

Safety and Quality Executive Meeting
Thursday 5 October 2017
12noon – 2pm AD77

ATTENDEES:		
Richard Shaw	RS	Non-Executive Director (Chair)
Caroline Warner	CW	Non-Executive Director
Des Holden	DH	Medical Director (Apologies for lateness)
Ben Emly	BE	AD Insight (Representative)
Ingrid Marsden	IM	Matron (Item 4.1)
Jonathan Parr	JP	Clinical Governance Compliance Manager
Ben Mearns	BM	Chief Medicine
Ashley Flores	AF	Nurse Consultant & Deputy (Item 4.1)
Bill Kilvington	BK	AD WACH (Representative and Item 4.1)
Vicky Daley	VD	Deputy Chief Nurse (Representative)
Paula Tucker	PT	Deputy Chief Nurse (Representative)
Pauline Lambert	PL	Non-Executive Director
Colin Pink	CP	Head of Corporate Governance
Zara Nadim	ZN	Chief WACH (apologies for lateness)
Alan McCarthy	AM	Chair (Attended through conference call)
Edwina Andersson	EA	Head of Legal Services (Item 12)
Lisa Holland	LH	Note Taker
Apologies		
Fiona Allsop, Ed Cetti, Barbara Bray, Kim Rayment, Angela Stevenson, CCG representation		

NOTES	WHO	STATUS
1 Welcome and apologies for absence as noted above.		
2 <u>Minutes</u> The minutes were agreed as an accurate record subject to the following amendments: CP noted there are some typos and will correct. CP raised item 3.3, page 5 - care forums to be amended as presented by BE.		
3 <u>Action Log and matters arising</u> Action: Close action from 3 August quality report re: PT and BE will look to review how aspects of the Safety Thermometer, including the VTE actions. Other actions are wither not due or are to be discussed on the agenda and closed.		
4 <u>Highlights from Executive Committee for Quality and Risk</u> CP presented this item highlighting the summary for September ECQR meetings. To note the first ECQR meeting was very short due to presentation of a live patient tracking system. PL raised the following queries: <ul style="list-style-type: none"> Chemo therapy drugs. CP noted that drugs are made in advance off site and sometimes the patient is considered too unwell to have the drugs and therefore wasted. VTE validation. BM noted there may have been an issue with the 		

	<p>automatic reporting. This has been looked at and reporting refined. There has been a change to Cerner Millennium so that when a patient arrives there is a tag within the system and this flags a VTE assessment as part of a plan do study act cycle. The risk assessment has been measured and the Trust is also looking at any identified consequences, no harm has been identified.</p> <ul style="list-style-type: none"> • The Committee asked for an update on pressure damage cases. PT noted they are doing a deep dive and have already met with Surgery this week. 5 of the cases relate to surgery orthopaedics. PT will update on progress of this. • Trust pulmonary hypertension peer review: BM would be happy to give an update on the peer review once it has been undertaken. JP noted it will come through the minutes of the Clinical Effectiveness Committee. Action: BM and JP <p>RS asked what was meant by the statement that expectant mothers may be turned away from the hospital during peak periods of activity but eventually give birth here: BK noted this refers to when there is a closure or divert in place for maternity. Women can be sent to St Peters as a precaution and then return to East Surrey to deliver, but this is very rare. The head of midwifery writes to all women affected in this way and explains why this has happened.</p>		
5	<p><u>Highlights from PQRM</u> BE reported this meeting was the first in the new structure called PQRM. This brings together performance and quality. Due to short notice attendance was very low with the discussion mainly on activity planning for the year. Anything to note will be fed back to this meeting. AM asked that measures of quality are kept on the agenda as a priority.</p> <p>The Committee discussed stroke and the Trust's SNAPP metrics. BM noted that the Trust is still a SNAPP C and when compared to the regional table we are still doing well. AM noted it would be helpful to have up to date position at a later meeting as CCGs improve community capacity.</p>		
6	<p><u>CQUIN update to include Sepsis</u></p> <p>BE reported on this item highlighting the follow:</p> <ul style="list-style-type: none"> • Full quarterly report next month at end of quarter 2. • Discharge and emergency access data care set went well and first submission next week. • Sepsis remains a challenge on the wards – audit results for Q2 still on going. • BM noted for world sepsis day they had a stroke summit and discussed each of the individual audits and plans to improve. Messages were valuable, getting towards 70% compliance across the board. Clear intervention in different areas and a joined up approach across the Trust. 		
7	<p><u>Quality Report</u> BE presented and highlighted the following:</p> <ul style="list-style-type: none"> • August was a good month with a number of challenges. • Improved on ED but didn't achieve access standard. 		

