

Item 6.2.3.1

## Quality Committee

## minutes

### Minutes of the Quality Committee held on Tuesday 9<sup>th</sup> January 2018

#### Present:

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

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

#### In Attendance:

Lynda Robinson (Item 7.3)  
  
Debbie McEllenborough

Head of Programme Management Office  
and Business Transformation  
Executive Assistant

#### 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 declare.

#### 3. Patient Story

The Director of Nursing and Quality read the patient story.

#### 4. Previous Minutes

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

#### 5. Review of Action Log support

The committee reviewed the action log and the following points were noted:-

**Item 1 Metrics for Respiratory Patients** – A brief summary report would be presented at the next Quality Committee meeting in April 2018.

**Item 2 Cancer Services Annual Report** – Due to meeting schedules, the paper would be submitted to the Quality and Patient and Family Committee in March 2018 and presented at the next Quality Committee in April 2018.

**Item 3 Quality Impact Assessments** – Agenda item

#### Action

**Item 4 Medication Errors** - Meeting with the Chief Pharmacist to be rebooked and a further update and brief summary of medication errors and impact on patients to be presented at the next meeting in April 2018.

**Item 5 Quality Report** – Dashboard updated to ensure narrative, data and timescales correctly aligned in relation to mortality. Item complete and removed from the Action Log.

**Item 7 Check in booths** – System configuration under development with resolution expected within the next few months. Staff informing patients of clinic delays. Further update at the next meeting in April 2018.

## **6. Quality**

### **6.1 Quality Report**

The Director of Nursing and Quality presented the Clinical Quality Performance for Month 08. The Key points included:-

**Mortality** – Work was under way to address the amber rated indicators:-

- Associate Medical Directors would be responsible for providing feedback to the Medical Director to confirm how issues had been dealt with in relation to mortality rates.
- Divisions would identify actions that needed to be completed on any number of avoidable deaths.
- Good progress had been made in terms of data collection and processes and the learning, including themes, decision making and opportunities to improve communication and standardisation of policies and approach.

As Trusts were still in the early stages of data collection following the publication of the National Guidance on Learning from Deaths it would be a number of years before NHS organisations were in a position to share their data with other hospitals.

### **Infection prevention and Emergency Re-admissions**

- 1 CPE in month that was not attributable to LHCH.
- Emergency readmissions for both elective admission and non-elective admissions were slightly elevated. The majority of readmissions were for cardiac surgery and an action plan had been developed for review at QPFEC.

### **Falls and Pressure Ulcers**

- All six falls in months were on one of the four wards which were the focus of improvement efforts to reduce falls. Benchmarking with Papworth and the Royal Brompton hospitals indicated that their fall rates were considerably higher than those of LHCH.
- One avoidable pressure ulcer in month.

**Medication Errors** – 26 medication errors reported in month with the details to be presented at QPFEC together with the action log.

A discussion followed on medication errors with the committee requesting a quarterly summary report, specific types/number of errors and how feedback to individuals and learning was monitored. The first report would be presented at the next meeting in April 2018.

MJ

**Radiology Alerts** – This was a new indicator introduced to provide visibility on key on-going issues. Significant improvements had been made in relation to opening alerts; actions taken and continual monitoring at Executive level. Recording of the actions had slightly decreased and this would be addressed within the Divisions to ensure

improvements continued.

**Complaints** – 6 complaints reported in month with no themes or issues identified.

**VTE and PPCI** – The internal primary PCI 120 minute ‘call to balloon’ target had not been met. This was attributable to ambulance delays from the call to LHCH admission, and to prolonged assessment and transfer to LHCH of patients from other trusts. Internal processes at the Trust were working efficiently and, despite the external delays, the national call to balloon time of 150 min was consistently achieved.

**Sepsis** –

- Blood cultures taken within 24hrs preceding first antibiotic given remained below target in for patients on the sepsis bundle. Although not always recorded. The Medical Director implied that patients had invariably had their blood cultures taken 24hrs before the first antibiotic was given.
- The percentage of patients receiving at least one antibiotic within one hour of prescription was satisfactory and above target in November.
- 95% of patients in 2017 did receive their antibiotic within the national target of 3 hours.
- An upgrade to EPR had affected the ability to produce detailed reports on where screening had taken place and the timings, limiting the identification of gaps. This was being addressed by the EPR team.

A number of actions were in place including a new sepsis initiative that had been launched with doctors and Advance Nurse Practitioners undertaking face to face training and education on the wards. Junior doctors were also being targeted during induction and improvements had already been reported for the November and December screening figures.

Improvements to outreach services and out of hours sepsis treatment were also being progressed.

**Patient and Family Experience (Inpatient)** – To help to improve the response rates the questions had been refined and reduced to 6 for both the friends and family surveys. The wards had been charged with achieving 20 completed surveys per month.

## **Quality Priorities**

### **Delirium-**

- Screening of surgical patients to identify those at risk of developing post-surgical delirium went live in October and had been well received.
- Work would continue during 2018 to ensure that the occurrence of delirium is included in the discharge summary and letter.

