

minutes

Item 6.1.2a*

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 13th April 2021

Present:

Nicholas Brooks (Chair)
Sue Pemberton
Raph Perry
Mark Jones
Karen O'Hagan

Non-Executive Director
Director of Nursing, Quality & Safety
Medical Director
Non-Executive Director
Non-Executive Director

In Attendance:

Megan Underwood
Michael Filek
Manoj Kuduvali

Personal Assistant (Minutes)
Head of Improvement and Transformation (item 6.3 only)
Associate Medical Director, Surgery (item 7.2 only)

1. Apologies for Absence

Marga Perez-Casal.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of e-meeting held on: 5th January 2021

The minutes were recorded as a true and accurate record.

The Chair raised an issue that had not been included in the action log, concerning the appointment of a second resuscitation officer as recommended in the external review of the service (item 6.4). The Director of Nursing, Quality and Safety (DoNQS) explained that the current arrangement was for the resuscitation leads for Medicine and Surgery to cover the RTO in her absence; however, Dr Joe Mills, Medical Lead for Resuscitation, was preparing a business case for an additional post.

4. Patient Story

The Director of Nursing and Quality read the patient story.

5. Action Log

Item 1 – Quality and Patient Family Experience Assurances / Risk Report 12th July 2020 – This item (research project on late outcomes of perioperative stroke) was to remain on the action log with the date unidentified.

Item 2 – Clinical Quality Performance Report Month 5 –HSMR of 171.84 in August 2020 rated green. This item was completed and removed from the action log.

Item 3 – GIRFT Report Actions and Progress Update – GIRFT reports for Cardiology and Critical Care had been received and presented to the Operational Board in April. They will be reviewed by the Quality Committee after completion of a gap analysis under the QPFEC agenda items. This item was removed from the action log.

Item 4 – Update Serious Incidents – Discussed as agenda item 6.4 and removed from the action log.

Item 5 – Clinical Quality Performance Report – NED complaint reviews were to continue, and the item was removed from the action log.

Item 6 – Clinical Quality Performance Report – This was discussed as part of agenda item 6.8 and removed from the action log.

Item 7 – QPFEC Key Assurances / Risk Report Quality Performance –radiology discrepancy reporting will be brought back to July's meeting.

Item 8 – Dr Foster Mortality Deep Dive – Issues are discussed every three months with the Dr Foster Analyst. The item was completed and removed from the action log.

6. Quality

6.1 Update Serious Incidents

The Medical Director updated colleagues on the serious incidents.

There had been no new incidents since January's meeting. Updates to current incidents were noted as follows:

- Missed renal cancer diagnosis – reformatting of the radiology report forms was yet to be finalised but is intended to include alert information at the top of the report in bold font. To be fed back to the Committee once completed.
- Missed aortic leak – changes to reporting, with over-reporting of fellows and introduction of a protocol for 3D reconstruction of images has been implemented.
- ACHD interventions – a cross-organisational root cause analysis, led by Alder Hey, is being undertaken and there is to be an external review of the ACHD service once the terms of reference have been agreed. It will be led by an adult congenital heart disease specialist from Leeds. Actions in progress include work on integrating the interventionalists at Alder Hey into the LHCH cath. lab. and cross-organisational discussion on training. The Committee received assurance that work was ongoing and that the results of the reports would be presented as a standard agenda item.

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- Patient who took their own life on Cedar Ward – the DoNQS explained that the final report was being delayed by the prolonged investigation involving the coroner and multiple witnesses. When completed it would be submitted to the Board and Quality Committee, but the timescale is unknown. Actions to minimise the risk of a recurrence were described to the Committee.
- Injury to subclavian artery during attempted insertion of a large bore cannula into the subclavian vein. The procedure had been carried out rarely during the Covid-19 pandemic and targeted training would resume with a return to normal operating theatre activities. An update will be brought to July's meeting.

