Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 1st December 2016, 14.00-16.00
Rooms 7/8 PGEC, 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 (by phone)
Alan McCarthy	AM	Trust Chairman
Caroline Warner	CW	Non-Executive Director
Des Holden	DH	Medical Director
Fiona Allsop	FA	Chief Nurse
Ben Mearns	BM	Chief, Medicine
Ed Cetti	EC	Chief, Cancer Services & pp Medical Director
Barbara Bray	BB	Chief, Surgery
Paul Simpson	PS	Finance Director
Victoria Daley	VD	Deputy Chief Nurse
Paula Tucker	PT	Deputy Chief Nurse (Innovation and Improvement)
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
Sue Moody	SM	Clinical Quality Manager, Horsham and Mid Sussex CCG
Presenting		
Ashley Flores	AF	Nurse Consultant & Deputy DIPC
Elaine Edwards	EE	Lead Nurse for Palliative and End of Life Care
Naomi Collins	NC	Palliative Care Consultant
Apologies:		
Angela Stevenson, 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 agreed as an accurate record of the meeting.	

1.3. Actions Log and matters arising

C/F 1st September 2016

- **SQC to receive an update on the outcome of the MRSA outbreak and SI investigation** – On the agenda 1.3.2
- **AF to present latest available SSI surveillance data** – On the agenda 1.3.2

C/F 6th October 2016

- **Plans to increase pharmacy support to antibiotic stewardship team** – DH confirmed that the additional hours for pharmacy support for the team has been allocated and is being funded out of the CQUIN budget for this year. It will be built into the budgets for next year. The recent peer review of infection control undertaken by Sarah Mumford from Maidstone and Tunbridge Wells NHS Trust has confirmed that this is the appropriate level of resource.

C/F 1st November 2016

- **JP to produce a mechanism by which the committee can be assured that gaps in NICE compliance have been appropriately assessed and agreed -** JP confirmed that this issue has been discussed at the Clinical Effectiveness Committee and Divisions have been asked to provide a statement of mitigation where non-compliance with a guideline or standard is reported. AM reported to the committee that he had been speaking to the Chairman of NICE who explained that they have a mantra which is "use your brain"; if you have a reason for not following NICE guidelines and the reason is documented then the organisation would be protected. RS confirmed that the process described by JP would give the committee adequate assurance that the decision making had been robust. JP added that if necessary the committee would use the risk register to document any concerns.

1.3.1. Update – Surgical Site infection data

AF presented her paper explaining that the Trust had been identified as an outlier for surgical site infections in fractured neck of femurs for the period July to September 2015. The infection rate has been improving, the last period for which data is available is April to June 2016 during which there was one superficial infection giving an infection rate of 1%. Over the last four quarters there have been 8 infections which gives a rate of 1.9%. The average for all hospitals over the last 5 years the rate is 1.4%, so the Trust is no longer an outlier but still at the upper limits.

A surgical site infection forum has been established comprising of members of the orthopaedic team, matron and infection control. Undertaking a number of quality improvement projects: normothermia, audits on post-op wound care, review of practice against national standards. RS asked whether this is enough to continue the trajectory of improvement. AF explained that each infection triggers a root cause analysis and that the T&O team is engaged in that process which is positive.

BB noted that the Trust receives a higher than average cohort of patients with a fractured neck of femur from nursing homes and the average age of admissions is high. Both factors increase the risk of infection. AF confirmed that SSI data is included within the infection control assurance report. AM

	questioned the comparison with 5 years of national data, AF explained that this is how the data is presented in the public health report.	
	1.3.2. Update on the outcome of MRSA incident AF summarised the lessons learnt from the incident for the committee. The ward is an endocrine ward which had been taking surgical vascular patients who have a very different set of nursing needs in terms of wound care and dressings practice. The ward was not aware of the bio hazard labels for patients on the ward. This has improved and is been proactively checked by the Infection Control team. There have been no further cases and the action plan has been closed. The infection control team has been doing ward based teaching with the Tissue Viability Nurse on aseptic technique to ensure everyone is competent with vascular wound dressings. The final action is to find a new location for the podiatry clinic. PL asked whether this ward was the most appropriate location for vascular patients. AF confirmed that it was as it is one of the newer wards. The bed spacing is good and the fabric of the ward is new and allows for efficient cleaning and better infection control fabric. RS asked about the training for agency nurses. FA explained that agency nurses are trained in infection prevention; the more complex patients would be managed by the established nurses and/or the tissue viability nurse. RS thanked AF for her time noting that the he felt the committee could take good assurance from the progress with surgical site infections and the response to the MRSA breakout.	
	1.3.3. Trauma and TARN update PL confirmed that she had been aware that there was a problem with the TARN data and would like an update on progress. BE updated the committee The information team has run the same script that TARN run on HES data which has confirmed that the Trust has submitted, for this year, all but 5 cases. Everything that should be submitted has been submitted. Some issues with coding have been discovered therefore a forum has been set up for coders and TARN auditors to problem solve. An issue remains; TARN believe that the trauma data has gone up from the HES data, while the Trust believe that the number has come down, with a mismatch of 200, using exactly the same logic. TARN is due to refresh their data w/c 5/12/16 following which the problem will be discussed further. BE agreed to update the committee on the outcome of the discussion. DH noted that a new lead for trauma is about to start and suggested that the committee might like to hear the initial observations of the challenges of the service in the new year. It was agreed that this would be timetabled for March 2017.	
	1.4. Highlights from Executive Committee for Quality & Risk Due to pressure of time, the paper was noted and RS asked for any questions or observations to be raised at the next meeting.	

