Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 4th May, 12.00-14.00
AD77, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Alan McCarthy	AMcC	Non-Executive Director
Pauline Lambert	PL	Non-Executive Director
Caroline Warner	CW	Non-Executive Director
Des Holden	DH	Medical Director
Fiona Allsop	FA	Chief Nurse
Paul Simpson	PS	Finance Director
Victoria Daley	VD	Deputy Chief Nurse
Ed Cetti	EC	Chief of Division – Cancer & Diagnostics
Colin Pink	CP	Head of Corporate Governance
Jonathan Parr	JP	Clinical Governance Compliance Manager
Kim Rayment	KR	Patient Safety & Risk Facilitator
Vicky Abbott	VA	Named Nurse Safeguarding Children
Richard Brown	RB	Director of Outcomes
Apologies:		
Simon Littlefield, Zara Nadim, Ben Mearns, Barbara Bray, Angela Stevenson, Ben Emly, Karen Devanny, Katharine Horner, Paula Tucker, Sarah Rafferty		

		Action
1 COMMITTEE BUSINESS		
	1.1. Chair welcomed everyone to the meeting. Apologies noted.	
	1.2. Minutes of the previous meeting The minutes of the last meeting were approved.	
	1.3. Actions Log and matters arising **C/F 2nd February 2017** Assurance report template - revised proformas on the agenda. RS commented that there was an expectation that the proforma requires a narrative box so the Executive lead can make comments regarding why they have scored the item as they have and an update on current position. CP apologised for the oversight and agreed that this will be added to the proforma. PS questioned why the proforma has the controls in place – level of assurance score as opposed to a risk score, as such the proforma is inconsistent with the internal controls process. CP replied that when he and KH were developing the assurance form they considered adding a risk score, the range each control covers is significant and an overall risk score would not be a helpful for assurance purposes. AMcC reiterated how important the narrative box is for the Executive lead to	

	be able to give substance to the score level and the benefit for the committee from a clearer understanding of the Trust position and level of assurance. PL commented that she found the proforma and reports very helpful and FA added that the original idea was to provide general assurance on one page. RS concluded that the proforma needs to have a narrative box added and more work done in light of the committee discussions. He asked for the amended proforma to come back to the committee in 3 months. **C/F 2nd March 2017** Update on TARN data – Mark Salmon invited to June meeting Duty of Candour quarterly update – report due in June CQC assurance framework – framework due in July **C/F 6th April 2017** Data Quality Audit Update – on May agenda but not discussed as BE unable to attend the meeting, carried forward to June ED discharge summaries – report due in July Benchmarking Report – review of the safety metrics and identified variances with other comparable organisations – action completion TBA Update on mortality review and pilot – report due in June DH to write to Coroners to explain the scope and potential of the death certificate pilot – Action completed **1.3.1 Data Quality Audit Update – AMU discharges and length of stay accuracy** BE and AS sent apologies to the meeting. RS requested that the update report is carried forward to the meeting in June. CP requested that a Board action regarding the RTT review is added to the SQC agenda in June. RS agreed that this will be added to the agenda.	CP/KH AS/BE
	1.4. Highlights from Executive Committee for Quality & Risk CP presented the report and explained that it includes a summary of only the first meeting held in April and will include the summary write up of the second meeting in the highlights paper for SQC next month. CP highlighted that therapies, ICU and estates and facilities presented their self assessment of their CQC position, each was very positive and overall good. He added that Gillian Francis-Musanu presented a paper on the well led framework which will replace the BGAF/QGAF reviews, the overall rating is green, the Executive team took a view on the overall self-assessment which went to the Board seminar in April. PL stated that the overview of the whole CQC process highlighted in the	

