

Wednesday 15th January 2014, 09:00-11:00am, Room 52, 1st Floor, Grosvenor Wing, SGH

Present:	Tom Coffey (TC) – Chair	Wandsworth CCG (WCCG) – General Practitioner
	Angelique Edwards (AE)	WCCG–Community Services Wandsworth CQR Chair& WCCG 111 Clinical Lead
	Tianne Thompson (TT)	WCCG – Interim Quality Assurance Lead
	Tim Hodgson (TH)	Merton CCG (MCCG) – General Practitioner
	Jackie Moody (JM)	Surrey Downs CCG (SDCCG) – Clinical Quality and Safety Manager
	Mary Hopper (MH)	Sutton CCG (SCCG) – Director of Quality
	Andrew Burnett (ABu)	London Borough of Wandsworth - Consultant in Public Health Medicine
	Su Woollard (SW)	NHS England (NHSE) – Service Specialist (Internal Medicine) (London Region)
	Felicity Dennis (FD)	NHSE – Service Specialist (London Region)
	Amelia Whittaker (AW)	South London Commissioning Support Unit (SL CSU) – Associate Director of Commissioning
	Lulu Awori (LA) - Minutes	SL CSU – Acute Contract Management Support
	Deirdre Baker (DB)	SGH – Assistant Director Finance - Resources
	Rosalind Given-Wilson (RGW)	SGH – Medical Director
	Theresa Douglas (TD)	SGH – Head of Contracts
	Kaye Glover (KG)	SGH – Performance Development Manager
	Nigel Kennea (NK)	SGH – Associate Medical Director
	Vikki Carruth (VC)	SGH – Deputy Chief Nurse
	Alison Robertson (AR)	SGH – Chief Nurse and Director of Operations
	Jonathan Round (JR)	SGH – Clinical Director for Children’s Services
	Sal Maughan (SM)	SGH – Corporate Risk and Assurance Manager
	TundeOdutoye (TO)	SGH – Clinical Director for Surgery
	Marion Louki (MLo)	SGH – Deputy Head of Maternity
	Harvey McEnroe (HM)	SGH – General Manager for Women’s Services
 Apologies:	Mike Lane (ML)	WCCG– General Practitioner
	Leo Whittaker (LW)	SL CSU – Senior Contracts Manager
	Laura Jackson (LJ)	Kingston CCG (KCCG) – Quality Manager
	Lucie Waters (LWa)	WCCG – Director of Commissioning
	Jenny Kay (JK)	MCCG –Director of Quality