	1.5. Highlights from Clinical Quality Review Meeting Due to pressure of time, the paper was noted and RS asked for any questions or observations to be raised at the next meeting.	
	1.6. Benchmark report BE presented a list of indicators which are in the Trust's current report, some that are in the single oversight framework (SOF) (noting a degree of cross over) with a suggestion of whether they should be included in the ongoing benchmarking report. In summary a number of indicators will be added to the benchmarking report; 8 or 9 indicators focusing on quality. Some indicators will be excluded because they are measured annually not quarterly. The productivity section will remain the same. The objective is currently expressed in percentage terms but the custom is to measure in quartiles, so BE suggested that the language of the objective be amended. RS asked whether the proposed safety metrics are enough to give assurance. FA agreed that metrics lists were appropriate. AM asked for information about the domain categorisation. BE explained that the Trust has mirrored the CQC domain areas and that the SOF is broadly similar. AM expressed a desire to adopt as much of SOF approach as possible. DH requested metrics be added relating to stroke and fractured neck of femur performance along with R&D. CP made the point that deciding the content of the benchmarking report is now a priority so that action plans can be formulated in order to improve performance to achieve the objective. Any additional metrics can be added or taken out as necessary. The committee agreed to measure the objective against peers and all Trusts, using quartiles. The report will be produced with all the indicators and taken to ECQR on 14th December for final approval. PS noted that the SOF performance metrics have a standard, but the safety and quality metrics do not, until the CQC publish their metrics in Q3.	
	1.7. CQUIN update Due to pressure of time, this verbal update was deferred until the next meeting.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report The report was noted. RS stated that the data had already been reviewed at Trust Board.	
3 PATIENT EXPERIENCE		
	3.1 Trust Board patient story In July the Medical Division presented a patient story to the Board which raised concerns about the communication between clinical staff and the family of an elderly lady admitting in an emergency to the Trust. The story was referred by the Board to the Safety and Quality Committee to follow up and assess what changes have occurred as a consequence of the story. BM explained that the Division has created an action plan as a result of the	

	incident, which has been completed. The patient's daughter had felt excluded from the care of her mother. Open visiting has been introduced since the incident occurred, which has presented some difficulties for the staff caring for stroke patients on Chaldon Ward. An anonymised staff survey is underway to pinpoint the reasons why. The medical division has posters on the ward to explain to patients and visitors who is looking after them. The team made sure that the posters were there and highly visible. The consultant had been made aware that there was a communication issue with the family and had worked hard to resolve it. He was shocked that he had failed to address it and will reflect on the situation. The feelings of the patient's daughter have been reflected to the ED team, who will ensure that families are cared for while treatment is underway. The Division will ensure that communication initiatives are effective. AM asked for the action plan to be updated to remove reference to frequent cancellations of the patient safety executive (PSE). The PSE has not been cancelled frequently and FA confirmed that the story had, in fact, been discussed at the PSE.	BM
4 SAFETY		
5 QUALITY		
	5.1 Presentation by the Palliative Care Team NC and EE were introduced to the committee. NC explained the structure of the palliative care team and gave a description of the service. It was noted that the aspiration is to move to a 7 day service which will be managed when the staff in the development post have gained sufficient experience to operate as an independent practitioner. Referrals are taken from across the Trust from staff, families and patients themselves. Referrals are for pain or symptom control, psychological support, and complex discharge planning for those approaching end of life. PL asked why some patients are care for in hospital as opposed to hospice care. NC explained that the number of adult deaths occurring in hospital has declined but remains significant at 48%. Care home deaths have risen and hospice deaths are static at 18%. The team are in constant dialogue with community partners, but the number of hospice beds are limited (St Catherine has 16). Some patients prefer to remain in hospital. AM asked whether it was wrong to assume that patients would prefer to die at home. BM agreed that it was, that the reality is often lonely and scary. The AMU often see patients who had hoped to die at home but a sudden deterioration or crisis has been frightening. The maximum package of care at home is 4 visits daily and on an exceptional basis 3 nights a week. EE described the case of women with young families who felt safe in hospital. AM questioned whether the hospital beds could be used better. The consensus of the clinicians present was that if support to patients who want to die in their own homes could be improved then it would be less scary and the preferred option. SM has whether the team keeps details of whether patients die in the place of their choosing. NC explained that team routinely record the preferences of the patients under the palliative care team but the caveat is that some patients change their mind, some become too ill to move, some are too well	

