Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
29 June 2017

AGENDA ITEM NUMBER	5.1	
TITLE OF PAPER	Quality and Performance Committee Minutes of Meeting 18th May 2017	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality and Performance Committee.		
STRATEGIC OBJECTIVE(S):		
Best outcomes	✓	
Excellent experience	✓	
Skilled & motivated teams	✓	
Top productivity	✓	
EXECUTIVE SUMMARY	The minutes are submitted for noting.	
RECOMMENDATION:	For noting	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	Included.	
Patient impact	Included.	
Employee	Included.	
Other stakeholder	Included.	
Equality & diversity	Included.	
Finance	Included.	
Legal	Included.	
Link to Board Assurance Framework Principle Risk	The BAF is included in items submitted to QAPC.	
AUTHOR NAME/ROLE	Mr Russell Wernham, Deputy Chief Nurse, on behalf of the Committee Chairman.	
PRESENTED BY DIRECTOR NAME/ROLE	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse	
DATE	29 June 2017	
BOARD ACTION	Noting	

QUALITY AND PERFORMANCE COMMITTEE (QPC) MINUTES
18th May 2017
Room 3, Chertsey House St Peter's Hospital
11.00 - 13.00 hrs

CHAIR:	Hilary McCallion (HM)	Non-Executive Director (Chair)
MEMBERS:		
	Suzanne Rankin (SR)	Chief Executive
	Michael Imrie (MI)	Chief of Patient Safety/Deputy Medical Director
	John Hadley (JH)	Divisional Director, Theatres, Anaesthetics and Critical Care
	Chris Ketley (CK)	Non-Executive Director
	Tom Smerdon (TS)	Director of Operations Unplanned Care
	Paul Crawshaw (PC)	Divisional Director, Women's Health and Paediatrics
	Jacqui Rees (JR)	Acting Head of Patient Safety
	Heather Caudle (HC)	Chief Nurse
	Louise McKenzie (LM)	Director of Workforce Transformation
	Liz Davies (LD)	Acting Company Secretary
	Mike Baxter (MB)	Non-Executive Director
	Jonathan Robin (JR)	Divisional Director Medicine and Emergency Services
IN ATTENDANCE:	Erica Heppleston (EH)	Assistant Director, Regulation and Improvement
SECRETARY:	Russell Wernham (RW)	Deputy Chief Nurse/Associate Director of Quality
	Kate Flynn (Minutes) (KF)	Risk & Incidents Co-ordinator
	Sue Harris (SH)	Lead Nurse Tissue Viability
APOLOGIES:		
	Russell Wernham	Deputy Chief Nurse/Associate Director of Quality
	David Fluck (DF)	Medical Director
	Melanie Irvin-Sellers	Divisional Director Medicine and Emergency Services
	Dakshita Takodra	Senior Audit Manager TIAA (Internal Auditors)

ITEM		Action
62/2017	**Apologies for Absence** As above**.**	**HM**
63/2017	**Minutes of the Last Meeting** Confirmed. The July QPC will be a meeting between the Non-Executive Directors who attend the QPC and the Divisional Directors and Executive Directors to discuss the future format of the QPC.	**HM**
64/2017	**Matters Arising** 21/2017 –The second half of the Maternity Deep Dive presentation will be made to the June QPC meeting. 53/2017 – SIRI Incident Report. Details of the Serious Incident Requiring Investigation (SIRI) regarding the patient who absconded from the Emergency Department (ED) have been presented to Board. SR advised that the Board paper should be rephrased to reflect that a number of incidents regarding patients who absconded from ED involved patients who were also under the care of the Psychiatric Team. Patient confidentiality and non-identifiability needs to be ensured. 21/2017 – Cedar Ward Action Plan. The presentation is now deferred and is to be given at the June meeting. 39/2017 – Staff shift patterns. HC advised that a staff survey had been undertaken, however, the responses have come mainly from Advanced Practitioner Nurses, who work 7 ½ hour shift patterns and with only around a 30% response rate from Ward Nurses. The survey will need to be repeated and a process found to take greater account of the views of Ward Nurses and to include demographics data. The outcome of the process to be undertaken needs to be presented at the June meeting. It was noted that the survey had been discussed at the Sounding Board forum.	**PC** **MI** **HC/Stroke Lead Nurse** **HC/CS**

