

Quality Committee

minutes

Minutes of the Quality Committee Meeting held on Tuesday 2nd April 2019

Present:

Nicholas Brooks (Chair)
Sue Pemberton
Raph Perry
Mark Jones
Marion Savill

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

In Attendance:

Lynda Robinson
Gillian Gow
Helen Martin
Janet Deane
Sue Sutton
Karen O'Hagan (Observing)
Debbie McEllenborough
Megan Underwood

Head of Quality Improvement (Item 6.3)
Chief Pharmacist (Item 8.4)
Risk & Safety Lead (Item 9.1)
Clinical & Audit Effectiveness Manager (Item 8.1)
Out of Hospital Therapy Lead (Item 6.5)
Non-Executive Director
Executive Assistant (Minutes)
Personal Assistant (Minutes)

1. Apologies for Absence

Marga Perez-Casal

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 22nd January 2019

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

5. Review of Action Log

Item 1 Standard Letter for bereaved families – completed and removed from the action log.

Item 2 GIRFT: Review stroke related elements – discussed as part of

the main agenda (item 8.3).

Item 3 The Patient and Family Experience vision – to be discussed at the meeting in July 2019.

Item 4 Issues highlighted in the patient story – had been raised as an informal complaint and, accordingly, removed from the action log.

Item 5 Benchmarking (medication errors) – discussed as part of the main agenda (item 8.4).

Item 6 CIP relating to staff opting out of the pension scheme – some lower paid members of staff had opted out of the scheme. To be considered by the People Committee and removed from the action log.

Item 7 CQUIN update (advice and guidance) – The 48 hour turnaround had been achieved by a number of consultant cardiologists and one respiratory physician.

MJ

6. Quality

6.1 Clinical Quality Performance Report

The Director of Nursing and Operations presented the Quality Report and the main highlights were identified:-

Mortality reviews – Consultant review of deaths within 30 days had fallen below 80% in June, but committee members accepted that this is a somewhat arbitrary internal target. New criteria will be implemented from April.

Infection Prevention and Emergency readmissions – Two further CPE bloodstream infections had occurred during the previous three months (total 5 YTD). No source had been identified despite rigorous efforts to do so. The committee noted that the target remains zero. Emergency readmissions were reported green.

Falls and Pressure Ulcers – The focus on preventative measures has resulted in a sustained reduction in the number of falls. Similarly, the number of pressure ulcers remains well below the 'target' level; the DN&O attributed the good results largely to the work of the tissue viability nurses.

Patient Safety Incidents – Slightly reduced as compared to 2017/18; none had resulted in severe harm or death. The committee was assured of the Trust's priority further to reduce potential harm to patients.

Medication Errors – Information on the performance of each division had been sent to their leadership teams in the expectation that an improvement plan would be created. The issues were further discussed under item 8.4

Radiology Alerts and Dementia – The committee noted the marked improvement in completion of actions in response to radiology alerts.

Serious Incident - The MD presented the case of a recent serious incident associated with the death of a patient with Down's syndrome who had been admitted with a heart attack. Primary angioplasty was not carried out because of the patient's extreme agitation and he was treated with thrombolysis. Subsequent anticoagulant treatment was withdrawn too early and the patient was discharged on day 3, only to be re-admitted

with a further heart attack and cardiac arrest from which he died. The death was considered to have been avoidable. A RCA had been completed and the case reported to STEISS.

The patient's brother who, it was discovered, had not received any support from the community teams has been invited to meet the head of nursing for medicine and the consultant for a full explanation of the events. The incident has already been reported to the Board of Directors and will be further addressed in relation to learning from deaths.

The Committee accepted that all appropriate actions in response to the incident had put in place

VTE and PCI Call to Balloon – The performance for VTE assessment and prophylaxis remains satisfactory.

Whilst the Trust's primary PCI door to balloon time performance remains good, a further deterioration in the call to balloon time was noted. As previously explained to the committee, the problem is attributable largely to pressure on the ambulance service and is outside the control of the Trust. The commissioners have been made fully aware of the issues.

Sepsis – Process indicators: use of the sepsis bundle and sending blood cultures to the laboratory prior to administration of the first antibiotic remain unsatisfactory. The MD assured the Committee of the on-going efforts to address these issues through education of junior doctors at induction and feedback of audit results. Further developments of the EPR have been made to support other key aspects of sepsis management.

