

Item 6.1.2a*

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 6th October 2020

Present:

Nick Brooks (Chair)
Sue Pemberton
Raph Perry
Marga Perez-Casal
Mark Jones
Karen O'Hagan

Non-Executive Director
Director of Nursing & Operations
Medical Director
Director of Research & Innovation
Non-Executive Director
Non-Executive Director

In Attendance:

Jennifer O'Brien
Hannah Rooney

Senior Executive Assistant (Minutes)
In Hospital Therapy Lead (Item 6.3 only)

1. Apologies for Absence

No apologies had been received.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of e-meeting held on: 7th July 2020

The Minutes of the e-meeting held on 7th July 2020 were recorded as a true and accurate record.

4. Patient Story

The Director of Nursing and Quality read out the patient story.

5. Action Log

Item 1 – Mortality amongst Welsh Patients

The Committee Chair confirmed that the Committee had received all the necessary feedback. This item would be marked as complete and removed from the action log.

Item 2 – Medication Incidents

The Committee Chair confirmed that the Committee had received all the necessary feedback. This item would be marked as complete and removed from the action log.

Item 3-QPFEC Assurances/Risk Reports

The Medical Director confirmed that the consent audit would be repeated in Q3/4, the outcome of which would be reported to the Quality Committee. This item would be marked as complete and removed from the action log.

Item 4-Dr Foster Dashboard-Mortality Report

The Committee Chair confirmed that the Quality Committee had received all the necessary assurance. This item would be marked as complete and removed from the action log.

6. Quality**6.1 Quality Impact Assessments & Update Report**

There were no issues raised by any member of the committee.

Committee members were assured that progress was being made with the two outstanding items.

**6.2 Quality & Patient Family Experience Assurances / Risk Report
12th July 2020**

The highlights from the July 2020 assurance report were presented to the Committee.

Secure health messaging

The Medical Director (MD) updated colleagues on the assurance relating to Secure Health Messaging (SHM) which resulted from a recent deep dive into discrepancies between the SHM weekly statistics and what was actually recorded in the department. The team was reviewing the whole process and looking into the option of a completely different system for alerting from radiology.

Readmission action plan

The Associate Medical Director (AMD) for medicine will be presenting a detailed report on the readmission action plan to the QPFEC in December 2020. The Medical Director confirmed that the actual readmission rate was reasonable and many of the requirements of the action plan from 12 months ago had been implemented; however no real feedback had been received and the QPFEC required an update on what actions were complete and what, if any, were still outstanding.

Radiology Q1 report

The Medical Director commented on the radiology report which had an amber assurance rating. Committee members were informed that, as a best practice, discrepancy and event meetings should take place on a regular basis in order to review any disagreements with the interpretation of investigations and to provide constructive feedback. The Trust had

established the meetings about 18 months ago and good progress had been made, but the reports now needed to contain a more detailed outcome analysis to ensure that feedback was included. Colleagues were assured that there was a clear process in place for feedback and to ensure that recommendations were followed

CUSUM curves

A question was raised over the surgical CUSUM curves on consultant mortality rates. The Medical Director confirmed that he and the divisional AMDs reviewed the curves and, as part of the Trust's performance management policy, would meet with any consultant outlier in order to discuss any necessary actions to restore their performance. It was noted that, by nature of the statistical process, negative curves took a long time to reflect improved practice. The MD reminded colleagues that the Trust has adopted tighter confidence intervals than are utilised nationally such that LHCH picked up any issues earlier than the National Society.

Quality Committee colleagues were informed that the Euro score is an internationally validated method for risk stratifying patients prior to surgery. The disadvantage is that the validation is only for coronary procedures and, since the Trust uses it for all operations including aortic surgery, its overall predictive accuracy is limited. The MD confirmed that the Trust recognises these limitations, and acknowledged the additional difficulty in determining whether a higher than predicted mortality might reflect the performance of more complex cases which would carry a higher mortality rate than that predicted by the score. The MD asked colleagues to note that emergency procedures are not included in the data, which relate only to urgent and elective work.

The Director of Nursing & Quality outlined the highlights of the September 2020 report.

Delirium

The main issue related to delirium. The Deputy Director of Nursing had made a presentation to the QPFEC which would be shared with Quality Committee members in due course. An emerging pattern of an ever-increasing rate of aggressive behaviour necessitating more frequent involvement of safeguarding colleagues was described. The Quality Committee was informed that numerous factors were contributing to the problem; in particular patients with complex needs such as alcohol and drug dependency, compounded by frequent and potentially disorientating moves within the hospital, and Covid, which precluded the presence of relatives to support the patients. The result was that the Trust is encountering an increase in the number of patients with paranoia, hallucinations and suicidal ideation, resulting in considerable pressure on the clinical workforce.

