

## Item 6.2.3(ii)

### Quality Committee

### minutes

#### Minutes of the Quality Committee Meeting held on Monday 29<sup>th</sup> October 2018

##### Present:

Nicholas Brooks  
Mark Jackson  
Mark Jones  
Sue Pemberton  
Raph Perry  
Marion Savill

Non-Executive Director (In the Chair)  
Director of Research & Innovation  
Non-Executive Director  
Director of Nursing & Quality  
Medical Director  
Non-Executive Director

##### In Attendance:

Lesley Hughes  
Lynda Robinson

Executive Office Manager (Notes)  
Head of Project Management Office  
(Item 6.3 only)

#### 1. Apologies for Absence

There were no apologies for absence.

#### 2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest to record.

#### 3. Patient Story

The Director of Nursing & Quality (DoN&Q) delivered the patient story.

The committee noted that although a negative story had been requested previously there were none to present. The DoN&Q proposed the review of a complaint but it was noted that these were considered by the Non-Executive Directors through the complaints review system. It was therefore agreed that these would not be required.

#### 4. Minutes of the Previous Meeting held on 24<sup>th</sup> July 2018

The minutes from the previous meeting held on 24<sup>th</sup> July 2018 were reviewed and the following were noted:

Page 3 VTE and PPCI should read “CTB” (call to balloon time).

LH

Page 5 second paragraph, line 5 to read “MEWS” and not NEWS.

LH

Page 7 item 7.1 Annual Complaints Report, final bullet point: Total complaint contacts for 2017/18 stood at 358, 153 of which were informal concerns and were resolved before being formally escalated. The DoN&Q informed the committee that contacts were not formal complaints; they were the number of contacts dealt with and resolved by the patient and family support team. The remaining 205 contacts were relating to requests for advice/information and are detailed within the quarterly reports.

Themes:

- Appointment/procedure enquiries.
- Access to health records enquiries.
- General Information about the hospital.
- Enquiries about Robert Owen House/Charity.
- Car parking.
- Communication issues.

Members of the QC agreed the amendments and the remainder of the notes were approved as an accurate record of the proceedings.

## 5. Review of Action Log

Item 1: The low reported rate of adverse events associated with PCI between November 2016 and March 2017 had been highlighted at the previous meeting of the Committee. The Director of Research & Innovation (DoR&I) confirmed that the figures reported were correct. He also informed the committee that there was a rigorous major adverse cardiac events (MACE) meeting in place which was attended by the interventionists where robust debate, adjudication and verification of the figures took place.

At the request of the Chair, comparative data would, if available, be provided for future reporting. In the meantime the original action had been discharged and would be removed from the Action Log.

MJ

Item 2: An update on the PPCI internal target to ‘call to balloon’ time was reported by the Medical Director (MD); the committee noted that the information was provided within the quality dashboard (item 6.1 within the main agenda referred with a detailed commentary provided by Dr Nick Palmer). Work was underway to improve both door and call to balloon time, noting that the main delays in call to balloon times were due to external factors e.g. ambulance timings and delays in A&E units.

The committee also noted that the occasional door to balloon time delays were due mainly to more than one PPCI patient arriving close together.

The committee was assured that the Trust, while recognising the pressures on the ambulance service, is working with the service to expedite the transfer of patients to the catheter laboratories. Activity and the on-call rotas were also being reviewed in relation to the high level of

PPCI activity occurring out of hours and at weekends.

It was agreed that the item had been updated and, since future reporting would continue to be monitored through the Clinical Quality Performance report, it could be removed from the Action Log.

Item 3 Quality Priorities: included in the Quality Strategy, item 6.2 of the main agenda refers. The item had therefore been discharged and would be removed from the Action Log.

Item 4: The mortality reduction target required resetting by the Mortality Review Group. The MD reported that work is in progress to assess the impact on mortality of the high risk MDT.

The committee noted that the action plan presented previously to the Board of Directors was being implemented. Progress would be reported to the Board at its November 2018 meeting with actions concluded in early 2019; a further update report would be presented to the Committee at its January 2019 meeting.

Item 5 Patient and family experience vision: to be reported January 2019.