Patient and Family Experience – The excellent results of the patient and family experience in-house surveys were noted.

Quality Priorities – Delirium screening, complex health needs assessments and offers of care partnership were all rated green. The number of shadows has fallen below expectations; the HON described favourable feedback from those who had undertaken shadows and informed the committee that the scheme would continue into next year. Shadows from the corporate areas were particularly to be encouraged.

CQUINS – Whilst quality standards for offering advice and guidance have been met, the Trust has failed to achieve the response time target, which will result in a modest financial shortfall.

Clinical Utilisation Report (CUR) – The Director of Nursing and Operations explained that the Commissioners had set the Trust a target of 90% bed occupancy, despite their having previously been advised that this was unlikely to be achievable. The Chief Finance Officer is to engage in negotiations over the target.

6.2 Annual Assurance Report

This report was for information only and was approved at the April Board of Directors.

6.2.1 Terms of Reference March 2019

Terms of Reference to be corrected for minor typographical errors.

6.3 Quality Impact Assessments Update Report

The Head of Quality Improvement presented the Cost Improvement and Quality Impact report.

It was reported the 45 CIP schemes in the 2018/19 programme had been completed and approved; all had been screened for equality impact and none had required a full Equality Impact Assessment (EIA).

Planning for the CIP target of £3.8m for 2019/20 has begun and the divisions are currently identifying cost improvements in order to meet their individual targets. Eight QIAs were completed and approved by the BTSG in March 2019 and 27 CIP Schemes with outstanding QIA's were presented at April's BTSG meeting; the Head of Quality Improvement reported that some gaps remain. All reports will to be brought to the Integrated Performance Committee (IPC). Further work to improve the reporting of EIAs is in progress and the Equality and Inclusion group will receive a report of EIAs that have been undertaken.

The Trust is working towards the development of a rolling programme with appropriate QIAs approved for up for 3 years but with annual review.

The Committee noted the report and its assurance that the CIPs are being subjected to rigorous quality and equality impact assessments

6.4 Quality and Patient and Family Experience Report

Summary Report from 22nd March 2019

The Quality Committee reviewed the summary report and the main issues that had not been discussed under item 6.1 were considered as follows:-

Complaints – A further reduction in formal complaints compared with the previous year was noted with satisfaction. In response to a question from the committee the Director of Nursing and Operations confirmed that learning from complaints continues to be a Trust priority, and that, a new committee is to commence in May in which all of the data from formal and informal complaints will be assessed for learning opportunities. The Terms of Reference of the new group will be presented to the Operational Board and to the Quality Committee at a later date.

GIRFT Report – This was included as part of the main agenda under item 8.3.

Lung Cancer Clinical Outcomes – The number of lung cancer operations has continued to rise and the Trust has a resection rate higher than the national average. 98% of patients had survived to at least 30 days post-surgery, and the majority of the procedures had been performed by VATS or robotics. The high readmission rate of 23.4% within 90 days was noted.

Resuscitation and DNACPR – Six cardiac arrests were recorded for the month of March, one of which had been presented to the MRG group. Discussion of another case had generated shared learning in relation to debriefing of staff after traumatic resuscitations and maintenance of observations in POCCU up to the point of transfer. A review of changes to the cardiac arrest management protocol will be presented at the QPFEC meeting in May.

The DNACPR bi-annual report identified one exception during the first two quarters which related to a patient who was at the end of life.

Missed dose medication report – The report was derived from EPR of medicines that had not been administered during a 24 hour period in February 2019. Although the audit demonstrated a continuing high rate, the number of non-administered critical medicines has halved since 2017. Many changes to medicines management have been implemented over the last year and the committee accepted the assurance of improvement from the Chief Pharmacist and Director of Nursing and Operations.(See also item 8.4)

Radiology Discrepancy Report – Dr John Holemans, Consultant Radiologist has been nominated to lead the discrepancy review process for the next 12 months; reports will be presented to QPFEC three times a year. The Director of Nursing and Operations was unsure if the cases were reported as incidents; this will be clarified with the Clinical Lead for Radiology.

DoN & O

NEWS2 / MEWS Compliance – The Medical Director explained the decision for LHCH to continue to use the MEWS scoring system, but any patients moved to another trust will be transferred to NEWS2.

Readmission to Critical Care – The Director of Nursing and Operations confirmed that there has been a significant reduction in the number of readmissions to Critical Care, and explained the on-going efforts to understand the reasons for and identify the patient characteristics predictive of readmission.

