

Item 6.1.3.2.

Quality Committee Item 4

minutes

Minutes of the Quality Committee Meeting held on Tuesday 24th April 2018

Present:

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

Non-Executive Director (Chair)
Non-Executive Director
Non-Executive Director
Director of Nursing and Quality
Medical Director
Director of Research and Innovation

In Attendance:

Joanne Twist
Lynda Robinson

Director Workforce Development
Head of Project Management Office and
Business Transformation (Item 6.4)

Hannah Rooney

Therapy Lead and Neuro Physiotherapist
(Item 7.5)

Dr Gill Gow
Debbie McEllenborough

Chief Pharmacist (Items 7.3 & 7.4)
Executive Assistant Notes

1. Apologies for Absence

There were no apologies for absence 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 and Quality read the patient story.

4. Previous Minutes

The minutes were agreed as a true and accurate record, apart from a few minor amendments that would be corrected following issue of the final version.

5. Review of Action Log

Item 1 – Metrics for Respiratory Patients – This was included as an agenda item and removed from the action log

Item 2 Cancer Services Report – Presented to QPFEC and included on the assurance report presented to Quality Committee in April 2018. This item was removed from the action log

Item 3 QIAs – Included as a standard agenda item and removed from the action

log.

Items 4, 5 & 6 Medication Errors & Sepsis – These items were included on the agenda and removed from the action log.

Item 7 – Discharge by 12 noon - Although the rate of timely discharge has been improving, a Service Improvement Project led by the divisions was further examining the process. In addition, from April 2018, targets were identified for patient discharge in relation to CQUINs and the Clinical Utilisation Review (CUR).

6. Quality

6.1 Clinical Quality Performance Report

The Director of Nursing and Quality presented the Clinical Quality Performance Report and the key points to highlight included:-

Mortality –

- The HSMR for all admissions and for the 56 diagnosis groups used for the Dr Foster Hospital Guide were above 100. The current information was up to and including December 2017.
- The reporting of mortality was being restructured and an update on this is included later in the agenda under item 8.1.

Mortality Reviews - completion rate at 30 days post death was slightly below target in month. Improvement efforts were on-going.

Infection Prevention – good performance in month and year to date with:-

- Zero MRSA and C.Diff reported in month with a total of one for each indicator year to date.
- Zero CPE reported in month with a total of 13 recorded year to date, but none attributable to LHCH.

Emergency readmissions – The emergency readmission indicators had been provided by Dr Foster. Over 90% were to other providers. Readmissions after both non-elective and emergency admissions were rated amber in month. The Associate Medical Director for Medicine is leading the development of an action plan for submission to the Quality and Patient Family Experience Committee in May 2018. In order to minimise the number of inappropriate referrals back to LHCH, patients were encouraged to take their documentation and copies of their ECGs if presenting to another trust.

Falls and Pressure Ulcers – There had been a total of 6 falls in March across all areas. Birch ward reported 23 fewer than last year. Cedar and Birch wards were trialling early warning devices. One unavoidable grade 2 pressure ulcer was reported for March 2018.

Patient Safety Incidents and Medication Errors – Although the number of patient safety incidents year to date had increased, the 15 reported in month was below target.

Radiology Alerts– Timely responses to radiological alerts was red in month. Opening of alerts was being monitored by the Executive Team. The Divisions had been provided with the information at individual requester level that identified non-compliance with the process. A deep dive within each Division had been agreed to provide interim assurance that SHMs were being managed effectively.

Dementia Assessment - All dementia targets had been met in month and year to date.

VTE – VTE Risk Assessment on admission was on target in month and year to date.

PPCI - The nationally recommended 90 minute door to balloon performance was slightly below target for March and year to date. Locally the Trust was commissioned on 120 minutes call to balloon as an internal target, and this was also

below target in month.

Sepsis – For patients with indications of sepsis the appropriate taking of blood cultures prior to antibiotic administration fell below the 100% target. The percentage of patients receiving at least one sepsis antibiotic within one hour was on target in month and 95% of patients year to date received their antibiotic within 3 hours (the national standard).

A number of actions had been put in place including:-

- Continuation of an education programme for junior doctors during Trust induction to highlight the importance of delivering key standards for sepsis care.
- Continuous feedback of audit results via Audit Day and through the Infection Prevention Team.
- Development of EPR to enable further documentation of monitoring of other key aspects of sepsis care.

Patient Experience – Inpatient - all targets had been met in month. The set up on iPads had been updated across the wards to make survey capture simpler and less time consuming.

Patient Experience – Outpatient and Community

No outpatient surveys were conducted during March as the set of questions was under review.

Family Experience – The committee asked for a breakdown of responses in relation to the question 'did staff have the necessary skills to deliver the care' as the score for this question was usually higher than 83%. The Director of Nursing and Quality would provide an update at the next meeting in July 2017.

