Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 6th April, 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
Des Holden	DH	Medical Director
Paul Simpson	PS	Finance Director
Zara Nadim	ZN	Chief, WaCH
Sarah Rafferty	SR	Chief, Education
Victoria Daley	VD	Deputy Chief Nurse
Paula Tucker	PT	Deputy Chief Nurse
Ben Emly	BE	Head of Performance
Katharine Horner	KH	Patient Safety & Risk Lead
Apologies:		
Pauline Lambert, Caroline Warner, Fiona Allsop, Ed Cetti, Jonathon Parr, Colin Pink, Karen Devanny, Julia Layzell, Angela Stevenson, Ben Mearns, Barbara Bray		

		Action
1 COMMITTEE BUSINESS		
	1.1. Chair welcomed everyone to the meeting. Apologies noted.	
	1.2. Minutes of the previous meeting The public minutes of the last meeting were agreed as an accurate record of the meeting. The private minutes were not available on board pad and will be approved via e-mail.	
	1.3. Actions Log and matters arising **C/F 7th July 2016** **Data Quality Audit (date of death) update** Ben presented the latest audit data. This is a standard audit completed which compares the data from the bereavement office with the date of death recorded on Cerner. BE circulated the data to the committee and noted that following the last audit there was slight improvement in August and September 2016. The error rate returned to historic rates - 26.1% consistently over the week. The error is that patients who have died are discharged the following day; adding a day to their length of stay and misrepresenting the day of the week on which they died. All corrections will be made and the data resubmitted to SUS to ensure that the data is accurate. Then a new approach to staff training will be taken to embed good practice. BE explained that this function is typically undertaken by ward clerks. The audit has raised the issue of accuracy of length of stay. Currently AMU has the highest volume of errors. A more focused audit will look at all discharges, including the non-deaths to ascertain whether an additional day is being added to all episodes of care.	

	RS asked what problems this recording delay causes. DH explained that it is a data quality/reputational issue. **C/F 2nd February 2017** On the agenda. **C/F 2nd March 2017** It was noted that this update is not due until June. DH asked that Mark Salmon be invited to the meeting.	
	1.4. Highlights from Executive Committee for Quality & Risk DH presented the report and explained that each of the services have been providing updates on their preparation for the impending CQC inspection. This report presents the deep dives into maternity & paediatrics, medicine, surgery and end of life care. In general the reports have been useful; the team presentations have been good and well supported. Overall the majority of self-assessments would suggest that we are "good" in some cases pushing into outstanding. This would correlate with the assessment by PWC who have done extensive work with CQC. DH noted that we code fewer of our deaths as EoL than most comparable Trusts (a third compared to half in other providers). This implies that a smaller proportion of SASH patients are receiving clinical input from the palliative care team. This could suggest that there is room for improvement. PS commented that the presentations have been positive and informative. The structure of the sessions allows objective challenge which has been constructive and involves the clinicians. AM asked how this information is being communicated to the Board and what level of understanding will be expected by CQC of the NEDs. BE explained that each Exec is the lead for a domain and/or a service. Their task is to understand what the challenges are what needs to happen to get to outstanding. The plan is that each Exec will have a NED buddy. Following the PWC workshop on the 28th April the non-execs will be given a paper including a summary of the matrix with: • where we are now • where we think we are going to get to • what we are doing about it RS asked ZN how she felt about the process. ZN summarised the main points of the maternity and paediatric presentations and concluded that the Division was happy with their position. In summary the committee agreed that this was an evolution of the four year deep dive process which has been refreshed and deepened to involve non-exec directors. The key lines of enquiry are to understand our services and what are we doing to improve.	