1.	Introductions & Apologies										
	As above. The meeting was held in the following order: 1, 4, 5, 2, 3, 6, 7, 8, 10, 9, 11, 12, 13, 14, 15, 16, 17.										
2.	Notes of the last meeting										
	The previous minutes were regarded as accurate.										
3.	Matters Arising – Actions from the last meeting.										
	<table border="1"> <tr> <td data-bbox="248 667 376 721"></td> <td data-bbox="376 667 2107 721"></td> </tr> <tr> <td data-bbox="248 721 376 1038">1.</td> <td data-bbox="376 721 2107 1038"> <p>VC to feedback about 1) the use of photos for compliance to use pressure relieving equipment, and 2) recommendations for an opt-out approach for equipment use to the Pressure Ulcer Taskforce. Update: VC shared that both points were raised with the Pressure Ulcer Taskforce and further feedback will be shared at the February CQRM. VC added that the group will also consider a review of documenting patients' refusal of pressure relieving equipment. Action carried forward.</p> <p>ACTION¹: VC to feedback about 1) the use of photos for compliance to use pressure relieving equipment, 2) recommendations for an opt-out approach for equipment use to the Pressure Ulcer Taskforce, and 3) review of documenting patients' refusal of pressure relieving equipment.</p> </td> </tr> <tr> <td data-bbox="248 1038 376 1118">2.</td> <td data-bbox="376 1038 2107 1118"> <p>KS to forward SI cases to add to the tracker to TC, AW, AE and LB on a weekly basis, until issues with new SI process resolved. Update: Complete.</p> </td> </tr> <tr> <td data-bbox="248 1118 376 1278">3.</td> <td data-bbox="376 1118 2107 1278"> <p>RGW to share with CQRM if Oliver's Protocol, currently applied in Maternity services which enables any staff member to escalate an issue, can be applied across the Trust. Update: this action was carried forward for comments from AR and VC. AR shared that there is a preference to promote a culture of safety where staff are encouraged to escalate safety issues. AR also referenced the Trust's safety forum where Serious Incidents are discussed with staff and lessons learnt are shared.</p> </td> </tr> <tr> <td data-bbox="248 1278 376 1353">4.</td> <td data-bbox="376 1278 2107 1353"> <p>Drew Fleming or deputy to attend January CQR meeting with a report on out of hours cover for surgery specialties. Update: Agenda item 4.</p> </td> </tr> </table>			1.	<p>VC to feedback about 1) the use of photos for compliance to use pressure relieving equipment, and 2) recommendations for an opt-out approach for equipment use to the Pressure Ulcer Taskforce. Update: VC shared that both points were raised with the Pressure Ulcer Taskforce and further feedback will be shared at the February CQRM. VC added that the group will also consider a review of documenting patients' refusal of pressure relieving equipment. Action carried forward.</p> <p>ACTION¹: VC to feedback about 1) the use of photos for compliance to use pressure relieving equipment, 2) recommendations for an opt-out approach for equipment use to the Pressure Ulcer Taskforce, and 3) review of documenting patients' refusal of pressure relieving equipment.</p>	2.	<p>KS to forward SI cases to add to the tracker to TC, AW, AE and LB on a weekly basis, until issues with new SI process resolved. Update: Complete.</p>	3.	<p>RGW to share with CQRM if Oliver's Protocol, currently applied in Maternity services which enables any staff member to escalate an issue, can be applied across the Trust. Update: this action was carried forward for comments from AR and VC. AR shared that there is a preference to promote a culture of safety where staff are encouraged to escalate safety issues. AR also referenced the Trust's safety forum where Serious Incidents are discussed with staff and lessons learnt are shared.</p>	4.	<p>Drew Fleming or deputy to attend January CQR meeting with a report on out of hours cover for surgery specialties. Update: Agenda item 4.</p>
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5.	FFT score by ward to be included in future FFT reports. DB to circulate updated report following meeting. Update: Complete.
6.	VC to provide a detailed walk-through of the FFT process, including the approach for non-English speaking patients. Update: Action carried forward. ACTION²: VC to provide a detailed walk-through of the FFT process, including the approach for non-English speaking patients.
7.	DB to provide further update on Cancer 62 Day breaches in January CQRM. Update: Agenda item 8.
8.	PCI to be discussed further in February, when a full report will be presented. Update: February CQRM – action carried forward. ACTION³: PCI to be discussed further in February, when a full report will be presented.
9.	LA to circulate June – August 2013 Dr Fosters PCI risk-adjusted mortality data to CQRM group following the meeting. Update: Complete.
10.	NK to share December PCI risk-adjusted mortality data with TC and ABu. Update: Complete.
11.	ABu to share a summary of the coroner's inquest which took place on 17/12/2013 as a result of the TB-related Serious Incident (STEIS: 2013/13767) with TC. TC to discuss GP recommendations outlined in the coroner's inquest with Dr Anne Rainsberry, NHS England (Director, London Region). Update: Complete. SI to remain on Serious Incident tracker until response received. ACTION⁴: TC to confirm when a response has been received from NHSE following correspondence regarding the GP recommendations outlined in the coroner's inquest related to the TB-related Serious Incident (STEIS: 2013/13767).
12.	NK to share nasogastric (NG) tube policy with SGH CQR group. Update: Complete.
13.	NK to share failsafe system for nasogastric (NG) tube insertion follows policy to February meeting. Update: Action closed.
14.	RGW to share a description of the existing failsafe system in place for the management of the order of investigations for inpatients, outpatients and the emergency department (ED) at February meeting. Update: February CQRM – action carried forward. ACTION⁵: RGW to share a description of the existing failsafe system in place for the management of the order of investigations for inpatients, outpatients and the emergency department (ED) at February meeting
15.	Further detail of MAD alert no. 131203-002 (frustration with lack of clinic-to-clinic referrals to eye clinics) to be provided. Update: DB confirmed that this alert relates to the Moorfield's clinic.
16.	Duty of Candour to added to January agenda for discussion. Update: Complete.

