

## Item 6.1.3.2 Meeting of the Quality Committee

minutes

Date: 24<sup>th</sup> October 2017  
Time: 10.00 – 13.00  
Venue: Boardroom

### Present:

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

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

### In Attendance:

Debbie McEllenborough  
Alex Naylor  
Helen Martin

Executive Assistant  
Project Management Officer (Item 6)  
Risk Manager (Item 7.4)

### 1. Apologies for Absence

There were no apologies to record.

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

There were no declarations of interest to record

### 3. Patient Story

The Director of Nursing read the patient story.

### 4. Previous Minutes

The Committee reviewed the previous minutes and agreed they were a true and accurate reflection of the meeting.

### 5. Review of Action Log

The Committee reviewed the Action Log and the following items were discussed:-

**Item 1 – Metrics for Respiratory Patients** – this item had been discussed at a previous meeting; the Medical Director re-iterated the current position in relation to gathering of performance data for respiratory patients and the issues that had been raised. A variety of national KPIs were available at organisational level but not for individual consultants. Work would continue and the action would remain on the log as the Medical Director was keen to ensure the Committee would in future be able to review the performance in respiratory medicine. The

Committee would receive a further update in 6 months-time.

**Item 2 PPCI call to balloon** – the target of 150 minutes call to balloon had been raised with Commissioners; this was a national target and meeting the target would continue to be a recurring theme because of pre-hospital delays. The Trust would continue to meet with the Ambulance Service and the Committee agreed for the action to be closed and removed from the action log.

**Item 3 Cancer Services Interim Report** – The report will be presented at the next Quality Committee in January 2018.

**Item 4 QIAs** – Item on agenda

**Item 5 Medication Errors** –

- The Clinical Quality Report had been enhanced to reflect a number of sub-categories for medication errors and this was well received by the Committee.
- A number of developments were planned for the Electronic Patient Record (EPR) to optimise the use of technology for the administration of medications, thus making the system easier for staff to use by reducing complexity and, potentially, decreasing the number of errors.
- One of the key areas of focus for the Care Quality Commission (CQC) going forward is how systems work and safety, and this will include medication administration systems. Improvements to the Trust's local systems would demonstrate how the Trust had enhanced its systems to address any shortcomings.
- The Medical Director would discuss with the Chief Pharmacist the provision of a brief summary report of medication errors to be made available to the Quality Committee for the next meeting.

RAP

## 6. Quality

### 6.1 Quality Report

The Director of Nursing and Quality presented the Clinical Quality Dashboard and focussed on the following key areas:-

**Mortality Review** – the Committee noted that various dashboard data were out of step with the dates and narrative in the report. This would be investigated by the Director of Research and Informatics. **MJa**

Review of the Hospital Standardised Mortality Ratios disclosed no untoward trends for all admissions, the 56 diagnostic groups, cardiac surgery, or for Major Adverse Cardiac Events associated with PCI.

. The Committee went on to reflect on the Red, Amber and Green (RAG) ratings and the limitations in drawing conclusions from the indicators due to the low number of deaths and wide confidence limits of the Dr Foster data. Although an Amber rating was above the expected target there was a large margin before the indicator would move into a Red category..

The Medical Director explained the use and limitations of risk scores to predict mortality rates for cardiac surgical procedures. The Committee noted that the recent LHCH results were all rated Green within the dashboard.

**Falls** – The 10 falls in September were all attributable to the four wards which were the focus of this year's improvement efforts. The falls had been categorised into avoidable and unavoidable and the majority of falls were considered to have been unavoidable. Improvement work continued to reduce the number of falls.

**Medication Errors** – There were 26 medication errors reported in September; this figure was queried by the DoN and Quality and would be investigated further by the DoR&I together with clarification on the **MJa** classification of Admin Errors.

**Radiology Alerts** – This was a new indicator to provide visibility and measure the completion of the actions in response to a Secure Health Messaging (SHM) alert raised against a suspicious radiological finding. Improvements had been made and the Committee were informed that 95% of SHMs had been opened, and work continued to ensure that actions were recorded.

