Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 3rd March 2016, 14.30-16.30
AD65 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Alan McCarthy	AM	Chairman
Pauline Lambert	PL	Non-Executive Director
Fiona Allsop	FA	Chief Nurse
Des Holden	DH	Medical Director
Paul Simpson	PS	Finance Director
Barbara Bray	BB	Chief of Surgery
Angela Stevenson	AS	Chief Operating Officer
Nicola Shopland	NS	Chief Nurse for Medical Division
Katharine Horner	KH	Patient Safety & Risk Lead
Jonathan Parr	JP	Clinical Governance Compliance Manager
Ben Emly	BE	Head of Information
Colin Pink	CP	Corporate Governance Manager
Sue Moody	SM	Clinical Quality Manager Horsham and Mid Sussex CCG
David Heller	DHe	Chief Pharmacist
Amy Lee	AL	Lead Antimicrobial Pharmacist
Donald Lyon	DL	Lead Consultant Microbiologist Antimicrobial Stewardship
Pawel Kaczmerek	PK	Consultant Haematologist
Apologies:		
Alan Hall, Ed Cetti, Vicky Daley		

		Action
1	**COMMITTEE BUSINESS**	
	1.1. Chair welcomed everyone to the meeting and apologies were noted. All attendees introduced themselves.	
	1.2. Minutes of the previous meeting CP requested one change to the minutes of the February meeting to clarify the details of the CQUIN discussion under section 1.4 ECQR. Taking into account this change, the minutes were formally approved.	KH
	1.3. Actions from previous meeting were discussed as follows **C/F 2nd April** **Discharge process** AS outlined a number of separate initiatives underway.	

	At the end of December a Medical registrar completed an audit of 101 sets of notes, covering one admission; 50 questions per set of notes. From this an action plan has been produced which is being taken forward. Key issues identified are; • Medical clerking – importance of establishing clarity of patient's pathway and length of stay as early as possible. • Use of whiteboards • The information given to patients around choice • Correct filing of notes with the medical record • Ongoing work through SASH+ patient flow value workstream Whiteboards – installed on each ward however did not meet the needs of the clinical teams, so Information Team has designed an alternative which has just been launched. The respiratory team has led the way with their operational respiratory pathway. Cardiology is keen to replicate the process within Cardiology. The project will continue to be monitored. Choice - A senior clinician from SCT has been working on site reviewing the choice process and the interaction with community teams. A number of opportunities for improving the knowledge and education of staff have been identified. In addition, Jayne Griffiths, new in post is reviewing the discharge process and team. AS suggested that the learning from each of these reviews will be consolidated into a report to be presented at SQC at a future date, with a specific action plan. The learning from Breaking the Cycle is being pulled into a winter review which will go to Execs in March. AS will ensure that it is loaded onto the Board pads for the April meeting and will take questions. AM asked AS to clarify what "rolling out" the use of the whiteboards means, whether it is voluntary or not. AS explained that the VMI initiative champions the principle that all design work be done by those on the "shopfloor". PS explained that the Trust is mindful of the importance of ensuring that new initiatives are useful to clinicians and that they "own" it. **C/F 1st October** **Audit of emergency readmissions** AS has reviewed the Quality Reports for the past 12 months and confirmed to the committee that emergency readmissions had not flagged as a concern. However, AS has asked the Risk Leads for Medicine and Surgery to undertake a small random audit of emergency readmissions within each Division which AS will report back next month.	AS AS AS

