Ashford and St. Peter's Hospitals
NHS Foundation Trust

Trust Board
30th January 2020

AGENDA ITEM NUMBER	15.2	
TITLE OF PAPER	Quality of Care Committee Minutes – 21st November 2019	
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 23rd January 2020		
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	Yes
AUTHOR	Joanne Finch, Corporate Quality & Regulation Manager
PRESENTED BY	Professor Mike Baxter, Chair of Quality of Care Committee
DATE	23rd January 2020
BOARD ACTION	Receive

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

QUALITY OF CARE COMMITTEE (QCC) MINUTES
21st November 2019
Room 2, Chertsey House
11.00 – 13.30

CHAIR:	Professor Mike Baxter (MB)	Non-Executive Director
MEMBERS PRESENT:	Marcine Waterman (MW)	Deputy Chairman and Non-Executive Director
	Mathew Barker (MBa)	Deputy Chief Nurse, Workforce
	Sarah Burton (SB)	Divisional Chief Nurse, MES
	Dr David Fluck (DF)	Medical Director
	Dr Erica Heppleston (EH)	Head of Clinical Effectiveness
	Melanie Irvin-Sellers (MIS)	Divisional Director, MES
	Chris Ketley (CK)	Non-Executive Director
	Sal Maughan (SM)	Associate Director of Corporate Affairs and Governance
	Olatokunbo Ogunbanjo (OO)	Chief Pharmacist & Divisional Director for Diagnostics and Therapies
	Yvonne Obuaya (YO)	Associate Non-Executive Director
	Gemma Puckett (GP)	Acting Head of Midwifery
	Suzanne Rankin (SR)	Chief Executive
	Jacqui Rees (JRe)	Assistant Director of Patient Safety
	James A Thomas (JT)	Chief Operating Officer
	Sue Tranka (ST)	Chief Nurse
	Johnathan Trickett (JTr)	Consultant Surgeon, TASCC
	Faris Zakaria (FZ)	Divisional Director, WH&P
IN ATTENDANCE:	Jo Finch (JF)	Minutes

	DR Henderson (DrH)	Palliative Care Consultant
	Jane Mitchell (JM)	Professional Head of Safeguarding
	Jane Ryman (JR)	Governance Lead TASCC
	Dr Shah (DrN)	Consultant ITU
APOLOGIES:	Andrea Lewis (ALe)	Deputy Chief Nurse
	Mr Shashi Irukulla (SI)	Divisional Director, TASCC
	Paul Murray (PM)	Chief of Patient Safety

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
	MB discussed the large agenda and asked that members consider what was being asked of the committee for the agenda items. The committee were also asked to consider the number of papers and the size of papers going forward to enable sensible time allocation.	
82 / 2019	**Apologies for absence** Noted above.	
83 / 2019	**Minutes of the last meeting**	

	The minutes were approved.	
84 / 2019	**Action Log** MB discussed the need as a committee to be better at setting timescales for actions. It was agreed that members would meet outside of the committee to set timescales for all of the outstanding actions. MB asked if there were any actions that required further discussion at the meeting. DF raised the SOP for escalation areas and noted that although the names against the action were Df and JT, the formulation of it was for the Divisional teams. All other actions were updated on the action log.	
85 / 2019	**Board Assurance Framework (BAF)** The BAF was reviewed to remind the Committee of what was being assessed, so that the Committee could later review if what was heard during the meeting changed any of the BAF assessment.	
86 / 2019	**Cardiac Arrest Outcomes Presentation** Due to unforeseen circumstances only the ReSPECT element of the presentation was brought to the Committee. The presenters were asked to summarise the important points due to time constraints. Dr Shah and DR Henderson presented. The background to the ReSPECT process was explained. The ReSPECT form was introduced into the Trust 18 months previously and was selected to enable engagement with all of Surrey Heartlands. It was to be considered a culture shift rather than a form or piece of paper that was to be completed. The idea of ReSPECT is that it helps to promote shared decision making by supporting conversations with patients and their families. Unlike the previous DNAR form, the ReSPECT form records appropriate care rather than detailing what would not be done**.** On completion of a form it belongs to the patient. They keep the original copy enabling all HCPs community wide to engage in the process. Metrics for measuring successful introduction of the process in ASPH, included a reduction in cardiac arrests, appropriate patients being appropriately resuscitated successfully and a reduction in priority calls and outreach referrals. It was noted that various training mechanisms have been put in	

