Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 4th August 2016, 14.00-16.00
AD65 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Alan Hall	AH	Non-Executive Director
Pauline Lambert	PL	Non-Executive Director
Fiona Allsop	FA	Chief Nurse
Alan McCarthy	AM	Chairman
Des Holden	DH	Medical Director
Paul Simpson	PS	Finance Director
Barbara Bray	BB	Chief, Surgical Division
Vicky Daley	VD	Deputy Chief Nurse
Katharine Horner	KH	Patient Safety & Risk Lead
Colin Pink	CP	Corporate Governance Manager
Ben Emly	BE	Head of Information
Sue Moody	SM	Clinical Quality Manager Horsham and Mid Sussex CCG
Debbie Hindson	DH	Head of Quality & Nursing East Surrey CCG
Ingrid Marsden	IM	Matron Neonatal Unit
Julie Chivers	JC	Adult Safeguarding lead
Apologies:		
Ed Cetti, Angela Stevenson, Ben Mearns, Zara Nadim		

		Action
1 COMMITTEE BUSINESS		
	1.1. Chair welcomed everyone to the meeting and apologies were noted.	
	1.2. Minutes of the previous meeting The minutes of the last meeting were accepted as an accurate record.	
	1.3. Actions Log and matters arising **C/F 5th May 2016** *Review of March Stillbirths* – on the agenda *Paper to update committee on the 2015/16 audit position* – on the agenda **C/F 7th July 2016** ***Update on the progress of discussions with Guildford about the management of the 62 day target*** VD feedback Cancer performance is going well. The Trust is having meetings with Guildford regarding the 62 day target which commences in October. The Trust is required to make referrals within 38 days to	

	Guildford, if not the responsibility for any subsequent breach of the target will sit with SASH. RS asked how much of a challenge this will pose; VD confirmed that she would need to refer to EC. ***CQRM Meeting report to include the names of those invited to the meeting and those who attended.*** BE confirmed that the CQRM report now contains the list of attendees. ***Medical Division to review the issue of the pneumatic tube failure and the phoning through of results within their Divisional Governance Meeting.*** Although BM was unable to be at the meeting due to operational pressures, DH reported that BM is in the process of investigating the pneumatic tube failures and is waiting to speak to Ian MacKenzie, who is on leave, for further information. RS confirmed that the outcome of the deep dives on diagnostics will be managed by the Execs. DH agreed that an update would be presented to SQC in October.	VD DH
	1.4. Highlights from Executive Committee for Quality & Risk CP presented a short summary of the two ECQR meetings in July. PL asked where the problems with the TARN data review will be addressed. BE explained that the TARN data issue was discussed at Execs not ECQR. DH clarified that the content of data will be discussed at the Clinical Effectiveness Committee which will feed into the ECQR report. The issue of incomplete data will be addressed through Execs until the issue is resolved. (Only 27% of data has been inputted against a target of 80%). PL noted that the peer review indicated that the care was clinically robust. PS added that the final report has not yet been submitted, so the final actions have not yet been confirmed. With reference to the work undertaken by Tim Briggs AM asked whether 5 surgeons should be allowed to undertake only one knee procedure per year. DH confirmed that the question is whether optimum care can be provided if low levels of procedures are undertaken in a year. BB clarified that this data referred to a unilateral knee replacement which is a less common procedure than the standard knee replacement. BB confirmed that staffing review is currently underway relative to the volume and types of procedures being performed. It was noted that there have been no complaints or concerns about this particular procedure. AM stated that the information around CQC inspections should be taken to the Board on the basis that it is a significant change. RS agreed. RS asked what is meant by “local intelligence”, CP explained that this has not yet been completely defined however it is likely to be information from the local area not provided by the Trust, for example newspaper reports, Healthwatch. AH asked how long the CQC “good” posters remain in situ and whether they “time expire”, CP advised that we are legally obliged to display them until CQC indicate differently. In terms of Board reporting PS counselled that it may be too early as the CQC have not yet confirmed their strategy, AM agreed that it would be sufficient for the changes to be included as part of MW’s report.	DH

