Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 5th May 2016, 14.30-16.30
AD65 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Alan Hall	AH	Non-Executive Director
Des Holden	DH	Medical Director
Fiona Allsop	FA	Chief Nurse
Paul Simpson	PS	Finance Director
Ed Cetti	EC	Chief, Cancer Division
Barbara Bray	BB	Chief, Surgical Division
Ben Mearns	BM	Chief, Medical Division
Zara Nadim	ZN	Chief, WaCH
Katharine Horner	KH	Patient Safety & Risk Lead
Ben Emly	BE	Head of Information
Colin Pink	CP	Corporate Governance Manager
Vicky Daley	VD	Deputy Chief Nurse
Sue Moody	SM	Clinical Quality Manager Horsham and Mid Sussex CCG
Presenting papers:		
Laura Warren	LW	Head of Communication
Julie Chivers	JC	Adult Safeguarding Lead
Ruth Morely	RM	Children's Safeguarding Lead
Apologies:		
Alan McCarthy, Pauline Lambert, Angela Stevenson, Jonathon Parr, Paul Simpson		

		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 AH noted that he had been present at the meeting, KH to update. The minutes of the last meeting were accepted as an accurate record.	KH
	1.3. Actions from previous meeting were discussed as follows **C/F 1st October** **Readmission audit** This action arose from a spike in one of the readmission metrics earlier in the year. Five random readmissions from Medicine and Surgery, which occurred during the winter period, were selected for assessment. The Medical Division concluded that none could have	

	been avoided. Surgery concluded the same but also found that some of the cases were frequent readmissions. While none could be avoided they did identify issues in the care received by the patients in the community. The audit provided reassurance that readmissions were not the result of patients having been discharged too quickly. **C/F 4th February** **Data Quality Audit (date of death) update** This item was deferred to July. The data quality team have had to prioritise the TARN audit. **C/F 3rd March** Breaking the Cycle will be rescheduled to July because Angela Stevenson could not be present. **C/F 5th April** **Feedback on stroke network discussions** EC reported that a meeting to develop a new thrombectomy service had taken place at St Georges Hospital in London which had been attended by the stroke physicians and the clinical lead for radiology. There is still some outstanding work to do on how images will be transferred between sites in timely fashion for review. BM explained that the thrombectomy pathway is one of the biggest advances in stroke care in the last ten years. It involves the removal or dissolution of a clot from the inside (like an angiography). There is evidence that it is more effective than thrombolysis. The service will be offered 8-8 at St Georges, the Trust will need to be prepared to undertake the imaging and transfer to SGH. The snap audit shows that the Trust rated A for access to CT, so BM does not anticipate a problem. RS asked about the access to MRI for all stroke patients, BM reported that discussions are ongoing with Radiology and that an additional MRI scanner has been proposed. It is hoped that in time the Trust Radiologists will develop neuro-radiology skills so that the service can be offered in house. **Summary of VTE deep dive to be included in ECQR report** CP confirmed that the first part of the deep dive is included in the report on the agenda. The second part, surgery, was not included because the second ECQR meeting was cancelled.	
	1.4 Highlights from Executive Committee for Quality & Risk CP presented the summary report, noted that the second meeting of the month had been cancelled due to the Doctors Strike. AH asked for clarification on the timescales set for the Divisions to produce their VTE reports to ECQR. CP reported that WaCH were given a shorter timeframe because they needed to provide more	

	narrative around the issues. Surgery had put actions in place and wanted time to access the impact of the changes. CP confirmed that the Surgical output would be on the next ECQR agenda. RS asked for further information on the piece of work regarding safety and activity. He asked whether the increase in falls, PALS concerns, complains might be as a result of increased activity. FA confirmed that it would. DH agreed that it might be expected that these issues would triangulate but that a further analysis of the data would be necessary before this could be concluded. AH noted that PALS concerns were presented in absolute numbers rather that per 1,000 bed days. He noted that more people would increase the number of incidents/complaints but not necessarily the risk. It was agreed that the output of this work should be presented at the July SQC alongside the Breaking the Cycle work. RS asked whether there had been any clarification on the antibiotic CQUIN. DH replied that it would be looking at total antibiotic use and that more work has been done by the anti-microbial team to pin point that figure.	DH
	1.5 Highlights from Clinical Quality Review Meeting BE presented the paper which summarised the meeting on 9th April, which reviewed February performance. RS asked for a brief summary of the outstanding issues prolonging the Doctors strike. DH reported that the total wage bill for junior doctors needs to stay the same, however junior doctor cover at weekend needs to increase; therefore there will be less junior doctor cover during the week. Junior doctors are concerned that this will reduce safety to patients during the week and more work which will remain undone. BM added that junior doctors believe that Saturdays should not be considered a normal day, as for other professional groups within the NHS. BM reported that the Medical Division is currently working through the impact of the new contract on working rotas.	
2	**QUALITY PERFORMANCE**	
	2.1 Quality Report RS asked for questions on the March Quality Report. BE confirmed that the report was not in the usual format because ECQR had not met, however the same level of detail has been summarised in a scorecard format. RS asked whether there was anything of unusual activity. BE noted the continued reduction in the ED standard, bed occupancy was up at 94.2% and ITU/HDU at 94.4%. ED FFT dropped off this month, but the inpatient FFT went up, so despite the operational pressure the response from patients has been positive. The number of serious incidents reported was high; this was discussed at Board. There have been no incidents of MRSA or Cdiff. From the elective access standards, the two week wait standard for breast symptomatic was not achieved and as a consequence the whole year was not achieved. There will be a two week wait summit in May to resolve the	