**Complex mental health patients** –Assessment of patients who had been identified on admission as having a complex mental health condition was undertaken by the safe guarding nurse in 100% of cases..

**Frailty Assessment** – Discharge summaries for GPs were now being fully populated from the final occupational therapy flow sheet.

### **CQUINs**

The Director of Research and Innovation presented an update on the

CQUINs for 2017/2018 and the following main themes were highlighted:-  
**Sepsis** - Timely identification of Sepsis was being monitored and managed within the divisions to ensure improvements were being made.

**Antibiotic review** - Reduction in antibiotic consumption and timely cessation of antibiotics was being monitored internally. Publication of the criteria to determine performance against the CQUIN was awaited from Public Health England. In addition the base line data had been changed by commissioners on account of a national shortage of one of the antibiotics (tazocin).

#### **Tobacco and Alcohol**

Enabling work was underway in readiness for data submission in Q1 2018 with targets dependent on commissioners.

#### **Improving Health and Wellbeing of NHS Staff and Health food for NHS Staff, visitors and patients**

As above, enabling work was underway in readiness for data submission in Q1 2018.

#### **Offering Advice and Guidance to GPs**

Following a decision at executive level, the Trust had chosen not to implement the advice and guidance functionality within NHS e-Referrals. The decision had been made following a scoping exercise on the time commitment that would be required to undertake advice and guidance, and this was deemed untenable in terms of consultant job planning.

#### **Medicine Optimisation**

A template had been submitted by the Chief Pharmacist with additional detail to follow on the upgrade of EMIS/Ascribe system.

#### **Cancer**

A number of service development improvement plans were underway regarding health needs assessment of cancer patients and identifying nursing resources.

The committee noted the report and the inclusion of the CQUIN information and values and supported the actions in place to achieve the required targets.

## **7. Key Reports**

### **7.1 Quality and Patient and Family Experience Summary Report**

The Director of Nursing and Quality presented the report that provided the Quality Committee with a summary of the items discussed at the QPFEC on 10<sup>th</sup> November 2017. The main themes to note were as follows:-

**WHO safety checklist for medicine and surgery** – both areas had a different system for completion of the checklist with Care Cube introduced into cath labs. The use of Care Cube was also being investigated for checklist completion in surgery. Both areas had achieved 100% compliance in month for completion.

**Nasogastric compliance** – a re-audit on compliance with nasogastric management had shown some improvements and work was underway to update training and management resources and ensure that all new and long term nursing staff were fully trained and familiar with the new guidance. A review of the Trust's management care of nasogastric tubes by the Head of Nursing for Surgery was also underway and would be reported on at the next QPFEC in January 2018.

**Complaints** – Five complaints had required an extension to the timeframes due to internal delays. The divisions had been reminded of

the importance of adhering to the guidelines in the Trust policy and were working to improve their processes.

**Research and Innovation Strategy** – An emerging risk in relation to a VAT underpayment had come to light. This was a national issue and the Trust was awaiting further information.

**Falls** – A falls improvement plan had been implemented to monitor both avoidable and unavoidable falls. This included the use of alarms to alert staff when patients identified as being at risk of falling were moving around. Benchmarking against the Royal Brompton and Papworth hospitals indicated that the Trust was experiencing a considerably lower number of falls than comparable institutions. **Incidents Trust Wide** –

- **Cancer Diagnosis** – a missed cancer diagnosis had been dealt with and a report sent to the family; the Trust was awaiting feedback.
- **Never Event (Cath Lab)** – an action plan for the never event in the cath lab was in progress and there had been a number of revisions to the policy and the check-in process.
- **RCA** - There had been a recent event concerning the mismanagement of a patient from the Isle of Man. A report had been completed and the outcome was awaited.
- **Proctorship Policy** – Following a recent event the introduction of a Proctorship Policy had been approved at Operational Board. The Policy outlined the requirements and governance of proctored clinical cases or procedures at LHCH. It would be applied to all internal and external proctors overseeing individuals who were learning new techniques or using new technology. (This did not apply to normal training of junior staff or students).
- **CQC Action Plan** – an update had been presented to the Board of Directors and the trust had made good progress on a number of items. The main areas of focus were:-
  - **Resuscitation equipment** and ensuring resuscitation trolleys had the complete set of drugs and equipment in place
  - **Mixed Sex Breaches and delayed discharges within Critical Care** - - had been closed; although there had recently been a small number of delayed discharges these had not been considered to be a cause for concern.
  - **DNAs** – more work was underway to look at cystic fibrosis patients
  - **Data Quality** – An external review of informatics had been undertaken by KPMG. The report had been presented to the Board of Directors together with a number of actions. Detailed reviews on the reporting of key metrics would follow.

The Director of Nursing and Quality went on to explain that a follow up clinic had been set up after a number of patients had experienced delirium during their stay in intensive care. A group of patients talked through what they had encountered and how they were managing the side effects. The clinic had been well received by patients.

The Committee noted the report and discussed the format of the QPFEC document as an assurance report for the Committee. Whilst reservations were expressed over its suitability, the Committee agreed to continue

with the the new reporting regime and to review it again at the next meeting.

