Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Tuesday 1st November 2016, 14.00-16.00
AD65 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Pauline Lambert	PL	Non-Executive Director
Alan Hall	AH	Non-Executive Director
Alan McCarthy	AM	Trust Chairman
Caroline Warner	CW	Non-Executive Director
Ben Mearns	BM	Chief, Medicine
Dr Bharti		Consultant
Ed Cetti	EC	Chief, Cancer Services & pp Medical Director
Zara Nadim	ZN	Chief, WaCH
Paul Simpson	PS	Finance Director
Victoria Daley	VD	Deputy Chief Nurse
Ben Emly	BE	Head of Information
Katharine Horner	KH	Patient Safety & Risk lead
Jonathan Parr	JP	Clinical Governance Compliance Manager
Colin Pink	CP	Corporate Governance Manager
Catherine Sharpe	CS	Freedom to Speak up Guardian
Sue Moody	SM	Clinical Quality Manager Horsham and Mid Sussex CCG
Angela Pennock	AP	Representing the Head of Quality & Nursing East Surrey CCG
Apologies:		
Angela Stevenson, Des Holden, Fiona Allsop, Barbara Bray		

		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 The minutes of the last meeting were reviewed. PL noted three typing errors, which once corrected the committee, agreed to accept the minutes as an accurate record of the meeting.	

	1.3. Actions Log and matters arising **C/F 4th August 2016** • **Update on the Diagnostics Deep Dive –** on the agenda (1.3.2) **C/F 1st September 2016** • **Benchmarking report to be endorsed by SQC, with final approval from the Board** – On the agenda 1.6 • **AF to present latest available SSI surveillance data** – On the agenda 1.3.1 • **Plans to increase pharmacy support to antibiotic stewardship team** – DH not present to give the committee an update.	
	1.3.1. Update – Surgical Site infection data AF submitted a report to the committee. AM stated that he had some questions about the report and with no one present to answer the questions the decision was made to roll the item forward to December.	
	1.3.2. Update from the Diagnostic Deep Dive CP asked for clarification on what was required by the committee. RS explained the committee had received a number of presentations from the services involved in diagnostics to look at how the pathways worked and how they might be improved. The committee had referred the issues raised back to ECQR to review and agree a way forward. Therefore the question that SQC would like to see answered is what changes are being made as a result of that deep dive and what was the outcome of the exercise.	CP/DH
	1.4. Highlights from Executive Committee for Quality & Risk CP confirmed that due to annual leave the report had not yet been written but would be included in the December report to the committee. He gave a short verbal update highlighting: • the sepsis pathway had been reviewed by ECQR, • DH and FA updated ECQR on their trip to Denmark to look at the living lab which is an AHSN initiative. • the staff raising concerns framework was reviewed by the committee and is being amended to a one page escalation framework. This is an action from the Good Governance review report. • Mark Edwards present software developed themes and trends to allow better analysis of incidents and identify opportunities for learning. The Trust will continue to work with Mark to develop the software and test the user interface.	
	1.5. Highlights from Clinical Quality Review Meeting PS presented his report and noted that there were no items for escalation. The majority of the meeting was allocated to a deep dive into paediatric services presented by Catherine Greenway. BE explained that the presentation was on acute service provision in response to a number of questions posed by the CCG, particularly around the transition from paediatric to adult services. BE confirmed that the CCG had taken positive assurance from the presentation. This was echoed by SM. AH noted that the reported had not included the names of those attending the meeting which had been requested in previous meetings. BE confirmed that this was an oversight and that this was included in future reports.	

