

TRUST BOARD
25 May 2017

AGENDA ITEM NUMBER	5.1	
TITLE OF PAPER	Quality And Performance Committee Minutes	
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 agreed these minutes at the 18 May meeting.		
STRATEGIC OBJECTIVE(S):		
Best outcomes	<input checked="" type="checkbox"/>	
Excellent experience	<input checked="" type="checkbox"/>	
Skilled & motivated teams	<input type="checkbox"/>	
Top productivity	<input type="checkbox"/>	
EXECUTIVE SUMMARY		
	<ul style="list-style-type: none"> • Mortality Reviews: The mortality review paper was discussed at length, with a paper to be tabled at Board. This was not read at last month's Board and therefore has been submitted as appendix 1 to these minutes. See paper 5.1.1. • Serious Incidents requiring Investigation (SIRIs): <ul style="list-style-type: none"> ○ There was a discussion about the SIRIs and the process to clear the actions backlog. ○ The SIRI pertaining to the Bariatric service was discussed and the Service has opened fully since the beginning of May. ○ SIRIs with the Emergency Departments around processes to keep patients lacking capacity from leaving the department and who were later found by the police were discussed. These cases are described in the confidential Quality Board Report for information. • Performance: The Trust is on trajectory for its ED recovery plan and Cancer and RTT targets also remain on track. • QEW: the new QEWS format was shown to QPC which will support the Quality Improvement approach, the full report would be presented in July 	

	<p>2017.</p> <ul style="list-style-type: none"> • Governance: <ul style="list-style-type: none"> ○ The Committee received the results of the CQC inspection with the Trust registration having no compliance actions. ○ The Committee received the QPC annual report. ○ The Trust's Learning Disability cover was described. The Trust has on-site presence for 3 days and on-call advice service for the remaining 2 days. The Trust's LD activity and plan to review LD deaths was also discussed.
RECOMMENDATION:	Receive and note the paper
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	
Patient impact	
Employee	
Other stakeholder	
Equality & diversity	
Finance	
Legal	
Link to Board Assurance Framework Principle Risk	The BAF is included in items submitted to QPC.
AUTHOR NAME/ROLE	Kate Flynn, Risk & Incidents Co-ordinator.
PRESENTED BY DIRECTOR	Hilary McCallion, Non-Executive Director and Committee Chair
DATE	22 May 2017
BOARD ACTION	Receive

QUALITY AND PERFORMANCE COMMITTEE (QPC) MINUTES
20th April 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
	David Fluck (DF)	Medical Director
	John Hadley (JH)	Divisional Director, Theatres, Anaesthetics and Critical Care
	Chris Ketley (CK)	Associate Non-Executive Director
	James Thomas (JT)	Director of Operations for Planned Care
	Terry Price (TP)	Non-Executive Director
	Paul Crawshaw (PC)	Divisional Director, Women's Health and Paediatrics
IN ATTENDANCE:	Erica Heppleston (EH)	Assistant Director, Regulation and Improvement
IN ATTENDANCE:	Daniel Dodd	Darzi Fellow (shadowing SR)
SECRETARY:	Russell Wernham (RW)	Deputy Chief Nurse/Associate Director of Quality
	Kate Flynn (Minutes) (KF)	Risk & Incidents Co-ordinator
APOLOGIES:		
	Louise McKenzie (LM)	Director of Workforce Transformation
	Dakshita Takodra (DT)	Senior Audit Manager
	Heather Caudle (HC)	Chief Nurse
	Hardev Gill (HG)	Associate Director of Operations, Maternity
	Melanie Irvin-Sellers (MIS)	Divisional Director, Medicine
	Jacqui Rees (JR)	Acting Head of Patient Safety
	Tom Smerdon (TS)	Director of Operations for Unplanned Care

