

minutes

Item 5.2.2a*

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 7th January 2020

Present:

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

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

In Attendance:

Megan Underwood
Danny Forrest
Hayley Kendall

Personal Assistant (Minutes)
Acting Chief Pharmacist (Item 7.3 only)
Chief Operating Officer (Item 6.2 only)

1. Apologies for Absence

There were no apologies to record.

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest.

3. Patient Story

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

4. Minutes of the Previous Meeting held on 1st October 2019

The minutes of the previous meeting were agreed as a true and accurate record.

5. Review of Action Log

Item 1 – Terms of Reference – The Committee agreed that the business of the Finance and Performance Group (formerly the BTSG) is not of direct relevance to the Committee and, accordingly that the minutes of the PFG do not need to be included in the Quality committee agenda. This item was completed and removed from the action log.

Item 2 – MRI Software challenge – The new software is now in place and the item removed from the action log.

6. Quality

6.1 Clinical Quality Performance Report

The Director of Nursing and Quality presented the Clinical Quality Performance Report and the following issues were discussed.

Mortality

For the month of November, the Trust was rated red for mortality reviews within 30 days for medical staff. The Medical Director assured the Committee of the on-going efforts to complete the reviews in a timely manner but since some cases were referred to the MRG, which meets only monthly, it is often impractical for these to be completed within the 30 day target. The Committee suggested that it would be more informative for actual numbers, rather than percentages, to be reported.

Infection prevention

One isolated *C.Diff.* infection was reported in November but none had occurred in the preceding three months. A single MRSA bacteraemia also occurred in November. All infection prevention measures are in place including the recent introduction of UV light for deep cleaning whenever possible. All infections are rigorously investigated. The Committee accepted the assurance provided by the low rate of infections and the improving trend over the second half of the year.

Falls

There were six falls during November; seven more YTD than at this time last year. Two of the six were judged to have been avoidable. In response to a question the Director of Nursing and Quality explained the definition of an avoidable vs. a non-avoidable fall. The Committee was assured that a review is undertaken of every fall in order that any learning can be acted upon.

Four hospital acquired pressure ulcers occurred in November, but there had been none in the preceding three months. Only one of these was judged to have been avoidable (category 2) and the learning has been discussed and shared.

Radiology alert

All targets were met for the month of November.

Complaints

The Committee noted that for the month of November there were two claims, bringing the YTD total to 16.

Call to balloon

The internal 'door to balloon' times for primary angioplasty remain consistently excellent but 'call to balloon times' have actually deteriorated. This is a national issue related in part to the new category 2 transfer time imposed by the ambulance services. The Committee noted that dialogue continues with the commissioners, NWS and through the network group and nationally through the British Cardiac Society.

Sepsis

The Medical Director explained that the current emphasis for improvement in management of patients with suspected sepsis is for appropriately timed blood

cultures; this slipped to 79% in November but YTD is 82% against the 95% target. Administration of the first antibiotic dose is now consistently within or better than the target times; this is of greatest importance in the highest risk patients and the MD plans for this group to be analysed and reported separately.

The Committee noted the evidence of progressive improvement in the management of suspected sepsis and the on-going educational efforts to ensure it is sustained.

Patient and Family Experience

The Trust has met all targets both for the month of November and YTD with good response rates and high levels of approval.

CUR

The first 2 quarters have been passed with the quarter 3 data ready to be submitted.

The Committee noted that the CQIN for high impact actions to prevent falls was rated red, with the result that funding had been withheld for Qs 1 and 2. The DONQ explained that this was due to absent documentation, and that compliance with the standard is anticipated now that the information is included in the EPR.

Quality Priorities

The progressive improvement in the rate of risk assessment for delirium, with the November figure of 84.2% against the 85% target was noted.

The targets for patients to be discharged by 4pm were set by the commissioners, despite representations by the Director of Nursing and the Medical Director that these are not currently achievable. It was suggested that the setting of an internal target might be helpful in focussing further efforts to improve the discharge process.

The Director of Nursing outlined the work being undertaken to identify patients with visual and or hearing impairments, and to undertake a risk assessment and formulate a care plan on admission. Numerical data would be available for future meetings.

For the month of November, there had been no medication errors associated with IV infusions or insulin. The Committee noted that there is continuing focus on education and training relating to these highest risk areas of medicines practice.

No concerns were expressed about the mortality data but the Committee requested future clarification over the graphical presentations; in particular why points marked 'special cause – concern' or 'special cause – improvement' appeared within the confidence limits for the expected range.

6.2 Quality Impact Assessments Update Report

The Chief Operating Office presented the Quality Impact Assessments report.

Only two of this year's 39 QIAs are outstanding: the funding for a cancer support worker had been granted at month 6 and a QIA/EIA is urgently required; and the ticagrelor to clopidogrel CIP had been abandoned by the medical division.

So far none of the QIAs have identified a quality impact or, accordingly, the need for an EIA.

The Chief Operating Officer concluded with information on the 2020/21 CIP programme; as of the trust-wide meeting on 13th January, the target is for 80% to be completed by the end of February 2020.

6.3 Quality & Patient & Family Experience Committee Assurance Summary Report from 8th November

The Director of Nursing and Quality presented the Quality and Patient Family Experience assurance report and the following were noted.