	report is good but would like more details.RS asked how useful people are finding the CQC review process and presentation to the Executive Committee.EC stated that staff find it very positive and a great opportunity to show case all the good work they are doing but he believes they tend to brush over work they are doing that could be celebrated as outstanding and highlight things requiring improvement. AMcC added that it is important to be self-aware and also encourage staff to feel confident in highlighting where they are doing things over and above which should be recognised as outstanding.JP stated that they do encourage the teams to celebrate their successes. RS commented that it was interesting that the head of therapies noted how little therapies were mentioned in the last CQC report and similarly in national reports. He asked the committee whether there should be more focus on therapies by SQC. VD agreed that it would definitely be positive to include therapies in SQC as they are integral to all the aspects of work that the committee look at and are vital in some of the new services which have a greater focus on rehabilitation. CP added that therapies have been included in the deep dive process. PL asked if the deep dive programme is continuing. CP replied that a plan for a new deep dive program was in discussion. AMcC commented that it was great to see a strong positive local story regarding staffing against national staff shortage. EC added that a therapies strategy for the Trust is being developed by head of therapies. RS concluded that this maybe a good way to link SQC with therapies and suggested that the head of therapies is invited to SQC to present the strategy when it is completed. AMcC commented that he understood the reasoning and agreed that the Executive team needed to form an opinion regarding the well led framework but felt there needed to be a wider discussion so everyone could feel comfortable with the new framework. CP replied that the BGAF and QGAF used to be discussed in a Board seminar and suggested that this could happen with the well led framework. AMcC agreed that would be good and requested CP to arrange this.	CP
	1.5. Highlights from Clinical Quality Review Meeting PS stated that the meeting was cancelled in April.	
	1.6. CQUIN update CP commented that in BE absence there was no CQUIN update however ECQR was informed that the Team is still negotiating the end of year position.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report RS suggested that the committee have a brief discussion about the activity levels within the hospital as a number of members of the committee have been unable to attend the meeting. VD confirmed that the hospital is very busy and has been for a while, the main pressure points continue to be ED and ensuring safe discharge or	

	admission to a bed but the demand and bed capacity remains high. In the operations update meeting this morning she confirmed that this position is reflected everywhere and it was a similar picture to last April / May. RS asked if there was anything that the committee needs to be aware of in particular and VD confirmed there was not and the escalation of status and continuity plans are in place and are working well in managing the high demands on the services. CP provided an overview on behalf of BE, the RTT target continues to be a challenge to meet whilst the drive and priority remains on cancer. He added that focused training on the wards regarding the accurate use of the safety thermometer tool and specific individual data quality cross checks, whilst time consuming has shown improvement in the safety thermometer data quality and performance for the second month running. AMcC commented on the balance between the cancer access standards and other elements of elective work. Going on to ask if there is a direct relationship between poor performance in other areas and the clinical impact and patient experience aspect of this. EC confirmed that there is an impact and a relationship between prioritising cancer referrals and treatments over other referrals as outpatient clinics are given up but it would be impossible to say if there is a direct causal relationship. RS asked where the data would show through that there has been a clinical impact on other areas. EC commented that there is close monitoring through the surgical division and this may give an indicator. PS added that the impact is not just due to the prioritisation on cancer access but there is also a higher level of acuity being put on the elective work. The Trust sets elective inpatient slots then prioritises cancer within that mix. However, the growth and demand on the elective base impacts on the position. AMcC agreed and added that there needs to be some qualitative information in order to fully understand the impact. RS added that he wants to be able to answer fully understand the effect is for other treatment referrals and pathways and be able to support and rationalise the cancer pathway priority. RS welcomed RB to the meeting and asked what his role is. RB explained that he has taken on a new role in the Trust and part of his focus will be finding out the impact we have on patients when managing access standards and priorities in terms of the long term operational impact, for example, cancelling a patients operation but they then have several ED visits or specific condition related inpatient episodes or understanding the impact because they have other co-morbidity or looking at re-admittance post operatively resulting from more complex surgery due to the delay than would have been if there had been no cancellation and looking at the patient experience aspect. RS thanked RB for the overview of his role and confirmed that the	

committee needs to have answers and the work he has described should help clarify the situation and provide a more holistic understanding.

RS asked if there were any other areas of concern that CP wanted to raise from the report on behalf of BE. CP highlighted that the C. diff incidences remains a focus of improvement efforts with 5 cases in March. CP confirmed that each case undergoes a full root cause analysis (RCA) investigation involving all operational people,led by the infection and prevention control team.

PL asked whether we are safe as Cdiff is one of the areas that the committee is continues to focus on and it would be good to have the wider contextual information and our position in comparison to other like organisations. VD commented that she had just been in a meeting discussing C diff and confirmed that when any new case of Cdiff is identified either Fiona or Des visit the ward and complete an after action review (AAR).

PL indicated that a recent email from DH it was very helpful to see the numbers and comparisons with other hospitals in order to gain a fuller picture in a regional and national context.