	C/F 8th December **Cdiff indicator to show a lapse in care** RS confirmed that the indicator is on the quality report. **C/F 4th February** **Non-execs invitation to Stroke deep dive** Completed	
	1.4 Highlights from Executive Committee for Quality & Risk Both meetings in February were cancelled due to operational pressures.	
	1.5 Highlights from Clinical Quality Review Meeting The February meeting did not meet.	
2	**QUALITY PERFORMANCE**	
	2.1 Quality Report AS talked through the main points of the report. RS observed that of the key areas of concern on page 3 relating to quality and safety, falls is to be discussed later in the agenda; VTE and Cancer are on the agenda for next month. RS requested that EC pick up the issue of breast symptomatic performance figure as part of his presentation. AM acknowledged that the operational pressures within the hospital were largely responsible for a dip in performance in a number of areas. He expressed concern about the stroke and fractured neck of femur figures. AS explained that on review it appears that in some cases there was difficulty in recognizing the stroke, access to a bed was not a problem. It was noted that performance in this area has improved and that SNAP performance is at a B; outcomes are also looking favourable. The same work is now being undertaken to assess the issues associated with achieving the performance target for fractured neck of femur patients. RS asked why ambulance performance had deteriorated in January. AS agreed that the numbers do suggest this but the experience is that operational performance is improving. The Trust did very well in the audit that SECAMB and the CCG undertook. SECAMB have stated that Trust performance has increased by 40%. The Trust is experiencing continued high levels of ambulance attendances. AS confirmed that this context will be included in the breaking the cycle report. PS informed the committee that improvement in ambulance turnaround had been recognised by the CCGs and the system	KH

	resilience group. Sussex CCG have agreed to repay all fines for the whole financial year, Surrey have agreed to repay three quarters of the fines for the year. RS asked about the crude mortality non-elective figure which had showing green at 3% for several months but is now red at 4.6%. JP explained that this was one patient with a complicated admission which is being reviewed by BB. AM asked what the process was for addressing issues raised by patients as part of the patient survey process, citing one specific example on the Quality Report. FA explained that this patient had also made a formal complaint. The consultant is aware and these comments will be included in the consultant's appraisal. RS asked about the FFT which he noted were mainly amber and red. FA noted that some of the figures related to response rates and some to the scores. She confirmed that the response rates are difficult to influence, for example there are particular issues around post-natal response rates and the number of touch points. The maternity team are handing out the card and asking for feedback at the time. There is now a ward manager and community matron in post which will help improve the figures. Maternity also have a user group, so FFT is only one element of feedback to the service. RS queried why the 97.4% inpatient rate is amber. CP explained that the RAG rating is based on the national target of 98% although the Trust figure benchmarks favourably against other Trusts. AM asked whether the Trust would achieve 95% for the year, AS confirmed that is the intention and that if the Trust delivers the target in March, it will be delivered for the year.	
3	**PATIENT EXPERIENCE**	
	3.1 Falls presentation FA presented the data collected for discussion. In summary a number of initiatives have been put in place over the past 18 months however the number of falls and falls with harm per 1,000 bed-days have remained broadly static. PL asked about the "Tilgate effect", what it was and whether it is transferrable. FA explained that it was a combination of focused effort, input from a senior nurse, attention to detail, engagement with the team and effective completion of paperwork. The experience of serious incidents is that paperwork is not often done. AM discussed the chart that indicated whether the patient that fell had been considered a falls risk and highlighted the importance of every	

	member of staff taking responsibility for falls risk. NS agreed that this, together with good leadership and a stable workforce, contributed to the success on Tilgate. NS explained to the committee that consideration is being given to a less strategic more operational approach going forward. AM asked whether falls prevention was a high enough priority among staff. NS replied that all staff are trained to complete the paperwork but that there are a number of competing priories and SI reviews show that the paperwork is not always completed. DH asked whether the success on Tilgate was at the expense of any other quality indicator, NS stated that she was not aware of any issues. Ward scorecard. FA questioned whether frailty would be a better indicator of falls risk. DH suggested that the BSUH experience was that completion of the falls paperwork did not impact the number of falls that the time saved could be spent providing support to patients. SM confirmed that recent research would suggest that the paperwork does not impact the number of falls. SM made the point that completing the paperwork does not, in itself, alert staff on the ward to the vulnerability of the patient. FA summarised that the Trust has tried one approach and the data would suggest that a new approach is appropriate which is what is being developed. FA two posts will be advertised at band 7 and band 6 and will report to the frailty lead who is starting in April.	
4	**SAFETY**	
	4.1 Presentation: The long term view of anti-microbial prescribing DL gave a summary of the background to the work being done on anti-microbial prescribing, then AL presented some of the work being done within the Trust. RS asked for clarification on the comparison of SASH antibiotic consumption compared to the national mean. The data shows that for three antibiotics (co-amoxiclav, meropenem and puperacillin-tazobactam), which were the subject of a CQUIN target, the Trust is below the national mean. DH explained that this is important because these are broad spectrum anti-biotics the use of which correlates with Cdiff outbreaks. In addition they breed resistance among the population which is of huge concern. The chart did not show eleven other narrow spectrum anti-biotics the use of which has increased. These anti-biotics are prescribed for specific conditions. Overall the Trust use of anti-biotics is above the national mean; this will be the focus of future work. DH informed the committee that AL and DL had written anti-biotic usage guidance which moves away from broad spectrum antibiotics.	

