Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 1st June 2017, 12.00-14.00
AD77, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Fiona Allsop	FA	Chief Nurse
Des Holden	DH	Medical Director
Pauline Lambert	PL	Non-Executive Director
Zara Nadim	ZN	Chief, WaCH
Ed Cetti	EC	Chief, Cancer & Diagnostics
Barbara Bray	BB	Chief, Surgery
Sarah Rafferty	SR	Chief, Education
Victoria Daley	VD	Deputy Chief Nurse
Ben Emly	BE	Head of Performance
Colin Pink	CP	Head of Corporate Governance
Richard Brown	RB	Director of Outcomes
Jonathan Parr	JP	Clinical Governance Compliance Manager
Karen Devanny	KD	Head of Quality, East Surrey CCG
Mark Salmon	MS	Consultant, Surgery (TARN)
Melanie Thorn		Visitor observing , SaSH Physiotherapist
Julia Sunkwa-Mills	JS	Interim Service Manager, Medicine (ED and Acute Medicine)
Nick Roberts	NR	Patient Safety Administrator, in attendance for notes
Apologies:		
Alan McCarthy, Angela Stevenson, Des Holden, Paul Simpson, Katharine Horner, Caroline Warner, Ben Mearns, Paula Tucker		

		Action
1 COMMITTEE BUSINESS		
	1.1. Chair welcomed everyone to the meeting. Apologies were noted.	
	1.2. Minutes of the previous meeting The minutes of the last meeting (4h May 2017) were presented. CP asked to make some amendments and represent the minutes at the July meeting. This was agreed.	
	1.3. Action Log and matters arising **C/F 6th April 2017** • **Benchmarking report: review of safety metrics** BE stated that this report was currently being drawn up for presentation to Executive Committee and Private Board in June. In future this will not be reviewed at SQC. **1.3.1 Data Quality Audit - AMU discharges and length of stay.** BE referred to this audit which was intended to determine whether inpatient discharges and transfers are recorded accurately on the Trust's Patient Administration System (PAS).	

	This audit was initiated following the last deceased date audit that highlighted a data quality issue for recording date of patient death incorrectly on the PAS.. This audit of 219 AMU discharges and transfers in March 2017 resulted in an overall error rate of 5.9%, where the transfer or discharge dates were incorrect on the PAS. The 13 errors identified showed that the discharge or transfer should have been recorded on the previous day and were mainly recorded after midnight or in the early hours of the morning. As with the deceased audit this could be linked to limited administrative support out of hours and retrospective data capture. BE stated that this result gave assurance around protocols for recording discharges and transfers against similar peer audits. RS agreed, but also suggested that these results imply that there may remain an error rate of some 20% in the deceased data that cannot be accounted for and asked about next steps. BE responded that quarterly audits will continue with on-going checks of current data and that EPR will drive improvement.	
	1.4. Highlights from Executive Committee for Quality & Risk CP briefly introduced the sub-sections of the report covering meetings on 27th April and 10th May 2017. PL noted that the Trust is experiencing difficulties in recruiting Histopathology staff. PL requested assurance about the blood-sampling techniques relating to MRSA blood stream infection. DH referred to the work in progress to embed best practice in blood-sampling. RS commended the reduction in complaints in the Medicine Division, since the introduction of open visiting times. FA added that these led to improved dialogue and involvement with friends and relatives, which could be instrumental in realising this reduction. With regard to NOF concerns, it was stated that inter-divisional scrutiny was being applied and the issue is kept under constant review. PL raised the matter of the new process to improve the discharge to nursing-home process for orthopaedic patients, asking for further detail. BE replied that a Care Home Forum had been set up with six local care homes, with an aim to improve this process. KD welcomed this initiative on behalf of the CCGs. It was agreed that the progress of this initiative was to be reviewed at SQC in September. NR to request this from Jane Griffith. **---ACTION 1--- Jane Griffith to be asked for an update at the September meeting relating to the developments with Care Homes Forum concerning proposed changes in discharge from acute services.**	**NR/JG**
	1.5. Highlights from Clinical Quality Review Meeting BE reported that no issues were escalated to the single performance conversation at the March meeting.	

