

Item 6.1.2a

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 7th July 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:

Megan Underwood
Michael Filek

Personal Assistant (Minutes)
Head of Improvement & Transformation (Item 6.1 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 April 2020

The Minutes of the e-meeting 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 Director of Research and Innovation reported a telephone meeting in January with Dr Foster, at which the apparent excess mortality among Welsh patients was reviewed and a deep dive undertaken. No mortality trend or difference in

mortality compared with English referrals was identified. The action was completed and removed from the action log.

Item 2 – Medications Incidents – The Director of Nursing and Quality reported that compliance with medicines management training within theatres had been reported inappropriately; the zero compliance rate related to practical functions, notably TTO management, which are irrelevant to theatre and catheter laboratory staff and for which training is not, accordingly, required. The reporting system will be modified accordingly.

6. Quality

6.1 Quality Impact Assessments & Update Report

The Head of Improvement and Transformation presented the Quality and Equality Impact Assessments (QIAs and EIAs) of the 2020/2021 CIP programme.

CIPs for 2020/21 identified by the end of Q4 2019/20 had totalled £3.329m, a gap of £0.471m from the £3.800m target. However, this had been revised in April in the context of the Coronavirus pandemic to £1.932m, roughly half of the original, based on 21 schemes. At the end of month 2 the divisions were forecasting delivery of 96% of the target but work continues to identify additional plans to deliver 100%; this will be monitored by the Finance and Improvement Steering Group (FISG).

Quality Impact Assessments had been approved for 19 of the 21 schemes by the Medical and Nursing directors and for 18 by FISG. No problems were foreseen for those outstanding; one (CIP203) awaits review by the Operational Board in accordance with the requirement for review of all schemes greater than £250K, and the other was initially paused after concern over the impact of the coronavirus pandemic and has now been reinstated.

None of the Equality Impact Assessments (EIA) on 20 of the 21 schemes identified the need for further assessment. The single outstanding scheme, to be completed by Clinical Services, is awaited.

Questions were raised as to how the programme aligned with the recovery and restart work that had been discussed at the previous Board of Directors, and if the reduction in the CIP programme was related to the QIA process. The Head of Improvement and Transformation explained that with the onset of the pandemic all RAG-rated red schemes had been removed from the plan and the others, following a subjective assessment, were either abandoned or scheduled for consideration for reinstatement as the situation evolves.

In response to questions from the Chair, it was confirmed that the SLA (CIP314) relating to radiology would impact on the Trust's diagnostic waiting time, but that this had been accounted for, and that non-recurrent schemes were considered not to require a QIA because they were used operationally to manage the budget rather than being directed at specific services. The Director of Nursing and Quality added that discussions were being held at the Operational Board on how the Trust would manage budgets for the reset and recovery phase; it was anticipated

that, following the Coronavirus pandemic, there would be significant changes in how the hospital will operate.

6.2 Quality & Patient Family Experience Assurances / Risk Reports

The Director of Nursing and Quality and the Medical Director presented the Quality and Patient Family Experience Assurances / Risk report.

Mortality - The Medical Director explained a misunderstanding in the mortality comment box; the 4.75% mortality was predominately but not solely due to Covid 19.

The Medical Director was asked about the pathway to the Trust of the Coronavirus patients. Very few presented with the virus or developed the illness from cross-infection. More than 90% were transferred directly to Critical Care from other trusts. Their mortality rate was around 34%, lower than the overall regional mortality of around 40%, but the Medical Director cautioned that the difference might be explained by referral bias, in that the very sickest patients could have been judged to be too ill to tolerate being transferred, and, indeed a significant number were managed with only oxygen support and without ventilation.

Sepsis - The Medical Director went on to discuss the on-going problem of the documentation of the timing of blood cultures in patients with sepsis. The Trust continues to focus on this area with intensive training and changes to the EPR, and the position is slowly improving. It was emphasised, however, that essentially all patients are having an appropriately timed blood culture.

MSSA - The Medical Director informed the Committee that the RCA of the single MSSA would be reported at the next QPFEC.

Lung Cancer Clinical Outcomes – It was noted that a report was discussed at QPFEC, but the data were historical, dating back to 2015 to 2017, and the value and relevance of the report was questioned by the thoracic surgeons.

Complaints Report – The number of complaints remained low. The Medical Director complimented the Patient and Family Support team for their timely responses to informal concerns which often pre-empted a formal complaint; and for the management of any that did arise.

NCEPOD – Pulmonary Embolism – Action plan was to be completed. There was nothing further to note.