	place. The ReSPECT process is discussed as part of BLS training in the Trust. The use of a learning app has been promoted but not mandated. The ASPH team would like the app to be mandated going forward. Areas for improvement included: • Senior clinicians to sign the form although anyone can start the conversation. The risk attached to Mental Capacity assessment was identified as an issue that has come up. • A need for improved communication with the community was identified. • The review of forms prior to discharge due to the differences in language used in the acute setting and the understanding of this in the community setting. • An issue with who provided training in the community was highlighted as a national challenge. On implementation the aim was to effect a culture change and to review the impact that the process was having on everybody. The audit included how well the forms were being completed, a survey of how staff felt about implementation of the process and how patients and families felt about it. Results of the latter audit were in the process of being reviewed. A variety of Trust staff were aware of the form however very few completed the learning app. Completion of the form required improvement. Senior nurses felt confident to be more involved in the ReSPECT process and to have those conversations, however Trust policy did not support this as documentation on the form required Registrar and above to document decisions. The presentation was opened to discussion. DF discussed test of effectiveness and made some observations. MB linked it to the readmissions work. JT discussed the timeliness of ReSPECT conversations and the cultural change required due to many conversations being held much later than needed and consequently patients received unnecessary tests. SR asked if SJR's looked at ReSPECT forms as part of the review. EH explained that phases of care and EOL care were included more broadly as part of the review. Dr Shah identified the importance of the ReSPECT process not being seen just as an end of life (EOL) process. A further discussion took place on the governance structure of	

	the form as it was going through EOL Steering Group, which was not considered the most appropriate governance structure. It was agreed that how it fits into a governance structure was to be decided, however the committee agreed a broader approach was needed. The presentation was received.	
87 / 2019	**Deep Dive into Readmission Numbers** EH presented the report for discussion. The purpose was to review 28 day non-elective emergency readmissions. The Trust performed more favourably than its peers, based on HES data**.** The majority of patients readmitted were for a different condition than their original admission, although since October 2018 readmission with the same condition was rising. Patients most likely to be readmitted were those diagnosed with UTI, Pneumonia or COPD when they first arrived. UTI was the most common same condition readmission. No association was found between the day of the week the patient was initially admitted and readmission. The day of the week a patient went home was also not predictive of readmission. The Trust readmission rate centres upon 7%. The graph showing 12% was because of different inclusion criteria such as day cases. MB observed the paper concluded that people readmitted with a different condition concluded that there was nothing more to be done at the initial admission, which he did not agree with. MB also observed that the top ten admission diagnosis was the same as the top ten readmission diagnosis and did not understand why the data did not coincide. MB also pointed out that UTI is not a diagnosis and that there would usually be another underlying co-morbidity. EH explained that this could not have been drawn out for the purpose of the paper. MB's advised that the cause generating the readmission needed further work. MB also acknowledged that the top four readmission reasons were all related to infection and that later in the meeting the Committee would be hearing about the Trust's high usage of antibiotics and believed that there was a disconnect. EH explained that a limiting factor into the analysis was in not	

	knowing what happened during the period the patient was not under the Trusts care. CK asked about the relationship between UTI and age. MIS explained the link of UTI to frailty and that the LACE assessment score being high increased the risk of readmission. EH explained that statistical analysis was underway to look at the correlation between LACE score and readmission. MB discussed patients with conditions such as COPD (among others) that had multiple admissions despite having community support. He felt that the paper did not address multiple admissions, patients on a route of decline and still attending the acute setting when community support would be appropriate. SR suggested that further analysis would be less helpful than understanding what more could be done in the community setting. Pathways for specific groups of patients such as those discussed are not robust, causing patients to feel that they only had one option, which was to attend the ED. It was suggested that the Trust needed to be more proactive around pathways to case manage patients believed to be susceptible. SR gave the example of the work completed ond the case management approach used with mental health patients' frequent admissions. MIS explained the evidence available for COPD patients and pulmonary rehab and how the current community situation meant that little support was available. DF pointed out that the small groups of patients didn't affect the massive number, although it was the right thing to do in terms of managing those pathways. The work on the paper was commended.	
88 / 2019	**Medicines Optimisation Annual Report** OO presented the Paper OO explained that the paper presented a summary of the activities carried out in last financial year and feeds into what was being achieved in terms of the CQC Well Led review and medicines optimisation. Some of the achievements were around the medicines safety programme, progress in terms of expanding roles and improving medicines expertise at ward level, collaboration across the ICS to deliver required changes and the transformation of the dispensary in pharmacy. Areas for improvement included the antimicrobial stewardship and the challenges already discussed in terms of data, showing	

