

Item 5.1.3a

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 1st October 2019

Present:

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

Non-Executive Director
Director of Nursing & Operations
Non-Executive Director
Non-Executive Director

In Attendance:

Manoj Kuduvali
Michael Filek
Helen Martin
Laura Forrest

Associate Medical Director (Item 7.1)
Head of Financial Strategy (Item 6.2)
Risk (Item 8.1)
Personal Assistant (Minutes)

1. Apologies for Absence

Marga Perez-Casal and Raph Perry.

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest to record.

3. Patient Story

The Director of Nursing and Operations read the patient story.

4. Minutes of the Previous Meeting held on 9th July 2019

The minutes of the previous meeting were agreed as a true and accurate record, with just a couple of minor adjustments noted by the Chair.

5. Review of Action Log

All previous actions were reported complete at the meeting on 9th July and no further actions were noted. However, the Chair would like to understand the £143k costing for the new drug application (item 6.3 quality committee 9th July) and will speak with Raph Perry.

6. Quality

6.1 Clinical Quality Performance Report

The Director of Nursing and Operations presented the Clinical Quality Performance Report and the Committee focussed its discussion on the main exceptions:-

Mortality Reviews within 30 days (doctors) – The Director of Nursing and Operations highlighted the progress made during the last three months though the amber status emphasises the need for improvement

Infection Prevention

Three reportable infections (19 YTD) were recorded in August, all of which were subject to a RCA. Learning in relation to MSSA is focussed on cannula care, with audit having highlighted lapses by doctors associated with poor documentation. Although the target infection rate has been exceeded, the target is low and the Committee was assured that no upward trend is apparent. The committee noted that it would be helpful to have a statement in the report outlining the clinical circumstances of the gram negative bacteraemias; the Director of Nursing and Operations will discuss this with Raph Perry.

Falls - One avoidable and five unavoidable falls had occurred in August. It was brought to the committee's attention that the Deputy Director of Nursing and Quality (Joan Matthews) is undertaking a review of bathroom temperatures as excessive warmth may be a contributing factor.

Pressure Ulcers – There were no pressure ulcers in August. In the YTD six avoidable ulcers have been identified. The Committee was assured that there were no overall concerns around pressure ulcers; the number remains exceptionally low and all cases are reviewed by the tissue viability team and reported to the DNO.

Safety Incidents –The number of reported patient safety incidents, dominated by potential medication errors, has remained stable. Of the 21 such errors reported in August, prescribing was numerically the highest category. None had resulted in severe harm. The DNO mentioned, however, that the Acting Chief Pharmacist (Danny Forrest) suspects that medication errors remain under-reported. The Committee noted the continuing focus on training and that every detected incident is recorded on Datix, raised at safety huddle and followed up. It was also noted that the reporting is three months in arrears and the Acting Chief Pharmacist is working to improve the schedule in order for the information to be reviewed in a more timely manner.

Mixed Sex Accommodation, Complaints and Clinical Claims – No

mixed accommodation breaches have been reported YTD.

Two serious incidents (both from the Medicine Division) and a clinical claim occurred in August. The committee was assured that all serious incidents continue to be subjected to RCA and the report submitted to the Board of Directors.

VTE and PPCI – In-hospital PPCI performance, assessed by the 95% 90 minute ‘door-to-balloon’ target, continues to be exceeded. However, the internal, 120 minute, ‘call-to-balloon’ objective has consistently been missed and, during July and August, the Trust failed to meet the national 150 minute target. As discussed at previous meetings of the Committee it was reiterated that the failure is caused by external factors within the Ambulance service beyond the Trust’s control; the issue has been raised repeatedly with the Commissioners and the Regional ACS Group.

Sepsis - Whilst there has been some improvement, the key indicators; in particular use of the sepsis screening tool and blood cultures taken within 24 hours of starting treatment, are still unsatisfactory.

The Committee noted the continuing efforts, led by the sepsis team, to improve performance: weekly audit with continuous feedback to each team; intensification of the education programme for junior doctors during induction, and further development of the EPR to improve documentation, including that of other key aspects of management: lactate measurement and administration of a fluid bolus

Patient and Family - The Director of Nursing and Operations shared the report on patient and family experience which is very positive with, in particular, the 99.8% positive response to the question “Would you recommend this hospital to your family and friends”

CUR compliance – The Director of Nursing and Operations talked through the CUR compliance data. The trust is consistently below target based on 90% occupancy, and for 85% occupancy in August, due predominantly to delays in critical care. NHS England has implemented a deadline for achievement of this objective.

Quality Priorities - Quality priorities is work in progress, and should be finalised by the end of 2019.

There are currently four priorities:

Priority 1 - Delirium pre-op screen to be completed on admission for surgical patients (target 85%)

Priority 2 - Cedar Ward to have 75% of its patients discharged by 4pm and Elm Ward to have 69% of its patients discharged by 4pm.

Priority 3 - Patients with visual and/or hearing impairment to be identified on admission and to receive a risk assessment and care plan. Nurse teams are in place to focus on vulnerability and Deaf Awareness training is due to take place in a few weeks. A Council of Governors special interest group is engaged on these issues and will be consulted on the desirable improvements

Priority 4 - Reduction of medication errors for insulin and drugs administered by infusion (target 10% reduction from 2018/19).