Quality Priorities – Delirium – the majority of targets had been met in month although diagnosis of delirium was not being placed on the problem list and this accounted for the low percentage for this indicator. This requirement would continue for the next financial year and the information would be recorded on the discharge summary for the GP.

CQUINNS – a number of targets were rated as amber pending verification with the Commissioners.

- Reduction in antibiotic consumption was awaiting publication of data to determine assessment against the CQUIN.
- Offering advice and guidance to GPs was still under review with cardiologists expected to undertake a pilot scheme to identify the volume of enquiries prior to launching the service.
- The utilisation of e-referrals had not met the required targets. However, improvements had been made and, in terms of mitigation, the Trust had been proactively involved with a number of organisations.
- Clinical Utilisation Review (CUR) - issues with misleading information had been highlighted and the CCG had arranged a meeting with the national team to discuss the latest submission; the outcome would be advised. It was explained that CUR was designed to ensure the patient was in the correct location at the correct time. Information was aggregated to review opportunities to improve patient flow and utilisation across the regions.
- **Medicine Optimisation** – A template had been submitted by the Chief Pharmacist with additional information provided as requested

6.2 Quality Committee Annual Assurance Report

The Quality Committee received the report that would be presented to the Board of Directors. In light of the Trust embarking on Listening into Action (LiA), this initiative would be included in the Quality Strategy.

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The Quality Committee received and approved the revised Quality Committee Terms of Reference.

6.3 Quality and Patient Family Experience Committee – Key Assurances Report

The Committee received the report presented by the Director of Nursing and Quality together with additional supporting papers that had been circulated prior to the meeting. The main areas highlighted included:-

- CQUINs in relation to e-referrals and balloon times that had been discussed earlier in the meeting
- Naso Gastric Care and Management – this action remained amber. An action plan had been put in place to ensure that all staff achieved the required competencies.
- Patients failing to turn up for their appointments had been discussed at a senior nurse meeting to identify steps to encourage attendance.
- Training is under review to enable clinical staff to be released to attend a full days training rather than several individual sessions. This would be built into the staff roster to ensure that cover was provided.
- National Lung Cancer Audit - It was explained that, following publication of the recent results, issues with data collection and concerns over risk-adjustment and potential survival rates for both high and low risk patients were being followed up by the president of the Cardiothoracic Surgery Society.
- Missed doses audit report - Although there had been an overall increase in the number of missed doses, the Committee was assured that there were legitimate reasons in most cases such that the number of 'true' missed doses was low. An action plan had been put in place to address the areas for improvement. Changes had been made in the EPR to document missed doses among cystic fibrosis patients and a review undertaken of the nurses' administration page.

The Quality Committee noted the report and agreed it was helpful to receive the additional papers to support the assurance summary.

6.4 Quality Impact Assessments Update Report

The Head of the Project Management Office and Business Transformation presented the report that provided an update on the Cost Improvement Programme (CIP) process and specifically the Quality Impact Assessments (QIAs) that were required. Since the last report a further CIP had been identified, one scheme had been approved and a further two were going through the process.

There were currently 37 CIP schemes over £25k for 2018/19 requiring a QIA; 14 schemes with approved QIAs and 23 with QIAs drafted or delayed. The large number awaiting completion was due to a delay in scoping or a requirement for further information because of delayed planning guidance from NHSE/NHSI. A well-established mechanism was in place to track progress and this included sign off from the Medical Director, Head of Nursing for Quality and also Business Transformation Steering Group.

The Committee discussed a QIA for Pulmonary Function, noted in the BTSG minutes, for which a retrospective QIA had identified an adverse impact on quality. The issue had been raised at IPC where it was confirmed this was due mainly to insufficient information contained in the CIP. The Head of the Project Management

Office and Business Transformation would check the adverse impact that had been identified and report back to Quality Committee.

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The Committee went on to discuss the savings identified by a reduction in weekend working. It was explained that improvements around capacity optimisation, job planning and theatre utilisation had negated the need for routine operating at weekends.

Subject to clarification on the adverse impact of the pulmonary function CIP, the Committee accepted that the processes in place are adequate to ensure there were no patient safety issues with the approved schemes.

7. Key Reports

7.1 Measures and Reporting of Respiratory Metrics

The Medical Director presented his report on performance and KPIs for thoracic medicine and surgery. LHCH reports lung resection data to the SCTS registry though the validity of the risk adjustment model has been questioned. The lung cancer pathway has a clear set of KPIs and these are reported routinely to the executives as part of the weekly performance report. A large range of process and outcome metrics are reported to the national cystic fibrosis registry. Other respiratory medicine and thoracic surgical outcomes are not currently reported internally.

The 2017 UK cystic fibrosis registry showed that the LHCH performance indicators compared favourably with other regional centres.

