Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
26 September 2019

AGENDA ITEM	15.2	
TITLE OF PAPER	Quality of Care Committee July Minutes	
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 19 September 2019.		
STRATEGIC OBJECTIVE(S):		
Quality Of Care	√	
People	√	
Modern Healthcare	√	
Digital	√	
Collaborate	√	
EXECUTIVE SUMMARY		
	The minutes are submitted from Quality of Care Committee.	
RECOMMENDATION:	For noting	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	√	
Patient impact	√	
Employee	√	
Other stakeholder	√	
Equality & diversity	√	
Finance	-	
Legal	√	

Link to Board Assurance Framework Principle Risk	Yes
AUTHOR	Jo Finch, Corporate Quality Manager
PRESENTED BY	Professor Mike Baxter, Chair of Quality of Care Committee
DATE	19 September 2019
BOARD ACTION	Receive

NHS
Ashford and
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QUALITY OF CARE COMMITTEE (QCC) MINUTES
18th July 2019
Room 3, Chertsey House
11.00 – 13.30

CHAIR:	Professor Hilary McCallion (HM)	Non-Executive Director
MEMBERS PRESENT:		
	Sarah Burton (SB)	Divisional Chief Nurse, Medicine & Emergency Services
	Zakaria Faris (ZF)	Divisional Director, WH&P
	Dr Erica Heppleston (EH)	Associate Director of Quality
	Chris Ketley (CK)	Non-Executive Director
	Mark Hinchcliffe (MH)	Programme Office Manager
	Andrea Lewis (ALe)	Deputy Chief Nurse
	Dr Paul Murray (PM)	Chief of Patient Safety / Deputy Medical Director
	Olatokunbo Ogunbanjo (OO)	Chief Pharmacist
	Suzanne Rankin (SR)	Chief Executive
	Jacqui Rees (JRe)	Assistant Director of Patient Safety
	Jane Rogers (JRog)	Associate Director of Nursing, representing Andrew Laurie
	Konstantina Stavrakelli (KS)	Divisional Chief Nurse, WH&P
	James A Thomas (JT)	Chief Operating Officer
	Mr Jonathan Trickett (JTr)	Consultant Colorectal Surgeon representing Mr Shashi Irukulla
	Marcine Waterman (MW)	Non-Executive Director

IN ATTENDANCE:		
	Jo Finch	Corporate Quality Manager (Minutes)
	Jane Mitchell	Professional Head of Patient Safety
APOLOGIES:	Dr David Fluck (DF)	Medical Director
	Dr Melanie Irvin-Sellers (MIS)	Joint Divisional Director MES
	Mr Shashi Irukulla (SI)	Divisional Director, TASCC Represented by Mr Jonathan Trickett
	Sue Tranka (ST)	Chief Nurse. Represented by Andrea Lewis
	Matthew Barker (MBk)	Deputy Chief Nurse for Workforce
	Professor Mike Baxter (MB)	Non-Executive Director
	Dr Andrew Laurie (AL)	Divisional Director Diagnostics & Therapies
	Sue Sexton (SS)	Divisional Chief Nurse TASCC
	Cathy Parsons (CP)	Director of Clinical Services, DTTO

Abbreviations: Acute Medical Unit (AMU), Accessible Information Standard (AIS), Children Adolescent Mental Health Services (CAMHS), Clinical Commissioning Groups (CCG), Clostridium difficile (C Diff), Cost Improvement Plans (CIPs), Clinical Negligence Scheme for Trusts (CNST), Care Quality Commission (CQC), Commissioning for Quality and Innovation (CQUIN), Divisional Director (DD), Director Infection Prevention Control (DIPC), Deprivation of Liberty Safeguards (DoLS), Diagnostics Therapies Trauma Orthopaedics (DTTO) Emergency Department (ED), Electronic Patient Records (EPR) ,Friends and Family Tests (FFT), Getting It Right First Time (GIRFT), Intensive Care Unit (ITU), Key Performance Indicators (KPIs), Integrated Musculoskeletal (iMSK), Local Maternity Service (LMS), Medicine and Emergency Services (MES), Mental Health (MH), Methicillin-resistant Staphylococcus aureus (MRSA), Patient Experience Monitoring Group (PEMG), Project Management Office (PMO), Quality Experience Workforce Safety (QEWS), Quality Safety Impact Assessment (QSIA), Quality and Safety Half Days (QUASH),), Registered Mental Health Nurse (RMN), Resident Medical Officer (RMO), Risk Scrutiny Committee (RSC), Referral to Treatment (RTT), Surrey and Borders Partnership (SABP), Specialty and Associate Specialist (SAS), Serious Incident Requiring Investigation (SIRI), Structured Judgement Reviews (SJR), Theatres Anaesthetics Surgery Critical Care (TASCC), Terms of Reference (ToR), Two Week Rule (TWR)Trust Risk Register (TRR), Workforce and Organisation Development (WOD) Whole Time Equivalent (WTE), Women's Health and Paediatrics (WHP)