	This is part of the Trust strategy for reducing Cdiff. RS noted that despite the attention given to the dangers of inappropriate anti-biotic prescribing the numbers are still rising, 12% over 4 years. AL explained the population is aging, patients are being admitted with higher levels of acuity. RS whether we are losing the battle to reduce usage? DH explained that the level of consideration prior to prescribing is increasing. He noted despite that the majority of anti-biotics being prescribed in the community the targets are being applied to acute. PL commented that a local health authority approach is needed. PL stated that she is reassured that the hospital is thinking very carefully about how staff are educated and that the use of anti-biotics is being monitored. It was noted that the Trust is working with GP's to improve awareness and decrease usage. AL added that in the past anti-microbial stewardship was seen as the responsibility of the Acute sector, but that now anti-microbial pharmacists are being recruited to work in the community and an extensive network is being developed to share good practice. PS asked where the Trust needs to be concentrating. AL explained that a multi-disciplinary approach needs to be embedded, that prescribing needs to be challenged. PS asked whether there is an ongoing action plan. DHeller explained that electronic prescribing will require the indication and duration of the course to be entered into the system. DL agreed that the scorecard is flat; actions are being managed at a divisional level, led by the Chiefs. RS looked forward to the time when the Trust can benchmark against other Trusts. RS asked about consumption. DL noted that there was a change in antibiotic prescribing in spring/early summer 2012 which was a response to Cdiff. Over the coming year this was brought under control and the overall usage of the high risk antibiotics reduced by 50% without an adverse impact on the control of Cdiff. RS queried whether there is any data on the use of other anti-biotics. DL confirmed that they have the data but it is not part of the presentation. BB commented on the GAP audit. To achieve 100% six criteria need to be met. In surgery 3 criteria are met 100% of the time. The remaining three criteria apply to a small number of patients and the gains are now marginal. Antibiotics are prescribed on a short basis in surgery as prophylaxis post-surgery. RS thanked AL and DL for their time.	
5	**QUALITY**	

	5.1 CQUIN update Deferred to next meeting.	
	5.2 Q3 update on Trust Audit plan Deferred to next meeting.	
	5.3 Data Quality Strategy update Deferred to next meeting.	
	5.4 Haematology Peer Review & New haematological malignancy pathway PK presented the output of a peer review which was undertaken in September 2015. The peer review identified that patients with, for example lymphoma, may potentially be at risk because their disease can present in a number of ways. There is a chance that these patients could be discussed at a number of MDTs until a diagnosis is confirmed. As a consequent the team has developed a pathway for patients with a suspicion of a haematological cancer. PK talked the committee through the pathway. BB asked a number of questions about the pathway and it was agreed that the pathway is broad and is not able to account for every haematological cancer. PS asked how the pathway will be signed off within the Trust, taking account of the impact that it might have on other areas within the Trust. PK explained that the pathway has been discussed within the cancer division and has been sent for comment to MDT meetings. FA asked whether it could be road tested prior to presentation at Clinical Effectiveness. RS thanked PK for his time.	
	Proposed agenda for next meeting RS outlined the agenda for the next meeting. It was agreed that the Safety Thermometer would be deferred to May to allow time for the papers deferred from this meeting. BB agreed to take the issue of Chief attendance at SQC to the Chiefs Meeting for discussion.	
	Any other business There were no items of any other business.	
	DATE OF NEXT MEETING Thursday 5th April 2016	

	14.00 – 16.00 AD77	