Ashford and St. Peter's Hospitals NHS Foundation Trust

TRUST BOARD
8th June 2023

AGENDA ITEM NUMBER	15.1.3	
TITLE OF PAPER	Quality of Care Committee Minutes, 23rd March 2023	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality of Care Committee, 25th May 2023		
STRATEGIC OBJECTIVE(S):		
Quality Of Care	√	
People	√	
Modern Healthcare	√	
Digital	√	
Collaborate	√	
EXECUTIVE SUMMARY		
	The minutes are submitted from Quality-of-Care Committee.	
RECOMMENDATION:	For receiving	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	√	
Patient impact	√	
Employee	√	
Other stakeholder	√	
Equality & diversity	√	
Finance	-	
Legal	√	
Link to Board Assurance Framework Principle Risk	Quality of Care Committee BAF risks 1.1, 1.1a, and 1.2	
AUTHOR	Rebecca Rutah Corporate Quality and Regulation Manager	

PRESENTED BY	Jane Dale Non Executive Director
DATE	May 2023
BOARD ACTION	Receive

QUALITY OF CARE COMMITTEE (QCC) MINUTES

23rd March 2023

12:00 – 15:00

CHAIR:	Jane Dale (JD)	Non-Executive Director
Members:	Dami Adedayo (DA)	Non-Executive Director
	Soma Champaneri (SC)	Associate Non-Executive Director
	Andrea Lewis (AL)	Chief Nurse
	Simon Marshall (SM)	Director of Finance and Information
	Sal Maughan (SM)	Associate Director of Corporate Affairs & Governance
	Jacqui Rees (JRe)	Associate Director of Quality
IN ATTENDANCE:	Harriet Barker (HB)	Divisional Clinical Professional Lead for Diagnostics, Therapeutics and Cancer Services (DTC)
	Ellen Bull (EB)	Deputy Chief Nurse
	Luke Casey (LC)	Associate Director of Operations General Surgery, Anaesthetics, Critical Care and Theatres (GS-ACT)
	Anita Coombes (AC)	School of Health Sciences
	Abigail Coggins (AC)	Corporate Risk Manager
	Claire Cunningham (CC)	Divisional Director General Surgery, GS-ACT
	Sunita Duggal (SD)	Advanced Paediatric Lead Nurse (Observer)
	Sam Edwards (SE)	Divisional Director (WHP)
	Caroline Farnworth-Newman (CFN)	Interim Head of Quality NHS Surrey Heartlands (East)
	Jo Finch (JF)	Head of Quality & Regulation
	Shirley Holmes (SH)	Governor
	Shashi Irukulla (SI)	Deputy Medical Director
	Mary Mault (MM)	Head of Nursing (GS-ACT)
	Janet McCauley (JM)	Divisional Chief Nurse General & Specialist Medicine (GSM)
	Jonathan Robin (JR)	Divisional Director GSM
	Julien Ruse (JRu)	Associate Director of Performance
	Rebecca Rutah (RR)	Corporate Quality Manager (administrator)
	Jaime Squire- Dean (JSD)	Divisional Chief Nurse Urgent & Emergency Care (UEC)
	Amit Vats (AV)	Chief of Patient Safety
	Faris Zakaria (FK)	Divisional Director Specialist Surgery & Musculoskeletal (SSM)

APOLOGIES:	Emma Bradley (EBr)	Acting Head of Midwifery
	David Fluck (DF)	Medical Director
	Donald Iro (DI)	Non-Executive Director
	Deborah Nicholson (DN)	Interim Quality Lead at NHS Surrey Heartlands
	Julianne Smith (JS)	Chief Executive
	Sue Sexton (SS)	Divisional Chief Nurse General Surgery, Anaesthetics, Critical Care and Theatres (GS-ACT)
	James Thomas (JAT)	Chief Operating Officer