## **7.2 Annual Report on Incidents Complaints and Claims**

The Director of Research and Innovation presented the Annual Report that had been presented to the Board of Directors. The report highlighted that:-

- incident reporting had increased by approximately 50% over the last few years.
- near miss reporting had improved with a dashboard introduced for the wards to help to highlight opportunities for incident reporting.
- closure of open incidents had improved.
- top 5 incidents remained unchanged.
- no severe harm to patients (apart from the Proctor case).
- Staff Safety Culture Survey had been repeated and showed some improvement across most categories.
- there were no recurring themes.

The Director of Research and Innovation explained that the implementation of Datix had provided clearer documentation of incident reporting at the safety huddle and at team brief.

The Committee referred to a section in the Staff Safety Culture Survey that provided a brief summary of the three least positive areas from 2017. One of these areas was 'the levels of staffing in this work setting is sufficient to handle patient numbers (perceptions of senior management)'.

The Director of Nursing and Quality explained that the Trust was very well staffed and a number of tools, together with professional judgement, were used to ensure safe staffing across the Trust. In addition, an extra 10 bank HCAs had been recruited to support specialising. This had been discussed in detail at QPFEC.

Staffing was addressed every day at the daily safety huddle chaired by the Chief Executive and staff moved around to cater for any areas of pressure.

The Quality Committee noted the report and the on-going work to improve incident reporting.

## **7.3 Quality Impact Assessments Update Report**

The Head of Project Management and Business Transformation joined the meeting to provide an update on the six remaining Quality Impact Assessments. Three QIAs had recently been approved:-

- Blood products (Clinical Services)
- Southport Clinics income (Medicine)
- Divisional pay scheme (Medicine)

A further 3 QIAs had either been rejected, due to patient safety implications, or withdrawn as the scheme was no longer viable.

1. Pulmonary Function (Medicine) was rejected at the Business Transformation Group due to its adverse impact on waiting times

- as result of the staffing reduction.
2. Community EPR (Medicine) had been further reviewed and was no longer viable for 17/18; it was therefore withdrawn.
  3. Catering Retender (Corporate): the anticipated savings were no longer achievable; therefore the scheme and the QIA were withdrawn.

A further 2 CIP schemes had been identified in year to support the 17/18 CIP Performance and would undergo the QIA process in January 2018 with further information available at the next Quality Committee in April 2018.

The Quality Committee noted the content of the report and commented on the importance of the Business Transformation Steering Group in withdrawing and rejecting unsuitable schemes as an indication the process was working well.

The Chair thanked the Head of PMO for her attendance and she left the meeting.

## **8. Compliance and Regulation**

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

The Never Event and Serious Incidents were covered previously in item 7.1. There were no new items to report.

### **8.2 Quality Risks**

The Director of Research and Innovation provided a verbal update on the Quality Risks. Secure Health Messaging had been covered earlier in the meeting together with the planned improvements.

A new risk had been identified in relation to the tracking of specimens from theatre to Liverpool Clinical Laboratories. This had been mentioned previously, and improvements were planned.

Improvements to the anticoagulation workflow are planned for implementation in EPR mid-January 2018. Specifically, users will be able see historical INR results and warfarin doses in an integrated fashion. This should improve the safety of warfarin prescribing.

The missed cancer diagnosis in radiology had been the subject of a root cause analysis which Dr Perry had covered under the previous item 7.1.

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

### **9.1 Approved Operational Board Minutes**

#### **\*9.1a 29<sup>th</sup> September 2017**

The Quality Committee received the September Operational Board minutes and asked for clarification on a point relating to staffing levels and recruitment that had been raised at the meeting under 'Any Other Business'.

#### **Post meeting note (via email from DoN to Quality Committee members)**

This issue was in relation to a number of informal complaints/concerns from relatives at that time which involved meeting with family members

to discuss some concerns regarding nursing care. These did not progress to formal complaints. The reason for raising this with the divisions at Operational Board was to gain assurance that the Heads of Nursing were confident that the skill mix in particular was adequate at that time - thus the reference to new staff nurses and the international nurses.

Following this the Heads of nursing had led an open day in conjunction with HR for recruitment into vacancies held at that time. No safety issues were highlighted; this was purely concerned with seeking assurance that we had the right mixture of new and experienced staff to meet the needs of the patients.

\*9.1b 3<sup>rd</sup> November 2017

\*9.1c 24<sup>th</sup> November 2017

There were no additional comments to record.

9.2 Business Transformation Steering Group (BTSG) Minutes\*

\*9.2a 5<sup>th</sup> October 2017

\*9.2b 17<sup>th</sup> November 2017

There were no additional comments to record

#### **11. Any Other Business**

The committee discussed progress on patients being discharged by 12 noon as the discharge lounge was currently being used as a medical unit. The Director of Nursing and Quality would provide an update at the next meeting in April 2018.

SP

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

24<sup>th</sup> April 2018 12.30 – 14.30 – Research Meeting Room 2