	Concerning the SSNAP Deep Dive it was reported that there had been considerable debate about the ESD service, access to the stroke unit metrics and the timeliness of consultant review. It was reported that the CCGs had raised questions about the stroke pathway. DH responded that whilst internal Trust improvements in provision could always be sought, the key issues are about recognition, referral, early intervention, transfer back to the community and rehabilitation. Stroke patients need a more robust pathway, developed across the STP, to improve clinical outcomes, functionality and quality of life. Significant specific improvements are needed in access to the specialist unit, and rehabilitation staff across the Trust and in the Community. KD agreed that the main requirement is to align systems to produce a robust pathway. Work is on-going within community systems. DH reminded members that it is the current models of provision across the Trusts that most require improvement so that they better support rehabilitation and in so doing lead to improved benefits across the system. RS asked about the expected time frame for these improvements. KD stated that there was an expectation that a common pathway would be set up by November 2017 with alternative care delivery models. RS emphasised the importance of maintaining focus on this issue and asked when a progress report should be brought back to this committee. DH stated that Board would be taking a view on this matter very soon, concentrating on what can be achieved within the Trust. He suggested that following this and a possible cross-Trust seminar progress may be evaluated in November of this year. **---ACTION 2--- Des Holden is asked to report back on how the Trust will proceed with this matter as the actions are carried out.**	**DH**
	1.6. CQUIN update This item was postponed until the July meeting.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report This item was postponed until the July meeting.	
	2.2 RTT Review Questions had been raised at previous meetings about the Trusts performance against 52 week targets, and in particular the potential impact on non-cancer patients of the priority placed by the Trust on Cancer. BE reported on a “system under pressure” where capacity issues and patient choices are making 18 week targets very challenging for all Trusts. KD stated that the commissioning groups are very aware of these difficulties. RCA investigations take place for all 52 week wait breaches of the access standard.. Plans and controls are also in place but the challenge requires maintained focus.	

	BE was asked to state the specialties where these are issues in the delivery of RTT access standards are an issue. BE highlighted cardiology, dermatology, neurology, upper GI, orthopaedics and pain management.	
	2.3 Quality Account This detailed report was introduced by JP following consultation with partners. There were comments relating to incomplete or unavailable data which will be added prior to Board sign off. Noting this gap and the assurance that the details would be included, the report was recommended for referral to Board this month (June.)	
3 PATIENT EXPERIENCE		
4 SAFETY		
5 QUALITY		
	5.1 Trauma Audit and Research Network (TARN) - update This was reported by MS who stated that • Our last quarter TARN returns demonstrated much improved performance in terms of number, quality and speed of data submitted. • SASH is now ahead of national averages and most of our local peers according to data return performance indicators. The quality of patient data submitted to TARN for Q3 is valued at 97.5%, compared with a national mean of 95%. • The Trauma Steering Group is working to ensure that these improvements are sustainable and not reliant on individual personnel. • Trauma Network representatives recently visited SASH for a peer review update and were satisfied with our progress and have written to Michael Wilson to that effect. • There is not likely to be a full peer review this year. We will complete a self-assessment and the network will only decide to visit if there are concerns. PL welcomed this improvement on last year's peer review, which had been positive but had identified a need for improvement in data returns. The Committee asked if the process was now sufficiently robust and sustainable. MS responded that the process is being driven by a very motivated member of staff and DH added that all the sisters in ED are being trained to deliver this initiative. RS thanked MS for his work in producing this encouraging report.	
	5.2 ED Discharge Summary Project This was introduced by JS. The aim of the project is to ensure that the quantity and quality of information provided to GPs, following an emergency visit, supports the continuity of care. The aim is that all Emergency Discharge Summaries are completed within 23 hours of attendance, with daily and monthly audits to achieve full compliance. At present approximately 90% of ED patient records are completed in this time-scale. JS pointed out the root causes, highlighting that the process can be bypassed on the supporting system.	

