Safety & Quality Committee

Monday 11 August 2014 14.00-16.20
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
Pauline Lambert	PL	Non Executive Director
Des Holden	DH	Medical Director
Paul Simpson	PS	Chief Financial Officer
Fiona Allsop	FA	Chief Nurse
Angela Stevenson	AS	Deputy COO, deputizing for Paul Bostock

In Attendance:		
Virach Phongsathorn	VP	Chief of Medicine
Debbie Pullen	DP	Chief of WaCH
Denise Newman	DN	Divisional Risk Matron, WaCH
Jonathan Parr	JP	Clinical Governance Compliance Manager
Natalie Powell	NP	Consultant and Mortality Lead - Medicine
Sally Brittain	SB	Deputy Chief Nurse,
Victoria Daley	SD	Director of Quality and Nursing Crawley, Horsham and Mid-Sussex CCG
Keith Middleton	KM	Medical Matron
Tapuwa Matinya	TM	
Linda Filby	LF	Surgical Matron and Gynae
Edwina Andersson	EA	Head of Legal Affairs
Gillian Cruse	GC	Note taking

			Action by
GENERAL BUSINESS			
1	1.1.1	**Welcome, introductions and apologies for absence** RS welcomed everyone to the meeting, especially Pauline Lambert as the new NED who will be a member of this Committee in the future. This was RD's last SQC meeting and RS expressed thanks to him for his hard work over the past years. PL gave a brief outline of her background and advised how pleased she was to be joining the Trust, especially after the good news following the recent CQC inspection. Apologies noted from Paul Bostock, Bruce Stewart, Karen Devanny, Kim Rayment, Colin Pink, Barbara Bray, Gillian Francis-Musanu, Barbara Bray	

	1.1.2	**Minutes** There were no amendments noted. The minutes of the meeting were recorded as an accurate record and approved. A request was made for a separate sheet to record actions from previous meetings. **Action 1: KR to produce a list of actions from previous meetings as part of the agenda.**	KR
	1.1.3	**Actions and matters arising from previous meeting** **Learning from mistakes.** **Action 2: FA to bring paper to SQC in November** **Fall reports** **Action 3: FA to bring falls update report in Nov** **Discharge data** Data coming from Cerner, but not recognized. There are arrangements in place for late discharges. BE is currently preparing an approach to recording data and a "Data Recording Group" is being set up. A data quality strategy will be put together as part of this group. An additional column to be added to give assurance around data quality. **Action 4: AS/BE to look at data regarding late discharges and bring back to next SQC. Review data validation regarding transport and TTO process to ascertain whether this is a recording issue.** PB to review the emergency re-admission rates, not including maternity from the March scorecard. YR questioned why the Trust is discharging patients after 10 pm and wanted assurance that these are not elderly or vulnerable patients. VP stated he was surprised at the high number and offered assurance that they don't discharge patients during these times. He questioned whether delays in transport may be a factor but those cases would not account for the high numbers. In response to a question from RS he gave assurance that patients are supported throughout the discharge. **Action 5: DH agreed to look into the details of the data and report to the next meeting**. DH asked for Dementia to be put on the agenda for the 2nd Executive Committee for Quality, Risk and Clinical Care in week 4 of the month. **Action completed.** **Clinical Audits** Outcomes, actions and learning to be included within clinical audits. The process has been agreed at a Chief's meeting. Each action to be agreed with a summary sentence of what it is about. The Executives are to drive this forward. YR advised that for BGAF/CQAF we need to understand what benefits the clinical audits bring to the trust for best practice.	FA Nov FA Nov AS/BE Sept DH Sept