	issues. RS asked whether the April figures would show the same pressure on ED. BE reported that the MRD figure had got higher. BM reported that during April there had been a week of respite in ED attendances (~240 per day), but that has reverted to ~317. BE confirmed that the ED trajectory for April had been achieved. AH asked about operations cancelled. BE pointed out that cancellations are not reported until they are treated therefore as the Trust moves out of the winter period these will be reported more. The clinical impact of the delays on the outcomes for patients will be assessed as part of the winter review. RS asked whether MRD patients coming to harm will be included in the review, BE confirmed that it would. RS asked about crude mortality birth which showed a spike. BE confirmed that the metric included stillbirths. There had been an unusual number in March. ZN reported that WaCH are reviewing each case. RS asked whether these numbers are surprising. ZN agreed that the division were concerned. RS asked ZN to inform the meeting of the outcome of their review work in July.	ZN
3	**PATIENT EXPERIENCE**	
	3.1 Q4 Compliments, Comments and PALS Concerns report FA presented the report. AH asked about the resourcing in PALS. FA acknowledged that this is a concern; the team is supported by bank staff and a large number of volunteers. Entering data within the system has been problematic and it takes time to train new volunteers and bank staff. AH asked whether it was a budget issue and FA confirmed that it was but that she is hopeful that it will be resolved soon. RS asked whether the issue of appointments is as a result of capacity or the process of managing the cancellation/rebooking process. In addition he asked whether this information was informing the SASH+ work. DH confirmed that the SASH+ work starts with the process in the booking office; the specialty under review is Ophthalmology. There are five work streams to be completed before the issues encountered on day of appointment processes are addressed. Therefore a separate piece of work is underway led by Angela Stevenson through the Outpatient Board. Some of the issues identified will be addressed by rules around clinical cancellations and ad hoc clinics. FA confirmed that there has been a lot of work on the environment in OPD and the training of staff. The patient experience workgroup are focusing on the format and content of letters. RS asked about the issue of patients not knowing how long their wait will be in ED. BE reported that there are now two screens in the ED waiting room which informs patients of the current wait time. AH asked whether anything had changed regarding the categorization of	

	upheld/not upheld, because the report shows an increase in the number of concerns that have been upheld. BM stated that he felt that this was a cultural change in the approach to complainants. FA agreed to check whether there had been any changes in process.	FA
	3.2 Q4 Complaints report FA presented the report. RS noted that the report presented good assurance around the lessons being learnt from complaints. RS observed that the process of handling complaints is getting better but the volume of complaints is going up. KH noted that the volume of complaints received in Q4 was the same as Q2 although Q3 was low. RS expressed concern that the volume is increasing, KH noted that the more an organisation seeks feedback (FFT, Your care matters etc.) the more complaints will be received. DH noted that the nature of the complaints and themes identified is a better indicator of quality than pure numbers alone. BM asked whether a record is kept of issues raised by patients that are moved into the complaints system by staff. KH replied that the source of the complaint (letter, e-mail etc) is recorded on Datixweb. CP commented that if the reopened complaint by quarter figure was shown by bed days, it might demonstrate a clear improvement in the process.	KH
4	**SAFETY**	
	4.1 Safety Thermometer VD summarised the report, describing it as a temperature check within the organisation. Point prevalent study recorded data on a single day in the month. It gives the Trust the opportunity to compare performance with other Trusts. VD made the point that the Trust will need to understand the data better, where there are anomalies and why that might be. Ward accreditation will give the Trust an opportunity to understand the data at a more granular level, set a benchmark for the completion of the submission but also to triangulate the data with the other performance metrics that we have. FA has met with a number of ward managers which has highlighted that there is not a single data collection methodology, therefore refresher training is important. Some Trusts display their information outside their wards on electronic boards; FA suggested that this might be worth considering. The collection process and the purpose of the data needs to be made more relevant to staff. BE confirmed that it would be possible to have a screen outside every ward to display the information patients and visitors. RS asked that the committee be kept up to date on whether this is implemented. SM added that the consensus nationally is that the project was rolled out with very little training which has weakened its value.	