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6.2 Clinical Quality Performance Report

The Medical Director and the Director of Nursing, Quality and Safety presented the report.

Mortality

Mortality was rated green. The Medical Director explained that, contrary to the report, the HSMR data was up to December 2020. The actual mortality rate could be discounted from an assurance perspective because the risk-adjusted rate (HSMR) remained within the expected range.

Work was to be completed on the production of the report and the new dashboard would be finalised at the beginning of May.

Infections

In February one MSSA, one C.Diff., and one gram-negative bacteraemia were reported. All had been reviewed with a mini-RCA. and identified lapses in care continue to be monitored. The targets were being reviewed in light of the extremely low numbers (despite the red ratings), and below the previous year. MSSA, however, requires continuing focus.

Falls and Pressure Ulcers

YTD there had been four hospital-acquired pressure ulcer attributable to a lapse in care.

Falls were fewer than in the previous year, although this could, in part, be attributable to the pandemic. There had been no avoidable, but two unavoidable, falls in February.

Reported Patient Safety Incidents and Medication Errors

The number of patient safety incidents was lower than during 2019/20. The DoNQS planned further work on the reporting culture across all areas.

There were six medication errors in month, and 211 YTD, reflecting about 25% of all patient safety incidents, none of which had resulted in severe harm or death. Insulin prescription and administration was the subject of

intensive efforts by the diabetic team. Approximately 28% of surgical patients and 18% of medical patients were diabetic.

A meeting between the Chief Pharmacist and the Deputy Medical Director had been held under the safety agenda to reconsider the focus on and display of medication errors.

The Medical Director and the DoNQS emphasised the importance of reporting all actual and potential incidents.

Radiology alerts and dementia

The current month dementia-refer score of 0% related to a single case and it was suggested by the Committee that in view of the low frequency it would be preferable for reporting to be numerical rather than as a percentage; a similar argument applies to radiology alerts.

VTE and PCCI

VTE performance was recovering. The main area of concern was the call to balloon time which was discussed as part of agenda item 6.8.

Patient Experience

The Committee noted the excellent results from the patient experience survey.

The DoNQS informed the Committee that, as families were not in the Trust during the Covid pandemic, the FF experience was not operating. Throughout the pandemic the Patient and Family Experience team had been telephoning patients after their discharge and the Trust had received favourable feedback. Complaint numbers had been low for the year.

The Committee received assurance from the report and commended the Trust for the fantastic work throughout the pandemic.

6.3 Quality Impact Assessments (CIP's) & Update Report

The Head of Improvement and Transformation joined the meeting to present the quarterly update on the CIP programme.

As previously reported (April QC), the Trust was fully compliant with the QIA and EIA requirements for the financial year of 2020/21.

Work was underway to identify CIPs for the 2021/22 programme. QIAs had commenced in April and would be completed by the end of June. The Committee observed that, for CIPs not approved until June, the time available for the projects to achieve their planned saving would be reduced. Performance would be monitored by the Integrated Performance Committee.

The Head of Transformation and Improvement left the meeting.

6.4 QPFEC Key Assurances / Risks Report

The Medical Director and the Director of Nursing, Quality and Safety updated the Committee on the QPFEC key assurances.

Primary PCI (see item 6.8), GIRFT and consent were rated amber. A presentation to QPFEC by Mr Dimitrios Pousios on re-sternotomy for bleeding had described the significant work in this area and some improvement (see item 7.2). The presentation would be shared with the Committee for further discussion at the July meeting.

The main area of concern in the QPFEC report was consent. Mr Pousios had presented the re-audit for Surgery; the re-audit for Medicine was to be submitted to May's QPFEC. It was noted that, despite the effort after the three previous audits, (including one by the MIAA), performance had not improved. A robust action plan was to be drafted and would include responsibility for individual consultants to take ownership of the process. In response to a question from the Committee, the MD explained that consent for procedures was not a responsibility for junior doctors.