ITEM	
	Apologies Noted above. No conflict of interests declared.
	Minutes of the last meeting During the meeting, the Chair would request assurance on points raised in the previous Performance Report in relation to audiology patients, and the Learning from Mortality Report regarding Structured Judgement Reviews. The minutes were approved.
	Action Log **03/2023** *To provide a run chart on patient safety severe harm incidents within the next SIRI report.* Action completed and closed. **03/2023** *Detailed report on Duty of Candour and plans to achieve 100% compliance.* Compliance of 100% in the reporting period. Action completed and closed. **03/2023** *Extend PSIRF Conference invitation to QCC members.* Conference postponed. Invites would include committee members when conference rearranged. Action completed and closed. **05/2023** *SJR figures to be separated into new figures and backlog figures.* Action completed and closed. **07/2023** *To respond to the question in relation to digitisation in histopathology and skilled personnel and improving reporting times. 'How much impact will digitisation have on waiting and turnaround times for histology results?' 'Will global access to skilled pathologists improve turnaround times for reports?'* Further clarity was sought on the information provided. Further information on timelines and assurance would be reported back to the Committee when available. **08/2023** *Further discussion was to take place to determine if the temperature issue in main theatres had been resolved.* Action completed. Refer to agenda item 24 for further detail. **14/2023** *Reset and relaunch of Clinical Effectiveness & National Audit Review Group.* Action completed and closed.
17/2023	**BAF -** AL presented the report. The proposal was for all the Quality-of-Care Committee (QCC) Board Assurance Framework (BAF) risks to be maintained at their current levels.
18/2023	**Performance Report (Quality Safety & Risk) -** JRu presented the report. Urgent care performance data included in the report had been revised from October 2023, due to a national outage of Adastra. The loss of automated data in the Urgent Treatment Centre (UTC) resulted in some errors and minor revisions had been made. Overall Emergency Department (ED) performance and flow had improved in February compared to January 2023, driven by improvements in both admitted and non-admitted pathways.

	There had been a reduction of long ambulance delays to zero in February, and the ambition was to maintain that, but was dependent upon surges in demand. Overnight decisions to admit (DTA) remained high, which affected flow out of the ED. Referral To Treatment (RTT) -The Trust was recording comparatively low numbers of patients against the current key standards of 78 weeks and 52 weeks, due to these patients comprehensively tracked and progressed throughout the pandemic. There were five patients left on the 78-week waiting list and all had dates and would be seen by 31/3/2023. The next NHSE expectation was not to have any patients waiting over 65 weeks by the end of 2024. Cancer -The Trust Two Week Rule (TWR) position of 97.6% for February was a 3% improvement compared to January. Of the 8 standards, 6 were compliant. The continued improvement was driven by ongoing management of the Dermatology demand and the 28-day Faster Diagnosis Standard (FDS) Nurse-led triage, introduced for the colorectal pathway. Good progress was seen across all specialties to reduce time to first appointment, with 60% of TWR patients seen within 7 days during February. The 62-day GP referral to treatment performance continued to be impacted by diagnostic delays. Several initiatives were in place to recover the cancer position, which included the provision of additional outpatient and diagnostic capacity, and prioritisation of existing capacity for suspected cancer patients. It was expected that the 62-day cancer performance would continue to be challenged. National benchmark showed the Trust was a positive outlier and most indicators were substantially improving. Diagnostics - February performance, excluding cystoscopies, was 89.1%, a considerable improvement on the 83.5% recorded in January. Challenges remained in Audiology, Endoscopy, Ultrasound, and Magnetic Resonance Imaging (MRI). Additional capacity and productivity improvements were being explored and implemented to support where patients were waiting greater than 6 weeks. A new trans nasal endoscopy was commencing in April 2023 and would support pathways. A new appointment booking application (LUNA) went live, and substantially positive feedback had been received. Assurance was provided that all audiology patients were recorded on Surrey Safe Care (SSC). Assurance was sought on Stroke performance, in particular patients not being seen by a stroke specialist within the first 12-24hours. There were Consultant vacancies, and the Team were working with the Integrated Care System (ICS) and the Integrated Stroke Delivery Network (ISDN) to formulate a sustainable plan for both the short and long term. The Stroke pathway would be reviewed and adapted to support use of the Consultants time, as some patients could be seen by other appropriate professionals. A discussion took place on the number of endoscopy referrals and capacity concerns to meet demand following closure of the mobile units and the rationale for that decision. The 5 units were reduced to three with productivity increased within the 3 units by up to 90%. The main challenge was surveillance and follow up patients. The Trust was unsuccessful in its bid for more money for Endoscopy capacity, which was awarded to other Trusts. The future ambition was to work with partners to improve the pathways. Assurance was sought over the cancer target for the GP 62-day referral to treatment, the 104-day standard and delays to the pathways. Under TWR, 60% of patients were being seen within 7 days. There was a decrease in the number of patients waiting over 62 days, which was ongoing with the aim to see continued improvement in the forthcoming months. Patients waiting over the 62-