A deep dive within each Division had been agreed to provide interim assurance that SHMs were being managed effectively. Once the improvement work was complete the 95% target would be recalibrated in 2018.

**Clinical Claims in month** – 3 clinical complaints had been received in September; no trends had been identified and claims were very mixed and often received months or years after the event, often with no direct link to an initial complaint.

**VTE and Prophylaxis** – VTE risk assessment on admission was consistently above target as was the appropriate VTE prophylaxis given.

**Sepsis** – Work continued to educate junior doctors and improve the performance for blood cultures taken within 24hrs and percentage of patients receiving at least one sepsis antibiotic within one hour.

**Patient Experience – Outpatient & Community** – 2 comments had been received in month relating to checkin booths which indicated incorrectly that clinics were running on time. The Director of Nursing **SP** and Quality would follow this up with the department.

## **6.2 Quality Impact Assessment Assurance Update and Remaining CIPs**

The Project Manager Officer provided the Committee with an update on the outstanding Cost Improvement Programme (CIPs) and Quality Impact Assessments (QIAs). Three QIAs had recently been approved and signed off by the Medical Director and Director of Nursing and Quality:-

- Medicine- Cath Lab/Cardiac diagnostics/Holly suite other pay savings
- Corporate- EPR (Electronic patient record) other pay savings
- Corporate- MIAA (Mersey internal Audit Agency) invoice holiday

The Committee noted the contents of the report and received assurance that there would be no adverse impact on patient safety from the QIAs presented to the Quality Committee.

The Committee would receive further updates once additional schemes were proposed.

### **6.3 Quality and Patient and Family Experience Committee Key Assurances Report**

The Committee received a new report presented by the Director of Nursing and Quality that would provide the Committee with assurance of the work that was undertaken by the Quality and Patient and Family Experience Committee (QPFEC).

The key issues for the September 2017 meeting included

- **WHO Safety Checklist** compliance reports presented by both divisions for surgery and medicine
  - Cath Lab checklists were completed consistently at 98% and 99% from April to July
  - Surgery was 91% for July and 93% for August. A robust process is in place to improve completion of the documentation and the provision of an audit trail
- **Secure Health Messaging SHM** – a thorough investigation had been undertaken to ensure the SHMs were acted upon in a timely manner. Improvements had been made and work continues to raise the importance of the SHM Alerting process.
- **NASO gastric compliance** – The NPSA had asked for assurance over the provision of supervision and training provided for LHCH staff, as there had been serious incidents affecting patients with misplaced nasogastric feeding tubes at other Trusts. Steps had been put in place to address the issues and these included:-
  - All new staff going through preceptorship attending an education program which has to be achieved and signed off.
  - For staff that had been at LHCH for a number of years and had not been signed off as competent to check feeding tubes, work with the Education team is needed to ensure compliance with best practice.
  - Records were now captured on EPR, and a snapshot audit of patients who had received nasogastric feeding tubes showed great improvement had been made. Work continues to ensure this is maintained.
- **Complaints** – There had been a slight increase in contact with family members and a decrease in complaints compared to the previous quarter. However, complaints were becoming increasingly complex and work was underway to review the timeliness of responses. Non-Executives attend the Complaints Review Process on a rotational basis.
- **National Safety Standards for Invasive procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)** – A lot of good work had taken place within the Trust including a clinical review of all policies to ensure harmonisation with National Standards, the creation of robust

audit templates and a governance pathway for monitoring compliance, and the development of an educational programme for all clinical staff to ensure understanding and compliance with LocSSIPs and NatSSIPs.

## **7. Key Reports**

### **7.1 Mortality Assurance Report**

The Committee received the Mortality Assurance Report that was presented by the Medical Director.

The paper detailed the results of the mortality review carried out in response to two alerts from NICOR (mortality from acute myocardial infarction relating to August 2016 and coronary artery bypass grafting + other procedures relating to October 2016), and concern over a gradual increase in the percentage of in-hospital deaths between November 2016 and June 2017, though this had fallen back in the last two months.

Mortality from acute myocardial infarction between April 2015 and January 2017 had fluctuated month by month but there was no upward trend, with in-hospital mortality over this period averaging 4.9%.