**SP**

Item 6: A copy of the standard letter to bereaved families that had been agreed with consultants had been circulated to committee members in August 2018. An update on the final agreed process would be provided by the DoQ&N at a future meeting. The current action had therefore been discharged and would be removed from the Action Log.

**SP**

Item 7: The DoR&I had been asked to explore options to monitor the high-risk referrals associated with the increasing number of requests for a surgical second opinion. He reported that a monitoring system is now in place. The action was therefore discharged and would be removed from the Action Log.

## **6. Quality**

### **6.1 Clinical Quality Performance Report**

The DoN&Q presented the Clinical Quality Performance report and the salient points were noted as follows:

CPE: Reported one case in month which was not LHCH acquired, and 13 YTD against a target of three. There had been three LHCH-acquired cases YTD (none in month). It was noted that the Infection Prevention Team has a plan in place to ensure that all possible prevention measures are being applied. The MD reported that although no definite proof existed, a reservoir of CPE was suspected since the 3 cases were of the same strain. An additional concern was that ultra-violet deep cleansing might not be being applied sufficiently often and this was being addressed.

The committee discussed the re-emergence of mycobacterial contamination of operating theatre water coolers. All LHCH systems had been replaced within the previous 18 months and underwent a deep

cleaning process every two weeks. Forty potentially exposed patients had been re-called and all were reported negative. At present there were no indications as to the source of contamination, but a thorough investigation was being undertaken.

The committee discussed escalation to the risk register but the MD advised that, since all appropriate actions were in place, this was unnecessary at this stage.

Falls and Pressure Ulcers: The committee noted the low number of falls and pressure ulcers.

Patient Safety Incidents: The DoN&Q informed the committee that the information reported was incorrect and that this would be addressed by the information team.

The committee noted that a considerable amount of work had been done to categorise the medication errors and that a more detailed report was available to the divisions.

Radiology Alerts & Dementia Find/Assess/Refer: The timely response to radiological alerts had improved (92.1% YTD; 96.5% in month) and further support for the process was under development.

Mixed Sex Accommodation, Complaints, Clinical Claims and SE/NE/AE: The committee noted that there were no mixed sex accommodation breaches in September 2018.

VTE & PPCI: Reported within the action log, item 5 above refers.

Sepsis: For patients with indications of sepsis, the appropriate taking of blood cultures prior to antibiotics being given remained below the satisfactory standard. The percentage of patients receiving at least one sepsis antibiotic within one hour and three hours were also reported below target for the month. However, 92% of patients YTD did receive their antibiotic within three hours, which is only slightly below the national standard of 96%.

The committee noted the on-going development of the EPR to enable further supportive documentation for monitoring key aspects in the management of sepsis.

Face to face sepsis training in all ward areas and an e-learning package are available to promote the elimination of sepsis management 'off-bundle'.

Inpatient and Family Experience; inpatient, outpatient and community were noted as very good with all areas reported above target.

Delirium, Complex Mental Health, Frailty: The DoN&Q reported satisfactory progress and highlighted the key priorities, namely:

- Delirium screen completed on the Risk Assessment document on admission for surgical patients.
- Patient shadowing ratio for corporate areas was low, the target of

365 was being driven by the Heads of Nursing within the divisions.

- Risk assessments on admission for patients with complex health needs were progressing well.
- Patients were being asked on admission if they would like a family/carer to participate in the delivery of care by identifying a care partner, and this was reported as being well received.

CQUINS & SDIPS Financial Year 2018/19: Reported green overall indicating that the Trust is on track to achieve against the prevention of ill health by risk behaviour and offering advice and guidance within the first quarter.

The remainder of the report was noted.

## 6.2 Quality Strategy – for information

The committee noted the Quality Strategy which was circulated for information.

## 6.3 Quality Impact Assessments Update Report

The Head of Quality Improvement (HoQI) was in attendance to present on the progress of the Cost Improvement Programme (CIP) and Quality Impact Assessments (QIA) for 2018/19.