	the Trust as an outlier in the prescribing standard and the auditing required around this. Other challenges were described as medicines storage on the wards, temperature monitoring and work needed on storage and use of liquids, as well as storage around bedside lockers. Some risks were described including those that were outside of Trusts control, such as Brexit and the medicines shortage being the worst it had ever been and that this had been unrelated to Brexit. MB inquired about the fridges and OO explained that the Trust had installed electronic monitoring. DF noted the pharmacy costs and wondered if the Trust had been carrying increased stock to prepare for Brexit. It was noted this was not the case. SR asked if the medicine supply challenge was driving costs in having to seek alternatives. OO explained the market forces were driving some drug costs. The NHS having to pay high prices was discussed as a growing trend and SR explained some of the reasons for the increased pressure to the NHS and why this had become a serious problem nationally. MB sought reassurance that the Trust is continuing to deliver high quality medicines and was not compromising on quality for cheaper alternatives. Assurance was given. SR raised antibiotic prescribing and what more could be done. DF explained that although much work has been achieved there was still a lot more to do. DF felt the main issue was review dates and switching from IV to oral antibiotics. DF also discussed this evidence that where EPR/EPMA has been introduced the risk around antibiotic prescribing had increased. The earliest expected date for EPR/EPMA introduction at ASPH was 2022. MW confirmed with OO that the key plans for next year had been funded and costed. The report was received.	
89 / 2019	**NHS LT Plan Gap Analysis** The report was taken as read and opened up to discussion. MB commented that it was well written but did not consider it to be a gap analysis and requested that it was retitled to Position Statement as this was more reflective of the paper. SR reiterated that the question for consideration was to what extent the Quality Strategy delivered on the LT Plan and whether	

	the committees judgement considered it did or not. This was expanded to consider if the Together We Care Strategy enabled the long-term plan to be delivered. ST agreed that the paper did not answer that question. It was agreed that the title of the paper would be changed and the committee would bring back how the Position Statement applied to identify the gap. **Action:** Paper title to be changed to position statement.	
90 / 2019	**Performance Report** JT presented the report. Emergency Department activity had increased and continued to do so. Ambulance conveyances were at an all-time high for the year and this was impacting on admissions. Plans were in place to address this. In response to MB's question about urgent care and demand JT explained that DTA's overnight in ED were getting higher, overall bed occupancy was increasing and UTC visits were high. The 'Making Every day Count' Programme was a significant piece of work that resulted in the teams having an improved level of understanding. It was also noted that the context of the Trusts performance against the rest of the NHS was an important factor and JT reported that whilst other Trusts were in a declining position ASPH had improved performance and was at 26 in the country out of 136 Trusts, the previous week. It was reported that for 18 Week Electives there continued to be on the day cancellations and the Divisions were working to prevent these by reducing elective activity in advance. The areas mainly affected was also the areas that winter pressures impacted upon and JT pointed out that it was something to be mindful of and monitor going forward. For diagnostic waiting times it was reported that endoscopy services had seen a 29% rise in demand over the previous 3 months, putting the service under significant pressure. MB asked about the prediction of the wait, what impact this may have had on those waiting and if the risk of prolonged waits had been risk assessed. JT explained that the TWR standard is met by prioritising these patients subsequently in their pathways but that this could have had implications for the routine waiting times. DF pointed out that the committee's role is to assess the impact of operational issues on Quality and therefore asked if there was any evidence of less safe care. It was advised that this was	