	day, or 104-day standard remained on the pathway until pathology results were available, including those without a cancer diagnosis. Innovative work within the colorectal pathway included rehabilitation with patients prior to surgery, as this improved the quality outcomes for the patient. There was a discussion on how improvements could be made in the ED for patients on the non-admitted pathway and possible alternative routes of support such as the virtual ward. The Trusts Main Effort work had impacted on improved length of stay within all cohorts. Community support was limited as most patients attending the ED had been referred by their GP or via 111 and virtual wards were appropriately used but had limitations in the types of patients suitable. However, there was further scoping work to look at reducing demand on the ED via the Alliance Business Unit. The report was received for assurance.
19/2023	**SIRI Report (closed) -** JRe presented the report. There were 1506 incidents in January and February, 76% were classified as patient safety incidents. Incidents of low and no harm accounted for 93.4% of the incidents reported. There were six new serious incidents (SIs) reported, one of which was a Never Event involving a patient who had an incorrect back lesion removed from a very complex area on the body with multiple lesions. There was significant assurance that all safety actions had been followed. There had been significant improvement in performance against the 60-day timeframe for completion of SIs. A deep dive into severe harms between July 2022 and February 2023, and on deaths (October 2012 to present) identified 50% were in maternity *. Local agreement within the Maternity Services was to grade all mortalities as severe harm based on the outcome rather than an identified adverse patient safety event alone. The other 50% were from falls. The Quality Priority for reducing overdue incidents by 50% from the 2021/2022 baseline was surpassed. Duty of Candour (DOC) was 100% compliant for the reporting period with the GS-ACT and Maternity Divisions commended on their work. Clarity was sought on the ophthalmology harms reported, and it was confirmed that on initial review the incidents were not severe harms. Clarity was sought over the SI investigation extensions in WH&P Division. This was mainly due to outstanding Healthcare Safety Investigation Branch (HSIB) Reports. (*Safety events are voluntarily reported and do not reflect absolute data as only a percentage of deaths are reported via Datix.) The report was approved.
20/2023	**Quality Report -** AL presented the report. There was an increase in complaints received in February. The most common themes for complaints received in the period was treatment and care and discharge. ViewPoint made a site visit in February and areas of work identified, which may improve patient feedback data capture. To increase engagement with ViewPoint there would be a focus on service users in the ED and Outpatients. Members of the Viewpoint Working Group had generated some good ideas for improvement. The successful programme of piano performances at St. Peter's continued. The staff COVID Memorial Queen Elizabeth Garden was due to be opened in May 2023. Infection Control Team resource had been challenged by staff absences, ongoing outbreaks, and high levels of COVID, Influenza and Respiratory

	Syncytial Virus (RSV), in addition to business-as-usual work. The Trust compared relatively well against peers with reportable infections. Reporting compliance with the antimicrobial stewardship (AMS) program had been limited whilst the reporting functions in SSC continued to be resolved. In addition, there were workforce challenges impacting on progress of the Trusts AMS workplan. Although mandated in SSC, the requirements for antibiotic indication were poor quality therefore a pre-defined list had been introduced to support improvement. The national shortages of antibiotics for Group A Streptococcus in December impacted on all Trusts locally. Surgical Site Infection (SSI) had seen good compliance overall. Overall compliance for Sepsis Six in the latest available audit was 67% and remained above the improvement target. The focussed work to improve pressure area care had continued. Improvement was seen in February 2023. A Pressure Ulcer Steering Group had commenced to progress further improvement. A mattress evaluation was underway, and the 100-day Pressure Ulcer free campaign continued. There were six falls with moderate/severe harm and 21 repeat falls, the latter was within the target threshold for 2022/2023. Improvement was required with lying and standing blood pressure compliance, although there was some improvement from the last reporting period. MUST Scores were being accurately completed and had stabilised. Training was ongoing. Compliance with accurately completed fluid balance charts was achieved. Venous Thromboembolism (VTE) reporting was in arrears. Risk assessment completion had improved and there was an expectation of further improvement with the reinstatement of the VTE risk assessment prompt on SSC in February, and the continued focus on practice from the clinical teams. The Committee were concerned that staff were relying on a system when there should be ingrained practice. It was identified that there had previously been a paper prompt in place prior to SSC and there was assurance that the VTE team were providing additional education and training to improve compliance. Seven-day services data was in arrears and performance with standards 2 (seen by a Consultant within 14 hours) and 8 (ongoing Consultant review) remained challenged. The Committee recognised fatigue following implementation of SSC but were not assured and were concerned that harms improvement was not consistent. The impact of SSC was substantial and was not to be underestimated. The work of the Harms Free Care (HFC) Team had been significant. Increases in admissions during the reporting period resulted in increased COVID transmission, which was reflected nationally. Escalation processes were in place, though staffing of these escalation actions had also impacted on the ability to deliver care. Assurance was provided in relation to gatekeeping patients in the Clinical Assessment Unit (CAU) prior to going to wards, by ensuring required risk assessments were being completed. In addition, care rounds would be commencing, which were protected time peer review rounds on wards with a weekly review meeting. These would feed into the Divisional and Corporate Harms Free Oversight meetings and the Safety Summits. The Divisional Chief Nurses contributed to the discussion in explaining both the challenges and local initiatives in place to make improvements. The report was approved.