	<p>17. London Quality Standards to be added to January agenda for discussion. Update: Complete.</p>
<p>4.</p>	<p>Specialised Commissioning</p>
	<p>4.1 Paediatric Oncology Action Plan Update</p> <p>FD gave background, sharing that the paediatric oncology action plan under discussion was devised in response to a clinical incident involving SGH, Kingston Hospital (KHT) and Royal Marsden (RMH) in which a patient died. FD shared that there was an inquest into the child's death in November 2013 and noted that NHSE has received the coroner's report, to which Jane Fryer (Medical Director, London Region – NHSE) is developing a response.</p> <p>JR gave a presentation on the clinical details of the incident and confirmed the incident took place in 2010. JR shared the following has occurred as a result of the incident:</p> <ul style="list-style-type: none"> • Antibiotics are now administered within 2 hours of admission • Early Warning System and escalation protocols have been reviewed • Paediatrics training has taken place <p>JR noted that there are currently lower numbers of paediatric-related SIs, and of the SIs declared few or none are related to clinical care. JR confirmed that the delay in declaring the incident as an SI (in 2013) was due to declaration following that of the other two providers, who had been more involved with the patient's care than SGH.</p> <p>Further outcomes include:</p> <ul style="list-style-type: none"> • Ensuring parents are aware of possible complications of the condition affecting the child • Ensuring the admitting team are aware of the change in the clinical state of the patient • Ensuring admitting team are aware of any possible complications which may arise • Preparing individualised care plans • Fully informing the consultant neurosurgeon of all relevant detail • Where an incident is suspected but not yet declared, the patient's parents should be informed

	<p>JR’s personal analysis of the incident, which takes into consideration the coroner’s comments from the inquest, is that there had been a lack of adequate teamwork and communications.</p> <p>JR commented on the suitability of the interaction between Paediatric Oncology Shared Care Units (POSCU) and Primary Treatment Centres (PTC) within the Specialised Children’s Networks (SCN) model. JR added that future steps include methods of bettering patient care across specialised children’s services, with a review of the model of care for PTCs and POSCUs and implementing neurosurgery expertise on several sites.</p> <p>RGW added that in the period between the incident occurrence and the declaration of the incident as an SI at SGH, initial discussions had been held with the parents regarding the monitoring of the patient’s blood pressure whilst in PICU. Following KHT’s declaration of the incident as an SI, regular three way meetings between all three Trusts and the parents followed. RGW noted that it was the institutional view of SGH that there were no elements of the patient’s care at St George’s that constituted an SI. The parents’ view was that SGH should declare the incident as an SI in order to get a report that covered the three institutions which RGW supported. RGW confirmed that the final report, upon SGH’s declaration, drew on evidence from both KHT and RMH.</p> <p>FD confirmed that the action plan has been addressed by SGH, but required more information on one or two areas. FD, JR and other individuals as appropriate are to meet outside CQR meeting and share updated action plan for information at February CQRM.</p> <p>ACTION⁶: Updated Paediatric Oncology Action Plan to be shared for information at February CQRM.</p>
<p>5.</p>	<p>OOH Surgery Cover</p>
	<p>TO gave an overview of the Trust’s out of hours surgery cover arrangements. TO confirmed that out of hours cover is from 8pm – 8am on weekdays, and is all day on the weekends.</p> <p>TO noted that there is a 2-tier system for General Surgery, Urology, Orthopaedics and Vascular Surgery; Advanced Nurse Practitioners (ANPs) cover the wards at night from 8pm. There is a handover from core trainees to ANPs at 7.30pm each evening in the Orthopaedics Seminar Room. TO noted that the handover is currently paper based but there is an aim to computerize the process.</p> <p>Orthopaedics, General Surgery and Urology</p>

