Ashford and St. Peter's Hospitals NHS Foundation Trust

Paper 5.2

COUNCIL OF GOVERNORS
3rd March 2021

TITLE	**Patient Experience Group Report**
EXECUTIVE SUMMARY	The minutes of the meeting of the Patient Experience Group held on 15th February 2021 are attached. Matters discussed in the meeting included: • Quality Report – Patient Experience • Feedback from Patient Panel meeting • Feedback from Group members on recent visits and meetings • Feedback from members to Governors relating to Patient Experience The Group also heard from Christine Redmond, ICU Matron, and Sue Harris, Nurse Consultant in Harms Free Care.
The Council is asked to:	Note the minutes of the meeting of the Patient Experience Group held on 15th February 2021.
Submitted by:	Chris Howorth, Chair of the Patient Experience Group and Appointed Governor for the Royal Holloway, University of London
Date:	March 2021
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS Foundation Trust

Council of Governors

Minutes of the Patient Experience Group
15th February 2020

via Microsoft Teams
15:00 – 17:00 hours

PRESENT:		Neal Adolphus	Public Governor, Spelthorne
		Tom Allan	Staff Governor, Volunteers
		Derek Barnes	Public Governor, Spelthorne
		Lilly Evans	Public Governor, Runnymede, Surrey Heath, Windsor and Maidenhead
		Shirley Holmes	Public Governor, Woking and Guildford
	Chair:	Chris Howorth	Appointed Governor, Royal Holloway University of London
		Chris Marks	Public Governor, Runnymede, Surrey Heath, Windsor and Maidenhead
		Michael Smith	Public Governor, Woking and Guildford
		Danny Sparkes	Public Governor, Runnymede, Surrey Heath, Windsor and Maidenhead
IN ATTENDANCE:		Charlotte Broughton	Head of Patient Experience
Item PEG-03/21		Sue Harris	Nurse Consultant in Harms Free Care
		Andrea Lewis	Chief Nurse
Item PEG-02/21		Christine Redmond	ICU Matron
		Jacqui Rees	Associate Director of Quality
		Anu Sehdev	Membership and Engagement Manager

Minute **Action**

PEG-01/21 Apologies

None.

PEG-02/21 Critical Care during Covid-19

Chris Howorth welcomed Christine Redmond, ICU Matron, to the meeting.

Christine advised that the ITU had been assigned 13 beds and patients requiring ventilation were usually nursed on a 1:1 basis. The Department of Health had asked the Trust to provide 26 level 3 beds during the pandemic and this had proved to be a challenge. During the first wave registered nurses were brought in and undertook a one-week intensive training programme. Staff nurses from wards and theatres were also brought in and provided with a short induction and training. They worked closely with the ITU nurses.

Christine explained the drugs and equipment used in ITU were different to the rest of the Trust. For example, inotropes which provided blood pressure support were used regularly but administered via a syringe which needed to be observed constantly to maintain a continuous supply. Another example was renal filtration which was a very complex procedure.

Christine explained that the main task for the registered nurses brought in was to provide nursing care, i.e. to wash patients, especially eye care and mouth care, as well turning patients regularly.

During the pandemic the Trust had tried to achieve a target of one ITU nurse looking after two patients but there had not been enough critical care nurses to achieve this. The unit had asked junior doctors to join them and they had expressed how much they had learnt from the experience.

Christine advised how during the first wave of the pandemic seriously ill patients with Covid-19 were ventilated and how later non-invasive ventilation had been utilised. During the peak, 26 patients on Aspen were treated with non-invasive ventilation at the same time. Patients were assessed regularly by the outreach team who assisted staff and tweaked oxygen levels where necessary.

During the second wave there were a number of patients that required invasive ventilation and at the peak 31 patients were being treated at the same time. The Trust had to request mutual aid where patients had to be transferred to other hospitals.

Christine advised that it required five to six members of staff to turn a patient and this had to done regularly, which was a challenge when the unit was so busy.