	1.5. Highlights from Clinical Quality Review Meeting PS presented the report although he had not been at the meeting. RS asked whether the committee should be investigating the performance notices issued by the CCG. PS explained that the performance notice had been received from Sussex, with regard to ED, RTT and diagnostic performance targets. Following further discussion this was withdrawn. The Trust then received a performance notice from East Surrey CCG for the same performance areas and the addition of ED discharge summaries with a view to the Trust formulating an action plan. PS explained to the committee that the ED discharge summaries had been variable in quality, the issues have been identified and the Trust has now put in place an action plan. It was agreed that a presentation would be brought to SQC in June 2017 to talk through the work undertaken and the outcome. BM would be asked to present along with a representative from ED.	BM
	1.6. CQUIN update BE explained that the Trust is currently concluding the year. The Trust's Q3 counter proposal is still under discussion, so the year end position is unknown. The main challenges have been around sepsis, anti-microbial resistance (there was a peak in Q3 antibiotic usage thought to relate to admissions). The scope for 17/18 will be different; there are no local CQUINS, only National CQUINs. The following areas will be included: • Health & Wellbeing continues • e-referral and advice and guidance is coming in and will be a challenge to current working practices • discharge • length of stay (improvement required in the 2-7 day length of stay of the 65+ age range) • sepsis and anti-microbial resistance continues (the implementation of EPR should support this) PS updated the committee on the financial position and the impact on the final accounts. The biggest financial portion of CQUIN money is assessed and agreed at the end of Q4. The Trust has not had the CCG response in terms of Q3. Q4 reporting is being collated ahead of the freeze date at the end of April. A two month contractual process then follows. The CQUIN final settlement will not happen until June or July therefore cannot be reflected precisely within the Trust accounts. Financially PS will assume a positive outcome in respect of the CQUIN, therefore there will be a risk in terms of the financial position reported by PS. DH drew the committee's attention to a CQUIN regarding patient activation and motivational interviewing. It was originally meant to be a 2 year CQUIN, but now not. • Patient activation – where do they fall on a spectrum from a level 1 (denial of their disease) to level 4 (self-management of condition	

	through apps). • Motivational interviewing is concentrating on aspects of the condition that most affect and impact the patient. DH noted that the work had been interesting and inspiring. He suggested that there could be opportunities to use this with staff health and wellbeing. By understanding how many of the Trust's 3,800 staff are "1s" or "4s" will enable the health and wellbeing strategies to be appropriately targeted. DH will be working with the research design service to work out the best approach.	
2 QUALITY PERFORMANCE		
	2.1 Quality Report BE summarised the key issues highlighted by page 3 of the report. RS asked that UTI's in patients with a catheter be added to the Quality report, BE agreed that the Safety Thermometer sub-categories could be added to page 18 of the Quality Report. DH noted that this will support the work which is about to start on reducing gram negative septicemia most of which is related to UTI and gut sepsis. AM asked whether there would be any value is determining whether certain safety events should be declared internal never events. DH agreed that experience shows that high profile interventions are useful in making operational staff aware of safety issues. However, the Virginia Mason "stop the line" process not as easy to apply in an organisation that provides obstetrics and emergency care. In an intense operational environment there may be unintended consequences of rapid response team being diverted from their normal ward activity. RS noted the work being undertaken by PT on falls where a zero tolerance approach is being taken. PT explained that the after action reviews are done as soon as possible to ensure that staff are debriefed in the moment. It is an evolving process which might have applications elsewhere. DH noted that the recording of data related to safety is a challenge within the Trust for example VTE assessments, day of discharge etc. and made the point that these are process issues, not outcomes for patients. DH noted that absolute safety should not judged on the number of VTE assessments done on admission, but on the number of patients who develop and die of venous thromboembolism. Last year SASH did not report any patients who died as a consequence of inadequate screening or treatment. DH concluded that work will continue to review how the Trust reports performance and the self-allocated KPIs, especially where Trust performance may not compare favourably to other organisations. Further analysis will demonstrate where safety improvements are required or where the variance is a function of process issues around data. RS requested that a paper be brought back to SQC to summarise the output of this work. AM requested further information about the urology and Gynae 62 day targets. BE explained that urology have put together a detailed plan around the resolving difficulties in meeting the target. These include clinic reconfiguration and how they co-ordinate with MDTs, on the day pre-assessments. The performance will also improve with changes to the rules	DH