ITEM		Action
47/2017	Apologies for Absence	

	As above.	
48/2017	<p>Minutes of the Last Meeting</p> <p>The minutes of the last meeting need a sense check prior to open board.</p> <p>36/2017 – remove ‘no paper provided’ and clarify that the presenters had to leave half way through the presentation due to a medical emergency.</p>	
49/2017	<p>Matters Arising</p> <p>19/2017 – Risk Register. MI to give the Exec leads a deadline to refresh their risks.</p> <p>20/2017 – Serious Incident Requiring Investigation (SIRI) Incident Report, detailed analysis of pressure ulcers. This to be deferred to the May meeting to allow for 2016/2017 analysis.</p> <p>36/2017 – Maternity Deep Dive, a report on the stillbirth audit to be brought to the next meeting. The second half of the presentation to be given at the May meeting.</p> <p>39/2017 – QEWS Triangulated Dashboard, staff are working long shifts not compliant with the Trust shift configuration. A surveyed view is needed from the nurses and the issue to be brought for discussion. A survey has gone out on Aspire and a meeting will be called to review shift patterns.</p> <p>39/2017 – Friends and Family Test (FFT) data is not being collected consistently Trust wide and we need to understand why. Verbal update given – Ownership of FFT collection has been pushed back to the wards. There is no interface between FFT and I Want Great Care and this is being worked on. A list of other concerns regarding I Want Great Care has also been given to the provider for action and feedback. The scanning now happens in Patient Advice and Liaison Service (PALS).</p>	<p>MI</p> <p>HC/CS</p>
50/2017	<p>Maternity Deep Dive Stillbirth Audit Report</p> <p>The second half of the presentation will be given to the May meeting.</p>	

51/2017	<p>Presentation on the Learning Disability Pathway</p> <p>The Trust has two learning disability nurses who job share on site three days per week. For the other two days there is a telephone advice service available to staff. The service is commissioned by North West Surrey Clinical Commissioning Group (NWS CCG) and provided by Surrey and Borders Partnership NHS Foundation Trust (SABPFT). The current learning disability policy is being reviewed. Learning disability passports are in use from the first contact point in either primary or secondary care and the Trust's learning disability patient flagging system is being updated. Knowledge of the learning disability passport is poor and patients are often flagged for referral to the learning disability team inappropriately. Awareness is being raised via regular awareness days with external speakers. The learning disability pathways, including referral and discharge, are also being reviewed and simplified. The Trust has signed up with Disabled Go which is a charity that reviews facilities in hospitals.</p> <p>There has been more discussion at the Equality and Diversity Steering Group regarding patient care in addition to having a staff focus.</p> <p>Mortality data will be analysed in terms of learning disability patients. A gap analysis is being done and will be circulated to Quality and Performance Committee (QAPC). The Trust should work on improving the data regarding classification of patients with difference.</p>	RW
52/2017	<p>Performance Review</p> <p>Urgent Care – There has been a slight improvement on the March position (89.6 %). There have been a few challenges at the beginning of the month such as new transport providers. The Trust is on track to be on trajectory for April. The way the national target is measured is being reviewed.</p> <p>Cancer – The Trust was compliant in March in 7 out of the 8 targets. There are capacity issues in Dermatology and the service is reliant on locum cover. The service has been put out to tender and the Trust has</p>	

	<p>put in a bid.</p> <p>18 week performance – The Trust was compliant in March but there are some issues such as manpower, which will present challenges and there is a risk that the target will not be met next month.</p> <p>62 day cancer wait target – the numbers are extremely small and further details are in the board finance paper.</p>	
<p>53/2017</p>	<p>SIRI Incident Report</p> <p>There are 6 new SIRIs for April. One has a long delay in reporting as it was raised as a result of a complaint (W37673).</p> <p>There was discussion regarding the members of staff who carry out Duty of Candour and whether they are of appropriate seniority. The initial conversation often takes place with a consultant but is not always recorded in the notes. There may be anxiety amongst clinicians about offering an apology to patients and this is a cultural issue.</p> <p>The 8 cases put forward for closure were agreed.</p> <p>There is a corporate action plan for pressure ulcers following a thematic review of investigations.</p> <p>The Divisions have been asked to close off the most historic outstanding actions and this will also be discussed at performance reviews.</p> <p>There was a recent incident regarding a patient who absconded from the Emergency Department (ED) and was found in a local lake. This investigation is being led by the CCG but the board needs to be made aware and the case also needs to be included in the next SIRI report to QAPC. The patient had a significant history with Surrey and Borders Foundation Trust.</p> <p>There are two ED deaths of patients who have absconded from the department and the Coroners inquests will be held in May. A short update will be given to Closed Board via an addendum to the Closed Board report and information will be provided to the Trust</p>	<p>MI</p> <p>RW</p>