DH commented that the graph shows a gradual incline up since the HSMR started to be considered 5 years ago. The data is presented as a rolling average so the historic month falls off over time. Dr Iain Wilkinson, Consultant Orthogeriatrician and regional lead and expert, reviewed the cases of the patients who died during December and January. He concluded there was no sub-optimal care only over representation in older age groups and coding in co-morbidity which is what would be expected. BE team reviewed the cases and re-coded them but concluded that the coding was not a problem or significant factor. DH stated that as yet there is no answer as to why the rate has increased. He added that another aspect of the work Dr Wilkinson and colleagues are measuring is access to the right bed but this is a parallel issue and the increasing rate is not due to access to fracture neck of femur beds.

RS asked that if there is no answer yet what the next avenue will be to explore. DH stated there has been some anecdotal indications suggesting re-scheduling of theatre lists which may be leading to fracture neck of femur surgery being moved as yet there is no clear evidence to support this at present. Work has been done to assure ourselves as a trust that current practice is optimal and we need to monitor this trend.

AMcC asked how the Trust sits against other trusts regarding mortality. DH replied that coding of mortality is variable across organisations; our coding of palliative care is significantly lower than other trusts even though these cases form approximately 30% of inpatient HSMR data. The mortality indicators look at overall care and the impact of having an acute admission and as a trust we are good at coding these.

CW asked if the lack of coding palliative care was due to not referring to the palliative care team or not using the palliative care service and staff appropriately.

	DH replied that the reason was due to staff caring for patients at the end of their life. He added that the palliative care service prioritise their seven day service across the whole trust. EC added that the palliative care service are about to expand further and aspire to see all patients at the end of life as this is a requirement in peer review. PL asked for an update on the trust position regarding pressure damage. FA confirmed that a national action plan has been submitted and there have been more educational training sessions, 5 in the last year. New guidance is due out in mid-May concerning categorisation of pressure damage. There are more link people in the ward environments. There are RCA report outs each week and closer monitoring of actions resulting from the RCA. Pressure damage is part of the ward rounds in some areas and needs to be part of all ward rounds. RS thanked FA for her update and confirmed that progress against the 12 month action plan will come back quarterly to SQC.	
	2.2 Draft Quality Account CP explained that this is the first version of the document and has been to Executive Committee. The document now needs to go out to the stakeholders and partner organisations for comment in accordance with the nationally set deadlines. AMcC commented that the all the details covered seemed to be consistent with the work taking place in the deep dive and CQC preparation work and asked if there are any surprises. DH confirmed there are no surprises, the C. diff story is in there, reference to the internal audit report which reported clinical audit could be better despite, in his opinion, it was in the best position over the last 5 years. RS commented that there are still a number of gaps in the report and asked whether any will be completed before it is sent out. DH replied that some of the data missing is due to the fact that it has not been released centrally but agreed that some of the information is within our gift to complete in time. He added that it is not good practice to send the report out with so much missing information as the stakeholders and partner organisations may comment that they cannot give full feedback on a partially completed report. FA made a commitment that as much as is possible of the missing information will be completed for the safety elements.	FA
3 PATIENT EXPERIENCE		
	RS commented that all the assurance reports were scored with either a 4 or 3 level of assurance and so wanted more focused discussion around the level 3 reports. **3.1 Q4 assurance report - PALS**	