	<ul style="list-style-type: none"> • Workforce – sickness and staff turnover indicators are up. <p>CP reported and highlighted from the September Trust Board:</p> <ul style="list-style-type: none"> • Focussed on ED access standard not being met • Cancer access and safety • Pressure on orthopaedics and surgery • Increase on admission for over 75s • Assurance of delivery of internal systems to hep winter • Urgent care centres • Sepsis management • Falls presentation led by Paula Tucker <p>AM raised the RTT report on strategy for electives. BE reports from Executive Committee are be considered and will be bringing this back to Private Board every other month.</p> <p>AM noted on page 6, that NHSI working is with the Trust on retention support programme and that the report should say reduction/turnover, BE agreed and will amend the wording.</p> <p>PL asked how the staff aggression and violence campaign is going. BM noted the “it’s not okay” campaign is working well as posters are up and visible and gave an example where two of his medical registrars came to him to talk about behaviour they had witnessed and they would not have done this if it had not been for the campaign.</p> <p>RS queried on Page 7 HSMR #NoF. BM explained HSMR is a rolling annual figure, based on coded data and a prediction on those expected to die versus those that actually do. The figure of 100 is a national average and for the purpose of our scorecard anything over 100 will show as red on the performance. Action: RS asked for an update back at SQC once more is known.</p> <p>RS raised page 22 - safety thermometer relating to overall improvement with a downward trend in pressure ulcers. This is to be monitored by the Committee.</p>		
7	<p><u>Expansion of Neonatal Unit - Risk Mitigation Report</u></p> <p>RS noted that the Committee had been set the question as to whether the risks around the expansion are being managed in the short term and patients won’t come to harm during the expansion of the unit.</p> <p>IM highlighted the following:</p> <ul style="list-style-type: none"> • Have created more space around cots • Clear escalation policy • Work closely with infection control and parents to reduce risk • When a potential infection is identified, babies go into closed incubators, there are daily meetings and liaise closely with Ashley <p>AF reported there have been no outbreaks since 2014 which is a testament to staff practice that no cross infection has occurred. There are regular hand hygiene audits. There is still a tight environment but staff work well to minimise incidents.</p> <p>BK reported the following:</p> <ul style="list-style-type: none"> • There should be 16 sq m per cot as detailed in the draft business case 		