	Communications team.	
54/2017	<p>Mortality Spike Report</p> <p>The February and March numbers are within the control limits but not back to baseline. Mortality reviews for December 2016 and January 2017 are currently at around 70%; the outstanding reviews are predominantly within Medicine and have been allocated for review.</p> <p>No cause for the spike has been identified and a short paper will be tabled at Board.</p> <p>There is a similar trend for the south east of England but not to the same extent.</p> <p>HC and HM attended the CQC Learning From Deaths in the NHS, New Responsibility for Board Members half day and fed back to the group.</p>	
55/2017	<p>Venous Thrombus Embolism (VTE) Action Plan and Progress Report</p> <p>A short paragraph of explanation for non clinicians would be helpful.</p> <p>The Trust is looking at obtaining a VTE bolt-on package for Vitalpac which will help in the recording of VTE assessments.</p> <p>It was explained that the previous VTE Nurse (currently on maternity leave) was carrying out a wider role and the current VTE Nurse has a different role, with capacity to monitor the assessment/audit process.</p> <p>The existing backlog is being monitored and there is a push back to complete the outstanding RCAs. The backlog has been reduced from 111 to 26.</p> <p>The Trust is currently looking at a business case to recruit an additional VTE Nurse when the substantive VTE Nurse returns from maternity leave.</p>	
56/2017	<p>Divisional Quality Update</p> <p>Specific surgical lines in the pathway of the Bariatric Service have been</p>	

	<p>paused and it is planned that this will be re-started on 1st May.</p> <p>The Vascular Service remains a considerable concern and the vascular board will be held on 5th May. Following this, there will be feedback to the Executive Team (Execs).</p>	
57/2017	<p>Quality, Experience, Workforce and Safety (QEWS) Triangulated Dashboard</p> <p>The Dashboard now has a front sheet to highlight areas for review. There have been specific changes in the methodology of measurement, as well as the way quality performance will be displayed:</p> <ol style="list-style-type: none"> 1. The FFT Red, Amber and Green (RAG) rating can appear to be inconsistent because it a percentage calculation and is based on footfall and satisfaction score. <p>The dashboard will be replaced with a more robust reporting system. It will contain additional historical data of quality performance rather than just a snapshot.</p> <p>Non submissions have now been highlighted in red and noted as NS.</p> 2. Safer staffing levels – Whilst the RAG rating system is showing shifts rated as red, each shift is reviewed on a shift by shift basis and is escalated appropriately. <p>March 2017 had the lowest number of stage 2 pressure ulcers reported in one month in the last 3 years and a heel Strictly Off Surface (SOS) campaign has been running. This was noted to be a great achievement.</p> 3. Best Care – The 12 indicators from the QEWS dashboard have been moved into run charts for Ward, Divisional and Trust level. The new draft report shows what this will look like. The data is based on experience, safety and outcomes. <p>Discussion took place regarding what processes need to be in place to influence the outcomes. The Project Management Office (PMO), Clinical Nurse Leaders and Ward Managers have</p> 	

	<p>been involved to ensure that there is a wider ownership. The draft report is a good starting point and needs to include the level of consultation that has taken place. We need to be confident that there is a forward view and consider what clinical measures will need to be incorporated.</p> <p>There needs to be Board Involvement and it may be helpful to have a Board seminar for discussion.</p> <p>The paper is to be presented to the July meeting following wider engagement.</p>	RW
58/2017	<p>QAPC Annual Report</p> <p>All comments to be provided to RW by mid-day on 21st April prior to submission to Board. The Care Quality Commission (CQC) draft inspection report arrived at the Trust too late to be included in the Board paper.</p>	
59/2017	<p>CQC Regulation Paper</p> <p>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.</p> <p>One of the TIAA (the Trust's internal auditors) audit report actions was that teams should carry out an assessment of head count requirement 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 Exec 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.</p> <p>It was noted that the NHSLA is now known as NHS Resolution.</p>	JT/ TS
60/2017	<p>Risk Register</p> <p>The Trust Risk Register has been to TEC and the proposed changes</p>	

	<p>were agreed.</p> <p>There is not currently a Financial Risk Register and there are not enough financial risks represented on the Trust Risk Register. MI will chase the Execs to update their Trust Risks.</p>	MI
61/2017	<p>Any Other Business</p> <p>It was suggested that June may be a re-boot month for the committee and regular papers can be by chairs action.</p>	
	<p>Date of next meeting:</p> <p>18th May 2017 11.00 – 13.00 Room 3, Chertsey House</p>	