It was reported that in the last 12 months 375 patients had had some form of delirium and between April and August 2020, 91% of the referrals to safeguarding related to delirium, low mood, and other mental health issues. Abuse of staff by patients is a considerable problem and examples of these types of behaviour were provided to Committee colleagues. It has been recognised that a new approach is required; a delirium lead is now in place, and the Director of Strategic Partnerships is to lead a delirium group to bring selected colleagues together with

Merseycare and the Trust's Mental Health Lead to review the changing pattern and identify new ways of working to manage it more effectively. Work is progressing on an SLA with Merseycare to put a plan in place as early as possible for patients presenting with mental health issues.

Quality Committee members were also informed that discussions were taking place on additional support from the LHCH in-house psychology team for patients and for staff.

The Executive team had acknowledged that new procedures were required and had accordingly ascribed a red assurance rating.

Quality Committee colleagues would welcome further information on the plans to be put in place to address the issue.

SP

Resuscitation

The Director of Nursing & Quality confirmed that whilst the resuscitation report stated that all actions had been completed, it would have been more accurate to have stated that they were in progress. Extensive improvement work had been done, including on staff training, and the completion of the recommendations in the external review would be monitored.

Medicines Management

The MD confirmed that the Chief Pharmacist is in the process of reviewing the new policy of warfarin administration at 2pm rather than 6pm, as the INR results were frequently not back in time, resulting in a delay in making the prescription.

6.3 Stroke Service Quality & Annual Assurance Report 2019/20

The In-Hospital Therapy Lead joined the meeting to present the highlights from the annual report.

Quality Committee members were informed that the Trust had experienced a year on year increase in the number of inpatient strokes, which is attributable to the increasing number of patients with multiple co-morbidities and risk factors undergoing complex procedures.

The results of the patient satisfaction survey results were included for the first time in the report and the question was raised as to how the team planned to address the few less positive results; in particular concern that the diagnosis was often not explained to the patient and relatives by a doctor. The In-Hospital Therapy Lead explained that although there was 24/7 access to the Royal Liverpool, discussion with the patient relied on local colleagues. Usually this took place after the stroke MDT and was often deferred to the therapy team. The team, however, is very conscious that this conversation should be undertaken by a doctor.

The In-Hospital Therapy Lead pointed out that conversations about a patient's long-term aftercare should not be conducted at a time when it is too early to anticipate how far they were likely to progress in their rehabilitation.

It was agreed that the questionnaire would be reviewed to decide if any changes in format or question content could be made better to align it with the patient care pathway.

Quality Committee members had previously suggested that it would be valuable if information on the late outcome of stroke patients could be collected, and this had been taken up by clinical colleagues. It was, however, not feasible to collect the information with the existing staff and clinic facilities. It was suggested that there might be better commitment if this were to form the basis of a research project of which the Director of Research & Innovation would be fully supportive. The MD would liaise with the AMD for the surgery division to encourage involvement from the surgical team.

RP/MPC

The Chair acknowledged the high standard of care delivered by the therapies team and the strong assurance provided by the audit results.

The Director of Nursing & Quality expressed huge gratitude to the Therapy Lead and the entire therapies team.

The In-Hospital Therapy Lead left the meeting.

6.4 Clinical Quality Performance Report – Month 5

The Director of Nursing and Quality and the Medical Director presented the Clinical Quality Performance Report for month five, focussing on the amber and red indicators.

A query was raised relating to HSMR all diagnoses which was showing a score of 171.84 in August yet remained rated green. The Director of Research & Innovation agreed to review how the RAG rating was scored and to report back to colleagues at the next meeting.

MPC

The following indicators were highlighted to the Committee:

- Mortality reviews was slightly below target for August; however, the YTD figure was acceptable. The MD would discuss the August figure with AMD colleagues.
- There was one C.Diff case on Cedar ward in August. It was noted that there had been some gaps in the documentation resulting in the patient not being isolated quickly enough; this issue had been picked up by the senior nurses
- The first avoidable pressure ulcer this year, on Cedar ward. Investigation disclosed insufficient documentation of regular skin inspection and learning had been communicated to staff
- The MD had written again to the lead of the ACS Group for the network regarding primary PCI as most of the issues related to ambulance and A&E triage which LHCH could not control. It was noted that rectifying these delays was a long-term process as NWAS was experiencing additional extreme pressure during the pandemic. It was thought probable that the local commissioners would remove the 120-minute call to balloon target from the dashboard.