	<ul style="list-style-type: none"> Managing risk through refurbishment which will be difficult but will know better once phasing around the build is done Experience will be taken from the building of the operating theatres as this is a good example. Looking at the same process for the neonatal unit. Infection control are very focussed on management of associated building dust <p>AM raised patient experience/parent experience: BK stated that our risk appetite is particularly affected. It will be a difficult balance especially when transferring someone dependent on the state of their labour. Teams assess the individual and come to the best decision under the circumstances for the least risk.</p> <p>BK stated he is the senior officer responsible for the project and Finance and Workforce Committee will monitor this build. BK noted there will be a quarterly feedback but if concerns it will be more frequent.</p>		
8	<p><u>CQC Assurance Framework</u></p> <p>CP presented this item noting the covering paper is a brief summary of what has been discussed at the recent Board seminar. The Committee went through the slide presentation looking at:</p> <ul style="list-style-type: none"> Safe – summary (concentrated on hard to reach groups so that they are involved) <p>RS felt as a non-executive director he should know more about hard to reach groups and ward level safety information. Discussion held on what would cause concerns on wards.</p> <p>CW asked if an example can be provided that demonstrates the type of work we are doing in areas of the report.</p> <p>Action: CP to ensure next report to SQC has examples of good practice or issues identified.</p> <p>Action: Hard to reach groups to be considered for a discussion at Board seminar to understand the Trust's approach.</p> <p>The Committee noted that the use of key lines of enquiry to drive improvement was a positive plan.</p>		
9	<p><u>Caesarean Section Rate – Re-audit Report</u></p> <p>ZN presented a review of the emergency and elective caesarean sections and the contributing factors further to the identification of upwards trends.</p> <p>CW asked for a little more definition on the data presented. ZN highlighted the NICE guidelines which gives more birth choice. The Trust is working hard to drive down numbers of elective cases. There are more emergencies which is believed to be due to possible high numbers of induction and women over 40 delivering at the hospital, both present increased chance of elective caesarean section.</p> <p>DH noted the Robson criteria will compare very specific examples and classifies any women giving birth under a heading to allow for comparison and review.</p> <p>DH noted the STP is setting up a maternity / birth network and ZN is providing an obstetrician.</p>		

	<p>CW asked about women wanting to experience more control over their pregnancies and birth choices. DH noted he has not seen any complaints here where women were being pressured through pregnancy/birth pathways, nor is data collected from clinics or incentive for doctors to deliver one outcome or the other.</p> <p>DH stated he was reassured by the numbers of successful delivery for both first and second pregnancy that were reported to the meeting.</p> <p>ZN reported that there is increased focus on both elective and emergency cases and that significant review and audit is in place.</p>		
10	<p><u>Medical Division Annual Report</u> BM presented this item and would welcome feedback on how, what and when the Committee wants for future reporting.</p> <p>BM highlighted the following pages from his presentation:</p> <ul style="list-style-type: none"> • 2017/18 achievements to date against annual plan • SWOT analysis for the division and its services • Top risks and how they are being managed • Priorities for the division • Improving productivity and efficiency summary • Summary of capital requirements from top priorities <p>CW raised how the opportunities are dovetailed in the Trust's annual plan and the objectives are aligned. BM reported that the SWOT is based on the business plan that reflects the wider trust plan and strategies. Alignment is important and this year it will be dependent on strategy there could be some consolidation and quality to work on. Divisions are very much part of the process and led by the executive team. It is a very collaborative process.</p> <p>AM asked whether BM and the division found value as well as taking into account the CQC around A&E. BM stated they do and want to deliver what they say they want to deliver. BM also confirmed they have taken into account recent CQC letter which focussed on the must do's across the system.</p> <p>RS thanked BM for the report, apologising for the lack of time available to discuss items in detail but going on to note that the report was good and the format allowed for a wide understanding of the divisions achievements and plans.</p>		
11	<p><u>Organ Donation Annual Report</u> Item deferred to next meeting.</p>		
12	<p><u>Legal Affairs Report</u> EA attended for this item and presented the report.</p> <p>DH highlighted that the urology issue appears in the report and is taking a great deal of effort on EA's part to satisfy the peroneal process, GMC and families affected.</p> <p>EW highlighted Section 3.2 with the high value cases and has done some serious incidents (SI) analysis which shows it is a 50/50 split, not every case was initially reported as an incident. However, upon identification the Trust considers</p>		

	<p>and carries out an appropriate investigation.</p> <p>The obstetric cases will be of a high level in value. RS asked for a follow up about the 50% which were not SIs whether we apply the same learning.</p> <p>CP noted that our incident reporting system is getting better, we know that over time this period the number of incidents identified by complaints is better. Although we have not done this type of analysis within the legal system you could assume it would be the same in order to reassure the committee.</p>		
13	<u>AOB</u>		
	To note the agenda for next meeting will be primarily be led by Richard Brown and will focus on Outcomes and the Trust's data.		