APPENDIX 1

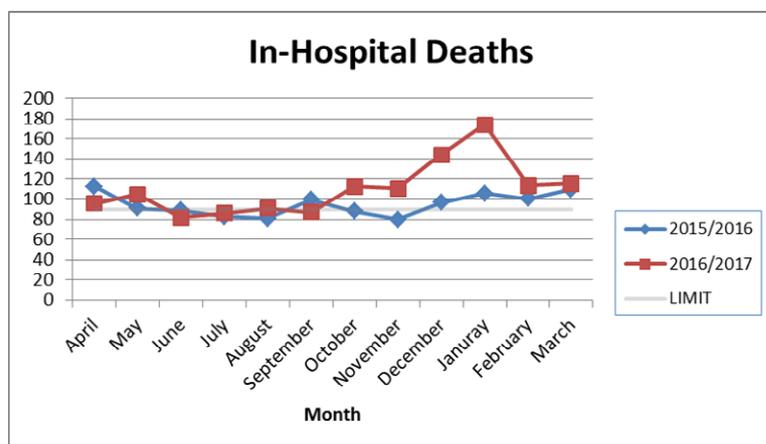
AGENDA NUMBER	ITEM	5.1.1
TITLE OF PAPER	Mortality Analysis for Mortality Spike in January 2017	
Confidential	NO	
Suitable for public access	YES	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality and Performance Committee		
<u>STRATEGIC OBJECTIVE(S):</u>		
Best outcomes	✓	
Excellent experience	✓	
Skilled & motivated teams		
Top productivity		
EXECUTIVE SUMMARY		
<p>The Trust has conducted an investigation into the initial concern over the rise in crude mortality, since October 2016, including, but not limited to, liaising with NHSI on this issue.</p> <p>The statistically significant increase in our mortality rate from December 2016 to February 2017, coupled with significant winter pressures have been drivers to Ashford and St. Peter's NHS Foundation Trust looking closely at operational and practice issues within this time period. The review, thus far, has not singled Ashford and St. Peter's NHS Foundation Trust out from the spike in deaths observed nationally. Although the variance in mortuary space distribution between hospital and community seems to be greater for us when compared with our peers, a coinciding factor was a concurrent change to hospice configuration in North West Surrey during that time.</p> <p>The special cause variation in the Trust's crude mortality at this point therefore remains inconclusive. There is no obvious cluster of quality and safety concerns specific to our hospitals with which we can triangulate this spike. However, a further, more in-depth notes review will need to be commissioned</p>		

	to supplement the work that has gone on thus far. The mortality review process is embedded but needs further improvement.
RECOMMENDATION:	Receive and note the paper
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	Mortality rates are an indication of the effectiveness of care in the hospital and therefore this spike is of concern, should the review reveal issues bespoke to our Trust.
Patient impact	Patients can come to harm if the quality and safety of services are suboptimal
Employee	Staff morale is affected if poor quality and safety issues go unresolved. The analysis of this paper does not indicate any conclusive causative factors to the rise in the crude mortality rate
Other stakeholder	Families and carers would be interested in the results of this investigation.
Equality & diversity	All patients are affected by poor quality unsafe care
Finance	
Legal	
Link to Board Assurance Framework Principle Risk	1.2; 1.3
AUTHOR NAME/ROLE	David Fluck, Medical Director, Mick Imrie Chief of Patient Safety and Heather Caudle, Chief Nurse
PRESENTED BY DIRECTOR	Hilary McCallion, Non-Executive Director and Committee Chair
DATE	22 May 2017
BOARD ACTION	Receive

Mortality Analysis for Mortality Spike in January 2017

Background

The crude mortality rate is monitored continuously and in December it was noted that the number of deaths within the hospital had risen to 144 compared to an average of 90-100/month and continued to rise for January to 174, before falling to 114 in February and 116 in March, which still remains higher than our average but within control totals. The mortality is also monitored through CHKS to take account of case-mix and co-morbidities as the national Standardised Hospital Mortality Index (SHMI) data is 6 months behind. The in-hospital SHMI, through CHKS rose from 62, in November to 68 in January but has continued to rise to 74 in March, there has also been a rise in the Risk Adjusted Mortality Index, which excludes palliative care coding, from 73 in November to 82 in February, but falling back to 66 in March.



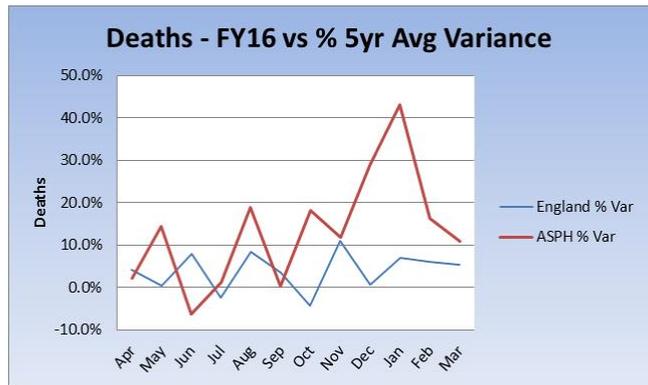
National Picture

It is not unusual to see a rise in crude mortality rates during the winter season, although in 2015/16 the increase was attenuated.