65/2017	**Maternity Deep Dive Stillbirth Audit Report** PC stated that here were 18 stillbirths in 2016 and around half of these involved a serious abnormality. In 11 cases a change in care may have made a difference and 2 cases involved SIRI investigations. The action plan focusses on learning. PC will liaise with JU and MI and feedback how closely the department adheres to the Royal College of Gynaecologists (RCOG) guidelines regarding stillbirth. National guidance on learning from deaths is to be considered and included. Linking in of the regular Heads of Midwifery Group is to be considered. PC will also include information on mortality rate benchmarking. SR raised the importance of challenging the paradigm of unavoidability and the cultural approach to this. Benchmarking data from the Comparative Health Knowledge System (CHKS) will be provided and uploaded to Boardpad. SR stated that the external perspective when looking at these cases needs to be considered be that either expertise from outside the Trust or from a different division to ensure impartiality. This is a cross divisional issue. The above item is to be discussed with the Chief Nurse of North West Surrey Clinical Commissioning Group (NWS CCG) in respect of the Sustainability and Transformation Programme (STP) aspects.	**PC** **PC** **HC**
66/2017	**Quality Account – Draft** A question was raised regarding the choice and capturing of measures for patient experience in line with the proposed Board strategic direction. It was noted that the Board has not yet endorsed the new draft Trust Strategy. EH clarified that the Quality Account priorities have already been both discussed with Council of Governors representatives and formally approved by Trust Board. It was noted that the draft Quality Account disclosures comply with the	**EH**

	national Regulations and that key performance indicators (KPIs) for 2017/18 measures were in the 3 prescribed categories of patient safety, clinical effectiveness and patient experience. The feedback letter from the Chair of the Patient Experience Group was noted. A discussion was held on whether the Care Quality Commission (CQC) data could be presented in a different way however, EH confirmed that this could not be modified as the disclosure form is prescribed by particular guidance.	
67/2017	**KPMG Audit Report on the 2016/17 Quality Account.** SR left the meeting to discuss with KPMG that the Audit Report to Management with improvement recommendations would be refreshed to be more anonymised with respect of individual identifiability. TS is to ensure the Emergency Department (ED) 4 hour wait data, ensure the Standard Operating Procedure (SOP) is finalised and approved and to progress the internal audit by TIAA.	**KPMG/EH** **TS**
68/2017	**Performance Review** ED performance was outlined and whilst the trajectory is being met performance is still below the required 95% national standard. The Referral To Treatment (RTT) pathway is compliant overall although there are issues with the Colorectal and Urology pathways.	**TS/JT**
68.1/2017	**Cancer 62 Day Standard Improvement Plan** The improvement does not show consistency and the drivers of this are uncertain. Information Services have advised that this reflects natural random variation. The demand for cancer diagnostics and treatments is increasing in line with national trends. The Department of Health National Intensive Support team was invited in last year and carried out a piece of work. The visibility of cancer pathways within information systems is still not well developed. This will be worked upon in June with a new system for timed cancer	**JT/TS**

	pathways. Robust Patient Tracking List (PTL) patient pathway management has now been implemented. A new interim Cancer Lead Clinician has now been appointed to focus on Multi-Disciplinary Team (MDT) leadership and engagement. A Urology Tumour Lead has been appointed and a similar approach is being considered in the Colorectal Specialty. There is a monthly meeting with the CCG and the Trust is linking in with the Royal Surrey County Hospital next month regarding the referral process for common pathways such as prostate cancer. EH advised that she had been contacted by Healthwatch regarding concerns raised as a result of media coverage. EH to link in Healthwatch with colleagues such as TS/JT and MI who can signpost Healthwatch to Trust work underway in this area.	**EH**
53/2017	**Serious Incidents Requiring Investigation (SIRI) Incident Report** Re. 69/2017 the Falls Service has been interrupted. HC advised that contingencies are in place. The Board paper on SIRI reports needs to reflect that a number of incidents have involved patients absconding from the Emergency Department. The SIRI report for case W37205 needs to be grammatically clearer to ensure the central issue is captured and information regarding this should be reworded. The narrative of the reports need to be clearer Re. the report for DTTO W38219 the template is to be re-done and a grammatical refresh is needed to ensure the issues are captured. There are 9 SIRIs beyond the CCG timescale and the Women's Health and Paediatric Governance Team will week to clear 4 next week. The potential reason for the delays include clinician engagement, a lack of governance capacity/experience to draft the reports and a lack of Central Team capacity to do re-work to ensure	**MI/JR** **MI/JR** **MI/JR**