The Committee took assurance from the importance attached to the issue and of the proposed actions for improvement.

Further updates were to be provided at July's meeting.

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6.5 Quality Committee Annual Report

The report had been approved by the Audit Committee. It was a long document but there was a deliberate policy to include details of all major categories of the Committee's responsibility.

The Quality Committee approved the report.

6.6 Quality Committee Workplan – For Approval

The Quality Committee approved the workplan.

6.7 Quality Committee Terms of Reference – For Approval

The report was approved with all amendments.

6.8 Update on PPCI Service

The Committee's longstanding concern over the time delay between the call for help and performance of the PPCI procedure in patients with heart attacks was addressed in a presentation by the Medical Director. The Liverpool performance was placed in the national context with data obtained from the British Cardiovascular Intervention Society (BCIS). The main points were as follows:

- The call to balloon time was increasing in all UK centres.
- A major cause was the change in ambulance service priority for chest pain.

- In addition the number of calls had increased, due partly to acceptance of patients with out of hospital cardiac arrests (OOHCA).
- The Liverpool/LHCH performance compares favourably with other centres, particularly with door to balloon time.
- The in-hospital and 30-day mortality was higher in patients re-perfused >150 minutes from the call, but for many this delay was attributable to additional factors associated with a high mortality, such as OOHCA.

A possible solution to prolonged delays between the onset of a heart attack and its treatment by PPCI is known as the 'pharmaco-invasive' approach: patients with an anticipated long transfer time are treated with thrombolytic therapy by paramedics on their way to the PPCI centre. It is used widely in France, with evidence that it mitigates the heightened risk associated with long call to balloon times. The MD explained that this could not readily be adopted in the UK where, unlike in France where delays are predictably associated with long distances to specialist centres, in the UK the delays are usually a consequence of the pressure on the ambulance service and heavy traffic in urban areas. The Committee accepted that the issue could be resolved only by a national policy change and received assurance that the LHCH service performance remained excellent.

The presentation was to be circulated to the Quality Committee.

7. Clinical Effectiveness

7.1 Dr Foster Mortality Deep Dive

There had been no change to the conclusions drawn from the discussions held by the Committee in January. It was explained that 'highlights' and 'alerts' did not point necessarily to preventable deaths. Discussions with Dr Foster will continue in the attempt to reduce the number of such false alarms.

There was no time for further discussion.

7.2 GIRFT report - actions and progress update (Surgery)

The Associate Medical Director for Surgery joined the meeting to present a further report on the progress of GIRFT.

The Division had maintained its focus on the GIRFT action plan, where feasible, throughout the Covid pandemic. Good progress had been made with further development of the aortovascular service.

Progress on day of surgery admission (DOSA) had inevitably stopped during Covid-19 because of the necessity for pre-operative screening of

elective patients. Similarly, cancellations had become more difficult to manage with the predominance of emergency cases during this period. Good progress, however, has been made on re-sternotomy for bleeding. and the Committee were pleased to note the progress on the development of aorto-vascular service with LUHFT.

Accurate data on stroke severity and outcomes has proved to be difficult to obtain. The Division is investigating the possibility of collecting data from the stroke physicians' database. Additional work was being carried out for aortic surgery to assess the impact in this high-risk group of patients. Discussions with the therapy team were also on-going. An update will be brought back to Quality Committee at a future meeting.

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The Associate Medical Director for Surgery left the meeting.

8. Patient and Family Experience

8.1 Patient and Family Support Team Annual Report

The marked reduction in complaints was noted and the Committee noted that the outstanding performance of the Family Liaison team.

Assurance was provided over all aspects of the report.

No formal discussion took place due to over-run of the allotted time.

9. Compliance and Regulation

9.1 Quality Risks

Quality Committee noted the report and there were no further questions.

10. Date and Time of Next Meeting

Tuesday 20th July 2021, 11am-1pm, Microsoft Teams