Contacts were made to the quality departments of national and regional offices of NHS Improvement. Although there was interest in our expressed concern about our hospital's crude mortality, the national movements in crude mortality rates across provider healthcare organisation did not reveal any cause for concern with regards to what we were reporting locally. In addition, the benchmarking data did not indicate anything enough to concern the departments about what was taking place in Ashford and St. Peter's. The Trust remains in contact with these departments with a reciprocal agreement to feedback any notable information on this issue.

Nationally ONS publish the weekly deaths across the country. Looking at this data there is generally an increase in deaths through December and February of between 10 - 20% (average weekly rate 10000 deaths increased to 11000 to 12000) over the last 5 years. The increase this year has seen a further 10% with an average rate of 13000 (30% increase from baseline).

England	England			ASPH		
	FY2016	5Yr AVG	England % Var	FY2016	3Yr AVG	ASPH % Var
Apr	43,828	42,025	4.3%	98	96	2.1%
May	38,695	38,570	0.3%	108	94	14.4%
Jun	39,361	36,503	7.8%	82	87	-6.2%
Jul	36,453	37,360	-2.4%	86	85	1.2%
Aug	37,989	35,042	8.4%	92	77	18.9%
Sep	37,720	36,444	3.5%	89	89	0.2%
Oct	37,828	39,493	-4.2%	114	96	18.3%
Nov	43,509	39,202	11.0%	111	99	11.9%
Dec	42,434	42,211	0.5%	149	116	28.7%
Jan	53,640	50,090	7.1%	174	122	43.1%
Feb	44,767	42,211	6.1%	115	99	16.4%
Mar	45,544	43,225	5.4%	118	106	10.9%



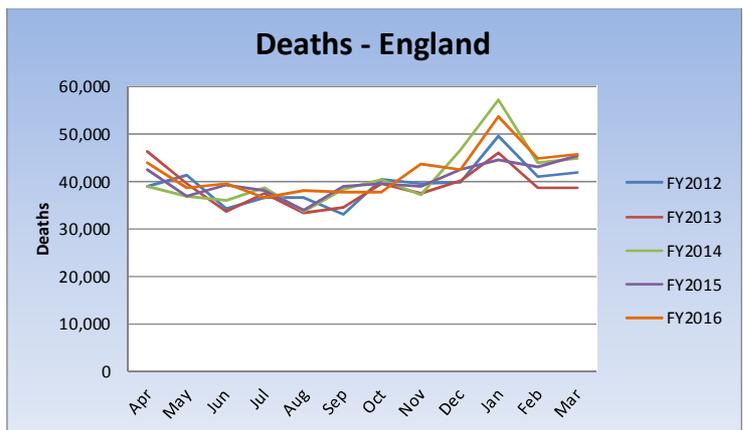
Due to ASPH having low numbers of deaths (compared to national data), significant swings are more pronounced although not a cause for alarm, as ASPH will be more sensitive to confounding issues.

The following charts provide the full 5 year overview, including a number of useful analyses at the national, regional, local & ASPH levels for comparison;

5yr Deaths ENGLAND

England	FY2012	FY2013	FY2014	FY2015	FY2016
Apr	38,928	46,352	38,729	42,286	43,828
May	41,087	39,475	36,880	36,713	38,695
Jun	34,303	33,503	36,058	39,289	39,361
Jul	36,657	37,260	38,512	37,916	36,453
Aug	36,435	33,322	33,640	33,823	37,989
Sep	32,934	34,350	38,339	38,876	37,720
Oct	40,394	39,585	40,201	39,458	37,828
Nov	39,330	37,322	36,967	38,883	43,509
Dec	39,669	39,974	46,481	42,495	42,434
Jan	49,492	45,929	57,034	44,356	53,640
Feb	41,002	38,566	43,727	42,995	44,767
Mar	41,915	38,573	44,809	45,286	45,544

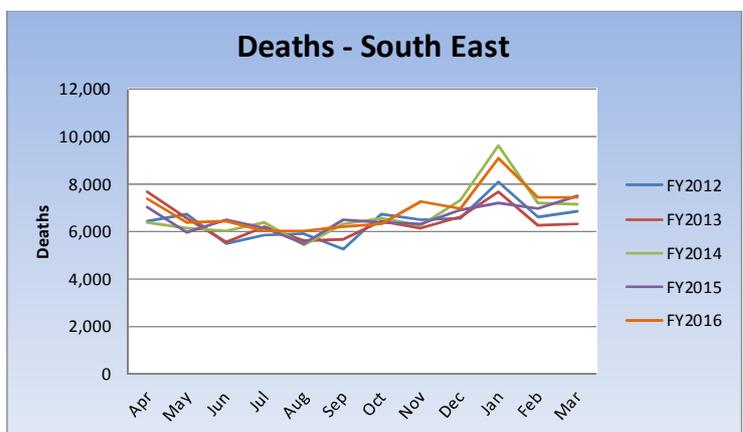
July vs Jan %	47%
Dec vs Jan %	26%
FY16 vs FY15 %	4%
FY15 vs FY14 %	-2%



