Surrey and Sussex Healthcare NHS Trust

Minutes of	Safety & Quality Committee (SQC) Minutes		
Date	Thursday 5th November 2020	**Time**	12:00-14:00

Members Present		
Caroline Warner	CW	Non-Executive Director (Chair)
Pauline Lambert	PL	Non-Executive Director
Richard Shaw	RS	Chairman
Jackie Moody	JM	Head of Quality Surrey Heartlands CCG
Angela Stevenson	AS	Chief Operating Officer
Ben Mearns	BM	Chief of Medicine
Yasmin Khan	YK	Non-Executive Director
Ian Maheswaran	IM	Chief of Surgery
Ed Cetti	EC	Medical Director
Colin Pink	CP	Head of Corporate Governance
Jane Dickson	JD	Chief Nurse
Paula Tucker	PT	Deputy Chief Nurse
David Heller	DH	Chief Pharmacist
Vicky Abbott	VA	Nurse Consultant Safeguarding
Richard Brown	RB	Director of Outcomes
Paula Tooms	PT	Chief Nurse Cancer & Diagnostics
Ashley Flores	AF	Nurse Consultant Infection Prevention & Control
Karen Jermy	KJ	Chief of WACH
Jonathan Parr	JP	Clinical Governance Compliance Manager
Gemma Johns	GJ	Patient Safety & Risk Facilitator
Apologies		
Michael Wilson, Katharine Horner, Paul Simpson		

		Actions
1	Welcome and apologies for absence as noted above. No declarations of interests noted.	

	Minutes The minutes from the October Meeting were reviewed and agreed as accurate an accurate record. Add apologies for PL. **Action log and matters arising** **C/F 05/03/20** **Report- Covid-19 recovery plan- RCA Review update.** The action has changed to focus on the reviews of the RCA's for patients who suffered delays and cancellations and have not met the 52 weeks / 104-day deadlines. The review will Include whether these patients came to any harm due to these delays. CLOSED.	
2	**Highlights from Executive Committee for Quality & Risk (ECQR)** Report presented by EC. Highlights from the 7th, 14th, 21st and 28th meetings: • Covid-19 Situation Report • Return of Volunteers to Macmillan Centre • Update from Chiefs • Population Health Management • National Clinical Validation Programme • SOP Business continuity guidance Governance Forums • Datix Cloud IQ Implementation Report • 2020/2021 Quality Account for review • HSIB Investigation update • Integrated quality Report RS commented on the Issues with Roche supplies, and asked whether there are any other supply issues or concerns for example with Brexit that the Trust is preparing for. EC said that there is ongoing work in the planning for these issues, alongside the work with the national central team. DH commented that the number of drug shortages has dropped over the past couple of months, there is a huge amount of work going on with the national pharmacy structures to improve stockpiles and the assurance that us being given nationally is that there is a lot of work going on to provide support and certainty with stock levels. DH commented that we have good relationships with clinicians and we are able to discuss alternative medications with clinicians. We also have a good relationship with the regional south east structure and a good flow of communication where we can discuss concerns. PL asked about the mortality data and coding, and also emergency response at Crawley. RB answered the question about the mortality data by explaining that the variation in HSMR is due to Covid-19 deaths being placed in the incorrect category, they should be placed in the category of viral infections which does not impact HSMR. Therefore, a review has been carried out and a number of deaths have been removed and re-categorised, reducing the HSMR. JD answered PL's second question about emergency response at Crawley discussing an incident where a patient died. An investigation and review was carried out and the actions are focused on ensuring there is an adequate emergency response process and team, and that there is clarification on who is in charge at Crawley, like the clinical site team that we have at ESH. The actions from the investigation include how we can utilise ESH staff in	

