

Item 6.1.3a\*

## Quality Committee

## minutes

### Minutes of the Quality Committee Meeting held on Tuesday 9<sup>th</sup> July 2019

#### Present:

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

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

#### In Attendance:

Lynda Robinson  
Janet Deane  
Debbie McEllenborough

Head of Quality Improvement (Item 6.2)  
Clinical & Audit Effectiveness Manager (Item 8.1)  
Executive Assistant (Minutes)

#### 1. Apologies for Absence

There were no apologies for absence and the Chair welcomed Marga Perez-Casal and Karen O'Hagan to the Committee in their new substantive roles.

#### 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 2<sup>nd</sup> April 2019

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

#### 5. Review of Action Log

Items 1 – 4 had all been completed and were removed from the action log.

**Item 5 Clinical Utilisation Report** – The Director of Nursing and Operations confirmed that the Trust had received payment for achieving the required bed occupancy. This item was complete and removed from the action log.

**Item 6.4 – Radiology Discrepancy Report** – The Director of Nursing and Operations confirmed that all incidents, if applicable, were reported on.

## 6. Quality

### 6.1 Clinical Quality Performance Report

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

**Mortality Reviews within 30 days (doctors)** –The Medical Director informed the Committee that a new internal target had been set for completion of mortality reviews: initial screening to be concluded within 7 days and completion of the review within 30 days. The Associate Medical Directors continued to monitor the process to ensure timely completion, and improvements had already been noted. Going forward, a planned electronic system should facilitate monitoring and apportioning of the work equitably among the consultants.

#### **Infection Prevention**

Three *C.Diff* cases were reported in May with mini root cause analyses (RCAs) completed for each. No themes were identified and none of the infections was with the same strain; however, one was associated with a lapse of care. Following a review it had been decided that in future, whenever feasible, the ultra violet system would be used for cleaning bed areas. The Committee received assurance from this policy and from the reinforcement of individual responsibilities over infection control.

**Falls** There had been four unavoidable falls in May. Early warning devices were being trialled on two wards and a reduction in falls on Birch ward had been observed.

**Pressure Ulcers** – Two small pressure ulcers due to lapses in care, and one unavoidable ulcer were reported in May. The Committee was assured that there were no overall concerns around pressure ulcers; the numbers were low and the Director Nursing and the consultant tissue viability nurse reviewed all cases.

**Safety Incidents** – The number of patient safety incidents remained stable and dominated by potential medication errors; none had resulted in severe harm. Work was underway with focus groups to raise awareness.

The Director of Nursing and Operations reported an increase in incidents of abuse from patients and families. These related to patients with delirium, to families that were not coping with stressful situations and to occasional 'problematic' patients. It was explained that this was a new issue for the Trust. Letters were being sent to difficult patients about the standards of behaviour expected of them. The display of posters to remind patients, their families and visitors how staff should be treated was being considered.

The Committee was assured that all staff had the appropriate training in conflict resolution.

**Medication Errors** – Intensive education and improvement work to reduce the number of medication errors has continued, including the

launch of a double checking campaign to ensure the 2<sup>nd</sup> signature policy was being followed.

**VTE and PPCI** – The 120 minute Call to Balloon time remains below target, due to ambulance delays beyond the Trust's control. The issue had been raised repeatedly with the Commissioners and the Regional ACS Group. The door to balloon target of 95% within 90 minutes has been met consistently, and the Medical Director assured the Committee that the few door to balloon times beyond 90 minutes were usually caused by the need for pre-procedural measures to stabilise the patient. Delay resulting from more than one patient arriving simultaneously outside normal working hours was exceptionally rare and could not justify provision of a back-up on-call rota.

**Sepsis (see also item 6.4)**

The Medical Director explained that use of the sepsis bundle was gradually improving as a result of intensive educational efforts, developments of the EPR and audit. The percentage of patients receiving at least one sepsis antibiotic with one hour, in May, exceeded the target, and administration within three hours was above the 95% national standard. Although the percentage of blood cultures taken within 24 hours of the first antibiotic fell consistently below the 95% target, the Medical Director explained that this is partly a reflection of the case-mix of patients in LHCH, with most cases occurring in critical care, where blood is routinely cultured at the earliest suspicion and often well before the development of overt sepsis and the initiation of antibiotic therapy.

The Committee noted the new LHCH sepsis pathway and accepted assurance of satisfactory measures of sepsis management in the Trust.