The executive summary within the report provided an update on the cost improvement programme process and specifically the QIAs that were required to be undertaken. QIA's that had been reviewed and approved by the Business Transformation Steering Group (BTSG) were presented to the Quality Committee for assurance.

There were 46 CIP schemes currently identified within the 2018/19 programme requiring a QIA, of which 41 have QIAs approved (details of schemes approved after the July's QC were noted in the appendix). One scheme, recently identified in month 6, has a QIA outstanding.

The QIA's had also been reviewed by the Equality Impact Assessment (EIA) review team where additional information to support EIA assessment for 5 QIAs was requested and provided; it was confirmed that none of the CIP schemes required a full EIA.

The 4 QIA's below were delayed; the committee were informed that the Medicine division were to discuss the QIA's further at their governance meeting which would then be presented to the BTSG in November 2018.

- Eff345- Recycle Platinum and other Cath Lab consumables (£25k)
- Eff326- TAVI income (£46k)
- Eff367- Pension Opt out (£59k)
- Eff369- Savings of Redesign of CF Homecare equating to £198k were identified within the division and were terminated

following the service provider withdrawing from the market.

QIA schemes were completed for all current 2018/19 CIPs over £25k; none of which required a full EIA.

The committee noted the content of the report and received assurance from the QIAs presented.

The HoQI left the meeting.

#### 6.4 Quality and Patient and Family Experience Summary Report

The committee received the reports presented by the DoNQ with supporting papers that had been circulated under separate cover. The following salient points were noted:

Mortality Performance: Discussed previously in the meeting (Item 4 above refers).

Medication Errors: The committee noted there had been an increase in medication errors within pharmacy and on the wards relating to the discharge medication processes, but that these were being addressed through training and an update to the Medicines Policy. A member of the Pharmacy team would be invited to attend the January 2019 meeting to present an update on the progress.

Radiology: The improvement on the alert compliance was noted. The MD was working with the Associate MDs to address the scan reporting pressures; reporting times were now being reported to the Divisional Governance committees.

The committee noted that a CQC Radiology Review report had been presented to the Executive Group which benchmarked the Trust against the CQC review of radiology reporting published in July 2018.

Serious Incident: The summary report referred to the gabapentin incident; a full report was provided, agenda item 9.1 refers.

WHO Checklist (Surgery): The committee noted the continuing improvement of performance within surgery.

Resuscitation Training: Following a review by the Learning & Development Department, proposals to improve the key elements of training across all disciplines had been agreed.

Standardised Bereavement Letter: Reported in item 5 above. The process was yet to be agreed.

Interim Cancer Annual Report 2018/19: Cancer performance had improved and funding for two cancer support workers had been agreed.

Patient Safety Alert – Resources to Support Safe Bowel Care: The alert highlighted the need for a Safer Bowel Care Policy; plans were in place to develop this by January 2019.

SP

PFEC Annual Report: The committee discussed the schedule around the PFEC Annual Report and it was agreed that a copy of the report would be circulated to committee members and brought to the January 2019 meeting for review.

SP

## 7. Key Reports

### 7.1 Getting it Right First Time: Progress Report

The MD presented an update on the progress made by the Surgical Division following the implementation of the improvement action plans May – June 2018 (Item 7.1a).

Following the visit by the national GIRFT team on the 27th September 2017, the Division had selected 12 key areas across thoracic, aortic and cardiac surgery which the report highlighted as potential areas for improvement. A summary of the action plans was included within the main report; they would be implemented throughout the course of 2018/19 and Q1 2019/20. Specific issues discussed by the committee included:

Assurance that the post-operative stroke rate was being investigated and that the outcome would be reported to the January 2019 meeting. The committee noted previous assurance that the Trust has a high quality stroke service and is meticulous in its reporting of accurate information. The AMD for Surgery would be invited to attend the next meeting together with the head of physiotherapy to review the stroke related elements within GIRFT.

RAP

Concerns in relation to the coding of complications were now resolved.

Patient Pathway and Bed Management: An action plan had been developed to reduce the number of cancellations and improve procedure scheduling. The report set out further processes in place to support the objective, including analysis of lead themes for cancellation and introduction of surgeon of the week within cardiac and aortic surgery to ensure consultant review of all inpatients and management of urgent referrals.