	FA commented that the report covered more than just PALS and was really a Patient Experience report. The overall level of assurance is a 3; adequate control, variable compliance. She highlighted that the PALS team are a small team which rely on volunteers and the number of concerns being dealt with by the team are rising. There is inconsistency with how the concerns raised are dealt with and this sometimes leads to an unacceptable time delay in closing cases, escalating to the appropriate senior member of staff on the ward / department or to the complaints team. She added that from a patient experience perspective the new platform came into place in April and will help improve the FFT aspect. RS asked why there has been an increase in PALS concerns. FA believes that this could be due to the change to open visiting meaning there is an increase of the 'in the moment' stuff, an increase in the volume of people on site coupled with the position of the PALS office near the main entrance. CW asked whether there is clarity amongst the staff about what defines a concern or complaint. FA confirmed that the policy is clear and staff on the whole are clear, although there is some variability amongst the volunteers in PALS and new staff on the wards. She added that there has been a positive push for the wards and departments to deal more proactively with concerns raised as they are usually in the best position to deal with them. She confirmed that the PALS staff are also being supported to not hold onto concerns too long and if they can't resolve them quickly to escalate them appropriately either to complaints of the relevant senior ward or department staff. CW asked whether there was a process within the trust that enables an objective review and assessment of the complaints and concerns after they have been closed in order to assure that the right process has been completed. FA replied that there is a different process for managing and investigating complaints and concerns and a recent internal audit confirmed that the right process is in place. There is no independent review or peer review type process in place. She added that options have been looked into and there are external organisations that can help but they have cost implications. CW stated that she is involved in a similar process outside of the trust and it is viewed as very supportive and helpful. She added that if it was seen as appropriate, she would be happy to offer her support in setting up a similar process within the trust. FA agreed that would be good and would arrange for them to meet up outside of the committee.	FA
	3.2 Q4 assurance report – Complaints FA presented the report stating that the level of assurance is also 3; adequate control, variable compliance. AMcC asked why we don't meet our agreed timeframe for completion of responses. FA stated there are a number of on-going issues that are being managed through the divisions regarding completion of investigations within the agreed timeframes. As highlighted in the report the quality of contributing statements vary in quality and this can be a factor.	

	PS asked whether we have a realistic measure in terms of the timeframe and what the risk of not achieving this is. FA replied that there is no national target but guidance that we set the timeframe against this is negotiated and varies from case to case. The main risk is one of reputation and poor patient experience. PS commented that the gaps in control seem significant and asked whether the actions for mitigation are adequate. FA confirmed that the review group is an appropriate form of mitigation as there is compliance 80% of the time according to the feedback survey but we need to work on improving the 20%. She added that in general the quality of the response is better but the Executive signing the final response letter remains the last check and in her experience there is still room for improvement.	
4 SAFETY		
	4.1 Q4 assurance report - Incidents FA presented the report and confirmed that the level of assurance is 4; adequate control, good compliance. She stated that it is an improving picture with fewer incidents overdue for review in quarter 4 compared to quarter 3, the relevant divisions are working hard to review and clear the backlog.	
	4.2 Q4 assurance report – Children's Safeguarding VD confirmed that the level of assurance is 4; adequate control, good compliance. She introduced Vicky Abbott. VA described how the team is awaiting location of a new training venue to ensure they can deliver the level 2 training. She added that it is challenging to keep on top of all the documentation requirements which have to be provided separately to both Sussex and Surrey. VA commented that they provide a lot of information but get limited feedback; they would like more information in order to have full learning and closure of the cases. She stated that the team has not identified a named nurse and doctor for looked after children yet as there is a capacity issue, although there is a lot of interest from the consultant body. VA confirmed that our trust is not unique in this as the capacity to fill the requirement is reflective across other organisations. VD added that the safeguarding children team has set up effective systems which in turn results in lots of referrals leading to increased workload pressure on the team. PL asked what they think our trust need to do in order to fulfill the requirements of the named nurse and doctor for looked after children role. VA stated that it is important that we don't duplicate what we already have in place regarding the role and responsibilities of our safeguarding children named nurse and doctor for looked after children. She added that we need to review what we currently have closely against the requirements for an acute trust, the expectations in the community are much clearer and there is a risk of duplication in acute and community settings that are unnecessary or could result in a lack of clarity of roles and responsibilities across the	