	for admission to the hospice. NC noted that there is evidence that if you express and document your preferred place of death you are more likely to achieve it. SM asked whether collaborative conversations are happening across the health economy to facilitate care for patients. NC explained that there are, but the problem is always resources. The team works closely with the Marie Curie discharge liaison service. The team is keen to advocate patient choice but need to avoid subsidising community care. EC informed the committee that the Trust has established an end of life working group care which includes the hospice, GPs and CCGs to think about the vision for the future and how that is achieved. Much of the discussion is about resourcing community teams. NC highlighted the results of the “famcare" audit which was sent to 100 families, 34 were returned. CW noted that the numbers were not statistically significant and asked whether the team had considered qualitative interviews with the families to generate more insight. NC agreed that it would be a good idea. Another option would be to survey all bereaved relatives not just those known to the palliative care team. RS asked about “everyone’s business” and whether the clinical teams across the Trust actively engage with the service offered by the Palliative Care team. BM confirmed that medical teams value the service offered and the soft skills offered to staff in terms of managing the patients’ care. BM explained that the geriatric and general medicine teams have a deep understanding of end of life care. This does vary according to the clinical teams and their exposure to these issues. BM noted that many of the crisis occur at the point of admission, the AMU team often encounter patients who do not have a specific care plan in place which makes their immediate care more complex. AM asked what the average length of stay is for a patient on an end of life care plan. NC explained that the idea of an end of life care plan is that it is used in the last hours and days of life, so it can vary from two weeks to twenty minutes. RS thanked NC and EE for providing the committee with assurance about the service being provided and the challenges being faced.	
	5.2 DNACPR VD presented a paper which outlined the issues involved in DNACPR. VD explained that there have been four cases since January 2016 (2 in the last quarter) where CPR has been attempted where a DNACPR has been in place. In each case a notes review takes place and the rests team will investigate each incident. In each case the paperwork has been found either during or following CPR. Two issues identified are to ensure that the documentation is appropriate filed in the notes and that handover is explicit about the wishes of the patient. RS asked whether provision has been made for the proposed audits, VD explained that this would be taken forward via the resus committee. PL asked how Trust staff know whether patients have a community based DNACPR on admission. BM explained that staff only know if they are told or	

	the form is brought with the patient. Trust staff will complete an additional Trust DNACPR with the patient to make sure there is no misunderstanding; if the patient is discharged then the need to continue the DNACPR in the community is discussed with the GP. The default position is to start CPR if a cardiac arrest occurs before the status of the patient has been established. BM noted that there is uncertainty among medics as to the legal position with regard to who can and can't consent to CPR. The legal position is that if the patient has capacity and requests CPR the medical team are obliged to do it. This is not in line with ALS guidelines and requires further clarification. VD added that Trust staff need to feel confident to have frank conversations with families about the CPR process and likely outcomes. DH noted that patients need to be informed when they have reached a stage in their disease process that is becoming irreversible and that they are entering the last year of their life. When these conversations occur routinely they will cease to be difficult and the management of the patient will be easier. RS asked about the role of relatives in the decision making process. BM explained that the Mental Capacity Act ensures that a "best interests" decision is made on behalf of a patient without capacity, taking into account the views of all interested parties (family, care givers etc.). If there is disagreement an IMCA is appointed who will make a decision on behalf of the patient. RS summed up the conversation, stating that more audits will be conducted on the process, the legal position will be clarified, work will be undertaken with the community to ensure that the DNACPR status of patients is clear on admission and work will done with staff on improving communication with patients and families.	
	6.1 Any other business PL went to SASH+ and was impressed by the work undertaken and the difference it will make to patient care. PL asked whether information from the report out should come to the committee for information. RS asked whether it would be possible for a one page summary come to SQC on a quarterly basis. This will be considered in the context of the current reporting structure.	CP/KH
	6.2 Proposed Agenda for next meeting The proposed agenda for the next meeting was approved.	
	DATE OF NEXT MEETING Thursday 4th January 2017 12.00 – 14.00 AD65	