		PS advised 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, why we are doing the planned audits for next year and what we hope will be gained from them. **Action completed. Plans will be taken to the AAC on the 9/9** **Outpatients Strategy** A 5 year plan is being developed. The actions noted from the CQC inspection are being addressed straight away and BS will report on progress to this Committee and the Trust Board next month. **Antibiotic prescribing** Actions to be taken outside of this meeting. **Committee Membership** RS reported that the Trust Board had approved the recommendation from the previous SQC Committee that Divisional Chiefs should become full Members of the Committee. They were therefore invited to attend all meetings. **Other actions from previous meeting completed or part of agenda for this meeting.**	
	1.2.1	**Highlights from Executive Committee for Quality, Risk & Clinical Care** **Key points highlighted:** • Positive assurance was given on performance relating to Mortality, Re-admissions, Maternity and the EQ programme. • Risk relating to Stroke performance was not escalated and the effective use of Stroke beds is being reviewed. • Progress continues to be made on SI closures. • Embolisms – need to feedback to next Executive meeting • A concern was noted about VTE Assessments / Treatments. **Action: DH/MS are dealing with this and will report to the Committee after further discussions.** In response to a question raised by YR regarding the timeliness of VTE, DH advised that there is a new “Whiteboard project group” set up which will create a 24 hour plan and establish data for discharges and risk assessment. • Junior doctor training: RD asked whether customer care training should be extended to all doctors, not just to junior doctors. FA advised that this is being reviewed via the Patient Experience Committee. The eventual plan is that everyone will have this training but initially it will be focused on the junior doctors, who have the most face to face contact with patients. Once the pilot with junior doctors has finished a further review of the benefits and any issues learnt from the pilot will be discussed prior to moving forward. • It was clarified that the work reported was in relation to the last Inpatient Survey results. These had drawn attention to “Noise at Night” as a particular problem, and noise has now been reduced following a number of improvements. • It was clarified that an effectiveness review of Executive Committees and its sub committees has been completed. The principal issue	

		concerned divisional attendance and the need for the right people to be in attendance. There should be a routine of exceptional reporting and the right information being sent back by the divisions to achieve a better and improved focus	
	1.2.2	**Highlights from CQRM** PS noted that no issue had been escalated during July to the Single Conversation. It was noted that good progress had been made in closing legacy SIs. There is a "Deep Dive" taking place in August relating to Maternity Services, and this will include a focus on non-elective caesarian sections, which has been raised in CQRM. VD noted that this needs to be aligned with existing reporting to avoid creating additional work and reports.	
QUALITY PERFORMANCE			
2	2.1	**Quality Report** FA advised that the divisional governance report was presented to the Patient Safety group on 9 July and included a review of items on the Risk Register which scored 12 or more as well as open SIs. There was discussion of the increase in Patient DNAs; also that the incidence of hospital cancellations remains a concern, with a current backlog of about 250. The Access and Responsiveness Committee is examining how these may be reduced. The backlog is being identified by specialty. Some Locums are undergoing additional work to reduce the backlog. Ophthalmology more difficult. A plan is being reviewed but noted that not all cases are one off problems e.g. cataracts which require follow ups. In response to a question about the about Theatre Efficiency, which remains below expectations, it was stated that a working party is reviewing efficiency as aiming to increase work levels at Crawley from late September onwards. YR questioned current mortality ratios. **Action 6: Denise Newman to produce a short summary report on maternity and neonatal deaths ratios so it can be recorded and taken to Clinical Effectiveness Committee** RS raised the issue around the colorectal pathway and the relevant data collection which was a CQUIN requirement. DH advised that in his view data collection was an issue and has requested the clinical effectiveness committee to review the data presented. **Patient Experience** The results from Friends and Family were good in May but were slightly lower in June. There were continuing low response rates from Post Natal. C White is examining this as it is a national requirement to meet targets.	DN