Christine advised that staff were under a great deal of stress especially as a number of patients had died during the second wave. This was a very difficult experience for staff to bear as their aim was to work hard to save lives. Christine added that ITU staff were very proficient in end of life care, for example making patients comfortable and bringing family members in. It had been particularly difficult that family members were unable to be with their loved ones and for staff being unable to develop relationships. There was a clinical psychologist in post now and they provided a forum to share experiences. Christine considered this post would be invaluable when coming out of the pandemic to help staff come to terms with what they have been through.

Christine advised that ITU staff had been worried that they might miss something when looking after four patients at a time. The Chief Executive and Chief Nurse had spoken with staff and provided reassurance that everything staff were doing was for the benefit of the patient.

Christine highlighted that storage was an issue when trying to house 25 ventilators. Coordinating a shift of 30 nurses was also a challenge when having to change in one changing area and meeting social distancing guidance. Chris Bell, Director of Estates, had been extremely helpful in finding other areas for staff to use as changing facilities.

Christine highlighted a junior doctor's remark to a patient which had been overheard by a member of the ITU Team whereby he spoke gently to a patient and said "I am your nurse for the day". This had been marvellous to hear by the nursing staff.

Christine advised that the unit would soon be beginning to de-escalate again and release staff back to wards and theatres so that services could begin to resume.

Christine added that after the first wave staff had expressed wonder at what they had experienced and how they had achieved what they had. The second wave had been much more difficult due to the number of patients presenting but the Trust had learnt a lot during the first wave and was able to manage it better.

Chris Howorth thanked Christine for her moving account of the experiences on ITU.

Tom Allan queried whether the team were able to get the breaks/rest they needed. Chrissy advised that the unit had a core of 41 nurses and in order to have breaks they would need to hold onto the registered nurses longer. Some of the team had managed get a break and the opportunity to have a de-brief with the Chaplains before returning to work. It was intended to hold team days and get everyone involved to allow for team building and the sharing of experiences.

Michael Smith considered that team had done a marvellous job and it was clear that there was increased respect from doctors for nursing staff. Chris Marks echoed Michael's sentiments and added that words were not enough to express his gratitude. Chris Marks queried if Christine was concerned that nurses would reflect upon their time during the pandemic and decide they wanted to retire early or leave. Christine advised that she was not concerned and added that the junior nurses that had assisted in the unit expressed how much they had enjoyed the challenge and how they had realised they were more competent than they had first thought.

Neal Adolphus advised how powerful he had found Christine's account and what a very effective half hour it was. Neal advised that he was delighted there was a clinical psychologist in post and how important it would be to pick up post-traumatic stress disorder (PTSD) early.

Chris Howorth queried whether the team were supported when considering inviting families to the unit. Christine advised that she and her team were indeed supported and agreed it was a great strength of Ashford of St Peter's. There were boundaries but discussions were enabled before decisions were supported.

Chris Howorth queried whether the team was supported emotionally. Christine advised that the work was very challenging and where possible she tried to take the stress away from her team members so that they could concentrate on their tasks. Christine advised that the team did feel supported and although support for mental well-being was offered staff did not always take this up as it was easier to continue instead of stopping and having time to think which was when it really hit home. Christine reiterated that the team would need to be supported when the pandemic was over. The Chief Nurse advised that the executives were already in discussions on how to look after staff and were aware that it would be important to support staff after they came out of the pandemic and for years to come.

Lilly Evans advised that she had been bowled over with learning of the challenge to staff and the issues with storage. Lilly queried whether there were any other issues and if these had been resolved. Christine advised that there had been a concern on the oxygen pressure at one time as so much was being utilised. The Trust had switched to different type of machine which resolved the issue very early on before it became a problem. The outreach team was instrumental in

this change.

Christine shared with the Group a heartfelt poem she had written over the weekend. Tom Allan considered the poem should be shared more widely and published.

The Group thanked Christine for sharing her account.

PEG-03/21 Harms Free Care Team

Sue Harris, Nurse Consultant in Harms Free Care, welcomed the opportunity to share the Harms Free Care Strategy with the Group. Sue advised newer Governors that she had been a Staff Governor previously. Sue had shared the strategy with Group members prior to the meeting and considered that the Trust was very innovative in its thinking.