TO shared that there is a Specialist Registrar (SpR) for Orthopaedics on site 24/7. For General Surgery, there is a core trainee present during out of hours based in the emergency department (ED) who also covers Urology and Vascular Surgery. A SpR is also present on site 24/7 and TO shared that during the previous two winters, an additional SpR was in post from 5pm – 9pm on weekdays and 8am – 8pm on weekends. TO noted that the Urology SpR is based at home, and a protocol has been established allowing for patients to be discharged from ED and seen in an emergency clinic the following day. Patients who need to be admitted are referred to the appropriate ward by ED and received by the ANP; if the SpR is required, they come in from home however TO highlighted that this does not happen often.

TO noted that at the weekends (depending on the specialty) there is either a core trainee, a physician assistant or a clinical fellow available for ward rounds with the consultant and SpR for orthopaedics, general surgery and urology.

ENT, Maxillofacial and Plastic Surgery

For the above specialties, a Specialist Advanced Nurse Practitioners (SNAPs) have been trained to manage emergencies related to ENT, MaxFax and Plastics. TO shared that recruitment efforts are underway as the Trust is currently operating with 3 out of 5 SNAPs in post, as one is due to leave the Trust on sick leave and another is leaving the post. TO highlighted that 2 SNAPs are in post overnight, from 7pm – 2am in particular for ENT and Plastics. The registrars for these three specialties are at home, and come in when required and TO added that the Plastics registrar spends the majority of time within the hospital, but this is less so for those facing ENT and MaxFax.

On the weekends, there is either a core trainee, a physician assistant or a clinical fellow covering wards with the registrar during the day and there is handover to the SNAPs at night.

There is out of hours consultant cover for all specialties on the weekdays and weekends, and TO noted that the consultants are on call from home. For all specialties, excluding Vascular Surgery, there are consultant ward rounds on Saturday and Sunday.

TO responded to the following queries:

Why are there no core trainees at night?

- 1) As a result of the European Working Time Directive, requesting core trainees to cover at night will breach regulation.
- 2) Quality of training – the London Deanery does not recognise unsupervised core trainees at night to be adequate for training.

Some of the medical cases are complex - are the SNAPs adept to manage them?

TO responded that the SNAPs are well trained and are as good as Year 1 SHOs (senior house officers). The SNAPs undertake a training

programme with exams, and are regularly appraised. Individuals can only become SNAPs upon passing the given exam. They are able to call a registrar as appropriate.

Is there an ANP each for Orthopaedics, General Surgery, Urology and Vascular Surgery?

TO confirmed that there are 2 ANPs at night (one each for medical and surgery) for all specialties. All basic ward work should be completed by 7.30pm, and the ANPs provide emergency cover for the wards at night. TO confirmed that this is a work in progress, as at times they may do basic ward work for a variety of reasons. In the event of any issues, the appropriate registrar (medical or surgical) is called as appropriate.

Is there extra pressure on A&E to prepare patients for wards, which would have ordinarily have been done by SHOs?

TO responded that this is not the case, sharing that the bulk of activity via A&E comes through to ENT, Plastics and General Surgery. There is a core trainee for General Surgery in ED. TO noted that it was established that there was insufficient registrar support to make decisions so winter funding was used to put an additional SpR in post.