Fasting Audit – Surgery – The Surgery Division has reduced the number of patients fasting unnecessarily. An annual report is to be completed.

Fasting Audit – Medicine – The Medicine Division has failed to make a significant improvement with unnecessary fasting. Work to improve compliance continues.

Natssips and Locssips –The findings of Natssips and Locssips are to be presented to the Commissioners.

CQC Update – The Director of Nursing and Operations stated that the CQC report had been delayed due to staff sickness.

6.5 Stroke Service and Audit Update

The Out of Hospital Therapy Lead presented the report on the stroke service and key indicators from the national sentinel audit.

The audit demonstrated further improvement during the last two years such that by Q2 of 2018/19 all key indicators were being met. The previous year's difficulties in achievement of the 72 hour swallow assessment have been resolved by the appointment of two speech and language therapists.

Other developments included regular education sessions and training for all members of the MDT, introduction of electronic patient satisfaction questionnaires, acquisition of additional equipment with a combination of capital and charitable funding, establishment of links with the Stroke Association and changes in OT staffing.

The report outlined plans for continued regular data collection including that of longer term outcomes, improvements to the patient satisfaction survey, introduction of a mood screening tool and additional training of OT staff on upper limb rehabilitation.

The Committee congratulated the team on their report which provides assurance on the high quality of the stroke service and the commitment to further improvement. Achievement of all the key indicators in the audit is particularly noteworthy, since the benchmarking is against stroke services in acute, rather than specialist, hospital trusts

7. Key Reports

Nil to report

8. Clinical Effectiveness

8.1 Review Progress against delivery of the Clinical Quality Forward Plan 2018/19, NICE and New Technology

The Clinical Audit and Effectiveness Manager presented the paper and highlighted the key issues undertaken by the CAEG.

The Trust has addressed national concerns over the organisational responses to patient safety alerts by strengthening the accountability, scrutiny and audit. A plan to ensure that previous alerts are tracked and followed has been implemented.

Audits of the key components of the clinical quality forward plan and those required for contractual requirements are supported and in progress.

All mandatory national audits have been completed and action plans are in place to address areas falling below national standards. Measures to improve data collection, including the embedding of NICOR audit data into EPR are in development. Congenital heart disease is being incorporated into the cardiac audit programme.

All NICE publications have been reviewed at CAEG meetings and referred for gap analysis by the relevant clinical teams, with monthly reporting. No critical gaps have been identified.

Seven new technology proposals have been approved since April 2019. An audit of the first 50 cases of thoracic robotic surgery disclosed excellent outcomes compared with most reported literature results and

historical VATS data

The Terms of Reference for the CAEG had been reviewed, with the inclusion of a process for reviewing new services in order to gain assurance on arrangements for training, consent and audit.

The MD explained, in response to a question about NICE guidance on consultant input into acute medical admissions, that the exception report commentary (p5) relating to weekend admissions is misleading; all emergency and acute medical patients are reviewed by the consultant responsible for their care. It was suggested that the Associate Medical Director for Medicine should review the wording of the statement.

The Committee expressed overall satisfaction with the assurance provided in the report. The chair requested that future reports to the committee should be accompanied by an executive summary.

8.2 Mortality Review Annual Report

The Medical Director summarised the report, explained the updated mortality reduction strategy, and responded to questions on performance for the year up to December 2018.

The Hospital Standardised Mortality Ratio (HSMR) indicators were slightly above unity, but had improved since 2017 and were statistically within the expected range. Outlier data – prompting ‘alerts’ from Dr Foster - were reviewed, discussed at the Board of Directors and reported to the CQC. Members of the Quality Committee accepted assurance from the rigorous analysis from which it was concluded that these alerts and the increase in unadjusted hospital mortality is attributable to the new national guideline compliant policy of accepting heart attack patients who have been resuscitated from cardiac arrest in the community (out of hospital cardiac arrest; OHCA). The number of patients coming to LHCH on the PPCI pathway with OHCA, who experience an average mortality rate of over 50%, has increased and is likely to increase further.

The MRG, led by the MD and Associate Director for research and innovation that produced the 2016 mortality reduction strategy continues to meet and revise the strategy in line with the changing landscape of patient referrals. In view of the increasing acuity of patients admitted to the Trust, the group recommended that the Trust target for overall unadjusted mortality should be unchanged: i.e. no worsening. Risk-adjusted mortality ratios, where available (for cardiac surgery and coronary intervention) should remain at unity or below.