	being closely monitored and that there was a degree of assurance with the static mortality line and continued monitoring of the situation. MB wondered if the mortality data gave reassurances or if there was a need for more granulated data. EH advised that reviewing mortality, for those patients with a longer RTT trajectory of weeks or months wouldn't pick them up as it would be longer term harm. JT advised that the Division always risk assesses and reviews stratification of individual patients. JTr highlighted that the conversion rate of cancer was actually very low, 3-4% and the harm is low, however 62 day treatment patients could be at risk of harm due to delays in receiving results and subsequent treatment delays. SR led a discussion on how general practice was risk averse resulting in a low pick up rate and that there was a global shortfall of histopathologists. A lack of obvious solutions led to the only available option of outsourcing. There was an AI solution approximately five years away; however in the short term there was a need for an additional outsourcing plan and some work to address demand management. It was noted for reassurance of the committee that the Trust was aware of the issue, had plans to address it, and that they should be aware that it would not completely eradicate the issue. With demand continuing to increase MIS suggested that a piece of work was needed to determine how to start reducing the demand because anecdotally patients were being referred via multiple TWR pathways. SR suggested that one way to improve demand management was to increase utilisation of ICE and order communications in the organisation. MB summarised that there was a need to correlate delays and outcomes, address demand, consider what could be addressed on the TWR pathway and gain a better understanding of internal delays. It was suggested that an understanding of the granularity needed to survey the organisation was needed because mortality data was not enough and was too late. JT clarified the work being taken away from the committee as follows: • **Action:** JT and ST would complete a piece of work around the actual impact of delays. • An ongoing piece of work already underway to tackle the waiting time and backlog	

	• Consider monitoring turnaround time for histopathology. SR informed the Committee that SBS had been asked to attend QoCC, as an operating Division within the organisation, to provide assurance surrounding quality. They would also be expected to provide a paper with all of their quality data. **Action:** Invitation to SBS to be extended.	
91 / 2019	SIRI Report JRe presented the report. Due to time constraints Committee members were asked to offer up any questions. The amended style of the report was welcomed. Further discussion ensued in relation to the duplication in the report especially around the narrative. JRe felt the report could be shorter and asked the Committee if the narrative was needed. It was agreed that this could be shortened. CK noted that the Trust was reporting more than regional peers and asked what the timescale was for this. JRe confirmed that this was for October 2019 and ST informed the Committee that this was good practise and considered to be a positive reporting culture. CK also enquired on the double checking processes for Datix when something had been inaccurately classified. JRe explained that this was completed at Divisional level for low level incidents, and for SIRI's amendments would be made centrally. JRe also explained that the Trust is an outlier for reporting harm rather than no harm and further understanding on reporting the potential for harm was important. SR discussed the triangulation and picture presented of the organisation in terms of being risk averse and reporting culture, which presented both good opportunity and some challenge. MB raised a concern about the falls section of the report and felt that JRe's explanation was not reflective of what was written. **Action:** JRe was to amend the report to reflect that falls actions are not consistently used. It was also reflected that the time frame for SI's was too long. JRe advised that this was due to the investigation process. MW inquired if there was a triangulation with SRI's and performance such as the diagnostic delays discussed and DF agreed that more needed to be done to tease out the information.	

	The report was commended. ST sought from the committee that it was satisfied with the report in terms of assurance. SR suggested that lessons learned be brought to the front of the report to allow the learning to be at the forefront and provide assurance to the committee that lessons were being learnt. The Committee agreed.	
92 / 2019	**Quality Report** ST presented the report In the interest of time, the highlights were identified. *Medication safety*: Data showed that month on month progress was being made in a number of areas. This had been sustained due to the improvement in safety culture and awareness around medicines. Proof of concept was being tested by introducing a new model of care in the ED. *Infection prevention:* SSI had not reported anything new due to the frequency of reporting. It was suggested that to see the changes embedded, a quarterly view would be more effective. Adequate resources were in post and some detailed work at granular level was being progressed. *Effectiveness***:** There were 98 inpatient deaths in October. (2 neonatal, 1 paediatric and 95 adult) The RAMI and crude mortality graphs were flat. ST explained that she and DF were completing some work to ensure that the Trust was being measured against appropriate acute peers. SJR's: In Q2 to date, no patients had received poor care. A full review of learning from deaths on the Q2 data was to be provided to Board in January 2020. There was a SIRI learning event arranged event on 25th November 2019, centring on a coroner's inquest and how human factors had contributed to the case. Divisions were asked to attend the learning event. *Quality and Safety Committee:* Previously QGC, the first meeting of the new format was on 7th November 2019 and was changing the way quality and safety would be completed in the organisation. The Quality and Safety Committee would feed into Quality of Care Committee. The Medical Examiner role was progressing and would soon be out to advert. *Stroke*: There had been an improvement in the data. Questions were offered out to the Committee. *Safety***:** ST highlighted that a lot of work had been completed on	