5yr Deaths SOUTH EAST

South East	FY2012	FY2013	FY2014	FY2015	FY2016
Apr	6,399	7,652	6,359	7,030	7,339
May	6,718	6,534	6,148	5,978	6,347
Jun	5,468	5,539	5,981	6,464	6,431
Jul	5,845	6,168	6,389	6,117	6,006
Aug	5,881	5,620	5,432	5,483	6,038
Sep	5,274	5,651	6,283	6,494	6,163
Oct	6,705	6,419	6,540	6,359	6,302
Nov	6,472	6,104	6,240	6,319	7,261
Dec	6,526	6,578	7,324	6,899	6,931
Jan	8,083	7,683	9,606	7,166	9,042
Feb	6,611	6,266	7,160	6,948	7,399
Mar	6,819	6,326	7,140	7,462	7,399

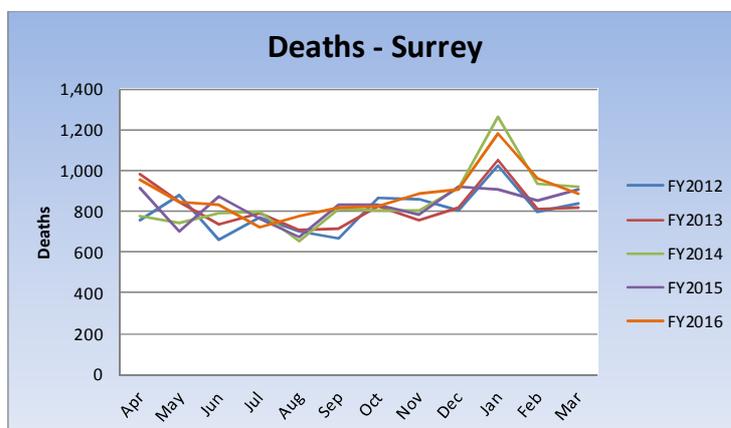
July vs Jan %	51%
Dec vs Jan %	30%
FY16 vs FY15 %	5%
FY15 vs FY14 %	-2%



5yr Deaths SURREY

Surrey	FY2012	FY2013	FY2014	FY2015	FY2016
Apr	754	980	777	915	953
May	879	848	741	704	845
Jun	660	733	787	875	834
Jul	771	793	798	761	724
Aug	698	710	654	676	777
Sep	670	716	809	833	817
Oct	869	826	805	834	826
Nov	859	756	804	781	886
Dec	807	819	913	922	905
Jan	1,025	1,048	1,262	906	1,178
Feb	800	809	934	852	959
Mar	837	817	920	906	883

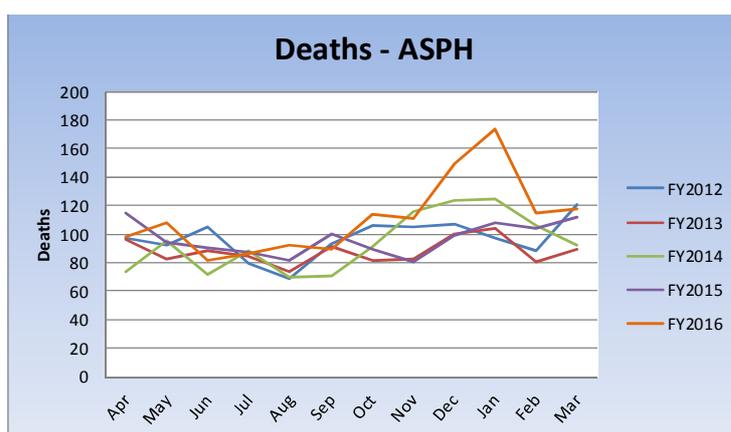
July vs Jan %	63%
Dec vs Jan %	30%
FY16 vs FY15 %	6%
FY15 vs FY14 %	-2%



5yr Deaths ASPH

ASPH	FY2012	FY2013	FY2014	FY2015	FY2016
Apr	97	96	74	115	98
May	92	83	95	94	108
Jun	105	88	72	90	82
Jul	80	84	88	87	86
Aug	69	74	70	82	92
Sep	93	91	71	100	89
Oct	106	82	91	89	114
Nov	105	83	116	81	111
Dec	107	100	124	99	149
Jan	97	104	125	108	174
Feb	88	81	106	104	115
Mar	121	89	92	112	118

July vs Jan %	102%
Dec vs Jan %	17%
FY16 vs FY15 %	15%
FY15 vs FY14 %	3%



As can be seen from the graphs above, ASPH July to Jan increase at 102% was much higher than the national, regional or local levels seen 47-63%. However, ASPH Dec to Jan increase at 17% is much lower than national, regional or local levels seen 26-30%.