Similarly the LHCH CUSUM curve for patients undergoing 'CABG-other', based on the logistic EuroSCORE over the relevant period, demonstrated that whilst the mortality was 1.1% higher than anticipated, this fell well within the 95% confidence limit for observed vs. predicted death rate. It was explained that the CABG-other category included only a small number of patients undergoing several different procedures of widely varying risk.

The Medical Director's report also detailed the multi-faceted approach adopted by the Trust with the aim of reducing patient mortality by 10% by 1920. This includes performance monitoring of surgeons who were on restricted practice or who had fallen outside of the cusum curve indicators.

A further discussion followed on how it was difficult to benchmark the Trust against similar organisations as the National Institute for Cardiovascular Outcomes Research (NICOR) were reluctant to release data on other surgeons.

The Director of Research and Informatics explained some of the complexities of the Dr Foster data and that patients who died following transfer to another organisation were attributed to LHCH,

A further discussion followed on the difficulties with understanding the data within the report. Going forward it was suggested that the Dr Foster data might be presented to show only the five most important categories and or diagnoses. This would be discussed with the Board of Directors in December, together with a mortality masterclass to assist with understanding of mortality data,

The Committee commended the meticulous level of detail in the report and how the Trust was open and transparent when reporting mortality data, even though some aspects of the reporting process were outside of the Trust's control.

The Quality Committee would receive a further mortality update in six months

## **7.2 Sepsis Annual Report and Summary of Quarter 1**

The Quality Committee received the report presented by the Medical Director that summarised the current practice and recent audit results in relation to the recognition and treatment of sepsis according to the definitions previously employed by the UK Sepsis Trust.

Compliance with the Trust's sepsis bundle on EPR meant that patients should receive treatment within one hour of diagnosis of sepsis. This included, taking blood cultures before administration of antibiotics, lactate measurement and administration of 1<sup>st</sup> dose of antibiotics.

The paper showed the year to date figures for the main Key Performance Indicators (KPIs) of the sepsis bundle; the slight improvement in time to first antibiotic; although this was disappointing given the introduction of the screening tool. Work continued on extracting the data accurately from EPR and a drive on education and training had been undertaken:-

The sepsis training was now part of mandatory training with a high uptake over the summer of 2017.

- A training video had been produced and put on the trust internet with appropriate communication
- The sepsis lead had delivered ward based training in conjunction with the matrons.
- The Medical Director had recirculated the sepsis screening tool with the reported data to all doctors in the Trust.
- An SPC chart was being circulated monthly to all staff to show improvements in sepsis screening and to maintain focus on the process

In conclusion, the emphasis was on getting patients onto the sepsis bundle on EPR to ensure the accuracy of data that was being assessed. In addition there was no evidence to suggest any deterioration in outcomes from patients being treated for sepsis.

## **7.3 Patient-Led Assessment of the Care Environment (PLACE) Annual Report**

The Committee received the report that was an annual assessment of the non-clinical aspects of the patient environment and how it supported patients' privacy and dignity and its suitability for patients with specific needs e.g. disability or dementia.

The PLACE assessment tool provides a framework for assessing quality against common guidelines and standards with the environment assessed using a number of question forms depending on the services.

The areas that required attention following the PLACE assessment included:-

- Wellbeing of patients and consideration of the provision of individual TV and radio access for all patients across the wards particularly on Birch and Cedar wards.

However, the Trust had decided not to implement this due to the high cost and affordability issues that would be passed on to patients.

- Parking was worth 6 points and each year the Trust failed to achieve the maximum score. The reasons are that the Trust charges for parking, does not provide concessionary schemes, and patients and family members are not able to pay by card.

As the Royal Liverpool and Broadgreen University Hospital were responsible for the parking there was little the Trust could do to improve the problems that had been identified.

No other major areas of concern were noted, however in order to improve the Trust's scores a number of small scale changes need to be considered:

- Improve the standards for dementia patients (toilet seats and flooring)
- Consider food provision and serving items separately
- Provision of more hot items at breakfast

In conclusion, the results for the Trust performance were above average for all of the key domain scores. The paper would be presented to the Board of Directors meeting together with an action plan.