	providing a site response team at Crawley. JD assured that there no actual safety issues at Crawley. CW asked the committee if we feel assured that Crawley is safe and issues are sited on. JD assured the committee that we do, but wants to ensure that there is a better structure for clinical site management at Crawley for escalation and emergencies.	
3	**Highlights from CQRM** RB provided a brief overview of this agenda item. No items were escalated. JM commented that there were no items for escalation. JD raised the action plan for Docman which will come to the board.	
4	**Quality Report** PL asked about the maternity incident on page 19, would like to understand that incident more. KJ discussed the incident and explained that the condition that the baby had was very specialised and therefore explained that during the investigation process the team wanted an external review and expert opinion. YK asked about the allergy SI and the intrapartum stillbirth review- There was confusion about the intrapartum stillbirth, this may be a typo error or incorrectly written in the report. GJ commented on the Milk allergy SI, explaining that the investigation is still underway. PL asked about the patient safety incident hotspots: admissions & delay in admission process, appointments, clinical documentation and abuse of patients. JD talked about the abuse of patients; ensuring that patients with cognitive impairments are chaperoned, but there is nothing that is causing great concern, there is some training in some areas that is required. EC commented on the readmission into hospital explaining that a detailed review has been carried out but nothing of great clinical concern has been found. Some readmissions have been coded incorrectly. In terms of admissions and clinical documentation, nothing has been raised as a concern therefore this will need to be taken away to be looked into. RS asked about ambulance turnaround times and cancer diagnostics and endoscopy waiting lists. AS discussed the performance on ambulance turnaround times of handing over in 30 minutes, which is fairly consistent, and trying to get to under 15 minutes. There is an Increase in attendance in ED- 90% activity to last year, and a bigger proportion of those are being admitted. Current cancer waiting list- AS talked through the slide- and discussed the cancer pathway; where patients are waiting on the pathway. The main issue is the diagnostic phase and endoscopy. Patients on a 62 pathway with a suspected cancer, the vast majority are in diagnostic endoscopy waiting phase. There is focus on ensuring that patients are being booked for their diagnostic procedure, there is only a small amount who have been waiting a very long time. AS and MW are focusing on individual patients with definitive targets and are ensuring that these patients are being managed to reduce backlog.	

	RS asked about how the second wave of Covid will affect the existing back log. AS commented that she feels confident that the work underway will be continued through the second wave, there are better procedures in place than before and procedures are not stopping like they did in the first wave. There is an ability to sustain. PL positively commented on the ED standard and falls management. CW raised the patient story. JD discussed the article in the Sunday Times and wanted to provide the committee with some assurance about the learning from the incident. JD discussed the views raised by the family and how they felt about the care that their family member received. JD mentioned that there is a belief that the care that this gentleman received was good but there are some aspects that the family raised concerns about which could be better. The learning from the incident is focused around visibility of staff, staff staying in the bays, and the perception of care seen by families. This family are overwhelmed with grief and there could have been more done in the preparation for end of life for the family CW asked about generic end of life care; how do we manage pain relief and is it accessible, are we able to allow people to die in the way they want to, is hospice capacity compromised, do we feel that we are able to provide comfort for a 'good death'. BM assured the committee by saying that we do encourage and allow visitors to come in to see end of life patients, providing family support. We encourage staff to support patients and provide comfort based on the patients needs, for example changing physical assessments to symptomatic and emotional management. We always support patients by getting them to their place where they want to die but Covid does make it difficult and there are challenges but we do encourage this. Pain control is not an issue, Covid patients suffer more with breathlessness than pain but we do our best and work well with the palliative care team to do the best we can. RB supported BM's comments, mentioning that the Medical examiners audit gives positive comments from families and RB read out some comments for the committee to hear. DH commented about pain control- there is a wide range of products for patients, and a variety of ways for delivering the medication with an MDT approach. EC commented that great work is being carried out in challenging circumstances. Visiting for end of life patients is vital and we will continue to support this throughout Covid. Palliative care support is important, as is the offering of support and advice to ward areas. JD commented on ensuring that we are doing the right thing, by ensuring we are supporting families and preparing them. PL acknowledged that this is a highly emotive subject and believes that the trust does extremely well, thank you. YK asked about grief and bereavement and whether there are any processes on offer for the family for support. JD explained that we signpost to services. Our chaplaincy service has called every single bereaved family. Medical Examiners are also speaking with every family.	