	safety and that this had been the first time VTE had been reported on. *Patient Experience*: There had been an improvement in complaints and pals, although more work was needed. *Education:* This was the first time education was being reported on in the quality portfolio. Education was the mechanism for driving and should have been driving not only transformation, but quality improvement in the organisation. MB noted that the emphasis on falls that appeared in the Board Report could not be seen in the numbers in the Quality Report. ST explained that the analyst did not think the data would make the step change but that he would be rerunning the data. MB suggested that the figures for severe harm were needed because the CCG data that was shown identified a clear spike that moved the Trust up the mean level. MB commented that Stroke data was being presented on percentages and the actual numbers were very small. It was suggested that the actual numbers should be reported alongside the percentages. **Action:** It was agreed that the way stroke data is presented in the future would be reviewed. SR identified that the medication safety work continued to be outstanding and that the graphs helped to demonstrate learning had been taken seriously. SR asked what the predictive indicators were that needed to be looked at and what the real quality challenge was. A discussion on this took place and patient experience was identified. It was felt that patient experience data from the pilot was not reaching the quality report and patient experience information was not in real time, forming part of real time discussions. CK noted that one of the greatest threats to quality of care was the high numbers coming through the door and the organisations ability to cope with this. SR commented that the use of Mortality data for measuring this was the least preferred measure and far too late. A discussion ensued as to how real time patient experience could be captured operationally to enable situations to be addressed at the time and before ever reaching SJR, which identifies themes in poor care. ST informed the committee that there was to be change in reporting as she and JT were working on an integrated Performance and Quality Report. A draft of that would be submitted to the committee in January 2020.	

93 / 2019	**Exception Reporting** <u>Safeguarding</u> JM Presented the report. The primary issue was lack of resources within the Dementia Team, due to staff sickness and vacancies. The Dementia Lead role had been shortlisted and interviews were due to take place on 3rd December 2019. The Trust was recognised as being good at identifying section 42's, although there was an issue around the turnaround time. A new work template had been introduced to address this. ST asked that JM considered how to create a complex needs team and integrated working group. It was explained that this was not about operationalising the committee but having an integrated team with cross expertise built in. The recruitment that was underway was considered an opportunity to identify the right people with the skills that were needed. <u>DTTO</u> OO presented the report. There were 77 incidents in October, 1 moderate which was a delayed diagnosis. Falls had occurred on Dickens & Swan wards. Baywatch had been used to improve this. The challenges faced were around demand and staffing shortages. Actions to address this included workforce redesign and new roles. Other issues identified were around data validation for some of the audits the Division was involved with. The report and the template for this were commended. MB suggested the table used in the SIRI report be adopted on a Divisional basis. DTTO's report was exemplar and the format should be adopted by all Divisions. ST inquired what the timeline was for the workforce redesign associated with MDT staffing levels on Swan. OO informed the Committee that work for the Pharmacist role was completed and that this had gone out for interviews. The other roles such as Therapies had not been progressed and was expected to take several more months. MB suggested that for audit activity and NICE guidance the Division needed to close the loop by recording that guidance has been read. If they were not adopting the guidance they were to	

	say why. WH&P FZ presented the report. SIRI reporting was progressing well. Previously there had been concern over a lack of reporting SIRI's. There were a lot of outstanding SIRI's; some of those were external issues beyond the Division's control. For clinical effectiveness there were 19 NICE guidance reviews related to the speciality and 4 remained under review. Audit activity was difficult to achieve, in particular paediatrics, which was associated with staffing shortages. Although struggling at local level the Division was participating in all national audits. For 7DS it was acknowledged that they needed to be more involved and had been poor in delivering this on a regular basis. EH confirmed that paediatrics had now reported and good progress had been made. Staffing: Issues with staffing in general were identified, particularly in paediatrics and middle grade workforce. Obstetric and Gyne workforce had improved and the position for the Gyne workforce was the best it had been for some years. Maternity staffing was fully recruited, although there were some WTE vacancies at band 6 in maternity. Various recruitment events were being accessed with some planned over recruitment. However Band 6 recruitment was considered particularly challenging. MB referred to the Shrewsbury case and wondered what work was planned to secure the Trust position against the challenges that Shrewsbury was likely to bring. SR identified that it was the job of the organisation to respond to patient concerns even if that caused discomfort. However good reporting such as the Exception Report and triangulation of data was how the Trust should openly respond and the importance of hearing patient anxieties was reiterated. Transparency with patients was the core of Trust values. FZ commented that the hard data suggested maternity services in the organisation were safe and that it can be difficult to both define and provide assurance associated with other softer material. GP pointed out the good work that had been completed in maternity including addressing culture and the 'across banding' working group that had been looking at it. There had also been	