	around shared breaches. Gynae have seen significant growth and capacity is not right. PS noted that a business case has been agreed to provide additional resources to meet the demand. BE noted that the Urology pathway is complex due to the number of investigations required and this is a national problem.	
3 PATIENT EXPERIENCE		
	3.1 NHS "Stop the pressure campaign – action plan" RS noted that there have been three grade 3 pressure cases recently and that grade 1 incidents have been showing as red on the quality report, so the committee would like assurance that the issue is being addressed. PT explained that the Tissue Viability Nurse will be meeting with BE to review the way in which pressure damage data is collected and that it will be measured in the same way as falls per 1,000 bed days. PT noted that two of the grade 3 incidents occurred on Tandridge in December 2016. It has been established that there were challenges relating to staffing and training on Tandridge at this time. The vacant posts have been filled; support and development has been given to the staff and they have grown as a team. No further incidents have been reported. The wards come together at the pressure damage panel to review incidents and discuss management strategies for example helping staff to manage conversations with patients about repositioning. Where patients have capacity and are non-compliant with advice, that the potential consequences are appropriately explained, documented and that the relevant matron is informed. Other measures include a new preventative dressing is being trialed that can stay on for two weeks, moisture damage will be reviewed in more detail. PT has unable to identify any change which may have led to the recent incidents of pressure damage. The action plan has been submitted to NHSI and runs for 12 months. RS noted that the success of the action plan will be monitored by the committee through the Quality Report.	
4 SAFETY		
	4.1 Children's safeguarding – lessons learnt RS informed the committee that this paper had been requested to provide assurance to the committee on the lessons for the Trust and the wider system from serious case reviews. VD summarised her report. VD acknowledged that serious case reviews can be disturbing because they concern vulnerable children who have come to significant harm because there has been a systemic issue in the relationship between the agencies tasked with protecting them. VD noted that such cases are relatively rare and that only a couple of the current cases involve SASH. VD explained that the Trust is monitored by the Safeguarding Boards on any actions assigned to the Trust as part of the review. Furthermore the Trust	

	will apply learning identified by other organisations. This is reported to and monitored by the Trust Safeguarding committee. The process is that each individual agency provides a report about the care provided to the child and this is consolidated into a single report. The Boards bring together the staff involved in each case for further questioning, analysis and learning. Cases are rare and it is difficult to identify interlinking themes. The cases are presented to the Safeguarding Boards in draft prior to the publication of the report. This can be a lengthy process. Learning is identified as the process is being followed; issues that require immediate attention are dealt with by the relevant agency. RS asked, in the case of AA, whether the Trust were sufficiently alert, and confident enough to flag up the issues of the parenting of the child. VD confirmed that information sharing between agencies is good but acknowledged that the home environment of child AA was challenging and recognised that it is important that staff seek full assurance prior to discharge. This is addressed through formal and informal training. Bespoke training is provided by the safeguarding staff in addition to the Level 2 and 3 mandatory training. AM asked in the case of child AA how we assure ourselves that, once the Trust has flagged a concern to another agency, appropriate action has been taken. ZN undertook to follow this issue up with her team and report back to the committee. RS thanked VD for an interesting and useful report. He concluded that the committee could take good assurance that these issues are being handled very carefully.	
5 QUALITY		
	DH explained that there was in event in London aimed at Execs and NEDs organised by NHS Improvement regarding the national expectation for mortality. There were two take home messages: • Trusts have to understand the learning that comes from deaths within the organisation. The Trust needs to devise a method of systematically reviewing as many deaths as possible to understand what that death said about the pathway of care and how the organisation works. • Must ask families how they felt about the death, it is not enough for the Trust to satisfy itself that the death was a good one. SASH has an established system of categorising deaths into expected and unexpected. There are some specialties that review all deaths; ITU, paediatrics and maternity. ED is not sufficiently knowledgeable of the patient to know whether the death was avoidable and often refer to the Coroner. Care for the Elderly will often judge a death to be expected with limited interrogation of the pathway, for example was the admission appropriate. A pilot is underway regarding the accuracy of the certification of death.	

	Established practice is that the death certificate is signed by a junior doctor who has been involved in the patient's care. As part of the pilot the junior doctor will review the patient's notes with a consultant and speak to the family. It is anticipated that this will improve the accuracy of referrals to the Coroner. DH will write to the Coroners to explain the pilot. DH will give a more formal update to the committee at the June meeting.	DH DH
	6.1 Any other business No other items for business raised.	
	6.2 Proposed Agenda for next meeting The proposed agenda for the next meeting was approved.	
	DATE OF NEXT MEETING Thursday 4th May 2017 12.00 – 14.00 AD77	