ITEM		Action
50 / 2019	**Apologies for absence** Noted above.	
51 / 2019	**Minutes of the last meeting** The minutes were approved.	
52 / 2019	**Action Log** Actions have been updated on the action log. JT queried the action that readmission rates would be included in the performance report. A discussion took place on readmission rate and how this quality measure can be brought to the meeting. **Action:** A deep dive on readmission numbers is to be performed and following that a decision on the applicable report will be made by the Committee. **EH** A discussion was held on how quality of care is captured within the performance report. ST and JT have been conferring about an integrated Quality and Performance Report. The Performance report going forward will include aspects on the quality of patient experience. SR raised that in the BAF there is a risk that implies operational pressure leads to poor quality of care. A consideration is whether the mitigation described in the BAF is being achieved, which the KPI's would reflect, and therefore if there is a mechanism in place that provides assurance. MW pointed out that Social Media feedback is referenced as commentary in the Patient Experience Annual Report, but no actual feedback is included. **Action:** Patient Experience Team to capture social media feedback. SR will provide steer on the Long Term Plan summary to EH, consistent with the approach being taken for the other Sub-Board Committees.	
53 / 2019	**Divisional Director Exception Reports** **WH&P** ZF presented the report on behalf of the Division.	

	There are plans in place for appraisal improvement. The aim is 100% compliance in nursing and administrative staff appraisal by the end of the year. KPI's: 10 week booking figures for maternity have been low. Booking process changes has resulted in significant improvement over the last few months. The Paediatric Emergency pathway across UTCC and Paediatric ED is being streamlined to address 4hr wait issues. HM suggested a QI approach, however it was identified that the making every day count work may pick this up. JT noted that paediatric performance is improving, although there is still work to be done. The resolved date of April 2019 in the report is a misstatement for correction. The 18 week RTT has been a challenge for several months. Significant work has been done to try and recover this and in recent weeks 91% was achieved. KS reported on continuity of care. The vision and national targets for this were explained. Currently the Trust isn't achieving its target, which NHS England is aware of and was expecting. The 2019 figure is an arbitrary target, due to the need to start somewhere. NHS England requires a robust deliverable plan, for achieving the continuity of care target of 51% by 2021. Currently the Trust has low targets for 'true' continuity of care and gap analysis showed that with the current establishment delivery of 25% is the best that can be achieved. The gap analysis demonstrating what establishment is needed is currently following processes prior to going to Board for consideration. A discussion took place about the current model of care, the redesign and the investment needed. The evidence shows that public health improvement starts with pregnancy and that investment now should result in less investment further down the line. Reduced impact on child mental health and use of CAHMs was cited as an example. The financial impact and achievability was discussed. ZF informed the Committee that the current ask is £500,000 per year over 3 years; however the demands and costs will continue to rise. Operational efficiencies are being made to achieve the 25% target. Other units within our LMS and STP are making headway. KPI's: Up to date on mortality reviews. No overdue SIRIs SR raised concern with regard to QSIA completion and what	