**CQUINNs**

- Health and Well-being – The Trust had not achieved the 5% improvement in three areas of the CQUIN. However, since the baseline score was already high, it was understandably difficult to achieve a further increment.
- Antimicrobial Resistance and Sepsis – some funding had been held back as the data were not available locally and the national criteria were not yet published.

**6.2 Quality Impact Assessments Update Report**

The Head of Quality Improvement presented the Quality Impact Assessments and explained that of 39 schemes as part of the 2019/20 CIP programme requiring a QIA; 26 had been approved and the remaining 13 were either being developed or going through the QIA process. All approved QIAs had been reviewed by the EIA Team.

The Committee noted that the CIP progress was showing an improved position from previous years and received assurance that the QIAs were very much on target for 2019/20.

The Chair thanked the Head of Quality and Improvement on behalf of the Committee and wished her every success in her new role.

### **6.3 Quality & Patient & Family Experience Committee Assurance Summary Report from 10<sup>th</sup> May 2019**

The Director of Nursing and Operations presented the summary report, which was additionally supported by the End of Life annual report, the Tissue Viability Service assurance report, the Diabetes Steering Group annual report and the annual reports of the Drug and Therapeutics Committee and the Safe Medication Practice Committee. The following areas were noted:-

#### **CQUIN and Quality Performance –**

- Incident reporting in Medicine Division had decreased in 2018/19 – work was on going to encourage reporting.
- Two outstanding RCAs had now been completed.
- Concern exists around delirium risk assessments not being completed for a small number of patients, notably those admitted as an emergency for primary PCI - this was being investigated by the matrons.

#### **ACHD travelling expenses**

- A process to support travelling expenses for patients in exceptional circumstances is being implemented.

#### **Diabetes Steering Group**

- The report provided details on activity, training and service development. Low attendance at steering group meetings is to be addressed.

#### **Drugs and Therapeutics Committee**

- The Committee noted poor meeting attendance by certain key individuals. It was explained that combining numerous meetings with clinical responsibilities was challenging, and that it was planned to address the problem by a review their frequency and format.
- The use of a 29mmol in 50ml infusion of potassium chloride, at an annual cost of £143,516.42 was questioned by the Committee and would be discussed outside the meeting by the Chair and the Medical Director.

#### **Mortality**

- The updated mortality reduction strategy had been approved.

#### **Safe Medication**

- The annual report listed numerous achievements and the workplan for 2019/20. A 58% increase in incident reporting had occurred, considered to reflect a change in reporting culture. Improvement work was on-going and incidents categorised to facilitate focus on principle areas of error, the predominate one being drug administration.

#### **Tissues Viability**

- Comprehensive report from this highly active group which included a new initiative to minimise moisture damage to the skin, and an extensive clinical audit assurance report. The DONO particularly commended the work of the service.

#### **End of Life**

- The annual report indicated high standards of care in all areas. In the national audit of care at the end of life only one score fell below the national average and this area was being addressed in order to conform to national policy.

#### **DNA/CPR**

- Quarterly audit has consistently confirmed compliance with the DNA/CPR policy. Completion of documentation remains an area for

improvement.

### **Discharge letters**

- On-going concern over the timeliness of sending out discharge letters and the summary given to the patient on discharge were discussed. Work is underway to combine all the information into a single letter, and although extracting the necessary text has proved difficult, consultants have now agreed to this approach.
- Patients already receive information on what to expect following their procedure and on recommended activity levels. This is followed up during rehabilitation and is not, therefore, included in the discharge letters.

**Consent** – The Medical Director explained that the Trust is required to demonstrate compliance with the national policy for obtaining consent for procedures. A previous MIAA audit report of June 2017 had included a number of recommendations; a repeat audit in 2018 had revealed similar results with few minor improvements.

The Medical Director explained the consent process and provided examples of consent forms for angioplasty and coronary bypass grafting. The main shortcomings identified in the audit were in failure to detach the green page which should be given to, and signed for by, the patient and illegible doctors' signatures with omission of their job titles. A discussion followed on how risks were described to the patient and it was explained that different levels of information, both written and verbal, were adapted to the patient's individual circumstances and the type of procedure to be undertaken.

The Committee was assured of the importance and continuing educational focus attached to this issue by the Medical Director and divisional leads; the MD made reference to the Montgomery v Lanarkshire case of March 2015 regarding informed consent.

