77 ESH	