	Questions were raised about the low threshold for minimum input (15 characters) recommended for one of the narrative fields, and whether this would encourage appropriate documentation. RS asked if the GPs are involved in the feedback process. BE replied that there are plans to consider ways to bring GPs into this aspect of the EPR process. KD stated that it was essential that there is joint working between the Trust and other stakeholders on this issue. PL stressed that patients too need to be fully informed and involved. After an audit in July there will be a report back . Later in the discussion RS asked for clarification of how this issue will be reported back and monitored. **---ACTION 3--- BE will audit and report monitor data on this project to ECQR .** FA stated that the process needs to be robust and asked JS what support might be needed to ensure this process is developed appropriately. FA also emphasised that this report should stress the quantative aspect of the process. Attention needs to be given to actions which will enhance the quality of information given to the patient and GP. RS welcomed the report and looked forward to hearing about the development of this initiative, through notes of ECQR meetings..	**BE**
	5.3 Mortality – understanding death, within the organisation DH referred to this report and two related slides. There is an increased focus on the management and learning from death following recent national high-profile cases. New guidelines and tools for the review of mortality will be available from NHSI later in the year this is likely to include a focus on review of all deaths of a patient with learning disabilities or special needs. DH mentioned the delay (now to 2019) in setting-up the national Medical Examiner Pilot. This would scrutinise and confirm cause of all deaths that do not need to be examined by a coroner before the issuing of a certificate. DH reported that the trust has set up its own internal ME system, involving 11 consultants and local GPs who are taking part in a rota to examine all deaths. This pilot was set up in April and has received largely positive initial feedback. There was considerable discussion about the vulnerability of special-needs patients. RS asked whether there were particular services within the Trust where this is a concern. DH stated that it is recognised nationally that those patients with special needs fare less well in care and that these are often challenging patients who are more likely to suffer in treatment. EC added that respiratory wards often have a high number of these patients. RS asked how well we identify and capture the needs of this client group as national criteria for their recognition are unclear. In response VD reported that liaison nurses in the Surrey and Sussex community groups make sure	

	that we are fully aware of the cohort and continue to support patients when hospitalised. KD added that there is a large cohort in Surrey and that the CCGs are assured about the treatment of these patients when in the care of the Trust. DH, highlighted data from the pilot medical examiners' project and referred to engagement with relatives of the deceased. The initial data 96% of the feedback for April 2017 was positive and through conversation the Trust will seek to improve this position. RS thanked all contributors for the assurance and asked to be informed after this report was received by the Trust Board. RS has taken the role of nominated Non-Executive Director for deceased patients.	
	5.4 Trust Audit Plan Q4 Update JP introduced this report, thanking all those who had facilitated these clinical audits and stressed the importance of producing the consequent action plans with outcomes. BB stressed that the richness of the discussion and relevance of outcomes depended heavily upon clinical governance time that is allocated. She added that being able to use Datix to record this process was a very useful tool noting that turning audits and their ensuing discussions into actions remains a challenge. ZN echoed the observation that Datix has helped improve visibility, especially of the action plans. ZN highlighted that the cancellation of audit time had affected the quality of discussion in some audits. DH stated that the loss of this set-aside time was unfortunate but operationally-necessary. EC agreed with the other Chiefs of Division that Datix was making the process more robust and he looks forward to improved quality of audit. PL expressed her opinion that the detailed report provides a very helpful overview of the audit programme. RS and other members found that there had been significant improvements in managing the clinical audit programme, with a more realistic programme set, closer management in-year and good learning outcomes. It was noted that a recent internal audit had provided a partial assurance opinion. CP stated that full assurance will be the Trust's target and agreed that the improved visibility of actions and focus on desired outcomes will be maintained and monitored by the Internal Audit until completion.	
	5.5 Cancer Division Annual Report EC spoke to this report, referring to a number of key issues, among them. • Vision of the Division is to provide excellent cancer care at SASH, closer to home where possible and support the discharge process for those patients who have complex needs. • Cancer wait-time performance has been very good and represents a turnaround from the position a few years ago. This is against a backdrop of a significant increase in referrals – 17% year on year and compares favorably with other Trusts	

	• Some pathways are challenged regarding wait times, particularly skin for 1st appointment and Urology for treatment within 62 days. • Urology has undergone 2 pathway reviews and significant focus is going into prostate biopsy turnaround times. • Performance has been supported by detailed patient tracking – weekly meeting, innovative informatics and Lung Z5 pathway • Radiology benchmarks very well for efficiency and productivity and has managed to cut agency spend dramatically (from 153 to 87 thousand pounds.) A two-day maximum target for back-log is being maintained despite staffing shortage. • Histopathology workload and staffing continues to be a focus for improvement. New recruits are due to start shortly. Turnaround times for reporting histology have an agreed improvement trajectory. • Haematology are setting up an innovative service, joint clinic with Care of the Elderly Physician to optimise patient pathways • Tandridge ward / IRU have been successful in helping reduce length of stay and expedite complex discharges. EC stated that a challenge for the division remains the need to provide a second MRI machine and to replace older x-ray equipment. RS thanked EC for a most encouraging report which details the significant developments being made whilst catering for a significant increase in demand.	
	6.1 Any other business None.	
	6.2 Proposed Agenda for next meeting The proposed agenda for the next meeting was not considered.	
	DATE OF NEXT MEETING Thursday 6th July 2017 12.00 – 14.00 AD77	