Sue advised that Harm Free Care could be defined by an absence of the four common hospital associated harms which include pressure ulcers, falls, catheter associated urinary tract infection (CAUTI) and venous thromboembolism (VTE). Ashford and St Peter's also included harms associated with nutrition and hydration.

Sue advised that the Trust was looking for a 10% reduction in falls next year. Sue had met with the Chief Nurse and Associate Director of Quality to finalise an action plan.

Sue highlighted the ways her team was engaging more widely with Trust staff and highlighted the poster that had been developed which provided a pictorial guide as to how patients should be nursed to avoid harm.

Sue explained that as more patients presented with Covid-19 there was an increased occurrence of venous thromboembolism (VTE) and skin damage.

Sue advised the team had had an away day before the pandemic when the team's new badge "Preventing Hospital Associated Harms Together" had been developed.

Sue welcomed the Group's comments especially as the team had been unable to gain patient feedback over the past year.

In response to Tom Allan, Sue advised that the 10% reduction target was on current figures and in response to Chris Marks advised that the Harms Free Care Strategy was aligned with the Trust's Strategy with a finite date of 2023.

Michael Smith referred to the restricting of visitors during the pandemic and queried how this had impacted on patient safety. Sue advised that falls tended to take place during certain times of the day, for example early morning and not during normal visiting times. There had been an impact on nutrition and hydration as visitors were not there to encourage eating and drinking. Chris Howorth queried how the Trust was tackling hydration and Sue advised that a ward had been selected for an audit to ascertain how many drinks patients were consuming. Urine infections, falls, pressure ulcers and dementia were all associated with a lack of hydration and highlighting the importance completing

hydration charts had been emphasised with staff. The Trust was looking at trialling special cups which were designed by a junior doctor where the coaster vibrated/flashed at regular intervals to remind the patient to have a drink.

The Group thanked Sue for her update.

PEG-04/21 Minutes of the Previous Meeting

The minutes of the meeting held on 16th November 2020 were agreed as a correct record.

The updated Action Log was noted.

PEG-05/21 Matters arising

PEG-20/20 - Feedback from members to Governors relating to patient experience - *Danny Sparkes to provide further detail to CB on concerns that was shared with her.*

Danny Sparkes advised that she had heard no further from the member concerned.

PEG-20/20 - Feedback from members to Governors relating to patient experience - *Chris Howorth to provide person's name in the concern shared with him.*

Chris advised that they had not responded to a request to share their name and, therefore, he could not pursue this any further at this time.

PEG-20/20 - Feedback from members to Governors relating to patient experience - *Shirley Holmes to email CB further details regarding concern shared with her.*

Shirley confirmed that she had done so and a positive outcome had resulted.

Neal Adolphus reiterated his request for a committee organisational chart and it was agreed to provide this. **AS**

Tom Allan highlighted the ReSPECT form and how he would like further clarification on the process followed. Charlotte Broughton considered having a member staff attend the next meeting who specialised in this area to go through the process would be a good idea. It was agreed to arrange this. **AS**

REGULAR ITEMS

PEG-06/21 Feedback from Patient Panel meeting

Danny Sparkes advised that the new Patient Panel was now in place and they had met for the first time on 12th January 2021. The first meeting allowed members to go through what they wanted from the meetings. The next meeting would be taking place on 9th March 2021 and the group would meet bi-monthly.

PEG 07/21 Quality Report – Patient Experience

The Chief Nurse introduced the Associate Director of Quality who was responsible for writing the report and highlighted the following in the report:

- Medication safety was back on track
- Infection Prevention and Control was not on track in some areas but reduced from numbers the previous year. An IV nurse was now in post.

The Chief Nurse updated the Group on Covid-19 and advised there had been a few outbreaks in the Trust with a small number of patients and staff being involved. The Trust was in the top 10 for the lowest rates. The Chief Nurse advised that there had been an increase in patient harms and these were due to the pandemic and were around VTEs, clotting, DTIs, deep tissue and pressure damage.

The Chief Nurse advised that the Ockenden Review had been shared with trusts. This report related to West Midland Ambulance Service and maternity services. The Trust had provided feedback and had found it was compliant. The Trust had made an investment in the maternity workforce but it was proving a challenge to recruit to these posts.