	organisations. FA confirmed that there is a provisional plan in place but at present we cannot quantify what is required of us and what is expected. She added that under current practice if a looked after child is under our care then we provide the comprehensive handover back to the community after that episode of care. FA concluded that if further resources are required to comply with the requirement the trust we go back to our CCG partners. RS asked what the barrier is with provision of the level 2 training. VD confirmed that the team are working with the training department to extend the training time and provision of a more appropriate venue.	
	4.3 Q4 assurance report – Adult Safeguarding VD presented the report stating that the level of assurance is 3; adequate control, variable compliance. She added that overall there is good practice in reporting adult safeguarding concerns through both the Surrey and Sussex processes and the team offer a supportive expertise and uptake of training and feedback is very positive. VD confirmed that the main area of focus is compliance and staff understanding of MCA and DoLS referral. She confirmed that there are plans in place to address this including consideration of a stand-alone post for MCA & DoLS to assist with demand, liaison with the West Sussex CCG lead for MCA to discuss strategies to improve compliance and meetings between the safeguarding adult leads and divisions to increase the understanding of DoLS and MCA referrals. RS thanked VD and requested an update report on DoLS and MCA in 3 months.	
	4.4 Q4 assurance report – Falls FA confirmed that the level of assurance is 3; adequate control, variable compliance. She confirmed that the current policy requires review but remains relevant; the full revision will be completed after the work on the pilot wards has finished, and this is the case for revision of other falls related documentation too as the revised falls assessment and care plan are being piloted. FA added that although the falls rate remains below the national average for the third month, repeat falls are occurring in some areas that are an area of focus. After action reviews (AAR) are not fully embedded on all the wards. RS asked if the repeat falls involve the same person. FA confirmed that in some cases it is the same person and they are generally the patients that are assessed as high risk of falls despite measures being put in place to try and prevent the falls.	
	4.5 assurance report – Infection Control DH presented the report and confirmed the assurance level as 3; adequate control, variable compliance. He stated that the main types of infection over the year have been E.coli and septicemia and the sources have been equally spread across catheter and surgical related sources. MRSA infections have been identified with 2 key contaminants and has resulted in work being done to review and deliver competency based training	

	for staff. There have only been 3 genuine blood stream infections, both were in the community under our SASH at home team. In some acute trusts there are specific staff trained to only take blood cultures but that is not something we do in this trust. DH continued that C diff continues to be a focus and 13 cases have been through the CCG review process. The main areas for improvement are clear documentation of thought process and rationale during clinical assessment and decision making regarding sending stool samples and consideration of infection. RS commented that Frimley Park seem to have a lower number of C diff and asked if there is anything we can learn from them that makes the difference. DH replied that our trust is involved in peer review with 2 other organisations already and linking with a 3rd maybe too much. He added that there is also all the SASH+ work that is supporting the management of diarrhoea.	
5 QUALITY		
	5.1 Q4 update on Trust Audit Plan JP stated that the effectiveness committee was cancelled in April so the trust audit plan will come to the June SQC.	JP
	5.2 Q4 assurance report – Mortality DH confirmed the assurance level as 3; adequate control, variable compliance. He added that RB, as the new Director of Outcomes, will be taking an interest in mortality, particularly in M&M meetings and the case reviews. DH stated that there are a number of gaps at present but a number of actions are planned to mitigate these. He added that the medical examiners work has started.	
	5.3 CQC Intelligent monitoring position JP reported there is no update as we are still waiting for new CQC insight model.	
	6.1 Any other business AMcC raised discussion about an article that was printed in the Daily Mail today asking if there is anything that the committee needs to be aware of. FA updated the committee stating that the article involved a lady whose partner logged a complaint against maternity services in December 2014 via patient opinion. At the time the concerns raised were picked up and contact was made with the partner. The concerns were investigated and the lady and her partner met with staff to discuss the findings and offer resolution in January 2015. All staff involved felt the meeting went well and there did not seem to be any outstanding issues for the couple. As there had been no further contact or follow up from them since that time it was assumed that all the concerns had been addressed and the case was closed. FA added that part of the concern was that the lady had not had adequate time, in a quiet environment, to recover from her labour. However, the expectations of what this looked like for the couple was beyond anything that could be offered not only in our trust but across the NHS. FA concluded that the comment from the trust to the Daily Mail reporter has been heavily edited	

	resulting in the article not giving a full transparent summary of the case. DH added that this case, as in many complaints and concerns raised by patients and their families, highlights the importance of having open dialogue and honest conversations with our patients and their families and setting clear expectations. RS thanked FA and DH for their summary of the situation.	
	6.2 Proposed Agenda for next meeting RS suggested that the June agenda may need review in light of the carry forward of the Q4 update of the Trust Audit Plan and the addition of the RTT review requested by CP an action from the Trust Board. VD asked if the adult safeguarding report due next month needs to be similar to the children's safeguarding report presented to the committee in April. RS confirmed that would be very helpful.	
	Review of meeting RS asked for any comments from the committee members regarding how the meeting had gone. DH commented that he enjoyed the meeting and felt there had been some good discussion. PL added that she felt the notes from the meetings were always good and found it very helpful that she is able to look at the assurance papers and cross reference with other reports such as the quality report to gains a full picture and understanding.	
	DATE OF NEXT MEETING Thursday1st June 2017 12.00 – 14.00 AD77	