Acute Kidney Injury Annual Report –Acute kidney injury occurs frequently following surgery, and a screening risk score has been introduced to prompt measures to minimise the risk of patients requiring renal replacement therapy. An audit from 2018/19 had disclosed a risk score calculation for 47% of patients; the intention is for the score to be completed in all patients and this will be audited later in the year

Consent Audit – The Committee shared the Medical Director's concern over the most recent audit that had shown little improvement during the last two years. The issue is considered to be of high priority and the medical and surgical divisions have been asked to develop action plans

for improvement. It was requested that the timeframe for implementation of the plans should be fed back to the Committee.

Diabetes Annual Report - The continuing focus on junior doctor training was noted.

Safe Medication Report – The formation of the medication incident MDT and on-going activities of the Safe Medication Committee were noted with approval.

Tissue Viability – the Director of Nursing and Quality commended the team for their excellent work. During the last year only six pressure ulcers due to lapses in care had been reported. The focus on preventing moisture associated skin damage was particularly noteworthy.

End of Life Report – The report highlighted good audit results against the NICE standards and the national audit. It was noted that more patients were being seen in intensive care; historically, this has been an issue mainly because the period of deterioration before death tends to be short in this environment. Feedback received for end of life care across the Trust was overwhelmingly positive. The team had seen an increase in the number of patients with non-cancer diagnoses, which contrasts with the activity of other palliative care teams.

Missed Medications – The report, on patients with Parkinson's disease, recorded better results than in the 2018 survey. Areas for improvement were the self-administration policy and post-operative planning.

The Chair considered it important to minute the generally excellent work that had been documented in the report.

6.3 Dr Foster Dashboard – Mortality Report

The Director of Research and Innovation presented the Dr Foster mortality report, which covered the 12-month period from February 2019 to January 2020. It highlighted significantly higher rates of crude mortality and relative risk than in peer group hospitals for both acute myocardial infarction (AMI) and in association with cardiac imaging. Moreover, the AMI mortality was notably higher at weekends than on weekdays. These observations were the subject of a deep dive carried out by the Director of Research and Innovation and were discussed in detail by the Committee.

The main findings from the analysis were:

1. Nearly all the patients in both categories (AMI 94/94 and imaging 35/37) were acute admissions on the primary angioplasty pathway
2. 25/94 and 16/37 respectively were not admitted to LHCH and were transferred back to their referring hospital.
3. The deaths were concentrated on days zero and one
4. Of the 91 deaths that occurred in LHCH, mortality reviews identified only a single case with strong evidence of avoidability

The Medical Director explained that the high mortality was among patients who were fast-tracked by the paramedic ambulance service

directly to LHCH following an out of hospital cardiac arrest (OOHCA). In response to the question as to why the LHCH mortality was higher than in the peer group hospitals, he explained that although the acceptance of OOHCA patients for consideration for primary angioplasty is now national policy, the other specialist cardiac centres do so only after triage and discussion with the co-ordinators by doctors at the initially admitting DGH, whereas LHCH admissions are brought directly to the hospital by the paramedic teams. Accordingly, the Liverpool patients were at uniquely high-risk, as exemplified by the high number who underwent only an imaging procedure based on which further active treatment was considered to be futile. An additional factor likely to affect the mortality disparity between LHCH and centres in the Southeast of England – The Royal Brompton and Papworth Hospitals – is the very much higher deprivation score in the Northwest. Moreover, whilst LHCH has a higher proportion than others of patients with no recorded Charlson comorbidity score, this is likely to be a reflection of the severity of illness among the patients, many of whom would be in extremis, and unable to provide information to complete the score.

In response to the excess mortality at weekends, the Medical Director pointed out that staffing for AMI admissions was essentially the same on weekdays and at weekends, and that the observation was most likely to reflect random variation. He also mentioned that requests to transfer patients from A&E units were more often made by junior staff at weekends, resulting in a higher number of inappropriate – and hopeless – referrals. The Director of Nursing and Quality added that as part of the recovery programme a consultant ward round, seven-days a week, had been established.

These explanations were acknowledged by the Committee, together with assurance that care at LHCH did not account for the mortality disparities, though the difference between LHCH and general hospitals (such as Oxford, Blackpool and Manchester) to which OOHCA and other profoundly sick patients would be brought by the ambulance teams and coded as MI, even if not then entered on to a cardiac pathway, remains, to some extent, unexplained.

A concern was raised about the potential for less than optimal end of life care for patients brought to the Trust, not having a procedure, and being immediately discharged with some, potentially, dying in the ambulance. Though not ideal, this is the established policy and most such patients would be within the last few hours of life and unaware of what was happening to them; others would have been receiving care in a different trust for co-existing severe illness.

The Committee accepted assurance from these discussions and noted that the issues would continue to be reviewed.

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6.4 Clinical Quality Performance Report – Month 2

The Director of Nursing and Quality and Medical Director presented the Clinical Quality Performance Report for month two.