	the report meets the required standards. The Trust has adopted the Root Cause Analysis (RCA) approach to SIRI reports rather than a narrative style, as required by the Serious Incident Framework. The RCA approach may also appear to lack empathy compared with a narrative report. A programme of work is needed to build capability and improve the quality of SIRI report writing and complaint responses. The cost of not doing this well at the outset should be considered as well as the possibility of external reviews. The capacity of the governance teams should also be reviewed. A paper should come to the September meeting led by DF/HC. An achievable trajectory should be agreed by the Divisional Directors for completion and closure of the SIRIs. This should be presented to the June meeting. LM to explore whether an action from 2013 allocated to Workforce is still outstanding. The 11 SIRIs put forward for closure were agreed.	**DF/HC** **DDs** **LM**
70/2017	**Mortality Spike Report** 2015/16 was an abnormal year in that there was no winter mortality spike. 2014/15 had a larger spike (benchmarked) than the current year. The Trust's mortality spike mirrored seasonal variation but was of larger size. In-hospital analysis considered ED breaches by day and with a 7 day running average. There was a 1 – 1½ % associated impact on mortality which whilst correlated did not demonstrate causation. Soft intelligence from mortuary data indicates that community deaths had reduced and in-hospital deaths had risen. The mortality spike report was not discussed at Board and needs to be presented against this month along with a front cover sheet.	**DF/MI**

	The conclusion reached from the report was that an internal cause from the mortality spike was not established. A conclusion should thus be added to the report and details of whether or not other factors were at play, such as operational capacity, needs to be included. The mortality spike data methodology needs to be reviewed against the original scope. It needs to be determined whether bed occupancy and escalation area usage has been measured. HC advised that more work is needed, it is thought, in some areas. SR advised that the Executive team have reviewed some data and the Trust needs a forward going hypothesis regarding what the Trust needs to test and understand. HC suggested a hypothesis regarding unprecedented activity and the relationship with individual deaths and external factors. MB questioned whether or not it has been determined whether the Trust is, or is not, an outlier regarding this mortality spike. MI advised that there are 200 deaths and will take two hours per review. MI suggested that data shows 2 months of special cause variation but the Trust has been unable to identify what this is. The item could just be the extremes of a statistical cluster. SR raised that the area of mortality needs to be kept under review.	**DF/MI** **DF/MI**
72/2017	**Divisional Quality Update** **Medicine** The Division remains worried regarding the ED trajectory in that a medium to longer term issue may exist and this is brought to the Committee's attention. ED may not be sustainable and a change in care model may need consideration. The Chair requested that a presentation regarding the ED issues be brought to the September meeting by the Divisional Directors for MES. Stroke – There is work to be done on the long term sustainability of	**JR/MIS**

	the service now that the new model is in place. Dermatology – The Trust has made a successful bid for the service and was congratulated for this. Going forward the service needs to be 'bid compliant' at a financially sustainable level. Maple Ward – There are longstanding concerns regarding clinical leadership and changes in medical personal and there are plans to address this going forward. The open SIRIs have been discussed at Divisional Management Board and the Division is seeking to close the outstanding actions as a priority. **TASCC** Bariatric Service - this has been restarted in early May and there is a challenging action plan. A retrospective MDT case review is underway. Colorectal – There has been a 25% increase in demand without commensurate increase in capacity. There have been secretarial issues and plans are progressing. The service may need short term Locum Consultant support and the Division wishes to avoid potential loss to follow-up for cancer patients. Vascular – A proposal for future service options is to be put forward and job planning has commenced. There are issues regarding junior doctor cover in some areas. Temporary proposals regarding the hospital at night are to be considered. Trauma and Orthopaedics – The possibility of virtual clinics is being explored. It was noted that in London one organisation had a virtual fracture clinic. **Women's Health and Paediatrics** Genito-urinary Medicine – The service has been re-procured with a new London provider. Integration is a priority and is complex. Presence in this area is not the long term intention in the currently proposed model.	

	There are issues with Midwifery staffing and seven Midwives are on maternity leave. This is a cyclical and across the Obstetric Doctors Middle Grade 4/10 Doctors are absent which is being addressed. 2 Obstetric Consultants have resigned and 2 Locums are due to start at the Trust. These posts are for important specialist work and will be difficult to recruit to. There have been recent whistleblowing cases that have gone to the CQC. Monitoring of whistleblowing cases needs to take place and be presented to TEC along with Freedom to Speak Up. A combined approach is needed. A safer sleep audit has been carried out and 50% performance was registered. The methodology was looking at information noted in the Health Visitor Red Book and the Midwives had been documenting details in the clinical notes therefore the information was not necessarily captured in the audit results. There is a plan for Midwives to enter information into the Red Book which will be beneficial for audits going forward. The current practice on safer sleeping is to be discussed and documented. An assurance piece is to be done in the context of an 80% to 50% drop in results. HC noted that the methodology does not capture the practice at the moment.	**LMcK** **JU**
Additional item	**Board Assurance Framework (BAF)** The BAF needs to go to all Subcommittees that own each aspect of the BAF. Staffing should go the Workforce and Organisational Development Committee. Patient Experience and Quality items should come quarterly to QPC. Finance items should go to Finance Committee. The Board owns the BAF and the Board is to refresh the BAF in the round. The risk regarding the CQC was agreed for closure.	**SR**
73/2017	**Quality, Experience, Workforce and Safety (QEWS) Triangulated Dashboard**	