Overall, ASPH have recorded a FY16 vs FY15 increase of 15% compared to national, regional or local levels being recorded at 4-6%. Interestingly, ASPH also recorded a 3% FY15 vs FY14 increase compared to national, regional & local levels who reported a decline of -2%.

In-Hospital analysis

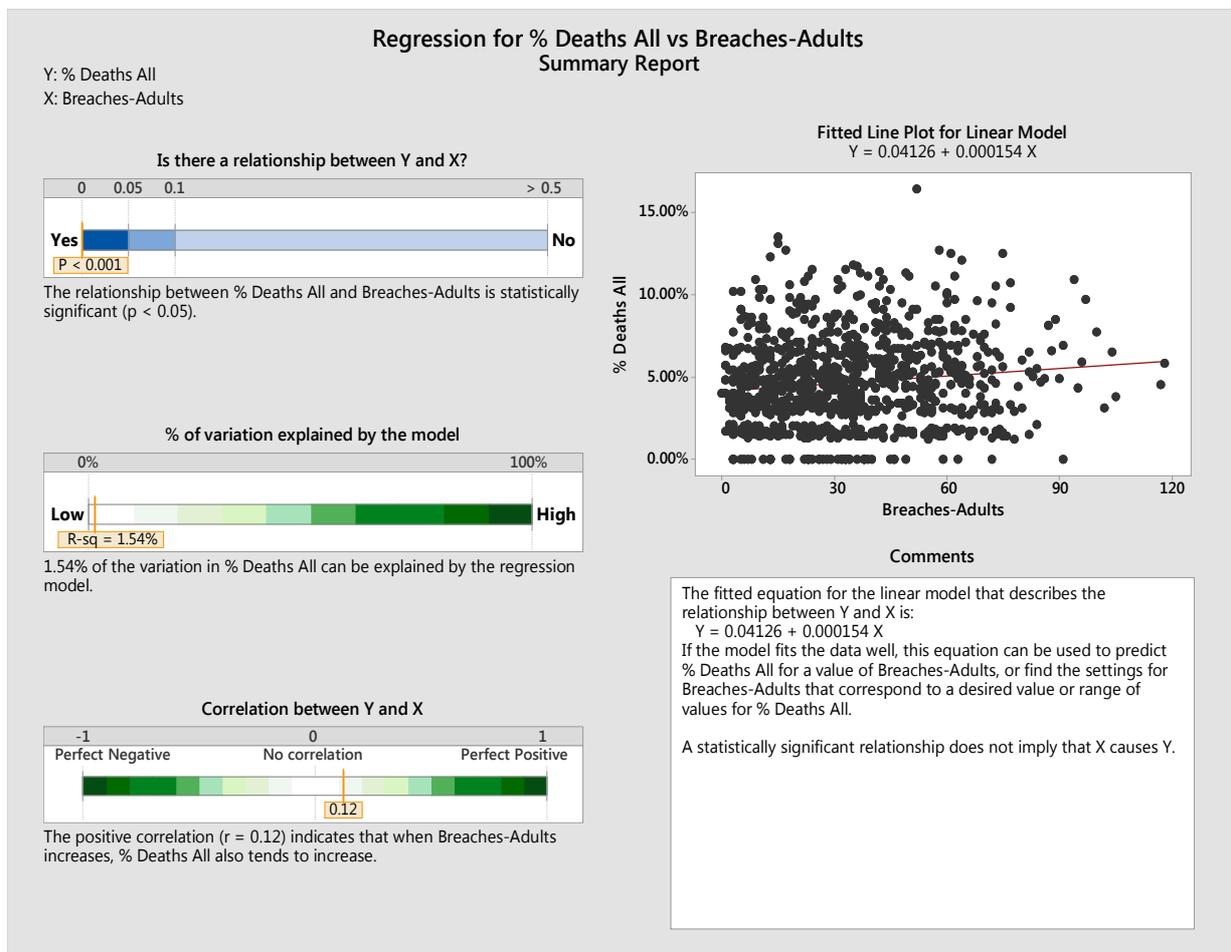
Detailed analysis has been undertaken reviewing many variables to identify correlation &/or causation, including comparison by month & previous years utilising many variables

including but not limited to; Age, Ethnicity, GP, Residence location, Care Home, Ward, Day/Time of Admission, Day/Time of Death, Hospital Consultant, Ward, Condition, & whether re-admitted; however no clear correlation has yet been found.