### **6.4 Sepsis Annual Report**

The Medical Director presented the report summarising current practice and recent audit results in relation to the recognition and treatment of sepsis. Uptake of the sepsis screening tool was inadequate but gradually improving in response to extensive education and input from the outreach nurses, ANPs during the day and registrars on call in the evening.

Current limitations in use of the EPR on the timing of blood cultures were being addressed by the sepsis group in the expectation that this will provide more reliable documentation. Other measures include trust-wide reminders on screen-savers and an up-dated mandatory e-learning package.

The Committee received assurance that everything possible is being done to improve documentation and timely management of suspected and proven sepsis, and also that no evidence exists to suggest any deterioration in patient outcomes.

## **7 Key Reports**

## **8. Clinical Effectiveness**

## **8.1 Clinical Audit and Effectiveness**

The Clinical Audit and Effectiveness Manager presented the annual report, which was prepared to provide assurance on the delivery of the Clinical Audit and Effectiveness strategy. It included assurance on the completion and evaluation of last year's programme, including participation in all relevant national audits, responses to NICE guidance and technology appraisals and their introduction, and support for local audits,

The Committee noted the contents of the report and was assured that all key requirements of the CAEG Terms of Reference had been achieved.

### **Clinical Audit and Effectiveness Strategy Implementation Plan.**

An implementation plan has been developed to ensure the Trust delivers its 2019-20 strategy for developing audit and clinical effectiveness, which includes mandated national, regional and local audits and conformity with nationally agreed best practice.

Processes were being established to support data quality with the transition of NICOR datasets into EPR. Work was also underway with the data warehouse team and clinicians to ensure fields were completed and that source data were available.

The Quality Committee noted the implied concern over data quality but accepted assurance from the plans for improvement.

## **9. Patient and Family Experience**

### **9.1 Patient and Family Support Team: annual complaints report**

The Committee received the annual report that documented how responses to complaints were monitored for timeliness and effectiveness.

Complaints were themed to ensure any trends were identified and that appropriate learning and actions were implemented by the relevant divisions.

Formal complaints in 2018/19 had fallen by over 26% from the previous year to 36; all were resolved within the Trust and none were referred to the Health Service Ombudsman. A survey of complainants disclosed a generally high level of satisfaction with the process.

The Director of Nursing and Operations explained that a new administration hub was currently being set up. The IT equipment was in place and it was expected that the hub, which would be up and running in September 2019, would help to streamline complaint management.

The Committee received assurance that the complaints process, management and procedures were robust and monitored for effectiveness, and commended the team for their work.

## **10. Compliance and regulation**

### **10.1 Quality Risks**

The Interim Director of Research & Innovation presented the Corporate Risk Register for June 2019. Three increasing risks (one red and two amber) were

identified :-

- Patient safety due to a locked bathroom. All staff now have access to a tool to open the door from the outside.
- Delivery of the 2019/20 activity and financial forecast due to reduced levels of activity, principally because increasing numbers of cancellations,
- Staff health and wellbeing due to low staffing levels impacting on longer waiting times for radiology diagnostics. This is a national issue.

Three static red risks included:-

- Achievement of the national diagnostic waiting time caused by increasing demand and limited reporting capability.
- Worsening delays in reporting histopathology samples by Liverpool Clinical Laboratories. Work is underway to identify an alternative laboratory with either Arrowe Park or Whiston as both are capable of providing a faster service.
- A delay in the delivery of the 18 week waiting time caused by increasing numbers of complex procedures.

One reducing risk related to HRG4+ payments from Wales that had been partially resolved.

Targeted work has resulted in a significant reduction in the number incidents open for more than 28 days. It has been agreed that in future incidents remaining open due to a delayed response from another trust will be categorised separately.

The Committee noted the items on the Risk Register.

## **10.2 SUIs Final Report – Premature death**

The Committee received the root cause analysis that had also been submitted to STEISS and the Commissioners. The Medical Director reminded the Committee that the incident related to the potentially avoidable death of a patient with Down's syndrome and learning difficulties following a myocardial infarction. The issues, contributory factors and lessons were identified and arrangements for shared learning had been put in place.

The Committee noted the contents of the report and there were no further comments.

## **11. Minutes for Information**

Approved BTSG Minutes held on:

- 28<sup>th</sup> February 2019
- 25<sup>th</sup> March 2019
- 23<sup>rd</sup> April 2019

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

## **Date of Next Meeting**

**Tuesday 1<sup>st</sup> October 2019**