Neal Adolphus advised that the reports were becoming much clearer. He was amazed that the Trust was still showing improvements during the pandemic. The Chief Nurse advised that this was a testament to staff and had been discussed in committee meetings when going through the Board Assurance Framework. Tom Allan agreed that the reports were getting better but highlighted some confusion with the tables and agreed to liaise further with the Associate Director of Quality. Tom was surprised that Covid-19 deaths at the peak were similar as the peak for flu the previous year. Chris Howorth considered that people were observing social distancing rules, as having the usual seasonal flu spike as well as a Covid-19 spike would have been disastrous. The Chief Nurse agreed and advised that there had been no cases of influenza in the Trust. Neal also offered to liaise further with the Associate Director of Quality on the reports. **TS&NA**

In response to Chris Howorth, the Chief Nurse advised that improvements had indeed been the result of Covid-19 and increased hygiene. Staff had worked extremely hard to meet targets/improvements.

Chris Marks highlighted that all data appeared in graphs apart from compliments and queried why that was. The Chief Nurse advised that she would look into this. The Associate Director of Quality added that the Trust received a lot of compliments but was not good at transferring data into graphs. JR advised that she would make this a priority. The Head of Patient Experience advised that her team had looked at 400 compliments which had been coded inaccurately and had gone back and recoded. **JR**

Chris Marks queried whether it was possible to access data which highlighted a better utilisation of 111 instead of attending A&E. The Chief Nurse advised that she would take this back to see if this data could be included in reports. **AL**

The Group briefly touched upon incidents.

FEEDBACK

PEG-08/21 Feedback from Group members on recent visits and meetings

None

PEG-09/21 Feedback from members to Governors relating to patient experience

Neal Adolphus advised that one of his constituents had shared feedback when recently undergoing a mastectomy. They were full of praise for the unit but struggled somewhat with remembering how to deal with a wound drain. Although the patient had been advised verbally they found it difficult to recall the conversation and found they could not open the hyperlink provided. It was agreed that Neal would pass on further details to Head of Patient Experience. **NA**

PEG-10/21 Any Other Business

The Group reflected on the death of Bertie Swan who had been Public Governor for Elmbridge as well as a member of the Group. Several conveyed their sadness on her death and how integral she had been as a Governor on the Council. It was agreed that Bertie's time as Governor would be reflected upon at the next Council of Governors' meeting.

Several Governors conveyed how impressed they were on the powerful and insightful account from Christine Redmond.

PEG-11/21 Further meetings for 2021

Monday 12th April
Monday 21st June
Monday 6th September
Monday 15th November

Although meeting rooms have been booked we will continue via Microsoft Teams until further notice.

All taking place 2-4pm

Meeting Date	Minute Ref	Topic	Action	Lead	Due Date	Update	Completed
15.2.21	**PEG 05/21**	**Matters arising**	Provide the Group with a committee organisational chart.	AS	ASAP	Complete	✔
15.2.21	**PEG 05/21**	**Matters arising**	Arrange for a member of staff to go through the ReSPECT process at the next meeting.	AS	12.4.21	Arranged for Dr Nik Shah and Paul Darling-Wills to attend the meeting.	✔
15.2.21	**PEG-07/21**	**Quality Report – Patient Experience**	Tom Allan and Neal Adolphus to liaise with the Associate Director of Quality re quality reports.	TA/ NA/ JR	ASAP		
15.2.21	**PEG-07/21**	**Quality Report – Patient Experience**	Look at highlighting compliments in a graph.	JR	12.4.21		
15.2.21	**PEG-07/21**	**Quality Report – Patient Experience**	Look at whether it was possible to pull off data which highlighted a better utilisation of 111 instead of attending A&E.	AL/ JR	12.4.21		
15.2.21	**PEG-09/21**	**Feedback from members to Governors relating to patient experience**	Neal Adolphus to pass further details to CB with regards to the concern that was raised with him.	NA	ASAP	Complete	✔

Poem for Pt experience of Covid 19

The phone rings on the unit, it's answered with care
Its's outreach here, we need a Dr now!
We have a patient for you
Do you have any beds?
The nurses act fast, the Dr's with speed
The bed space is checked and has everything we need.