	support is needed to get these completed. **Action:** A collaborate workshop to focus on QSIAs with high and extreme risk plans, will be held before the September meeting in order to support completion. **EH** Divisional investigations to be more multi-disciplinary with a focus on early sharing of learning. MW identified that the report doesn't include anything on complaints. **Action:** The exception report is to include a complaints focus going forward. The report was noted. **MES** SB presented the report on behalf of the Division. Key concerns are around staffing levels, nursing in particular. There has been a recent successful recruitment drive with Australian nurses, which will help to improve risk areas such as AMU, ED and Aspen. Alamac are going to help with daily staffing reviews, together with a series of metrics this will support a staffing overview across the Division. The aim is that this will enhance current staffing huddles. The Division is making good progress with SIRI completion. A new Matron has started with a focus on urgent care pathway. This has led to instigating a 'Matron of the day' in ED who will focus on a range of issues, in particular hand hygiene, which has been identified as a specific issue in ED. The Division has an EOL care plan. The CQC are making an EOL engagement visit at the end of July. The Division has a high number of Datix open incidents despite an event to support the closure of outstanding low grade incidents. The day did have an impact, however another series of Datix have come in giving the appearance that the metric has not changed. JRe reported that Datix training will be accessible and has offered help from the central team. The challenge is one of time for owners to close them. The processes for Divisional Director sign off and monitoring of SIRI's was explained. **Action:**	

	SR has requested that JT work operationally with the Division to investigate ways of supporting them to address the outstanding Datix. It was identified that the staffing forecast is not described in the paper and it was suggested a figure to aim for would provide the Committee with more knowledge. The work carried out by MBk for safe staffing was highlighted. **Action:** SB to include a trajectory for safe staffing in the report. The report was noted. **DTTO** JRog presented the report on behalf of the Division. There has been a drive with VitalPac to increase uptake of observations in a timely way. Some improvements have been seen, although further work is required. Additional iPods in the clinical area has improved monitoring by the nurse in charge. The importance of this metric has been highlighted at the Incident, Matrons, and Ward meetings. Dickens has an LCD screen as a visual prompt. This is being replicated on Swan. The Division have made good progress on appraisal completion. Where there are delays, an action plan is in place. Dickens will be 100% in two weeks. The Mortality reviews backlog is being worked on and there is a plan in place to clear those. New reviews are being screened on time. The Division has no outstanding complaints and is meeting timescales. Datix's are being addressed via a weekly incident meeting. This provides opportunity to focus on moderate / high level incidents, low grade ones that can be closed quickly and professional discussions where needed. The Division has a target of between 40 to 60 incidents open at any one time. The report documents no QSIA completion, which will be looked into. **Action:** DTTO is to provide more detail on the status of the QSIA sign offs. The report was noted. **TASCC** JTr presented the report on behalf of the Division. Appraisals are improving due to having more clinical appraisers	

	and the appointment of a new Matron has helped improve compliance. Staffing levels is a theme as it is globally, however patient safety levels remains good especially on Kingfisher. Observation levels can be improved and the Division is on trajectory to do so. There have been two pressure ulcers in ITU, one hospital acquired. The Committee view is that pressure ulcers are avoidable. ITU in particular should not have patients developing pressure ulcers, with one to one nursing and specialist equipment available to them. SAU has reached 200 days pressure ulcer free, which was commended, particularly because during the winter period SAU has had many more frail medical patients. The Division have no overdue SIRI's. KPIs: Nursing vacancy continues to be challenging. Medicines management compliance is improving. Governance and operational immediate concerns are around Ophthalmology and clinical capacity. The Division has been awaiting an external review of the service, which has not progressed. The Division are currently refining the Terms of Reference and seeking Royal College review. The Committee commended the Divisions completion of QSIA's. A discussion took place on the percentage of observations on time and why TASCC is doing better on this measure. A number of reasons for differences were cited and it was suggested that any work to improve observation compliance must involve the clinicians as part of owning this. The report was noted.	
54 / 2019	**Performance Report** JT presented the Performance Report. A&E is busier than June last year causing increased pressure on the system. Paediatric graphs confirm performance is improving as discussed in the WH&P Exception Report. Bed occupancy is still high and winter escalation areas are still being used. DTA's in A&E overnight is reducing. This reached such a high level that after 5 months of reducing it is still at the highest peak	