#### **7.4 Sign up to Safety Annual Report**

The Head of Risk Management joined the meeting and presented the report. It was explained that Sign Up to Safety had been a three year National patient safety campaign which aimed to deliver harm free care for every patient, every time, everywhere.

An LHCH Safety Improvement Plan had been implemented with three main areas of focus:-

- To develop reliable care bundle to support the improvement of documentation of care by 50%
- Improving the Safety Culture within the organisation and improve incident reporting by 50% by 2017
- Introduction of a new incident reporting system

LHCH had been a partner in the Sign up to Safety campaign for three years and was at the end of its involvement in the campaign. During the campaign there had been:-

- A change in how the staff report incidents
- An increase in incident reporting
- Daily safety huddles embedded into safety awareness
- Training for a significant number of staff on the enhanced use of EPR
- Introduction of change Wednesdays to make changes to improve EPR

- The introduction of Datix risk management software to improve integration with incidents, complaints and claims
- The development of the sign up to safety dashboard.

In conclusion, all of the above had supported the improving safety awareness and culture of the organisation. The Trust would continue to receive information from the national campaign which would be used if it was determined to be of benefit to the Trust.

The Quality Committee noted the details of the report and received assurance that the Trust had made improvements in the areas identified for action as per the Sign up to Safety Improvement plan.

## **7.5 Radiology Alerts Update**

The Committee received an update on radiology alerts that related to earlier discussions in the meeting on Secure Health Messaging. A lot of work had been undertaken by the Division's to ensure that alerts were opened and actioned by the appropriate individual. The number of unopened alerts had reduced significantly from 5% to 1%

## **8. Compliance and Regulation**

### **8.1 Never Event and Serious Incidents update**

#### **8.1.1 Update on missed diagnosis**

The Committee received the detailed report presented by the Medical Director that outlined a serious incident that occurred in December 2013 and the set of events that followed.

Following completion of the detailed Root Cause Analysis (RCA) of the incident the following actions would be taken:-

- To formally advise the patient of the outcomes of the investigation and to offer the opportunity to meet with the Trust and discuss the findings;
- To continue the further development of AllScripts EPR, including user training and communications in the results-tracking functionality as a priority.
- To share the individual and organisational learning from this incident formally and widely across the Trust.

The incident had been reported via STEIS and the organisational learning shared within the Divisions.

#### **8.1.2 Update on Proctor Case**

The Medical Director provided a verbal update on the Proctor Case that was currently under investigation. Ineffective communication between surgeons before the case had started and a delay with the arrival of the proctor had contributed to delays and complexities with the process.

A RCA had been completed and was currently under revision.

The Committee was informed that the Clinical Audit and Effectiveness Group were now heavily involved in defining the process in order to tighten up the procedures when a proctor is required.



The Trust had also sought an independent review and it had been identified that no one in theatres had spoken out or questioned the decision making at that time. The incident had also been through the mortality review process.

In conclusion, the Committee noted the findings; the steps that were being put in place to avoid a re-occurrence and the learning that would be shared with staff.

## **8.2 Quality Risks**

The Director of Research and Informatics informed the Committee that:

- The Secure Health Messaging risk on the risk register had been reduced from 16 to 12.
- The short term issue with junior medical staff had been resolved by support from consultants and advanced nurse practitioners and again this had been reduced from 16 to 12.

There were no quality risks to report to the Board of Directors meeting in September 2017.

## **9. Receive Minutes for Information**

### **9.1 Operational Board**

#### **9.1a Operational Board Minutes – 29 June 2017**

The Committee received the minutes from the Operational Board on the 29 June 2017 for information only.

## **10. Business Transformation Steering Group (BTSG) Minutes**

10.1a BTSG Minutes 26 June 2017

10.2b BTSG Minutes 20 July 2017

10.2c BTSG Minutes 24 August 2017

The Committee received above minutes for information only.

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

**9<sup>th</sup> January 2018 10.00 – 13.00**