		RD noted that the workforce figures imply a reduction in agency staff numbers while the figures in the financial reports imply an increase. He will pursue this in FWC Committee.	
	2.2	**SQC Dashboard** It was noted that the Dashboard was showing a mainly positive performance. The recent "Never Event" is still being reviewed and did not appear on the Dashboard for end June.	
	2.3	**CQC Inspection Report** The report had been discussed in full at the Trust Board, and SQC therefore restricted its discussion. RS congratulated staff on the positive outcome which achieved a Good rating across all domains. It was noted that some actions were needed to address areas of concern, notably in Outpatients. Following the inspection a Quality Summit, involving CCGs and other stakeholders, was held to report the Inspection findings and outline remedial actions where needed. The TDA will write to the Trust and stakeholders. The report and TDA letter will be tabled at a CQRM meeting. **Action 6: PS will to raise at CQRM.**	PS
	2.4	**CQC Intelligence Report** JP introduced the CQC Intelligence report for end July, which confirmed that the Trust continued to be given a Band 6 rating for risk, the lowest of the risk ratings. Four risks however had been identified relating to: 1) New CAS Alerts which are not closing on time. 2) Cancer wait times 3) Operations for Cancer 4) Data Quality. PS noted the increase from 1 – 4 risks, and that the recent Never Event will also be a risk in the next report. Identification of 6 indicators, or of one escalated risk, would lead to a change in the risk rating for the Trust to Band 5. It was noted that Executive Committee has reviewed the risks and put actions in place to mitigate them.	
PATIENT EXPERIENCE			
3	3.1	**Learning and Actions resulting from Patient Experience Feedback – ward perspective** Two presentations were made to the Committee about learning from Patient Experience feedback from the ward perspective and actions taken in response. The first presentation was given by Lynda Filby, Matron in Brockham Ward. Brockham Ward has 20 all female beds with Gynaecology and early pregnancy condition patients. There is a high turnover of patients with up to 8 – 10 patients per day being discharged. This presentation showed how the ward receives information from a number	

		of patient sources, including: **Your Care Matters** Your Care Matters leaflets are distributed in different colours. Family and Friends leaflets are given to patients on discharge and require a more focused feedback. **PALS** General comments are received and discussed **Compliments and Complaints direct from patients or families** Can come in both verbal and letter format. **Patient Opinion** There is an option to give more information after the initial blue card response. **Direct approach from patients** Lynda holds a "Meet the Matron" session weekly as well as discussions with other Matrons across wards to discuss patient comments. The information is shared in a number of ways, including: **Your Care Matters** All information received is shared with staff. Information goes onto the notice board in the ward and a board in the office. A Staff of the month nomination is made based on positive feedback received, and a League of Commendations encourages staff to be responsive. A summary is made of all issues raised and staff feedback encouraged. Even small changes can make the patient stay more positive, an example being the introduction of quiet bins and earplugs to respond to concerns about night noise. **Friends and Family chart** Green band is the recommended target. **PALS** The ward encourages PALS to visit or call the ward and speak to patients. Problems can usually be dealt with without becoming a formal complaint. Items are recorded in a Communications book to encourage learning. **Complaints** Complaints are discussed at ward meetings. **Patient feedback** Two examples given where feedback had led to changes. One related to discharges where the information was out of date. The second related to a nurse who had let other people down. The Matron was able to communicate directly with the staff member and deal with the issues outlined.	
	3.2	**(Abinger Ward) - Keith Middleton and Tapuwa Matinya** KM and TM's presentation covered the feedback received from a different perspective. They showed how negative comments/communications were turned around for the benefit of patient/staff.	

		In November 2013 the ward were receiving negative comments about poor communications. A Management programme was then attended by Tapuwa. The course based on the B&Q approach, where staff are encouraged to speak to people and the company is very customer focused. It was felt that a similar approach should be adopted in the ward environment. The ward has now issued badges to all staff to wear. a) Ask Me Anything Staff Nurses b) Happy to Help Nursing Assistants Patients and their families often perceived that nurses are always so busy that they could not be interrupted. The "Ask Me Anything" badge has resulted in increased confidence from patients and their families to ask questions, putting their minds at rest when often they had worried about what could be quite simple problems. Elderly patients often don't like to bother people and again the wearing of the badges has resulted in more positive feedback. A step was also taken to enter times on boards within the ward when doctors will be available. And a staff member sits in the bay during visiting hours to be more accessible. By being more proactive in offering information the ward has eliminated the queue that used to form at the nurse station. The YCM survey has seen an increase from 47% to 81% in affirmative responses to the question whether staff went "above and beyond" their duty to be helpful. The Committee commended the two ward for their efforts. In response to questions it was reported that: • Learning was shared through divisional meetings; • Consideration was being given to rolling out the badges to other wards at the Nursing & Midwifery Group; • Wearing a badge has led to a noticeable change in staff behavior; it has also been an important staff development in building their confidence to communicate with patients and their families; • Even small changes to the physical environment help to change culture but demonstrating to staff that when concerns are raised they are acted on. **Action 7: FA to discuss the rolling out of badges at the next Nursing & Midwifery Group (NEGs) and review costs.**	FA
SAFETY			
4	4.1	**Claims / Litigation Annual Report 2013/14** EA presented a report which has amalgamated data from previous reports and new data. She summarized the key points of the report: • 280 legal cases were open in 2013/14 and the current figure has now risen to 318.	