	it ever was previously. A discussion was held on the high LOS and patients moving more than three times during a stay. All patients greater than 21 days LOS are actively under review, through the Making Every Day Count Programme. Local Authority funding is having an impact on support services but the problem is multifactorial. The extent to which the performance report helps the Committee understand how much the pressure in the hospital is having an impact on quality was discussed. JT reported that he is working with STon a more integrated Performance and Quality Report. It was agreed that going forward, the Performance Report will move up the agenda. The report was noted.	
55 / 2019	**SIRI Report** JRe presented the SIRI Report. There were ten reported SIRI's in June. There have been four patient falls, two of these were inpatient falls and two were outpatient falls. Divisions are doing very well with investigations. A deep dive into last year's diagnostic treatment delays and incidents was carried out. Themes and trends showed most diagnostic delays were cancer related. MDT now has good quality surveillance and innovations in place. LTFU serious incidents have not increased, however further work is required on disposal code reductions. The code 5 process is being explored for improvements. Whilst it is evident that there is good understanding of what the organisation needs to do in terms of changes and processes, tests of effectiveness are not evident. LTFU was identified as concerning. JT reports significant investment has been made for tracking patients, the team were fully aware of the missing disposal codes and that some of this was due to the recent IT issues the Trust experienced. The aim in the long term is that the new EPR system will resolve the issues. PM identified the difficulty in trying to benchmark against other organisations and the national data, but that we appear to be doing well. How information is shared with the wider organisation was also raised with the example of code 5 being a problem. How engagement from clinicians to help solve some of	

	these issues is being examined. A discussion took place in relation to a stroke patient who had a delay in receiving thrombolysis, and if this was linked to ring-fenced beds. Sufficient assurance was not provided and this requires further investigation. **Action:** Clarity on the reason for the delay in the patient receiving thrombolysis is to be provided. The case of a vulnerable patient with mental health issues who attended ED in February 2019 and was moved multiple times into various escalation areas, and who subsequently died, was discussed. The case has had a structured judgement mortality review and is due a second stage review. If the review shows evidence of avoidable death, this would become a SIRI. **Action:** A response is to be provided to the Committee on the lessons learned and changes made, following completion of the SJR and SIRI if progressed. HM highlighted issues in relation to the 2222 number experienced in another organisation and suggested that teams may want to do some communication on this. Incident number W59458 on the vascular aneurism patient death needs more consideration regarding the potential for avoidance and additional information will be brought to the Committee. **Action:** Further information to be provided to the Committee on W59458 incident number. The report is approved for Board providing questions have been addressed and the question in relation to thrombolysis reflects what has been discussed.	
56 / 2019	**Quality Report** EH presented the Quality Report. The report has changed to harmonise how information is shown across all sections. The report now presents more of a journey approach. Individual section leads have provided the updates on their sections. EH described examples of the expanded report in areas including SSI's, stroke, patient experience and safety alerts. A section on research, time and QI related learning events is also new to the report. The standard of the report was highly commended by the Committee. The importance of this information being shared with other	

	teams such as Clinical Matrons and Team Leaders was identified and is addressed in the quality presentation. The organisation is taking a learning view and there are a number of vehicles for which the learning can be disseminated. The Fighting for Life play and timeliness of getting death certificates was discussed. The current and future pathway for this process was explained. The issues are wider than the signing of death certificates, as much distress can be caused by not accurately recording the correct cause of death. **Action:** Data captured is to be included in the report in future. AL The report was approved.	
57 / 2019	**Safeguarding Committee Annual Report** JM presented the Safeguarding Committee Annual Report. There has been consistent and good engagement with Safeguarding Child and Adult Boards. This is particularly important within the context of Surrey Children's Services inadequate Ofsted Report, the structural changes to the Children's Board and the child death processes; The Adult Board acknowledged the good work between the hospital safeguarding team and adult social care, with the high number of S42 enquiries being identified as a positive, transparent efforts to learn and improve care. There was a small drop in activity regarding adult referrals and a significant drop in referrals for children, possibly due to Greenbrook now managing the UTC. The referral rate for 2017/18 saw a huge increase on the previous year, possibly due to over reporting, which may have been due to children's services at the time, encouraging reporting in response to their poor report. Training for SG children improved. An adult training strategy is being tabled at the July 2019 Safeguarding Committee. Clarification was sought in relation to a business case being presented at Trust Board – this was the understanding when the report had been written, but is now on hold. **Action:** Adjust the paragraph in the safeguarding report which states the business case went to Board. The report was approved.	
58 / 2019	**Director of Infection Prevention Control Report** PM presented the DIPC Report on behalf of DF.	