	lots of staff engagement work and the MDT working in the service was very good. ST asked members to consider all that had been presented to the Committee in the past year and to consider if the work presented around the culture, leadership, staffing and resources and the governance, provided the assurance that was being sought and that if it had not, a conversation about this was to be held. ST also confirmed that when the Shrewsbury report was available, a gap analysis would be performed. MB confirmed that they were assured. Due to the timing overrun and the need for some members to leave, it was agreed that the remaining Exception Reports would be heard and that the BAF and 7DS items would also be addressed as agreed at the start of the meeting. Other reports could be accepted as read. DF asked about the well led score and noted that this particularly stood out and wanted to understand more about that and what the Division was doing to address it. GP acknowledged awareness of the tensions DF described between management and staff and GP explained the work they were doing around the culture piece and how they were working to understand ways to break the barriers and the disconnect that existed in some areas. It was also acknowledged that this would not be a quick fix due to the history in the service. <u>MES</u> MIS presented the report. There were some SI reports overdue due to time constrains with the authors and extra support was being given. The Division was also ensuring that actions from previous SIRI's were being closed. The area of well led was not very good and work with the wards to improve this was ongoing. It was identified that there were a number of Perfect Ward non-submissions and that the next Divisional report would have a better submission rate. Awareness of completing the audit was identified as a factor for non-submission and this had been addressed. **Action:** Low submission of Perfect Ward audits and awareness of audit completion was to be addressed. Falls were reported as similar to the other Divisions. BACU was recognised for having 100 days free of pressure	

	ulcers. The next SNAAP rating was being awaited and the team hoped to maintain its A rating. Performance in August/September dipped, due to the high number of patients in general medicine, but improved again in October. Performance overall was improving and the service was considered to be good and this was something the team was proud of. On the acute side, work was being completed with the Making Everyday Count Programme, to address long length of stay and improve discharges. Both 21 day LOS and 7-14 day LOS were down. The risks noted included gaps in the Consultant rota in ED for which, contingency plans were in place. MB suggested including achievements and progress at the end of report. DF wanted to draw attention to the ED scores as this was impressive. It was suggested that this was fed back. OO asked about risk 1556 on page 9. MIS informed members that they had done well with tier 3 and 4 and that the gaps were with the Consultants. SR raised concerns on the variations in the Divisions for perfect ward non-submissions and over a prolonged time period. The conversations with the clinical teams leading the clinical areas were questioned as to why some wards had full compliance whilst others had none, and at what point the leadership identified that it wasn't being submitted, given that it dated back to April 2019. SB identified that Health Assure was previously being used to pull data and that Perfect Ward wasn't business as usual due to this and they therefore hadn't had that view. It was acknowledged that this needed to be addressed as a matter of urgency. DF discussed how embedded this was following the pilot and wondered if this same process needed to be followed. ST identified that this was a leadership issue and that the Matrons needed to contribute to quality in their ward areas through asking every week/month where the quality gaps were and what needed to be done differently. SR also related this with telling a story of a team and Division under enormous pressure and that it was important to manage the balance between the improvement required and celebration of the good work. The Division were asked to consider what the	