The Committee acknowledged the meticulous, on-going work under the leadership of the MD in continuously re-assessing and revising all aspects of the mortality reduction policy.

8.3 GIRFT Deep Dive into Postoperative Stroke

This report had already been presented to the Board of Directors. The Committee was happy to accept its principal conclusion: that the rate of

post-operative stroke at LHCH is not high in comparison to comparable cardiac surgical units. The plans put in place to minimise the risk of this complication were also noted.

8.4 Medications Assurance

Benchmarking (see action point 5.5)

The Chief Pharmacist presented comparative data collected from the Royal Liverpool Hospital:

Administration Errors:

January LHCH 5, RLH 22; February LHCH 6 RLH 21.

Prescribing Errors:

January LHCH 8, RLH 35; February LHCH 3, RLH 20.

Dispensing Errors:

January LHCH 2, RLH 13; February LHCH 0, RLH 14.

Other than demonstrating that medication errors are not unique to LHCH, the Committee questioned the value of these comparisons in view of the radically different spectrum of patients in the two hospitals and the absence of a denominator. The DoNO raised another issue: how the reporting culture will affect figures from other trusts. It was, however, agreed that continued collection of the LHCH data is important in order to drive improvement.

Medications Assurance Report

The report provided comprehensive information on the Trust medicines policy, the results of monitoring and of multiple audits, and on numerous improvement initiatives both in training and equipment.

Referring to item 6.4 the Committee questioned the 800 doses of medication that had not been administered during the last year. The Chief Pharmacist explained that many were PRN prescriptions – e.g. for pain – that were not needed; it was perfectly correct for the prescriptions not to have been deleted in case required later.

A member of the Committee commented on the difficulty in being assured by the findings. The Chief Pharmacist emphasised that the level of harm had been minimal; that harm reports are reviewed regularly and that an improvement project is in place. Another member considered that it would be useful to see documentation of the extent to which performance had improved over time, but accepted that with changes in data collection this would have limited value.

A member of the Committee questioned sections under the “Medicines Administration Procedure” relating to elements of EPR being on the risk register: the clinical decision support system and the delay in receipt of a new process for prescribing and pharmacist verification. The Medical Director reminded the Committee that the existing support system had been inactivated as not fit for purpose but that a new version would be introduced with the next version of Allscripts. Pending these developments mitigation of the risks is dependent on the almost universal review of inpatient prescriptions by pharmacists. In response to a question from a member of the Committee it was confirmed that daily ward rounds are supported by a pharmacist.

The Chair asked the Chief Pharmacist about the Medicines Policy Audit which identified issues during the month of January: expired medicines in the drug trolleys, medicines left on the worktop in the drug room, drug trolleys not attached to the wall or not locked, and an unlocked fridge.

The Director of Nursing and Operations confirmed that these issues did form part of the ward EECS assessments and mentioned that the CQC had seen the report and not raised concerns. The findings have been addressed with and actioned by the ward managers. A further audit will be conducted.

The committee also expressed concern over the failure of adequate documentation of self-administered insulin and blood glucose levels (appendix 4). The Chief Pharmacist assured the Committee that intensive training in relation to insulin and its self-administration was being undertaken.

The Chair thanked the Chief Pharmacist for her report and for the wide-ranging work on patient safety. It was requested that an executive summary should be included in future reports.

9. Compliance and Regulation

9.1 Quality Risks

The Risk and Safety Lead presented the Corporate Risk Register.

The only patient safety risk to have increased is the worsening of delays in reporting histopathology samples. Additional problems have resulted from blood samples going missing. The Chief Operating Officer is looking for another company to provide a reliable service.

Risks relating to administration processes in relation to PAS, DNA rates and safe prescribing have been downgraded.

Nine incidents remained open for more than 28 days; it was noted that the divisions are working to reduce this number which is routinely reported to the governance meetings.

10. Minutes for Information

- Approved BTSG Minutes held on: 20th December 2018*
- 24th January 2019*

The Committee had no comments.

11. Date and time of Next Meeting

Tuesday 9th July 2019 11am, Research Meeting Room

The Chair and the Quality Committee members thanked Marion Savill for all of her support during her time in office and wished her well for the future.