CQUINNs - Three high impact actions to prevent hospital falls not implemented. The DNO reported that this resulted from failures of documentation since the actions are not reportable on EPR.

6.2 Quality Impact Assessments Update Report

The report was presented by the Head of Financial Strategy (Michael Filek) who introduced himself to the committee and explained that he will be taking over from Lynda Robinson (Head of Quality Improvement). The Trust is on track to deliver of the CIP programme, which is monitored monthly by the BTSG. The QI Team continues to have responsibility for managing and reporting the QIA process.

The report provided a status update on the number of QIAs that have been reviewed and approved by the Business Transformation Steering Group (BTSG), and signed off by the Medical Director and Executive Director of Nursing and Quality or their delegated deputy, as per the established protocol.

Of the 42 schemes requiring a QIA, 34 have been signed off, of which 32 have been approved by the BTSG. Of the remaining ten, eight are in the process of approval and two are pending. None of the QIAs to date have identified an adverse quality impact and none has required a formal EIA to be undertaken.

There was a discussion concerning the BTSG which has now evolved into the Finance and Performance group (F&P). The Committee asked to see the new Terms of Reference.

The relevance of BTSG minutes to the Quality Committee was questioned and it was agreed that further discussion should take place as to the need to see those of its successor, the new F&P group.

Action: Terms of Reference to be shared with Quality Committee

6.3 Quality & Patient & Family Experience Committee Assurance Summary Report from 12th July and 6th September 2019

The Director of Nursing and Operations informed the committee that the Trust is losing its Patient and Family support Manager (Lisa Gurrell) to the Walton Centre. The committee expressed the view that her departure will be a great loss to the team and wished her well in her new role.

The Director of Nursing and Operations presented the Quality and Patient Family Experience Committee Assurance Reports from 12th July and 6th September 2019. The following areas were noted:-

CQUIN and Quality Performance –

- ✓ Pressure ulcers: slight rise in numbers although no harm to patients (see also item 6.1).
- ✓ Rise in falls for July – mostly unavoidable – confusion a common theme (see also item 6.1)
- ✓ CQUINs achieved with the exception of patient safety in relation to falls, there was a further discussion with regards to the falls screening that was put into EPR until Quarter one; no money will be lost as a result.

Following discussions with other trusts, the time of warfarin administration has been changed from 6.00pm to 2.00pm. It is anticipated that this will improve

the timeliness of administration and reduce delays to patient discharges. Monitoring will be undertaken to assess the success or otherwise of the new protocol.

It was noted that, currently, there are no major issues facing the QPFEC, but the next meeting will address a deep dive into mortality statistics. A further update on the quality strategy will be presented to the Operations Board in November.

7. Clinical Effectiveness

7.1 GIRFT report actions and progress update

Manoj Kuduvali presented an update on progress by the Surgery Division in relation to the Getting It Right First Time (GIRFT) quality improvement action plan.

The report displayed positive results in relation to reduced cancellations with an overall downward trend during the last 12 months to a level roughly half of that in 2018. The main reasons for cancellations are:

- ✓ Lack of POCU beds
- ✓ Emergencies taking priority
- ✓ List overruns
- ✓ Overnight emergencies
- ✓ Clinical Cancellations

Cancellation data are reviewed and presented weekly at Operational Performance and monthly at the cardiac business meetings to allow colleagues to analyse the leading themes and maintain the momentum for improvement. MJ stressed, however, that the LHCH cancellation rate already compares favourably with other cardiothoracic centres. .

The committee discussed the complexities associated with patient cancellations.

Other areas of good progress included day of surgery admissions (DOSAs) which had now been extended to essentially all elective cardiac and thoracic cases and pooling of cases which has had a positive effect on the referral to treatment (RTT) performance indicator.

It appears that the previously noted outlying one-year mortality after lung cancer resection is related to shortcomings in risk adjustment, but further investigation of this issue is to be undertaken.

The committee commended the excellent work and achievements over such a short space of time.

8. Compliance and regulation

8.1 Quality Risks

Helen Martin (Lead for Risk and Safety) presented an update on the corporate risk register and reported that a new risk was reported in August in relation to the requirement for a software upgrade for the MRI scanner. Funding for the work has been approved and it is anticipated that the risk will be resolved in due course

The Committee noted that all other scores on the risk register remain static.

Following discussion, it was agreed that verbal updates to the Committee are generally satisfactory provided that formal reports can be available when more detail is required.

The committee was assured that implementation of the Risk Management policy continues to be in place, with all managers responsible for ensuring their risks are reviewed monthly at divisional level and that any escalation of risk follows the correct protocol.

ACTION: Interim Director of Research & Innovation (Marga Perez-Casal) to report back to the Committee on resolution of the MRI software risk.

9. Minutes for Information

Approved BTSG Minutes held on:

✓ 23rd May 2019

The Committee received the minutes for information; there were no comments.

Date of Next Meeting

Tuesday 7th January 2020, 11:00 – 13:00, Research Room