All assurances have been rated as green but the Committee questioned the absence of completion dates for the proposed actions. The Director of Nursing and Quality assured the Committee that all reports and action plans are discussed by the QPFEC group and that full reports can be made available to any member of the Committee wishing to see them.

Whilst the customer care report was rated as green, it was noted that the main theme highlighted within the complaints data related to waiting times. The Committee was informed that extra clinics have been arranged in order to address this problem.

The Chair asked how the Medicine and Surgery Divisions were progressing with the issue of fasting compliance. The Director of Nursing informed members that improvement is still required of the Medicine Division and that telephone calls are now being made to patients the day prior to admission to reiterate the instructions regarding fasting. The Surgical Division has already shown considerable improvement.

7. Patient Safety

7.1 Mortality among Welsh Patients

The Director of research and Innovation presented the results of the investigation into the report by Dr Foster, received by the BOD in September, of an excessively high mortality for Welsh patients undergoing elective coronary artery bypass grafting. The Dr Foster data could not be confirmed; indeed the mortality among Welsh patients was slightly lower, though not significantly, than among those from England.

The Director of Research and Innovation is due to meet with Dr Foster in January and will provide feedback to the Committee.

MPC

7.2 Annual reports on Incidents, Complaints and Claims (ICC)

The Director of Research and Innovation presented the annual report on incidents, complaints and claims and the following were noted.

Quarters 1 and 2 had seen a decrease in the number of complaints, while receipt of new claims had seen an increase. Monthly learning and sharing meetings continue to take place and organisational learning has been incorporated into the monthly team brief meeting. The top 5 reported incidents were in the categories of:

- medications
- communication

- administration
- medical devices – a high number of incidents had been reported in theatres and critical care, the two areas with high use of medical devices in which user error/user damage was a consistent theme.
- documentation

Four Serious Incidents were reported during Quarters 1 and 2, one of which was an attempt to insert a pleurocentesis needle into the wrong side of the chest. This was reported as a Never Event, and the Heads of Nursing for Surgery and Clinical Services have met with Liverpool CCG to review it.

Members of the Committee were pleased with the report and complimentary of how the Trust follows up on complaints.

In response to a question about the process for booking out-patient appointments it was explained that the majority of new patients are given dates at the time of referral through the Choose and Book system. The main problem relates to the long waiting list of follow up patients for the ACHD service, which is being addressed.

7.3 Medications Incidents

The Acting Chief Pharmacist presented the Medications Incident report.

The Trust has a good record for monitoring and learning from medication incidents, that has resulted in a number of demonstrable system improvements. A recent Quality Improvement project resulted in several key changes to the way the Trust is able to process incidents in terms of data quality, the reporting platform and cascading and learning from incidents.

It was noted that the great majority of medication errors were graded as minimal or no harm.

The Acting Chief Pharmacist informed the Committee that the reported number of incidents was comparable to that from Papworth Hospital, which has a similar bed base and case-mix to LHCH. However, he believes that significant under-reporting exists, in particular relating to near misses.

As part of the Quality Improvement project, a survey conducted on the barriers to the use of Datix, found that:

- Only 19% of staff thought Datix was well laid out and had relevant fields.
- 70% of staff thought the Datix fields were too complicated.
- 30% found completion to be too time consuming.
- 56% of staff have reported all incidents but 44% have reported only those they consider to be significant.

The Trust continues to encourage the reporting of all near misses. It was noted that an MDT has been established to discuss all reported incidents, enter the information onto a dashboard and circulate to the Executive team on a weekly basis.

Finally it was noted that compliance with medicines management training was poor among theatre staff, and 0% for practical assessments in both theatres and the cath labs. The Director of Nursing and Quality undertook to discuss this with the respective managers.

SP

Overall, the Committee accepted assurance of good medicines management in the Trust and commended the plans for further improvement in incident reporting and analysis.

7.4 EXCEL study

The Chair provided the Committee with background information regarding the recently published EXCEL study and consequent concern that some LHCH patients with high-risk coronary artery disease might not be receiving the most appropriate treatment. The Medical Director explained that LHCH had been a contributor to the study; that such patients are relatively few in number and all are routinely discussed by the MDT, whose members are fully aware of the results of the study and the subsequent controversy.

8. Compliance and regulation

8.1 Quality Risks

The Director of Research and Innovation presented the Quality Risks and the following were noted.

Four static red risks rated above 15:

- A risk to deliver the 2019/20 activity and financial position, due to operational pressures and changes in the pension law for consultants and, occasionally, to POCCU availability. Measures were being implemented.
- A risk to patient safety and effectiveness due to the significant delays in reporting histopathology samples. The Divisional Head of Operations for Clinical Services was meeting with St Helens and Knowsley Hospital to examine potential solutions.
- A risk to the quality of care and to the patient and family experience due to the significant increase in TAVI referrals. The Chief Operating Officer and Divisional Head of Operations for Medicine were monitoring this situation through the monthly Operational Board and the monthly Divisional Performance meeting.
- A risk to the patients on Maple and Birch wards caused by the potential failure of the lifts serving this area.

9. Date of Next Meeting

Tuesday 7th April 2020, 11am-1pm, Research Meeting Room