RGW added that the current arrangements are the result of ongoing work by the Trust to ensure the safe replacement of the historical system in which Junior Doctors would work out of hours. RGW noted that the arrangements are a work in progress, and referenced the Trust's recent HESL (Health Education South London) visit which raised issues around handover between SNAPs and Junior Doctors in the morning.

Will the arrangements cope with the removal of the winter-funded SpR?

TO responded that at present the arrangements are working well, however over the past few years the workload has exponentially increased. TO confirmed that General Surgery are in the process of developing a business plan to enable the winter-funded SpR post become permanent. DB confirmed that funding for this will be discussed with commissioners as part of the conversations around Non-Emergency Threshold Adjustment (NETA) monies.

What has been the feedback from staff in response to out of hours cover arrangements?

TO shared that it is possible the SHO-level junior doctor felt unsupported covering the on-call duties for General Surgery, Urology, Orthopaedics and Vascular Surgery at the time of the survey. The individual had been called repeatedly to the ward in order to prescribe drugs, and TO highlighted that this is a work in progress as ANPs and SNAPs initially had not yet been trained to prescribe certain drugs which has gradually been streamlined and occurs less often at present. TO reiterated that previously ward rounds on weekends were undertaken on an ad-hoc basis and are now held regularly.

	<p>What measures are the Trust using to indicate that out of hours cover is safe?</p> <p>RGW responded that there are a number of audits taking place, for example on Early Warnings Score and escalation. RGW also noted that in 2010 the Trust had a number of SIs involving the supervision and workload management of Junior Doctors, which haven’t been seen recently to the same extent. TO also added there is a SNAPs committee where issues and appraisals are discussed. TO noted that ANPs are outside of the surgery directorate, and AR added that the process of extending nurses roles is carried out systematically and there is a clear indication of which protocols need to be followed and they are trained and signed off as competent.</p> <p>ACTION⁷: Out of hours mortality data to be discussed at February CQRM.</p>
<p>6.</p>	<p>Francis Report</p>
	<p>6.1 Friends & Family Test (FFT)</p> <p>VC shared that the response rate (RR) is improved at 19.2% Trustwide in November, compared to 15.6% in October (target 15%).</p> <p>Inpatients – Score: +65, RR: 33.2%. A&E – Score: +51, RR: 11.4%</p> <p>Inpatients and A&E score and response rates for November were as above. VC highlighted that maternity has been rolled out, however there are no national benchmarking figures available as yet.</p> <p>VC noted that when extremely unlikely scores are given, patients do not always give a reason to justify. VC noted that additional patient experience questions are asked and recounted occasions where patients have considered themselves extremely unlikely to recommend the Trust to friends or family but have indicated positive responses for all other questions.</p>
<p>7.</p>	<p>Performance Reports</p>
	<p>MRSA and C.Diff</p> <p>AR shared that there were an additional 2 cases of C.Diff in December (26 YTD within trajectory of 36 for the year).</p> <p>There were no additional cases of MRSA in December. There are 4 cases of MRSA YTD, as was the case in November. AR noted that the London</p>