5	**Covid-19 Update** EC provided the update. Covid prevalence rising and accelerating. Currently 48 positive patients, 4 within critical care, 2 ventilated aged (50-69), 2 on high flow oxygen. ED activity slightly below this time last year, paediatric activity way below what it was this time last year, bronchiolitis not materialised. Challenges- trying to minimise hospital acquired infections. Anticipate national guidance- strengthen infection control, mask wearing across all areas in the hospital. 2 ward outbreaks- both orthopaedic. Patients who came in negative, contracted Covid during inpatient stay. Trying to optimise rapid testing. Critical care beds- splitting between hot and cold. Continuously working through plans for transferring patients to other trusts. <u>Questions</u> PL asked about visitors, are we still open to visitors? EC explained that visiting is restricted to hot Covid wards in the hospital although this is relaxed for end of life patients, patients with learning disabilities etc. Not allowing visiting for elective surgery. Maternity visiting is still allowed. Other wards- 1 nominated visitor for 1 hour per patient a day. This is being reviewed daily and will follow national guidance and future changes. YK asked about discharge capacity and whether there are any hurdles in the discharge process. EC- it is difficult discharging patients if they have had a positive Covid test in the past. Care homes and community providers are providing challenges for patients being accepted back home. Patients are being tested again prior to discharge and we are following the national guidance about the non-infectious period. JD Anticipates this becoming more challenging. BM discussed cases in IRU- explaining that staff are working hard on providing care homes and families with giving confidence and support. Trying to improve length of stay of patients (reducing days) by giving confidence to partners, allowing patients to go home sooner when they are fit or discharge. RS asked about capacity for testing and staff morale. EC explained that we have acquired 2 more machines for more rapid testing on site, but this is logistically challenging and will take time to set up but will allow for greater rapid onsite testing. Having more capacity on our current machine would help massively. AS commented on staff morale- staff anxiety about the unknown of not knowing how bad the second wave will be. We are focusing on listening to staff and involving psychologists to talk to staff, working with them to understand how we can share our high-level plan with all staff. It is important that we understand what information staff want to know to know that will help their anxieties. There was a discussion around the fact that we recognise the importance of listening and understanding staff anxieties so that we can help manage them. JD talked about clinical staff and their level of anxiety about the things they can and can't control in the workplace. There is a plan for more listening events and sharing plans as they emerge and change.	

	JM- heartening to hear about the work that is being done by listening to the staff. Good to hear.	
6	**Review of SQC terms of reference** RB suggested looking at strengthening the narrative for clinical effectiveness. GJ/KH, RB to strengthen this in the TOR offline.	
7	**Quality Account Review** Committee agreed to endorse this Quality Account to go to the board at the end of the month.	
8	**IPCAS annual report** CW thanked the individuals involved for this report. AF discussed the highlights from the report. PL thanked AF for the report. She asked about MSSA and BSI with the cases being high and the relevance. She asked about catheter related infections, surgical site infections and asked whether we should be worried about them. AF discussed the importance of ensuring staff are completing phlebitis scoring and mentioned that catheters rates have improved on last year and year previously. There is better reviewing of catheters and removing when not required. There is focus on improving the use of them and using other devices instead. JD supported AF's comments, and said that there is less tolerance for long term use of catheters. In relation to surgical site infections-there is an action plan, which has been to patient safety and assured the committee that it is taken seriously and work is being done. The Committee approved the report	
9	**National Inpatient Survey and Action Plan** JD presented the report and explained that there is an action plan which is being monitored via Patient Experience.	
10	**Assurance Reports** (Incidents, Pressure Damage, Safeguarding- combined, Sepsis, Achieving Cancer Targets, RTT, Stroke, C-Sections, NICE Guidance, Neck of Femur). <u>Questions</u> RS asked if we are struggling with Sepsis? EC commented possibly, due to the focus on Covid and value stream paused during Covid. Work needs to be refocused and refreshed. YK asked about safeguarding and about 16-17yr olds being inpatients in adult wards, what is the scale of this? VA explained at any one time 1-3 outlying 16-17yr olds in adult wards at any one time. These patients are reviewed regularly to ensure that they are on the correct	

	pathway. This is nothing to do with bed capacity on the childrens ward, this is the choice of the paediatric service. PL mentioned that this is not unusual in acute hospitals, and claimed that other hospitals do it. VA clarified that all of these patients are assessed that they are safe on these wards and environments. AS also commented by saying that this is standard practice in district hospitals. Specialist hospitals tend to have adolescent units and transitional care units. JD reiterated VA and AS comments- these patients are monitored daily and the exec team know where these patients are. To ensure and protect the emotional wellbeing of these patients, there is an exception and they can have someone staying with them to provide them with appropriate support.	
11	**Proposed agenda for next meeting**	

Date of next meeting	Thursday 3rd December 2020	**Time**	12.00-14.00	**Room**	AD77

Date first raised	Agenda Item	Action	Lead	Review Date	Status