	1.5. Highlights from Clinical Quality Review Meeting PS noted that the attendees have been listed on the report as requested and confirmed that no issues were escalated from the meeting on the 21st July 2016. PS explained that performance was discussed and in particular ED performance. He confirmed that the Trust has met the ED target for the first quarter of the year; however, there has been significant activity growth in respect of emergency activity. There have been increases in ambulances, not all patients being brought to the Trust by ambulance are admitted. The consequence has been that a number of escalation areas remain open which has affected the Trust's capacity to undertake elective work. RTT risk was discussed. PS confirmed that there is an activity plan which allows for growth but the Trust is experiencing unplanned activity from the South of the region particularly in ophthalmology. PS informed the committee that there have been a number of general conversations about making the CQRM more effective. Trust has received proposed changes to the Contract Review meeting which appear to include some of the issues normally discussed at CQRM. PS explained that the Trust response has been to ask for clarification from the CCG about what should be discussed at each meeting, and where the CQRM and Contract Management Meeting report.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report RS about the timing of the data included in the Quality Report. Given that the committee is receiving June data in early August (after it has been to the Board) RS asked significant issues occurring in the meantime are brought to the committee's attention. Following this request BE informed the committee of the following highlights for July: • ED 4 hour standard achieved in July. • Cancer 2WW target exceeded 95% • Breast symptomatic 93.9% RS asked DH about an MRSA bloodstream infection which has been reported in August. DH explained that the incident is so recent that a root cause analysis has not yet been undertaken. DH confirmed that the patient is deceased. The patient was one of a number of patients that have been found to be carrying a particular strain of MRSA which is not responsive to antibiotics. DH confirmed that he would bring an update to the next meeting outlining the methodology employed by the Trust to manage, limit and investigate an MRSA outbreak. BB informed the committee that there had been an elective death, a 90 year old lady who underwent a hip replacement, but died that evening. She had been deemed high risk, but she had accepted the risk. There has been an investigation into her death which revealed some learning points for the Trust, but none which were felt to have contributed to her death. The post mortem showed that she had suffered a cardiac event	DH

	that night. PL asked whether paediatric bed occupancy is reviewed. BE stated that it is reviewed although it does not appear on the scorecard. AM picked up RS's original point about the timing of the reporting to SQC and acknowledged that the committee cannot provide expert analysis to the Board because the Board sees the data first. The position is reversed in that the Board then asks the committee to review particular points of concern. AM concluded that the timing cannot be changed and therefore it would need to be accepted that SQC works in a different way to other sub-committees. RS agreed that there would be less emphasis on live data and more emphasis on long term issues. RS explained to the committee that one of the stated objectives of the Trust is to be in the top 20% nationally for safety, but that the method of measuring that position has not been defined. It has been agreed that an options paper will be brought to the committee next month on what metrics might be measurable. AM asked how the patient's comments on page 38 are followed up, AM explained that he was particularly interested in the comment about cancelled appointments. FA confirmed that all comments are followed up depending on whether the patient is identifiable from the source.	
3 PATIENT EXPERIENCE		
	3.1 Q1 Compliments, Comments, and PALS concerns report FA highlighted that PALS contacts have increased this quarter by 10%, and have increased 34% over the same period last year. Many of those contacts relate to cancelled appointments, which reflect some of the challenges faced by the organisation in terms of managing capacity, and the booking processes which are sometimes not as efficient as they could be. There is a SASH+ work stream reviewing OP processes relating to booking. The two day response rate is improving as staffing has been improved. 4,400 responses to "Your Care Matters" are received in a quarter, 1,800 additional comments, most positive, are received. The main subject headings are poor communication, staff attitude and waiting times. Patient Opinion also provides feedback. In Q1 there were 75 postings which were read 10,000 times by people external to the organisation. 68% of these postings are responded to within 48 hours.	
	3.2 Q1 Complaints Report Complaints are broadly static, appointments again accounting for 20% of the total. FA highlighted the work being undertaken by the central team to make contact with complainants, clarify the main issues of the complaint and then explain the ongoing process of resolution. AM asked whether complaints are resolved at this stage, FA confirmed that this was happening and that there has also been a reduction in the number of reopened complaints. FA confirmed that 57% of complaints have been either upheld or partially upheld. PL asked for clarification on what this means and whether the patient is informed. KH explained that it is a judgment as to whether the complaint was well founded.	

	RS noted that there are similarities between the two reports; issues with appointments, staff attitude and communication. RS asked what assurance is there that these issues are being dealt with. DH confirmed that the value of complaints lies in the action they generate at a very specific level; however he noted that they are a tiny fraction of the activity. PL requested that some contextual information relating to activity is included in the report. DH informed the committee that analysis has shown that the complaints received are not reflective of activity pressure. PS added that the new complaints process gives an individual action plan for each complaint. CP noted that it is important to ensure that the initiatives being undertaken in the Trust to improve patient experience are aligned to the key issues being identified by the complaint categories within the report. RS summed up noting that the committee should review the effectiveness of actions being taken at a Divisional level to address concerns flagged by complainants.	
4 SAFETY		
	4.1 Q1 Incident Report FA presented the incident report. PL asked about the increase in maternity incidents, KH noted that maternity report clinical events as incidents to ensure that they are appropriately investigated, however in most cases there is no suggestion of clinical mismanagement. FA added that WaCH have not flagged any concerns at the Patient Safety and Clinical Risk sub-committee. RS informed the committee that a report on the ongoing management of falls will be brought to the next committee meeting. FA confirmed that the report will give the committee assurance on the steps being taken by the Trust to implement a new approach to falls. PS asked whether an appointment has been made to the post of Deputy Chief Nurse for Innovation and Improvement. FA confirmed that an offer has been made. DH reflected on the number of maternity incidents and made the point to the committee that time should not be spent reviewing variation in data if it sits within acceptable confidence limits. The committee should be disciplined and Trust the exceptions flagged by the scorecard. KH asked whether the committee still found value in the quarterly reports given that performance data is now readily accessible to all users at a Trust, specialty and ward level. It was agreed to review the approach outside the meeting.	