Bang goes the door
The alarms can be heard
The patients brought in with what looks like a herd.
The Dr's and nurses are all masked up
Gowns, gloves and visors, not recognisable like this.
The patient looks scared, her eyes tell a tale
Her SATS begin to drop and she looks very pale

Her skin is clammy, her face looks marked
She's had a tight fitting mask and looks visibly scarred.
We welcome her kindly but there are people everywhere
She can barely speak to us and just looks with a stare.

We tell her we must put the tight mask back on now,
We know how it feels as we have tried it ourselves.
Some say it's like putting your head out of the car,
It's difficult to breathe due to the force and the gasp.
She has some sedation, this helps her to cope
We settle her quickly and can only hope.

The bloods are taken and the observations recorded
It's obvious now that this needs to be aborted.
The Dr talks slowly through his tightly fitted mask,
Muffled and sweetly he describes our next task.
He tells her it's the end of this tight fitting mask and in order to save her we must work fast.

She needs to sleep now while we place a breathing tube
It's the only way forward, to give her a chance.
She nods her head terrified, please don't let me die,
We will do all we can is the Dr's reply.

The nurses move fast, drugs, lines and tubes, everything past.
The tube goes in and all looks good at last.
When suddenly we lost output
Not another, not today.

Resuscitation starts with a nurse pressing hard,
On her chest that needs pressure for her heart to re start.

Drugs are given timely and we continue our task.
One hour goes by to save a life that could easily pass.

Her body looks grey, purple and blue
There is no hope now, everyone knew.
At one hour in, the Dr Calls time,
Does everyone agree, this is such a crime.
We stop with great sadness, sorry in our hearts,
Silence surrounds us and movement seems slow.

The Dr calls the family, the fourth of the day
It's an exasperating experience no one wants it this way.
The nurses prepare her with love and with care
Washing and cleaning her for viewing, we prepare.
The family attend, the sadness is felt
The tears and crying felt by everyone around.

Why does this keep happening?
It's cruel and unfair
There needs to be an end
There needs to be a prayer.

Staff leave the unit, broken and sad
Knowing tomorrow is going to be bad.

They are the light in the darkness
Provide hope amongst fear
A connection for families to pass on love to ones so dear.
We can't always cure patients
We've lost too many to count.
This is not what we are used to, as previous to now, the majority of patients survive
They come back to see us
Celebrate their success
Nursed back from illness
Smiling at their best.

It is a difficult time, but hope is not lost.
We are united in our mission to survive.
A life not lost is our purpose and drive.

The sun does go down, but it will always rise!!

By Christine Redmond, ICU Matron

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Harm Free Care

Sue Harris MSc, BSc (Hons), RN
Nurse Consultant in Harms Free Care

Patients first • Personal responsibility • Passion for excellence • Pride in our team

Harm Free Care definition

- Harm Free Care can be defined by an absence of the four common hospital associated harms which include pressure ulcers, falls, catheter associated urinary tract infection (CAUTI) and venous thromboembolism (VTE).
- ASPH include harms associated with nutrition and hydration

Harms Worldwide

- 1 in 10 patients harmed while receiving hospital care (World Health Organization, 2019)
- Patient harm is estimated to be the 14th leading cause of the global disease burden – comparable to tuberculosis and malaria
- Largely associated with HAI, VTE, pressure ulcers, delayed or wrong diagnosis and medication error
- 15% of total hospital activity and expenditure is a direct result of adverse events. The most burdensome include VTE, PU and infections

Harms

- Analysis into Disability Adjusted Life year (DALY) showed the greatest burden was associated with pressure ulcers
- Total excess bed days due to six adverse events,(deaths in low mortality condition, pressure ulcers, central line infections, inpatient hip fractures, VTE, sepsis) was 500,00 per annum
- These bed days equate to £21.3 million
- Average English hospital 2,024 bed days, £617,00
- Estimated up to 15% of patients are harmed more than once