Two indicators were highlighted:

- Primary PCI call to balloon time
- Mortality

All other indicators were rated as green, including reportable infections, avoidable falls, pressure ulcers caused by lapses in care, radiology alerts and dementia assessments and referrals.

Call to balloon time – As at previous meetings of the Committee, the consistent failure to achieve the external 150 minute or internal (and European Society of Cardiology standard) 120-minute call to balloon targets for primary PCI was again highlighted. The delay is attributable to external factors: delay in patients calling for help, the time for the ambulance to reach the patient and bring them to the hospital and, for some patients, their decision to take themselves to the local hospital rather than to call an ambulance. It was noted that once an ambulance arrives with the patient the paramedic assessment and journey to hospital is usually a slick operation, and the subsequent delay to revascularisation is commendably short in most cases. When, rarely, there is a delay in transporting a suitable patient to the catheter laboratory, thrombolysis may be administered. The Medical Director assured the Committee that the ACS Network group was well sighted on the issue, which is known to have a direct impact on the mortality from myocardial infarction.

The Chair acknowledged that the matter can be resolved only at system level and asked if it would be possible to ascertain the performance in other parts of the country. The excellent performance within the Trust was, again, commended.

Mortality - The Medical Director took the committee through the mortality data. The YTD mortality of 3.21% was mainly Covid 19 related, either as the direct or a contributory cause, and accounted for about 60% of deaths in Critical Care. With the declining number of Covid patients in the Trust it is anticipated that mortality will continue to fall over the coming months.

7. Patient Safety

7.1 Annual Report Clinical and Audit Effectiveness Strategy

The Director of Research and Innovation presented the annual report of the Clinical Audit and Effectiveness Group and the Clinical Quality Forward Plan for 2019-20.

The Committee noted the support the group had provided for completion of all mandated national audits, documentation of CQUINs, and in demonstrating compliance with directives from NICE and NCEPOD; the evaluation of new technologies, mortality reviews and learning from deaths; and data quality and completeness.

The Committee noted the assurance provided by the excellent work of the group and the Director of Research and Innovation was asked to pass on their appreciation to the Research team.

8. Clinical Effectiveness

8.1 Mortality Review Annual Report (to include review of cusum curves)

The Medical Director presented the Mortality Review Annual Report.

It was noted that the average HSMR of 118.4 was driven by acute myocardial infarction and diagnostic cardiac imaging as discussed in item 6.3. The risk-adjusted mortality rate for cardiac surgery was 1.09 and the MACE rate for non-primary PCI was 0.07. The revised mortality reduction strategy is now in place. The Committee had nothing further to note.

8.2 Infection Prevention Annual Report / Covid-19 update

The Medical Director presented the Infection Prevention Annual Report.

The annual report was dated to the end of March and hence it included data on only 12 cases of Covid-19, three of which were considered to have been acquired in the Trust. The Q1 report, to be presented to the Board of Directors at the end of July, would address Covid issues along with the six-point plan.

There had been a small cluster of surgical site infections, all of which had been reviewed and would be discussed at the next Infection Prevention meeting; the surgical site infection prevention working group had been re-established. The number of infections with 'alert' organisms remained low and all cases were thoroughly investigated. Of note is that there had been only a single case of MRSA infection attributable to the Trust during the year. Audit activity, education and training, environmental hygiene, antimicrobial stewardship water safety and decontamination activities were noted together with the on-going work on sepsis to improve the documentation of timing of blood cultures.

The report provided assurance that all areas of infection prevention were being thoroughly addressed.

9. Compliance and Regulation

9.1 Quality Risks

The Director of Research and Innovation presented the Quality Risks.

It was noted that 40 risks currently scored 12 or above, but this was a significant improvement from the previous month (June) when 56 risks scored at or above this level. Pooling of risks of a similar nature resulted in a total of 29. The majority were Covid related and there was:

- 1 new risk
- 0 risks with an increasing score
- 16 risks with a static score
- 9 risks with a decreasing score
- 3 risks which had been closed:
 - Issues around reporting MRI scans
 - Turnaround times for histopathology samples
 - Issues around anaesthetic support

The Trust had continued to monitor and manage the risk, working with the Divisions and Corporate Services to ensure appropriate assurance.

A question from a member of the Committee concerning the high score of risk C10376 – risk to safety of patients, staff and visitors due to failing emergency lighting – was explained as being because, although a priority, it had not been signed off by the Capital Programme group; the Director of Nursing and Quality stated that this would be addressed within the next few months.

The Chair invited comments from the Committee on the conduct of the meeting. A member approved of the opportunity to submit questions and reflections in advance, and there was unanimous agreement that this was a helpful innovation which should be continued when face to face meetings resume.

10. Date and Time of Next Meeting

Tuesday 6th October 2020, 11.00am-1.00pm, Research Meeting Room