	1.6. Benchmark report BE presented the Q1 benchmarking report and noted the indicators that had been added since the last report: CDiff per 1,000 bed-days, MRSA per 1,000 bed-days and the sub-indicators of the safety thermometer. As a result the Trust is now in the upper quartile for quality within our peer group. The calculation is not made nationally; AP noted that nationally the Trust performs well. BE explained that the challenges remain cancer 2ww and cancer breast symptomatic; however corrective actions taken in May/June mean that the Q2 figures will be improved. Conversely diagnostics will go from top to bottom quartile; diagnostic standards have not been achieved this month because of the challenges within Endoscopy. The new indicator CDiff puts the Trust in the second quartile, MRSA in the bottom quartile. The other big challenges are outpatients FFT and Safety Thermometer (falls with harm). The committee were updated on the actions underway to improve the recording of VTE assessments and the safety thermometer indicators. RS explained to the committee that the corporate objective set by the Trust Board is for the Trust to be in the top 20% of its peers for safety. Overall BE has set out 29 indicators which cover both safety and quality. PL acknowledged that the work undertaken to date is very helpful in scrutinising the position of the Trust. The following steps were agreed: • AM stated that he would like the indicators within the Single Oversight Framework to be included in this report. • The Trust Board will need to assess whether the Safety indicators included are sufficient to evaluate whether the Trust is in the top 20% for safety or whether the wider range of quality indicators should be used. • BE will assess whether the data can easily be presented in percentage terms (not quartiles) to reflect the Trust objective • BE agreed to present the revised report at the December SQC meeting, it will be reviewed and approved at Execs first. It will then pass to the Board for approval and to inform its objectives for 2017/18. PL requested that the committee receive an update on the actions taken following the Emergency Department peer review, with specific reference to the TARN data. It was agreed that this would be added to the agenda of the next meeting. BE to arrange update.	BE BE
	1.7. CQUIN update BE presented the report and clarified the content of each of the indicators for the committee. AM asked who completes the sepsis screening. BM explained that it can be a nurse or a doctor. The aim is for a sepsis review to be triggered by an EWS score of 3 or above, this would be a nursing responsibility. BE noted that the EPR digital business case includes more system driven solutions. BM explained that a pilot on Bletchingly is looking at the bedside electronic capture of clinical observations. Cerner incorporates algorithms which monitor all results including pathology and vital signs which will trigger an alert where a review would be advisable. BM explained there was much	

	work to be done and warned of alert fatigue and the importance of ensuring that the alert is clinically relevant. PS noted that the CQUIN targets are worth £5.2 million to the Trust. RS thanked BE for the update noting that the progress is encouraging.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report BE drew the committee's attention to the Cancer 62 day target (page 3) the latest update being that the Trust has achieved the standard. BE noted that it is the third month in a row that every cancer target has been achieved. The ED target was achieved in September and October. RTT was achieved in September but remains a significant challenge. PS noted that following evidence presented at the Cancer Performance Review the improvement is sustainable and is expected to be maintained. PS also noted that recent data shows the Trust to be one of only 5 nationally to have met the ED target. RS asked whether there are knock on consequences to other areas of performance. EC explained that suspected cancer referrals are given priority which impacts the ability to deliver the RTT standard. BM informed the committee that the Medical Division would be working closely with the new Deputy Chief Nurse for Improvement and Innovation to reduce the number of falls with harm.	
3 PATIENT EXPERIENCE		
	New format of assurance reports RS explained to the committee that the new format of assurance report has been designed to present committee members with objective information relating to each topic area. They are designed to provide assurance on the effective management of the risks presented and any material concerns that the Trust has. AH noted that the reports are difficult to objectively calibrate and would like some context added to the report in terms of the scale or frequency in the gap in control. This would enable the committee to assess changes. AH suggested that a risk score, similar to the BAF, could be applied. AM pointed out that the reports should be working documents in view of contextualising risk. He requested that following review at the relevant sub-committee a cover sheet be added to each report to alert SQC to the key issues. PS noted that where gaps in control have been identified there ought to be some form of mitigation in the form of an action. The reports need to be balanced. RS summarised the discussion stating that he felt that this was a good move forward. KH agreed to take the comments back to the authors. The next assurance meeting is February 2017.	