	There were no Trust apportioned MRSA bacteraemias last year and the Trust was below the apportioned clostridium difficile target. All clostridium difficile cases have a Root Cause Analysis and two cases were the result of lapses in care linked to antibiotic prescribing. The clostridium difficile target next year is 28 cases and includes community onset where the patient has been an inpatient in the previous 4 weeks. The MRSA target remains as zero. The Trust achieved a reduction of 10% for inpatient E.coli but has not achieved the overall target. The flu vaccination target was achieved. Next year's target is set at 80%. Business cases have been agreed for key new team members including an IV specialist nurse, SSI surveillance nurse, new Consultant Microbiologist and a new antibiotic pharmacist. The workstreams will triangulate with work across the organisation. Of the four CQUINs two were achieved and two were missed. The missed CQUINs were antibiotic review at 72 hours, and the access target relating to use of narrow spectrum opposed to broad spectrum antibiotics. It was noted that the DIPC is the Annual Report and not six monthly as on the Agenda. The means of measuring hand hygiene via observation audits was explained. Light boxes are used in training to demonstrate to individuals, the areas they specifically may need to pay attention to. It was requested that next year's annual report has SPC charts included. The work Ann Birler contributed to the report was recognised and thanked. SR commented on the interesting feedback in the GIRFT report and will share this when it has received all appropriate approvals. The report was approved.	
59 / 2019	**Corporate Quality and Regulation Report** EH presented the Corporate Quality and Regulation Report. The updates from the CQC regulation improvement plan identifies that there are three amber must actions: fire safety, training and the security access of the Paediatric Emergency Department. The latter action has been resolved since writing	

	the report. The Report was noted.	
60 / 2019	**QGC Exception Report** EH presented the QGC Exception Report. The findings are familiar to the Committee. Steps are being taken to harmonise information coming to reports and Committees, to streamline the information and improve efficiency. This is explained further in the presentation. The Report was noted.	
61 / 2019	**Nursing Establishment Paper** ALe presented the Nursing Establishment Paper on behalf of MBk. The paper will go to the People Committee for approval. This is the six monthly establishment review and is next due in September. The key headline is that the tool produced information that coincides with the current establishment. Winter pressures and escalation means the Trust used 133 wte over the establishment. The plan is to look at the current vacant band 5 posts and re-profile the skillmix. This permits an additional 31new Nursing Associate (registered) band 4 role. The conversion of bank to permanent posts was discussed. The aim is to reduce vacancies so more nurses are inclined to work on the bank rather than agency. ALe will address the wording of the report with MBk. The report was noted.	
62 / 2019	**Quality Assurance Presentation** EH Presented. The aim was to give the Committee overview and assurance on the annual information coming from all sources and particularly the Clinical Divisions. The Committee agreed with the findings of the presentation and approved the progression of the improvement actions.	
63 / 2019	**Clinical Guidelines Verbal Review Update** ALe gave the Clinical Guidelines Verbal Review Update. The ratification of clinical guidelines and onward use is to be tightened by forming a Clinical Guidelines Committee. Further information will be shared when available.	

64 / 2019	**Board Assurance Framework (BAF)** The prior paper to support the Quality of Care BAF discussion item did not get circulated as planned and apologies for this were made. The Committee needs to renew its BAF risk and formally review and approve its KPI's. The dashboard on KPI's was submitted via the balance scorecard. SR confirmed that no balance scorecard was being submitted to Board this month. The mechanism to be put in place is for the Committee to receive and review the BAF, the assessment of the risks determined and what the dashboard will look like in order to demonstrate measures of strategic objective achievements. All Sub-Committees need to complete this work. **Action:** Submit BAF risks and KPI's to next meeting for approval and review.	
	Any Other Business The Finance Director asked for further assurance of CNST sign off processes and evidence over and above that already in place via delegations. Chair gave approval for a Board paper on this to be submitted direct to Board.	
	Date of next meeting: **19th September 2019** 11.00-13.30, Room 3, Chertsey House	