TRUST BOARD IN PUBLIC		Date: 27th April 2017 Agenda Item: 2.2
REPORT TITLE:		Safety & Quality Committee Chair Update
EXECUTIVE SPONSOR:		Richard Shaw, Chair Safety & Quality Committee
REPORT AUTHOR (s):		Richard Shaw, Chair Safety & Quality Committee
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)		n/a
Action Required:		
Approval ()	**Discussion ( )**	**Assurance (✓)**
Purpose of Report:		
To provide an update of the activities of the safety and quality committee.		
Summary of key issues		
The report provides a summary of the key agenda items discussed at the Safety and Quality Committee in April 2017. Apart from standing items, the main focus of the meeting was on gaining assurance about pressure damage and children's safeguarding.		
Recommendation:		
The Board is asked to note the report		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe – Deliver safe, high quality care ***and improving*** services which pursue perfection and be in the top ***25% of*** our peers **SO2:** Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy **SO3:** Caring – Work ***with compassion*** in partnership with patients, staff, families, carers ***and community partners***		
Corporate Impact Assessment:		
Legal and regulatory impact		Compliance with CQC, MHRA and Audit Commission
Financial impact		Serious incidents often become claims
Patient Experience/Engagement		Included within the report
Risk & Performance Management		Reporting, investigation and learning from serious incidents informs risk management
NHS Constitution/Equality & Diversity/Communication		As per the report
Attachment:		

Trust Board Report – 27th April 2017
Safety and Quality Committee Chair's Report

The Safety and Quality Committee met on 2nd March 2017.

ECQR and CQRM

The Committee received a summary report on the meetings of ECQR and its sub-committees in February. The report focused on deep-dive self-assessments of how services measure up against CQC domains. The report considered Maternity, Paediatrics, Emergency Department, Acute Medicine, Medical Care, Surgical Care and End of Life Care.

The Committee took good assurance from the rigour of the review, the constructive challenge involving clinicians, and the attention being given by the Executive Committee. The outcomes of the assessment also gave confidence, with services judged to be either Good or Outstanding, which correlates with recent work by PWC.

The aim of the deep dives is to understand what needs to happen to get to outstanding in each service. This phase will conclude with a PWC workshop on 28th April, leading to an overview of the current position, and actions needed to get to outstanding. The intention is that each Executive lead will have a NED buddy to aid the process.

The Committee took good assurance from this evolution of the four year deep dive process. We will continue to monitor progress and use it to increase awareness of the Trust's strengths and opportunities for further improvements.

We noted that no items were escalated by the CQRM in respect of clinical quality performance to Single Performance Conversation. We discussed a performance notice raised by East Surrey CCG in relation to a number of areas of performance and were assured that the issues were already known and the subject of action plans. However, a presentation will be brought to SQC in June to explain the actions taken and the outcomes.

Quality Report

The Committee explored a number of questions arising from the monthly Quality Report, including:

- It was agreed that all of the Safety Thermometer sub-categories would be added to the Quality Report to help performance monitoring and to support the work about to start on reducing gram negative septicemia, most of which is related to UTI and gut sepsis.
- There was a wider discussion about approaches to avoidance of patient harm, with suggestions that there could be some form of internal "never events" or "stop the line" approach, and that the zero tolerance approach to falls might have lessons for other areas. The Committee did not recommend a specific course of action, and recognized the risk of unintended consequences from focusing on a particular area, but it was agreed that the potential to improve our approach should be kept under review.
- We discussed the distinction between the recording of data related to safety, which is a challenge for the Trust in some areas such as VTE assessments or day of discharge, and the safety outcomes for patients where performance is strong. There will be further work to ensure clarity about the nature of any improvements needed, with a report to SQC.
- We discussed performance in Urology and Gynaecology in meeting 62 day targets, and were assured that plans are in place to improve performance. These include clinic reconfiguration and strengthening of capacity in Gynaecology, which has seen significant growth in demand. We noted the complexity of the Urology pathway due to high numbers of investigations required.

NHS Stop the Pressure Campaign

The Committee had asked for a report on the four cases of major (i.e. Grade 3 or above) hospital acquired pressure ulcers since September 2016 – after a period of three years in which there were no such cases. Grade 1 incidents have also been showing red on the Quality Report. Overall the incidence of pressure damage has reduced in the past four years from over 200 to less than 60, which represents good progress. Other positive achievements have also been made. Nevertheless it is agreed that more work needs to be done.

The Committee explored further the reasons for the recent incidents, noting that two occurred on a ward which was experiencing challenges in staffing and training. These have since been addressed.

An action plan has been drawn up for 2017/18 that sets clear objectives for reducing the overall incidence of pressure damage and for zero incidence of pressure damage at Grade 3 or above. There will be a strong emphasis on accurate and timely risk assessments, accurate reporting and grading, and on relevant training. The collection of data is being reviewed and measurement will in future be on the basis of incidents per 1,000 bed days, as for falls. The action plan has been submitted to NHSI and runs for 12 months. The success of the action plan will be monitored by the Committee through the Quality Report.

Children's Safeguarding

The Committee took a different approach to assurance by requesting a report on the learning from recent Serious Case Reviews considered by the Surrey and Sussex Local Safeguarding Children's Boards. A Serious Case Review is undertaken where a child has died, or has come to serious harm, and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

We found that there is a robust process for carrying out these reviews, which engages front line staff and managers in reviewing cases and the reasons why those involved acted as they did. This includes involvement of a wide range of practitioners, managers and agency safeguarding leads in debating the draft overview report and drawing learning from the review.

The Committee took good assurance from the process, and also from the fact that there had been very limited involvement of this Trust in the care of children who were the subject of Serious Case Reviews. The most important learning point for the Trust was a need for staff to be constantly vigilant for signs, not only that children may already have come to harm in the community, but that they may be at risk of coming to harm in the future; and that staff should be ready and willing to raise a concern.

Next Meeting

The next SQC meeting is at 12.00 noon on Thursday 4th May.

Richard Shaw
Non-Executive Director
Chair Safety & Quality Committee
April 2017