21/2023	**Learning from Mortality Reviews Quarterly Report -** AV presented the report. The report format had been amended and feedback was welcomed. The Trust Risk Adjusted Mortality Index (RAMI) had increased in January 2023 along with peers, but had reduced in February, a reflection of the national picture of excess deaths in December 2022 and January 2023. The Summary Hospital Level Mortality Indicator (SHMI) was another method of reviewing Trust mortality and for the period November 2012 to October 2022, the Trust had a SHMI value of 0.92, which was within the control limits and as expected. From January 2023 a dual approach to the completion of Adult Mortality Review Forms (AMRF) had been trialled. Whilst the completion of the forms remained the responsibility of the clinical teams, the Mortality Improvement Lead was reviewing forms. The process had improved the timely identification of cases for Structured Judgement Reviews (SJR), with 100% of screening being completed in January and 99% in February 2023. Completion of 95% of mortality review screening within 2 days of death was a Quality Priority, which had not been achievable. Nineteen patients died whilst COVID-19 positive, in January and February 2023. Thirty-nine stage 1 SJR's had been completed, of which 85% showed good quality of care. Of the cases awaiting SJR between January 2018 - December 2021, 77% had been investigated and closed by another form of review process. The remaining 33% of cases had no Datix or family complaint linked to them. There was a request to seek approval from the Committee to remove the outstanding cases from the SJR backlog, enabling the team to focus resources on more recent cases, identify and action relevant learning. The decision was delayed following further information and discussion with the Medical Director. There was a desire for future reports to include more detail to highlight any inequalities in death. This would be forthcoming once the Mortality Lead and Chief of Patient Safety had completed the associated work.
22/2023	**Learning From Deaths BDO Report Action Plan -** AV presented the report. Most actions were completed or progressing well. The action to make the AMRF a mandatory completion prior to discharge from SSC could not be completed, due to differing processes and practices between the Trust and Royal Surrey County Hospital. The Committee agreed that if the recommendation for the action was incorrect then the report and action plan would need to be referred to the auditor. The action plan was received for assurance.
23/2023	**General Surgery, Anaesthetics, Critical Care and Theatres (GS-ACT) -** CC presented the report. The Colorectal straight to test pathway for cancer patients was fully implemented. Nurses would accept a referral, complete the fit test, and refer straight to colonoscopy as required. The robot for robotic surgery would be arriving in weeks, providing access to state-of-the-art surgery, reduced length of stay, and improved outcomes. Lists for colorectal, gynaecology and bariatric would be commencing initially with plans to widen the scope. The culture in theatres had seen good progress with the development of a Theatre Charter for staff, Unmask Your Stories initiative, and a Wobble Room at Ashford Hospital (plans were in place for a wobble room at St Peters).

	Overdue Datix had seen an improvement from 205 to 35. Datix daily huddles had been introduced to promptly address incidents. Areas of concern were around VTE management, which was replicated in other Divisions. There had been education provided at junior doctor forums and discussions via the Surgical and Divisional Board meetings in relation to the expected standards. Timely Documentation of nursing assessments had been a priority area of focus. The Divisions improvements were commended. The Committee addressed the quality of documentation since the introduction of SSC. There had been issues with the Wi-Fi connection, which had improved, and a lack of familiarity from staff members using SSC. Discussion included the importance of familiarisation with SSC and making local changes to meet service needs. Opportunities for automating prompts in SSC could be better utilised, though the challenge was prompting the right person in the right place at the right time and avoiding prompt fatigue. Compliance on guidelines in antibiotic stewardship was commended by the committee. Work to with review equipment stored and keeping only what was necessary was in progress to improve environmental cleaning and IPC standards in main theatres. The report was received for assurance.
24/2023	**CQC Maternity Inspection Report** - AL presented the report. Encouraging areas of the report included the positive staff culture and support, good access to antenatal education for people preparing for childbirth, and the local focus on quality improvement within the service. The main area of concern raised by Care Quality Commission (CQC) was maternity triage and since January 2023, the Trust had been updating CQC with several actions and improvements. The work undertaken to address the key concerns was acknowledged and the Division were commended on the quality of actions and improvements implemented since the inspection. The Quality Team were also commended for their work and support. An update was provided on where the Trust were with the installation of a lift to improve access. The report was received for assurance.
25/2023	**Maternity and Neonatal Report -** SE presented the report. The Quality and Executive Team support to the Division was commended. There had been an agreement to recruit into the midwifery and allied health professional vacancies and there had been support in realising the medical workforce gap and needs. In relation to waiting times, having the right professionals in post would support quality improvement in that standard. There were several exceptional outcome metrics, which showed that despite the complex and challenged population, the Trust had some good outcomes for babies that exceeded national expectations. Assurance was sought over the increased admissions to Neonatal Intensive Care Unit (NICU), due to babies getting cold when born in main theatres. There was evidence provided that the admissions to NICU were less than 5%. The Committee were assured. The neonatal workforce had a high turnover of nursing staff and the skill set required for NICU was band 6 nurses with additional qualifications. There had been some recruitment of band 5 staff, but time was required for upskilling