Day of Surgery Admission (DOSA) : To improve on the rate of day of surgery admissions a pilot had been implemented in August 2018 for suitable elective cardiothoracic patients.

Return to Theatre: Rates appeared higher than the national average. A clinical audit was in progress covering the previous 12 months to identify trends and areas for improvement. Whilst it is important to minimise the number of patients requiring re-exploration after heart surgery, the MD emphasised the dangers of delaying the return to theatre for patients with evidence of continuing bleeding.

The committee noted that progress on the action plans was being presented bi-annually from July 2018 to the Surgical Audit Day, and would also reported to the Board of Directors.

## 7.2 Mortality Alerts

The DoR&I presented the mortality alert report following notification from Dr Foster of two alerts in relation to coronary atherosclerosis and coronary artery bypass. The committee noted that a detailed review of mortality data had been undertaken and a comprehensive report had previously been presented to the Board of Directors.

Discussions followed around comparative data, the shifts in the case mix and the mortality improvement work that was being done within the Divisions. The committee accepted the report, that the Trust responded to all alerts and took assurance of the active management of mortality in cardiac surgery and specifically CABG (other).

## 8. Clinical Effectiveness

Nothing to report this period.

## 9. Compliance and Regulation

### 9.1 Serious Untoward Incident: Gabapentin

The MD presented the findings from the root cause analysis (RCA) following a labelling error in pharmacy which led to a patient taking a higher than prescribed dose of gabapentin over a 24 hour period.

The report set out the background to the incident and appended detail on the investigation identifying that a safety process involving the dispensing robot had been bypassed.

As a consequence safety procedures for dispensing and checking drugs within pharmacy have been reiterated with all staff. The discharge process on the ward has been re-emphasised to ensure the correct procedure is followed prior to a patient leaving the ward.

The committee was informed that lengthy discussions had been held between the MD, DoN&Q and Chief Pharmacist, noted that the medication system would be incorporated into the development of EPR, and accepted the findings of the RCA.

### 9.2 Corporate Risk Register

The DoI&R presented the Trust's Corporate Risk Register by circulation of a document which set out the static red (score 15 or above) and amber risks. The committee noted that the level of risks had not increased during the monitoring period and that colleagues had previously had sight of the information as this was incorporated into the Chief Executive's report presented to the private Board of Directors meeting.

The following were noted:

- HRG4+: The Welsh Commissioners had not agreed to the contract offer; accordingly the risk to the income and future



financial stability of the Trust is unchanged.

- Strategic development of the business intelligence function (re-named CIO) had commenced; a reduction in the risk rating was expected.
- Safe prescribing within EPR. The clinical decision support system was not suitable for use within the UK (based on a USA model).
- Safe and timely treatment of Welsh patients: The Trust had noted a temporary improvement in the service following engagement with Welsh providers, but had subsequently experienced a decline, causing delays in treatment for urgent and elective patients. The committee noted that an alternative strategy was in place.
- National diagnostic waiting time target: Consistent underperformance caused by an increase in demand and limited reporting capacity resulting in an overuse of outsource scanning. A new CT/MR scanner business case had been approved with expected benefits from February and May 2019 respectively.
- 2018/19 Financial Plan: Shortfall in the cost improvement programme, impact of devices payment restructure, pay award and recruitment issues.
- Breaches of 18 weeks RTT driven principally by surgery, due to lack of capacity, growth of the waiting list and late referrals.
- Consultant Anaesthetist Recruitment: Reduced staffing capacity due to retirements in anaesthesia and inability to recruit. The service had considered all possible options and reviewed anaesthetic processes, and is actively exploring recruitment and service support.
- Patient Administration Policies and Governance: The risk was under review by the Risk Management Group and was expected to reduce.

All risks rated amber were noted by the committee.

#### **10. Approved Minutes for Information:**

BTSG Minutes held on 25<sup>th</sup> June and 23<sup>rd</sup> July 2018 were noted.

#### **11. Date and Time of Next Meeting**

Tuesday 22nd January 2019, 09.00-11.00, Research Meeting Room

**ALL**