	4.2 Q1 Children's Safeguarding report VD presented the key issues of the report tabled to the committee. She highlighted that there have been 1,402 referrals, which is a 27% increase on the previous year. The main driver of this is the robust DNA policy in place for children who fail to attend an outpatient appointment or leave ED without being seen. VD informed the committee this approach has been highlighted as good practice in a national CQC report published in July. Progress is being made on updating Cerner to facilitate electronic referrals to external agencies. PL asked what is meant by information sharing as opposed to a referral. VD agreed that in the next report a breakdown of what information is shared with which agencies. VD summarised the current priorities as being FGM, domestic abuse, child exploitation and Prevent training. PL noted that the target set by the local Safeguarding Board is 85% but that the Trust is currently at 51%. VD explained that additional sessions are being set up to address the shortfall. Given the shortfall AH asked what this translated to in terms of materiality of risk. FA explained that by targeting key staff groups (those that regularly care for children) the risk is limited. PL asked whether there have been any allegations against staff. VD confirmed that these would be included in the figures, but that there have been no recent cases. Oversight is kept within the Safeguarding team. PL asked how many FGM risk assessments are done within the Trust, VD said that she find out the answer. PL also asked how many dog bites the Trust has reported under the Dangerous Dog Act. The figure was not known, but will be confirmed. PS noted that the number of safeguarding referrals amounts to four per day, he asked whether this was proportional to the risk involved and what the impact was on the families involved. VD explained that the volume of referrals is a consequence of increased training, awareness and high profile media cases. DH asked whether there was any evidence that families that have been referred as a consequence of an outpatient DNA are subsequently reluctant to seek professional medical attention. VD explained the process involved and noted that without consistent feedback it is not possible to know the endpoint of a referral.	VD VD VD
	4.3 Q1 Adult Safeguarding report JC attended the committee to present the Adult Safeguarding report. JC highlight the progress that has been made in terms of working closely with Adult Social care. Training tot al sits at 52% with the target being 85%. The team are undertaking team based training to improve compliance. Key issues for the Adult Safeguarding team are domestic abuse; honour based violence, FGM, modern slavery and will be working more closely with	

	the Children's Safeguarding team as these issues are often family based. The team intends to increase their regular meetings with ED to once a week; most domestic abuse is identified in ED. As a consequence of a domestic violence incident at Blackpool Hospital which resulted in the death of a member of staff, the Blackpool Guidelines will be adopted within SASH to protect our staff against potential domestic violence. The team is working with the police to improve the robustness of the processes relating to missing persons. PL asked what the outcome of raising concerns is. JC confirmed that feedback is not comprehensive, although the Trust informed if the concern raised is not relevant. RS noted that assurance could be taken that where Trust staff identify a concern it is appropriately escalated. However, it is not possible to be assured on the management of that the concern because this process sits outside the remit of the Trust and feedback is limited. PL added that the Trust must trust our multi-agency colleagues. RS asked what assurance exists that the safeguarding concerns raised internally about Trust staff (12) have been dealt with appropriately. JC explained that social care lead on the investigation and give the Trust a "section 41" plan which itemises the steps to take. The information gathering is competed within 28 days; it is reviewed by social care and discussed with the family of the vulnerable adult. The family decides whether an outcome meeting is required. In each case an action plan is produced. Oversight is provided by the Safeguarding Committee. CP suggested that the internal and external Governance structures for safeguarding are included in the Annual Safeguarding Report.	VD
5 QUALITY		
	5.1 Q1 Update on Trust Audit Plan Held over to next month. RS requested a clear account of the end of year position for 2015/16 position.	JP
	5.2 CQUIN Update Held over to next month. DH confirmed that the report will include the milestones agreed for 2016/17.	DH
	5.3 Summary of the review of March stillbirths Held over to next month.	
	5.1 Any other business No items raised.	

	5.2 Proposed agenda for next meeting The proposed agenda was agreed: • Surgical Division report will be deferred to October due to BB's leave. • The item on RTT will include the question "Does delay in treatment cause harm to patients?"	
	DATE OF NEXT MEETING Thursday 1st September 2016 14.00 – 16.00 Room 7/8 PGEC	