Harm Free Care

- Trust Strategy
  - Quality of Care – creating a learning organisation and culture of continuous improvement to reduce repeated harms & improve patient experience

- Patient Safety Strategy 2019
  - Our vision is for the NHS to continuously improve patient safety

Harms Free Care Team

- Bringing Hospital associated harms together under one umbrella
- Harms are intrinsically linked however often seen in isolation
- Nurse Consultant appointment the first in England
- Strategic oversight
- Clinical role and expertise

Hospital associated harms

- Falls
- Harm associated with nutrition and hydration
- Venous thromboembolism
- Catheter associated urinary tract infections
- Pressure ulcers

Harms Free Care Strategy

- moving away from only counting harms to a more proactive way of working that highlights and celebrates the prevention of harm
- being clear in our message that no patient should come into our care expecting to be harmed
- apologise for any trauma suffered when harm does occur
- learn from incidents of harm to prevent future harm(s)

Harms Free Care Strategy

- Embedding prevention of hospital associated harm in the culture of the organisation
- Working together across the specialisms to remove barriers and enable us to look at common aims and goals to reduce hospital associated harms
- Have one validated measure for each harm
- Have trajectory improvement goals set for each harm at ward, division and Trust level
- Build on the successes already achieved within the individual harms

Harms Free Care Strategy

- Improving falls prevention by reducing the incidence of harm to patients as a result of a fall.
- Improving pressure ulcer prevention by reducing the incidence of avoidable harm from hospital acquired pressure ulcers.
- Improving venous thromboembolism (VTE) prevention by reducing the incidence of avoidable harm from hospital associated thrombosis (HAT)
- Improving “provision” of nutrition and hydration to reduce associated harm
- Improving catheter associated urinary tract infection (CAUTI) by reducing the incidence of harm to patients resulting from CAUTI

Governance

- Harms data displayed in clinical areas
- Monthly Divisional meetings to discuss harms and report on action plans focusing on harms reduction
- Monthly Harm Free Care & Scorecard Corporate meeting
- Sharing of practice and action plans at Safety & Quality

Engagement

- Trust induction
- Introduction of Harms Free Care Coaches
- Members Event by the Harm Free Care Team
- Bi- monthly Harm Free Care Newsletter for staff
- Clinical areas Harms and Quality Boards
- Trust Quality Improvement Programmes

Harm Free Care

Ashford and St. Peter's Hospitals NHS Foundation Trust

Provide care as below throughout your shift

1. EATING & DRINKING:

Offer a drink every waking hour unless contraindicated. Ensure suitable meals and snacks are offered little and often. Consider allergies and swallow risk

2. BREATHING:

Nurse at minimum 30 degrees with knee brace activated to prevent patient slipping down the bed and shearing forces

3. PRESSURE AREAS:

Nurse on an alternating air mattress. Reposition every 2 hours. Elevate heels, use Repose wedge, Repose foot protectors or pillows

Our patients are at heightened risk of harms

4. VTE PROPHYLAXIS:

Ensure enoxaparin (or other anticoagulant) administered as prescribed. Ensure Anti-Embolic Stockings/Intermittent Pneumatic Compression worn as prescribed