	them. The local neonatal network recommended 80% qualified in speciality (QIS) nurses, which the service had just attained. The neonatal network was working to develop a neonatal critical care course to train and upskill nursing staff locally. Challenges in the medical workforce were related to doctor contracts and the Deanery being unable to provide the required number of doctors. There had been some additional funds via Ockenden to add to the Senior House Officer (SHO) workforce. Further challenges were recent acuity within NICU. There were challenges in capacity for medical staff to attend training due to clinical acuity and demand. To meet training standards medical staff would require an additional 5 days allocated to training. The report was approved.
26/2023	**Draft Quality Account Priorities -** JRe presented the report. The priorities were approved. Amendments would be required once the recommendations from the Learning from Mortality Report were agreed (see section 21/2023). The report was approved.
27/2023	**Health and Safety Biannual Report** - SM presented the report. Previously reported violence and aggression incidents toward staff continued to trend at high levels. There was continued work to train staff in managing aggression. Vital upgrades to Ashford Hospital fire detection systems had been implemented. There was further work with external contractors to ensure compliance with Trust requirements when they were on site. The report was approved.
28/2023	**BDO Waiting List Management Report -** SM presented the report. The report was due to be submitted to the next Audit & Risk Committee. Substantial assurance was provided over design of systems, and more was to be completed on the applications. There was a recommendation around Trust planning and further work to reduce the 78 weeks wait to 65 weeks, as shared in the Performance Report. The Trust continually made recovery plans in line with resources. Fundamentally the Trust improvement plan was accepted, and actions would be implemented in the next quarter. The report was received.
29/2023	**Corporate Quality and Regulation Report** - JF presented the report. There had been several CQC reports released, and these were briefly summarised. The Trust position was shared in relation to the report findings. A review of **'**Experiences of being in a hospital for people with a learning disability and autistic people - Who I am Matters' (CQC) highlighted gaps in the commissioning services for the Trust. Assurance was sought on how reasonable adjustments for children with LD were considered. The LD Nurse supported planned visits and where required the Safeguarding Team could provide additional support. The Oliver McGowan Training was being rolled out in 2023.

	A summary of enquiries the Trust received from CQC between December 2022 and February 2023, identified six enquiries, three related to complaints and of these one was also a safeguarding enquiry, two were related to serious incidents, and one was an assurance request. Quarterly engagement held in February 2023, with Children and Young People Services was positive, and no concerns were raised. The November 2021 Trustwide CQC Inspection Action Plan remained non-compliant with Regulation 12, due to the necessary flooring work in main theatres taking more time than expected. On completion of the floor work the Trust would be compliant. Self-Assessment against CQC Compliance continued with the internal mock inspection programme, mainly focussed on Women's Health and Paediatrics (WH&P). Mock inspections were completed in ED and Outpatients (DTC Division). Bi-monthly CQC Oversight Committees in recent weeks had been focussed on progressing the action plan in response to the latest CQC Inspection of Maternity Services. A summary of TENDABLE audit results was shared. The Committee commended the report. The report was received for assurance.
	BAF Review The Committee agreed with the recommendation to maintain the Quality-of-Care Committee BAF risks. The Alert, Advise, Assure Report items for the board meeting were agreed.
	Any other Business There was discussion and then agreement to move the meeting time to 1pm going forward.
	Date of next meeting: 25th May 2023, 1300-1600hrs