		• Since April 2009 there has been an increase in actions for inquests. • These increases in activity are reflected nationally. • Page 6 of the report extracted information for Q4 and Q1, broken down by divisions relating to new inquests and types. • Table 4 on Page 6 identified new cases throughout the year which has seen an upward trend. • Staff members who have suffered injuries are covered under Public Liability but there is a £10K excess. The trust does defend cases where possible. **Annual report** The report fulfilled a requirement by the Corporate Assurance Framework for a report to be submitted annually to SQC annually on litigations. EA noted that there was a change in the law coming into force in 2013 regarding conditional fee arrangements, which saw an increase in the number of clinical negligence claims submitted. This is reflected nationally. Legal team holds meetings with divisions to discuss trends and relevant cases. EA requested feedback from the Committee regarding the types of information that would be useful for future reports and the timescales. RS suggested that trends should be identified that were of particular relevance to a SaSH perspective, for example benchmarking against other hospitals. He also emphasized that what was important for SQC was to see learning emerging from the analysis that would lead to improved patient care. This should be triangulated with other sources of data, such as complaints or patient surveys. YR would like to receive raw data identifying what percentage of cases and findings come back to the trust that highlight any shortfalls to the trust. RD stated that the costs of payouts and administration and the efficiency of the process were of interest to the Trust. PL agreed this was a useful document but would like additional information regarding litigation claims and how they are analysed. SA suggested that divisions needed feedback from litigations and inquests to facilitate learning and that they may be able to help draft a template for reporting. EA suggested that improvements may be needed to Datix to enable identification of trends from the raw data. FA questioned whether Datix was a way forward for inputting data to make it more practical. It would be useful to have this information aligned to HS codes. **Action 8: EA and PS to work through Clinical Effectiveness Committee to develop a new report that would better lead to actions in response; and to report again to SQC in three months' time and**	EA/PS Oct

		quarterly thereafter.	
	4.2	**Update on Patient Safety Committee Task & Finish Group** Doctors were present at the last meeting for the first time. Opportunity to move forward. DN introduced the report and advised that there was currently an underreporting of incidents and differences in the way divisions report incidents. Midwifery had a better reporting culture, with no blame attached, but more training was needed in other parts of the Trust. DN and David Heller were leading a task and finish group on improving incident reporting and were half way through their task. It was important to learn from incidents. This required a move away from blame culture. Staff need to be assured that actions will be taken when incidents are reported, with better feedback. Historically it had been felt that it was pointless to report an incident if no action was going to result. The questionnaire could also be made more user friendly. It was important to ensure that moderate harm reports were genuinely moderate incidents. Mandatory training on Risk Management could be stepped up Maternity have ½ day training, but other divisions tend to have more limited time allowed. FA noted that a system has been implemented but not embedded to make it work. RS thanked DN and FA for this important work and asked for the conclusions of the task and finish group to be reported to the Committee in due course. **Action 9: FA to report the outcome of the Task and Finish Group to the Committee**	FA
QUALITY			
5		**CQUIN Report – achievements 2013/14 and Programme for 2014/15** PS produced a report on CQUIN achievements against objectives for 2013/14. This demonstrated that all objectives had been fully or almost fully achieved, subject to formal CCG approval by the CCG. He noted that coding of measurements should be an easier process in future years. The Committee expressed its satisfaction at this positive outcome.	
		Any other business No further business raised.	
		Review of Meeting	

		Positive debate, successful meeting. Meeting closed at 16.20.	
		Date of next meeting: 2 October: 14.00 – 16.00, AD77	