	3.1 Assurance Report – PALS & FFT The report was presented by VD. AH reiterated the previous discussion regarding context by asking whether the upward trend in PALS activity will be accommodated by the staffing increase.	
	3.2 Assurance Report – Complaints KH presented the next report and informed the committee that the most significant issue is the length of time it is taking to respond to complainants. Staffing issues experienced over the summer months are being resolved following a successful recruitment process and this should result in a better service to complainants.	
4 SAFETY		
	4.1 Board Assurance Framework (BAF) CP presented his paper which was requested to assess whether the safety issues identified within the BAF are discussed at SQC. This is important because the SQC provides support to the Board in monitoring any significant risk to the implementation of its key strategies. CP recommended that SQC receives two reports a year both from the Chief of Education and the Head of Research and Development which highlight the work being undertaken on internal and external initiatives. This will improve assurance on the second BAF risk. The committee agreed that these reports would be helpful. RS thanked CP for his paper. RS asked how much peer review is undertaken within the Trust. JP confirmed that a number of peer reviews are undertaken by the alliance science networks (enhanced recovery, fracture NOFs) and the Cancer network. It was agreed that these should be monitored through Clinical Effectiveness with an overview provided to SQC. EC suggested that a bi-annual report be presented to SQC with key outcomes.	
	4.2 Assurance Report – Incidents RS asked KH to identify the key issues. KH highlighted the time taken to review incidents and the time taken to complete serious incident investigations. KH informed the committee that a new process for the investigation of SI's is currently being piloted with a view to making the outcomes timelier. RS asked whether the 8 was cause for concern, KH responded that it is part of the normal annual fluctuation.	
	4.2 Assurance Report – Children's Safeguarding VD presented the report. RS noted that the issue of feedback was discussed at Trust Board and it was felt that it should be possible. VD explained that the Trust is constantly in open dialogue with other agencies and feels confident about the referrals being made, however, acknowledged that this does not provide assurance. PS noted that the report does not mention whether the Trust is compliant with the law. PL requested that this is explicit.	

	4.2 Assurance Report – Adult Safeguarding VD presented the report. RS asked why members of staff feel challenged by DoLS. VD explained that the legal framework is less understood and embedded in practice, staff are feeling their way and progressing slowly. PL noted that we should be able to demonstrate improvement although the position within SASH is similar to other organisations. VD agreed to ensure that the Q2 report references legal compliance and is more succinct.	
	4.2 Assurance Report – Falls VD presented the report and noted that the new Deputy Chief Nurse for Improvement and Innovation will be starting within the Trust shortly. VD noted fluctuations in the number of falls with a recent spike, it is expected that work with the Medical Division and the Pendleton Unit will reduce falls. RS asked for clarification on the statement "Trust scorecard figures are based on reported incidents previous Trust data and standard deviation they are not benchmarked against national data." KH explained that there is a lack of good national data on falls. PS advised this should be moved into a gap in control.	
	4.2 Assurance Report – Infection Control PL noted that the controls in place appear to be inconsistently successful resulting in partial assurance. RS expressed concern about the ability to fully clean equipment because of high bed occupancy and also a lack of consistency across the Trust. PS explained that the infection control rates have improved year on year. In addition there is a particular focus on infection control following the Cdiff outbreak, PS was concerned that the assurance report had not captured this key work. CP noted that the concerns echoed AH's previous point in that the report does not quantify the concerns.	
5 QUALITY		
	5.1 NICE compliance JP explained to the committee that the October Clinical Effectiveness Committee had been shorter than normal due to the requirement to deliver the seven day services audit. The committee focused on recently published NICE guidelines and Quality Standards. It was felt that summarising these processes would be a useful piece of assurance for the Committee. JP summarised the NICE guideline process and how the Trust monitors progress towards full compliance. Quality Standards are evidence based standards for a variety of conditions and are used by CQC as the gold standard during their inspection process. The committee focused on four of the standards published in the last month, each of the leads in the relevant clinical area will be asked to undertake a gap analysis and assess what actions are required to achieve full compliance. AH stated that it would be interesting to know where the Trust is not fully compliant whether this is a Trust or a commissioning based decision. JP	

	explained that the report does not yet show this but that the issues have been discussed with the CCGs at CQRM. AH agreed that the shared responsibility for delivering these standards should be discussed at CQRM. RS noted that there is a process in place and asked whether the process thereby gave assurance that non-compliance had been assessed and was appropriate. JP explained that the Divisions assess the gaps in compliance; the Clinical Effectiveness Committee reviews that process. PS asked how the Clinical Effectiveness Committee can provide assurance to the Safety and Quality Committee. JP agreed to discuss this with DH.	
	5.2 Review of Governance Framework CP presented the report which provides the committee with assurance around the analysis performance data within the Trust. RS thanked Colin for the summary.	
	5.3 Assurance Report - Mortality JP confirmed that a morbidity and mortality assurance report would be available for the Q2 Assurance Meeting in February 2017.	
	6.1 Any other business None.	
	6.2 Proposed Agenda for next meeting The proposed agenda for the next meeting was approved and the following items added: • TARN and trauma unit • Surgical site infections • Feedback from Diagnostics deep dive	
	DATE OF NEXT MEETING Thursday 1st December 2016 14.00 – 16.00 Rooms 7/8 PGEC	