	<p>Scorecard is showing a recording error of 5, and this has been confirmed with the Performance and Infection Control teams in the CSU. AR shared that the root cause analysis investigation did not identify areas of poor practice. AR shared that there it is possible that the origin of the infection may be from a cannula site during a pre-hospital attempt to cannulate a trauma patient by the roadside.</p> <p>A&E The Trust achieved 95% for all types (Type 1 + 3) in December (Type 1 – 94.4%, Type 3 – 100%).</p> <p>Complaints AR expressed concern that the percentage of complaints responded to within 25 days is decreasing (61% in November compared to 65% in October against a target of 85%). AR noted that care groups within the surgery directorate have been required to develop an action plan and submit to AR by the end of January, noting that addressing their backlog of complaints would have a significant impact on Trustwide performance.</p> <p>Pressure Ulcers There were a total of 8 Grade 3 & 4 pressure ulcers in December. AR noted that a pressure ulcer paper will be shared at CQRM meetings on a quarterly basis.</p> <p>ACTION⁸: AR to circulate the quality report schedule, indicating which reports will be circulated for discussion at which CQR meetings.</p>
<p>8.</p>	<p>Cancer 62 Day Breaches Action Plan Update</p> <p>DB shared that the November performance was under the 85% target at 80.8%. DB noted that following a reallocation due to late referrals by Croydon and Kingston Hospitals, the figure is higher although still below target at 83.1% in accordance with the London Cancer Alliance protocol (but this is not the reported performance).</p> <p>DB shared optimism for improvement in Q4 considering plans for all Urology TWR clinic patients attending Queen Mary’s Roehampton (QMR) to have an MRI at QMR in the same week, which can be delayed by up to a month at the SGH site. DB highlighted the effect of this will only be realised from January onwards.</p> <p>DB shared that the cancer directorate have been asked for an update and report to the Trust’s Executive Management Team.</p>

	<p>ACTION⁹: DB to circulate Cancer 62 Day Breach paper at February CQRM.</p> <p>TC queried whether there is an expectation for the Trust to meet or exceed the 85% target by March. DB responded that an improved position is expected, and emphasised that SGH cannot legislate for late transfers received from other Trusts where the breach is shared.</p> <p>ACTION¹⁰: DB to indicate to the SLCSU which Trusts refer late (and subsequently affect SGH's Cancer 62 Day Breach performance).</p>
<p>9.</p>	<p>Post-Natal Clinic Audit</p>
	<p>TC introduced the discussion by recounting previous audits 2 years ago; at this time, patient to midwife ratio was high on labour wards, and there were an increasing number of SIs on the maternity unit.</p> <p>The audit was undertaken in order to ascertain the appropriateness of the postnatal clinic service in terms of risk assessment. 50 randomly selected sets of postnatal records for women who had delivered at the Trust between September and December 2013 were audited.</p> <p>MLo noted that the risk assessment form used is robust and covers medical, obstetric, social and other risk factors. The results of the audit (attachment 5) confirmed that all women's first postnatal visit took place at home. 80% of women had the home visit within 24 hours of discharge from hospital, with those not seen within 24 hours having been discharged late in the day and one patient requested a later visit for religious reasons. 24% of notes revealed risk factors had been identified by the visiting midwife, 100% of patients with identified risk factors had a plan made for a home visit. For all cases, risk assessment templates were not filed in the notes. MLo confirmed that as the forms need stapling, sheets become loose and are easily lost. Currently, purple postnatal national notes are being used, to which the risk template is not essential and risk assessments are completed, with the findings being written in the notes. A review of risk assessment documentation is to be undertaken. MLo also shared that the DNA process has been strengthened and the follow up of DNAs has improved.</p> <p>MLo confirmed that the Lavender clinic sees some Merton patients, with other Merton patients being seen by Epsom & St Helier (ESH).</p> <p>TC queried if ESH have postnatal clinics – MH to confirm.</p> <p>ACTION¹¹: MH to confirm whether ESH have postnatal clinics.</p> <p>ACTION¹²: CQC Maternity survey results to be discussed at March meeting.</p>