	RS asked whether UTIs in patients with catheters should figure on the scorecard. The data collection methodology is unclear. It has not been flagged as concern. RS asked whether the Trust is an outlier on patients with catheters with a UTI. VD stated that it has not been flagged as an issue. BM reported that there is a tension between the demands of the sepsis pathway which indicates the insertion of a catheter and the ongoing risk management of catheters. This is currently under review by the Care for the Elderly team and the Sepsis group. BM made the point to the committee that the VTE outcome is reassuring.	
	4.2 Q4 Incident Report FA asked whether the committee had any questions. FA noted that the latest NRLS report has been published which places the Trust in the lower quartile with 28.85 incidents per 1,000 bed days reported. In terms of context, Frimley Park reported 29.13 per 1,000 bed days and Western Sussex reported 23.05 incidents per 1,000 bed days, both CQC rated as outstanding. KH noted that the value of reporting incident lies in what is done with the data, not the volume. AH noted that WaCH are able to consistently review 80% of their incidents within the appropriate timescales, where the other Divisions struggle to achieve 60%. AH asked for assurance that the investigations still underway from 2015 was due to late reporting. KH stated that this was not the case. BM acknowledged that the investigations have not been done when they should. KH confirmed that all reviewing managers have been made aware on a number of occasions of their responsibility with regard to open, overdue incidents. BM gave the committee assurance that this matter is being addressed within the Division. It was agreed that a summary of outstanding incidents would be brought back to the next meeting for further discussion. KH reported that week commencing 27th April the Trust reported the lowest number of open overdue incidents since November 2014, so the situation is improving. BM was clear that he was unhappy with the recent strategy of reassigning the overdue incident to the line manager for action. ZN reported that within WaCH there is good clinical engagement with the risk team which ensures that incidents are reviewed promptly.	KH
	4.3 Q4 Children Safeguarding Report The report was presented by RM outlining the work of her team which is to refer vulnerable children to the appropriate agencies to ensure that they get the help and support that they need. RS asked what the top concerns are for the team within the Trust. RM noted that training is a priority, that the team are committed to ensuring staff are trained and aware of their responsibilities. The team are working to improve the use of IT with a move away from faxing to secure e-mail. AH noted that there is not much feedback within the report to gauge the level of success and outcomes. RM noted that their job is to prevent harm which is not a reportable outcome. RM reported that there has been feedback from	

	MARAC (multi-agency risk assessment committee) that families have been made safer as a direct result of ESH referrals. AH asked whether there is any evidence of where the trust has got things wrong. He noted the ongoing serious case review mentioned in the report. RM explained that the preliminary findings from the review are reassuring. RM explained that the team are alert to the possibility that situations may exist where a referral should be made, but was not made. Therefore the team undertake regular audits. The team reviewed every set of notes from the 151 attendances at the Child Assessment Unit over the period of a week. The team assessed whether information sharing forms were appropriate and whether there was evidence that they had been done. This was a re-audit and the results were better than last year. The team has put in place some additional training and measures to reduce the figure further this year. SM asked whether feedback is give as part of the weekly meeting with Social Services. RM pointed out that the volume of referrals made would make individual feedback difficult. RM's team keeps a database and record feedback as and when they get it. West Sussex MASH (multi-agency safeguarding hub), brings together and shares all relevant data which is an improving process. RM stated that a national priority for 2016 will be the emotional and mental well-being of children. RM suggested that by focusing on this cohort of children and getting help to them earlier may result in fewer admissions to hospital. RS asked for an update on the progress of the action plan which was presented at the last SQC. VD explained that it is reviewed and monitored through the Trust Safeguarding committee. RS thanked RM for her time and noted the good work that is in progress.	
	4.4 Q4 Adult Safeguarding Report JC presented the Q4 report. JC noted that the implementation of the Care Act in 2015 had lowered the threshold for safeguard which combined with an increase in Trust activity had resulted in a significant increase in the number of investigations carried out by the team. RS asked whether pressure damage to patients on admission is captured by the safeguarding team. JC confirmed that it was. RS asked whether the Trust is seeing a decline in the numbers as a consequence. FA explained that pressure damage is multi-factorial and it is hard to draw that conclusion from the data. FA confirmed that if a trend was identified around a particular care home or agency then the Trust would report the findings to the relevant Council and the CQC. SM noted that many of the care homes are independent providers therefore CQC is the only overseeing body. The CCG collects data from acute and community providers. VD noted that the whole care sector is a challenged environment at the moment. RS asked whether there had been any instances where a referral to the	