	HC reviewed items of note by exception. At the high level there are no level zero Wards and the rise in level 3 Wards compared to the previous month was noted. Paediatric ED had 3 SIRIs and a very low FFT response rate of 0.4%. Other areas reviewed included hand hygiene on Cedar Ward and areas with a low percentage of VitalPAC observations at night - Cherry Ward, BACU and Wordsworth Ward. Pressure ulcers were reviewed. The response rate for FFT was noted as slightly improved despite being low overall. Regarding the predictive aspect of QEWS the AMU Ward was noted with a QEWS level 1 alongside a Best Care level of 0. Soft intelligence suggested some leadership struggles were occurring in Aspen Ward with some impact on care quality noted with respect to appraisal levels and safe nursing staffing levels. A pop-up Schwartz Round took place on Aspen Ward at which feedback was received that staff felt burdened and unsupported. It was put forward that this finding may perhaps be more widespread elsewhere within the Medicine and Emergency Services (MES) Division. It was considered that MES Division might be safeguarding quality of care through sacrificing workforce measures and staff experience. HC is to discuss support of Clinical Nurse Leaders and Ward Sisters. There was some mention via feedback that the matter may be uniprofessional and pertaining to Nurses rather than Doctors. In respect of the MES Division - A written paper is to be provided to the June meeting updating on the following areas: 1. interventions in the Medical Areas 2. An update regarding Paediatric ED – for which the 3 SIRIs were noted. 3. A narrative to describe what has changed on Aspen Ward should be included.	**HC** **HC with MIS/JR**

74/2017	**Pressure ulcer report** The report was presented by the Lead Nurse Tissue Viability. The Strictly Off Surface (SOS) campaign is underway. The review looked at pressure ulcers by body areas. Regarding wards and trend lines Swan, Swift and ITU are high by number but on a downward trajectory. Aspen, Cedar and Cherry Ward have seen an increase in pressure damage and there has been early intervention. There is no correlation in pressure ulcer trends with when the hospital was busy and nor is there correlation with the red and amber nursing shift ratings. The Wards have been learning from each other through internal peer support and the Divisional Chief Nurses are scrutinising the pressure ulcers on the wards. SR expressed concern with the number of pressure ulcers in ITU and SR was not satisfied with the explanation that patients are at increased risk in that clinical area. SR raised the need to consider whether there had been triangulation with workforce items such as agency and temporary staffing levels and whether there was a skill mix factor. Acuity and dependency on the Wards also needs to be added into the analysis as part of the triangulation. The above items should be added as an addendum to the report. HC noted that campaigns are aimed at leadership. Substantive staff need to train and on-boarding new staff. Swan Ward continues to struggle with staffing and carries a greater 'gap'. There is a need to consider team support.	**Lead Nurse Tissue Viability**
75/2017	**CQC Regulation Paper** The NHS Litigation Authority (NHSLA) is introducing a new regulatory requirement for early notification of brain injury at birth. This may result in an increase in the annual premium for the maternity service. One of the TIAA (the Trust's Internal Auditors) audit report actions was that teams should carry out an assessment of head count requirement	**JT/ TS**

	for Governance in the Divisional Teams and the Central Team. This action has been raised in several reports and is still outstanding. Executive level support is needed to progress this review. It is recognised that the Divisional Teams consider that they do not have sufficient capacity and there is also a piece of work ongoing at Executive level around transformational functions and this may be another way in which teams can be supported. A report on this is to come to QAPC in July. It was noted that the NHSLA is now known as NHS Resolution.	
61/2017	**Any Other Business** SR raised that a corporate level issue has arisen regarding the administration and preparation for Coroners' Inquest cases. It was noted that there was learning in terms of the preparation, approach, documentation in medical notes, and also report writing more widely. HC noted the conflict between learning as an objective from the SIRI process and the aim of the Coronial Process. An action is for preparation for Coroners' Inquests to be a workstream of the wider review of undertaking work such as SIRIs [refer to point 53/2017].	**DF/HC**
	Date of next meeting: 15th June 2017 11.00 – 13.00 Room 3, Chertsey House	