<p>10.</p>	<p>Serious Incidents</p>
	<p>10.1 SI Tracker(Attachment 6a)</p> <p>Page 3: SM noted the commentary for the TB-related SI (STEIS: 2013/13767 – Infection Control: Communicable Disease) which had previously been discussed at the September CQR. TC confirmed that he has received the coroner’s inquest summary report and suggested the SI remain on the Serious Incident tracker until a response has been received from NHSE regarding the GP recommendations outlined in the inquest.</p> <p>Page 4: SM noted the commentary for the Delayed Diagnosis SI (STEIS 2013/24573) discussed in December and for re-discussion in February with a report on the Trust’s failsafe mechanism for the management of the order of investigations for inpatients, outpatients and the emergency department (ED).</p> <p>NK added that the Nasogastric (NG) policy had been shared following the previous meeting, and TC confirmed that it was adequate and no long needed to be discussed in the February meeting.</p> <p>Page 13: Two SIs has been added to the tracker relating to a delayed diagnosis to be discussed in the February CQRM, and a patient fall to be discussed in the March CQRM.</p> <p>10.2 Closure Reports</p> <p><i>STEIS: 2013/29436 – Patient Death Following a Fall (Attachment 6c)</i></p> <p>NK gave narrative. NK shared that the key learning resulting from the SI includes:</p> <ul style="list-style-type: none"> • Recognition that there is no standard approach in the assessment of new wheelchair equipment for patients’ use and a checklist is being developed as a result • Heightened awareness of anti-coagulation for patients using Warfarin • Awareness of protected pressure devices on the Mary Seacole ward <p>AE noted that the action plan will be discussed further with the community services division (CSD) at the CSD CQR next week Tuesday (21st)</p>

January).

STEIS: 2013/30288 – Breach of Patient Confidentiality (Attachment 6d)

RGW gave a verbal overview of the events of the incident. Actions as a result include:

- Ensuring individuals presenting for work at the Trust present up to date identification
- Ensuring correspondence to locum agencies requesting staff are treated as confidential

RGW confirmed that police are involved in the incident and the employment policy for locums has been updated as a result. ABu noted that the incident can also present learning opportunities for GPs employing locums.

ACTION¹³: RGW to share the Trust's policy regarding the employment of locums (in response to the breach of confidentiality SI STEIS: 2013/30288) with TC to share with GP colleagues.

STEIS: 2013/28590 – Delayed Diagnosis (Attachment 6b (i) and 6b (ii))

RGW gave narrative, and shared that key learnings from the incident relate to quality of handover, documentation and the need for an agreed daily consultant review of all patients in neurosurgery. RGW confirmed that currently, there are two daily Junior Doctor ward rounds and a consultant review of their own patients.

ABu commented that there are several incidents with issues founded in inadequate verbal and written communication between staff, and proposed discussion into communication independent of conversation related to any particular SIs.

RGW acknowledged that communications is also one of the main themes for complaints and highlighted following a query from TC that an updated handover policy was launched last year which specifies precisely which details need to be relayed in the handover process and who should be present. RGW also referred to the formal handover framework 'SBAR' (Situation Background Assessment and Response) which should be used for the escalation of any unwell patient and request for additional help in the management of a patient.

AR noted that there are a number of additional initiatives related to communication, and suggested a briefing paper is brought for discussion at the March CQRM.

	<p>ACTION¹⁴: Briefing paper on improving communication within the Trust to be discussed at the March CQRM.</p> <p>RGW confirmed that the Trust has been invited by the Health Innovation Network to be part of a joint bid with other South London providers. The Trust has put ideas relating to communication forward and a meeting is to take place at the end of January.</p> <p>10.3 Undeclared SIs Report (Attachment 6e)</p> <p>There were no comments on the incidents not declared as SIs.</p>
11.	London Quality Standards
	<p>TC noted that surgery aside, the Trust is scoring well. TC added that commissioners' discussions are under way in relation to the proposed surgical assessment unit (SAU) for which the provision would enable the Trust to meet current red-indicated surgery-related targets.</p> <p>DB highlighted the maternity indicators and noted that conversations regarding maternity are being held with commissioners about CQUINs.</p>
12.	Duty of Candour
	<p>ACTION¹⁵: Duty of Candour paper to be circulated for discussion in February's meeting.</p>
13.	CQUINs
	<p>A meeting took place on Wednesday 8th January in discussion of 2014/15 CQUINs. TC noted that discussions are ongoing and CQUINs are to be finalised by March 2014.</p>
14.	Make A Difference (MAD) Button
	<p>TC noted that some of the issues arising from MAD alerts are being incorporated into CQUINs negotiation discussions.</p>
15.	CQC Intelligent Monitoring Report