Significant statistical analysis has also taken place, to determine whether constrained hospital flow leading to delays in ED and being admitted to wards, led to a higher proportion of deaths [Further information: Does Process Flow Make a Difference to Mortality and Cost?, Silvester et al (2014)].

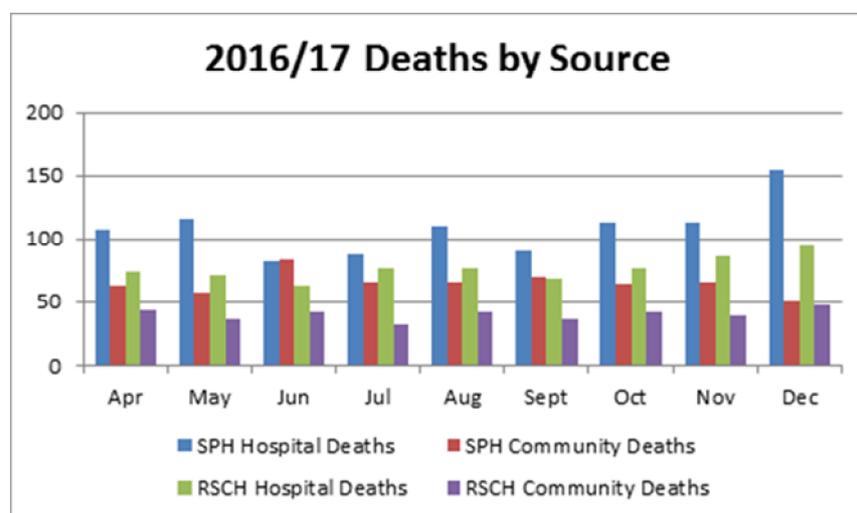


However, the analysis determined that reviewing both daily & 7 day high average number of ED breaches has not led to an increase in the number of patient deaths.



Community: Hospital ratio

We looked at whether the number of deaths that were occurring in the community compared to the hospital had changed. The data is presented below and does indicate that with a rising rate within the hospital there has been a reduced rate in the community – which is at odds to our neighbouring trusts.



It is an observation – but does indicate a change. One explanation may be the reduction in hospice provision which has occurred and/or support in the community.

In-hospital Mortality reviews:

The stated aim is to review more than 90% deaths in the hospital. Last year outturn was 56% of a total of 1082 deaths. So far we have achieved a completion rate of 72% of deaths in January, 70% in February and 61% in March. This does indicate that we need a more robust review process, which has been stipulated nationally. However the Chief of Patient Safety has reviewed the mortality reviews for this critical time and has not uncovered a thematic issue of concern. A further more in-depth notes review is needed to supplement the current mortality reviews.

Next Steps:

The mortality metrics are returning to baseline but it does indicate that we need to follow the nationally mandated process for mortality review and strengthen our learning in accordance with the most recent guidance, [The National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board \(March 2017\).](#) A business case will be presented to the Trust executive Committee (TEC) as it will require investment.

Conclusion:

The Trust has conducted an investigation into the initial concern over the rise in crude mortality, since October 2016, including, but not limited to, liaising with NHSI on this issue.

The statistically significant increase in our mortality rate from December 2016 to February 2017, coupled with significant winter pressures have been drivers to Ashford and St. Peter's NHS Foundation Trust looking closely at operational and practice issues within this time period. The review, thus far, has not singled Ashford and St. Peter's NHS Foundation Trust out from the spike in deaths nationally. Although the variance in mortuary space distribution between hospital and community seems to be greater for us when compared with our peers, a coinciding factor was a concurrent change to hospice configuration in North West Surrey during that time.

The special cause variation in the Trust's crude mortality at this point therefore remains inconclusive. There is no obvious cluster of quality and safety concerns specific to our hospitals with which we can triangulate this spike. However, a further, more in-depth notes review will need to be commissioned to supplement the work that has gone on thus far. The mortality review process is embedded but needs further improvement.

The Board is asked to receive this paper as assurance that extensive analysis has taken place on this issue leading; thus far; to no cluster of quality issues specific to Ashford and St. Peter's NHS Foundation Trust that would have a causative link to the mortality spike observed.

The Board is also asked to note the need for further work to both look into this mortality spike as well as to strengthen our learning in accordance with the most recent guidance, [The National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.](#) National Quality Board (March 2017).