	broader leadership team could do to support some of the challenge. MB requested that more clinical effectiveness NICE guidance be included in future reports and SR requested compliments be included. <u>TASCC</u> JTr presented the report. SIRI's were completed within appropriate timelines and there was evidence of learning. For 7 day services a high percentage of patients were seen within 14 hours and seen daily by a Consultant 7 days a week. KPI's were appropriate with community catheters being important in nurse led discharge. Perfect Ward required some work and new Matrons were in place to address this and improve reporting. Not all of the Divisions M&Ms and NICE guidance were completed on time, however JTr pointed out that when they are reviewed the peer review team did this properly. The Division was working to improve Medicines Management compliance. SR commented that the same issues and message around Perfect Ward applied as it did for MES. <u>Risk Scrutiny</u> CK expressed concern on the point that nursing workforce in MES was at a catastrophic level. SR stated that this did not triangulate with the data they had observed in other meetings. The vacancy rate was the lowest it had ever been, bank rate at the highest, and the 'spend' was vast. Establishments in the organisation were set rich and there was no ward level tolerance for having one less nurse on the rich establishment. Given the context of the discussion held, the statement in the report was considered to speak of a cultural belief and was extraordinary when compared with the evidence. MB suggested that the wording in the report was inappropriate but that the Committee needed to both understand the problem and describe it in a different way. ST identified that the Division had also rated the risk themselves and that did not align to the comment in the report.	
94 / 2019	**Quality of Care Committee Annual Report** The report was taken as read.	

95 / 2019	**7DS BAF** EH Presented the report. Performance had improved in 3 of the 4 priority standards. This included priority 2 (time to first consultant review), priority 5 was fully compliant (ensuring patients were able to access MRI and ultrasound out of hours), and priority 8 (ongoing inpatient consultant directed reviews). A QI approach was implemented for obtaining more accurate data in priorities 2 and 8. This was summarised in appendix C of the report. The Committee approved the paper for submission to NHSEI. DF commended the work of EH. MB was interested in the Trusts progress. EH informed members that the national team had given good feedback, however they did not provide data that allowed the Trust to measure itself against other organisations. DF explained how the Making Everyday Count Programme was contributing to the experiential elements.	
96 / 2019	**HMP Bronzfield Report** GP presented the report. The paper was for receiving and noting, not approval. The context was given, as explained in the executive summary. Part of the remit was women going through Bronzfield prison, one of the largest female prisons in Europe. As a remand centre and sentencing prison the population passing through was very transient resulting in a difficult population to care for with difficulty measuring clinical outcomes. Due to the difficulty in measuring outcomes the report focused only on women that remained at the prison and therefore the numbers were very small. Woman at the prison could be at any stage of pregnancy and either accessed varying levels of antenatal care or did not access any antenatal care. It was noted that there was no base data for comparison when the team had been set up. The service the Trust provides was described. The aim was to provide continuity of care, which was topical nationally. Continuity in labour was an issue and work was underway in the Division to look at this, including capacity within the team, as well as the whole of the service provided to the prison and women from a vulnerable population.	

	GP described the data reviewed. Birth weight centile was one of these and this was good for all of the babies from vulnerable women. Infant feeding was an area that required further work. A service report for vulnerable women would be completed annually. Further plans included meeting with the prison to look at opportunities and working with them to understand what more could be done particularly around the wider maternity care such as infant feeding. ST commented that there was no patient experience data included in the report. GP responded that they did not have anything formally but had some anecdotal data and a video that had been made, in which a woman in Bronzfield had talked very positively of her experience. SR requested that the video link be included in the Board Report. MB suggested using the interview to create a word cloud. There was also a card made by a woman in the prison.	
97 / 2019	**Corporate Quality and Regulation Report** The report was taken as read.	
98 / 2019	**BAF** Risk 1.1 and 1.2 were reviewed. ST identified that these were rated medium and asked the members to consider if this was still appropriately rated given the information received in the meeting, or if anything had suggested that the risk was off track. For mortality it was agreed to leave the ratings the same and to change the risk to neutral. For patient experience it was agreed that the risk would stay the same as there was not any real time patient experience feedback. It was agreed that the arrow should change to an upward direction and that this would help to gain traction on progress. CK asked the committee if the measures were sufficient for capturing the whole aspect of patient numbers, flow and impact of patient safety and the nursing care. MB responded that they were the right things to measure because the mortality outcome was hard evidence and the other was experience. However observation from the meeting was that more granularity was needed around mortality to assess risk, and the data on patient experience was needed but did not exist. ST commented that the BAF was looked at in its entirety through	

	other Committees. DF requested clarity on what was moving up. It was agreed that the impact was the same and that likelihood was what was driving the arrow up. It was agreed that likelihood would increase to 4 and impact would remain the same.	
	Any Other Business No AOB noted. It was agreed that more time was needed for the meeting.	
	Date of next meeting: 23rd January 2020 Room 3 Chertsey House.	