5. PRESSURE AREAS:

Ensure Dermal pads under face mask and straps

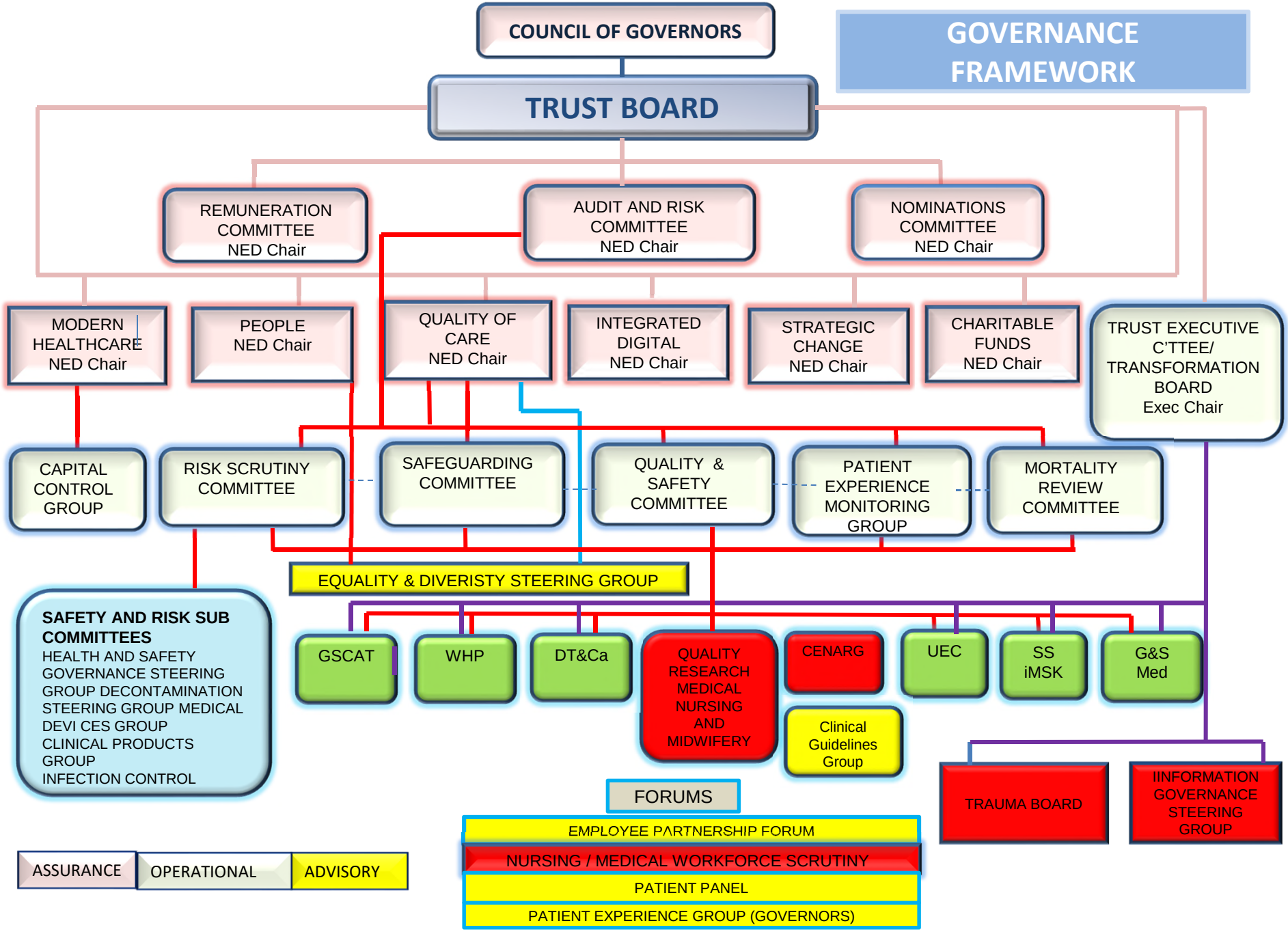
6. FALLS:

Record lying and standing BP. Encourage wearing of well fitting shoes or slippers. Use non-slip socks only when mobilising. Remove when patient in bed

7. CAUTI:

Ensure catheter bag below bladder and off the floor

Preventing Hospital Associated Harms Together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HEALTH AND SAFETY
GOVERNANCE STEERING
GROUP DECONTAMINATION
STEERING GROUP MEDICAL
DEVI CES GROUP
CLINICAL PRODUCTS
GROUP
INFECTION CONTROL
GSCAT
WHP
DT&Ca
QUALITY RESEARCH MEDICAL NURSING AND MIDWIFERY
CENARG
UEC
SS iMSK
G&S Med
Clinical Guidelines Group
TRAUMA BOARD
IINFORMATION GOVERNANCE STEERING GROUP
FORUMS
EMPLOYEE PARTNERSHIP FORUM
NURSING / MEDICAL WORKFORCE SCRUTINY
PATIENT PANEL
PATIENT EXPERIENCE GROUP (GOVERNORS)
ASSURANCE
OPERATIONAL
ADVISORY