	Channel panel was considered necessary. JC replied that one referral has been made in the last year, which was reviewed and no concerns were identified. From September 2016 the Safeguarding team will be undertaking WRAP training (workshop to raise awareness of prevent), this is a statutory duty. Training compliance has been set at 100%. JC highlighted that training is currently 48% and that capacity on the allocated training day is an issue. FA confirmed that WRAP training is pre-determined script of an hours duration which combined with the other Safeguarding requirement necessitates two hour slot in the day. Other options for delivering the training are being considered. JC reported that a review of the core skills framework might release additional time in the day. RS thanked JC for her report and the assurance that it had given the committee.	
5	**QUALITY**	
	5.1 Q4 Update on Audit plan DH presented the report. It was brought to the committee's attention that there are inconsistencies in the report which have been discussed at the Clinical Effectiveness Committee. DH acknowledged that notwithstanding the errors in the numbers, the position is not as good as the Trust had hoped. DH confirmed that it had been agreed by the Chiefs at the Clinical Effectiveness Committee that the audit programme needs to be at a size where it can deliver 100%. DH will table a paper at the next SQC meeting in June to update the committee and take questions if required. AH expressed concern that the 15/16 audit programme had been re-dimensioned from previously over ambitious programmes on the basis that the revised plan was achievable and could be delivered. However, the trust is in the same position despite the steps taken. DH agreed that a well-considered plan and good delivery had been the strategy. The intention had been for more local, relevant audits arising from complaints and incidents at the expense of national audits and local interest audits. However, this does not appear to have been cascaded to local teams and Divisions lost sight of their audit plan through the year. It was accepted that two divisions lost their audit facilitators during the year; however the move to an electronic system will provide better monitoring over 16/17. RS asked Chiefs for their view. BB noted that there were only 8 audits for surgery that had not been started which is less than 10% and that circumstances and priorities during the year will change. She confirmed that these are being looked at in some detail. BB agreed that it was disappointing that more action plans were not completed, but reiterated that electronic tracking will make this much easier to manage. BB noted that the audits are completed and reported within the department, but miss the final stage of documenting actions. BM stated that audit is still owned and completed by the clinical teams who are perhaps not aware of the importance of documenting and recording	DH

	results centrally. He added that the process feels passive when it should be more active. He confirmed that audit activity is good, but that it needs to be directed. The electronic system will allow audits to be linked to incidents and be far more visible as a tool for improvement. ZN echoed the comments of BB and BM and acknowledged that the WaCH audit plan needs to be reviewed. RS noted that it is difficult to take assurance from the evidence being presented to the committee that the audit programme has been of value to the Trust; that important audits have been identified, undertaken and learning used to inform future practice. DH expressed concern that this assurance has not yet been given. The paper for the June meeting will give a short qualitative summary of what the 15/16 audit programme has delivered	
	5.2 2015/6 Trust Quality Account LW introduced the report and requested that any changes or additions be forwarded as a priority as the report needs to be circulated to stake holders on Monday 9th May for their comments to be included in the report. LW noted that it is slightly less formulaic this year, to make the report easier to read. It is hoped that the report is reflective of the achievements of the Trust over 2015/16 and the standards that have been delivered. RS asked for clarification on the process, which was confirmed to be consultation, comments from stakeholders, internal audit review, then to Board. The Trust is required to upload to the internet by 30th June 2016. Meeting confirmed that a paper copy of the report is still required. RS whether it is sent to public libraries. LW can be supplied for significant conferences. Members and governors will be signposted to the online version. RS asked about PROMS and whether this was a topic that SQC should review. DH explained that the work is underway on non-mandatory PROMS which are currently reported to the Board, he noted that there are surprisingly few mandatory PROMS. RAS confirmed that the committee was happy for the report to go out for consultation. LW reiterated that any changes should be notified to her by Monday.	
	6.1 Any other business No items raised.	
	6.2 Proposed agenda for next meeting RS summarised the agenda for the next meeting which is an in-depth focus on issues of safety and quality in the area of diagnostics.	

	DATE OF NEXT MEETING Thursday 2nd June 2016 14.00 – 16.00 AD77	