- The Director of Nursing & Quality informed Quality Committee members that the poor response rate to the patient experience survey was at least in part the result of the increased workload on the ward staff and the recent ward reconfiguration taking place together with other pressures. It was also noted that there had been IT issues due to the increasing age of the ward iPads. Colleagues were informed that the Chief Digital & Information Officer was aware of the issues and an upgrade forms part of the digital strategy.

The positive work on falls and pressure ulcers was acknowledged by the Committee as were the excellent results recorded regarding sepsis.

The MD provided an update on the recent Coronavirus outbreak on POCCU and Cedar ward (which was confined to one bay). It was confirmed that several patients and staff had been affected, and more positive tests were seen over the weekend. The Director of Nursing & Quality and the CEO had held discussions over the weekend on how to respond, and the entire Executive and Senior Leadership Team met on Monday 5th October to discuss the matter further. The usual infection prevention and control processes were put in place immediately, with deep cleaning of the affected areas, re-segregating wards and asymptomatic testing of the affected staff groups. On Monday 5th October 2020 it was decided to stop all urgent or non-elective surgery (apart from cancer work) and further options were considered in order to make the hospital even cleaner and safer.

Quality Committee colleagues were informed that two staff members had come into work when they were showing symptoms and subsequently tested positive. The Senior Leadership Team had reinforced the message that it would be a disciplinary issue if colleagues come into work when they have Covid symptoms. It was also confirmed that spot checks on adherence to the rules in non-clinical areas, such as staff rooms, would be taking place.

As of Tuesday 6th October, temperature checking on arrival at work has been in place in all departments. The importance of wearing masks has been re-emphasised, and the social distancing rules were also reviewed, ensuring that the signs on the doors contained accurate data relating to capacity. Staff breaks were taking place in a much more structured fashion and daily hand hygiene audits by matrons and ward managers were being carried out. Silver command were meeting daily to consider the measures that had been put in place and to review the audits of the day. The possibility of staff changing their masks from blue to white to signal when they were on a break was being considered.

The MD explained that the number of Coronavirus cases in Liverpool continued to rise and it was considered unavoidable that some asymptomatic staff would bring the virus into the Trust from the community. There was a slight discrepancy with the testing site as LHCH wanted to go to five day testing for all inpatients, however, the calls labs were concerned that they would become overwhelmed if all hospitals did that, although due to the small numbers currently at LHCH it was felt that this wouldn't make too much of an impact and therefore discussions were on-going.

Quality Committee members were also informed that fixed transparent screens had been installed in bays across the Trust, and ward staff had been educating patients about not going into another's space. It is now mandatory for patients to wear a mask unless their medical condition precludes them from doing so. The importance of regular cleaning, particularly of toilets and bathrooms, has also be reiterated, with implementation of constant monitoring.

It was noted that the changes described above are linked to the earlier discussions over the decline in the mental health of the patients, highlighting the importance of ensuring that adequate support was in place as soon as possible.

It was confirmed that the outbreak would be reportable to STEIS. The MD did confirm that outbreaks had been seen in many of the hospitals across the North West.

The Quality Committee took assurance from all the processes the Trust had implemented.

7. Clinical Effectiveness

7.1 GIRFT Report Actions & Progress Update

The on-going action plan had been progressing well within the surgical division, with it being noted that certain sizeable elements had taken time to implement.

The cardiology GIRFT was being dealt with on a regional basis, with data from the Wirral still outstanding. The MD was expecting a partial overall view of any gaps in the service across the patch by the end of December 2020.

In relation to the Liverpool Lung Cancer Unit, no specific issues were raised at the recent meeting; however, a full report would imminently be available.

GIRFTs for radiology, intensive care and pathology were anticipated, although delays had been experienced due to Covid. Once these reports were published, the MD would present them to the Quality Committee.

RP

8. Compliance and Regulation

8.1 Quality Risks

The Director of Research & Innovation informed colleagues that since this report was presented to the Board of Directors (BoD) on 29th September 2020, two risk scores had been reduced.

- The faults affecting the Elm ward telemetry have now been resolved
- Actions are now in place to mitigate the risks linked to the loss of diagnostic results in the community

10. Date and Time of Next Meeting

Tuesday 5th January 2021, 11.00am-1.00pm