	N/A.		
16.	External/Internal Audits		
	The Trust's CQC inspection will take place on Monday 10 th February 2014.		
17.	Any Other Business		
	<p>Falls Following a query from TH, AR confirmed that a report on falls will come to the CQR meeting every 6 months.</p> <p>NHS Change Day (Monday 3rd March 2014) Following a query from TH, AR confirmed that the Trust may participate in activities related to NHS Change Day.</p> <p>Safeguarding Following a query from SW, AR confirmed that the annual safeguarding report is discussed at CQR following ratification at internal meetings.</p>		
21.	Next Meeting: Wednesday 19 th February 2014, 0900-1100, Heritage Room, 2 nd Floor, Grosvenor Wing, SGH		
	<p>Monthly Rolling Agenda Items</p> <ul style="list-style-type: none"> - Friends & Family Test - Make A Difference (MAD) Button - Specialised Commissioning 	<p>February CQRM</p> <ul style="list-style-type: none"> - Sickle Cell Action Plan - Intervention Radiology Process and GI Bleed Pathway - Percutaneous Coronary Intervention (PCI) - Workforce Document - SGH Failsafe Systems for Inpatients, Outpatients and the Emergency Department - National Quality Board (NQB) Workforce Document - Duty of Candour 	<p>March</p> <ul style="list-style-type: none"> - Subarachnoid Haemorrhage Weekend Service - CQC Maternity Survey Results - Communication Briefing Paper

ACTION SUMMARY – CQR Meeting of 15th January 2013, 09:00-11:00am

Minutes ref	Action	Description	Lead
3) Matters Arising	1.	VC to feedback about 1) the use of photos for compliance to use pressure relieving equipment, 2) recommendations for an opt-out approach for equipment use to the Pressure Ulcer Taskforce, and 3) review of documenting patients' refusal of pressure relieving equipment.	VC
	2.	VC to provide a detailed walk-through of the FFT process, including the approach for non-English speaking patients.	VC
	3.	PCI to be discussed further in February, when a full report will be presented.	NK
	4.	TC to confirm when a response has been received from NHSE following correspondence regarding the GP recommendations outlined in the coroner's inquest related to the TB-related Serious Incident (STEIS: 2013/13767).	TC
	5.	RGW to share a description of the existing failsafe system in place for the management of the order of investigations for inpatients, outpatients and the emergency department (ED) at February meeting	RGW
4) Specialised Commissioning	6.	Updated Paediatric Oncology Action Plan to be shared for information at February CQRM.	FD/JR
5) OOH Surgery	7.	Out of hours mortality data to be discussed at February CQRM.	RGW/NK
7) Performance Reports	8.	AR to circulate the quality report schedule, indicating which reports will be circulated for discussion at which CQR meetings.	AR
8) Cancer 62 Day Breaches	9.	DB to circulate Cancer 62 Day Breach paper at February CQRM.	DB
	10.	DB to indicate to the SLCSU which Trusts refer late (and subsequently affect SGH's Cancer 62 Day Breach performance).	DB
9) Post-Natal Clinic Audit	11.	MH to confirm whether ESH have postnatal clinics.	MH
	12.	CQC Maternity survey results to be discussed at March meeting.	DB
10) Serious Incidents	13.	RGW to share the Trust's policy regarding the employment of locums (in response to the breach of confidentiality SI STEIS: 2013/30288) with TC to share with GP colleagues.	RGW
	14.	Briefing paper on improving communication within the Trust to be discussed at the March CQRM.	AR
12) Duty of Candour	15.	Duty of Candour paper to be circulated for discussion in February's meeting.	AR