A lengthy discussion followed on the potential usefulness of data relating to other diagnoses and how the Trust could benchmark itself against comparable organisations. It was explained that whereas cardiology and cardiac surgery, being largely procedure based, were highly amenable to audit and national benchmarking, the heterogeneity of respiratory diagnoses and the generally low-risk procedures did not readily lend themselves to this process. Individual operators maintain their own databases on outcomes, and OPD numbers are provided annually to the clinical lead to inform appraisal and job planning. All deaths in respiratory medicine are reviewed in the normal way through the mortality review process. In seeking to obtain assurance of continuing improvement, the Committee discussed the value of comparison with similar trusts and long-term trend analysis.

Two options were considered to be feasible:

- A review of available internal data and the use of informatics to extract meaningful information for LHCH trend analysis.
- Development of a dashboard to focus on metrics for CF patients, readmission rates and complications.

7.2 Sepsis Report

The Medical Director presented the report 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. A sepsis group had been formed, meeting monthly to manage the approach to sepsis pro-actively and address the difficulties in achieving the targets.

A continued small improvement compared to 16/17 data was reported but the Trust remained non-compliant with the initiation of antibiotic therapy within the one hour target of 70%. Performance for three hour administration exceeded the 95% target.

The target for blood cultures being taken within twenty four hours prior to antibiotic administration remained below the target of 95% although there had been a marginal improvement.

Only 39% of patients with suspected or confirmed sepsis were treated using the sepsis bundle. Practitioners not using the bundle tended to be junior medical staff or nurse practitioners rather than consultants. However, the majority of these patients were on the critical care unit and were managed appropriately.

It was the Medical Director's opinion that the majority of patients did have appropriate management despite not being put on the sepsis bundle. Work continues to train and educate staff to use the bundle; recent awareness sessions had resulted in a spike followed by a decline in achievement of the targets.

The Director of Nursing and Quality went on to say that standards of sepsis recording were notably reduced out of hours and at weekends but this should improve by Sept/Oct 2018 as advanced nurse practitioners (ANPs) would be in post to assist junior doctors.

In conclusion, the Quality Committee received assurance that everything possible was being done to raise awareness and improve the use of the sepsis bundle.

7.3 Medication Incidents Strategy

The Chief Pharmacist attended the meeting to present the Medication Incidents Strategy that had been developed to reduce the number of incidents relating to medication, including prescribing, administration and dispensing errors. A number of enhancements had been implemented on the Electronic Patient Record (EPR) system and an action log developed to address the issues.

Medication incidents were reviewed monthly to identify trends and investigate any potential harm to patients. Work was underway to improve the discharge process and ensure patients were discharged with the correct medication.

A discussion followed on drug to drug interactions and the clinical decision to disable the electronic system because of the number of inappropriate alerts. There had been no incidents since the facility had been switched off but this is now on the risk register as a new system would not be available for another two years.

The Quality Committee thanked the Chief Pharmacist for presenting such a comprehensive report.

7.4 Medicines Policy Annual Report

The Chief Pharmacist presented the report which provided assurance that all aspects of medicines were managed and audited appropriately with due regard to training and education, the EPR system, medication incidents, safe and appropriate storage of medicines and missed or omitted doses of medicines.

The safe storage of medicines was imperative to ensuring the safety of patients, staff and visitors. The pharmacy department had conducted a monthly audit of storage on all wards in January and this had identified a number of issues that were highlighted in the paper together with the actions to mitigate any risks.

The pharmacy department had a rigorous audit plan for the year to examine adherence to the Medicines Policy. Prescriber training would continue, and the

documentation of training and signatures would be reviewed. All action plans would be monitored and re-audits conducted once the actions had been completed. The training proposals for nurses included witnessing and administration tasks which required a second signature, reading policies, one to one training and supervised practice. An increased pharmacy technician presence on wards, when resources allowed, would also support nursing staff. Additional steps had been put in place for:-

- Pharmacy staff to be included as part of the MDT process for surgery to speed up the discharge process.
- Ensuring that patients self-administering insulin were doing so where feasible and safe
- Categorisation of medication errors in the Quality Report

The Quality Committee took assurance from the work that was underway to address concerns and that, although the number of missed doses was high, the medications were being omitted in most cases for legitimate reasons. In addition, all medication errors were discussed at the Safe Medication Practice committee.

7.5 Sentinel Stroke Audit and Stroke Update

The in-hospital Therapy Lead and Neuro Physiotherapist presented their report that provided an overview of the LHCH stroke service. A service level agreement with Royal Liverpool and Broadgreen Hospitals NHS Trust provides three sessions of a consultant and specialist nurse to assess and treat patients with strokes. The team also has direct access to stroke professionals at the Royal Liverpool Hospital and Walton Neuro centre for urgent or out-of-hours problems.

On average, the Trust had 70 inpatient strokes per year, most commonly as complications of surgical procedures.

Since the last update to the Committee in 2016, the stroke team had continued to benchmark and develop the service against national stroke management recommendations.

Ten key indicators relevant to the Trust showed progressive improvement in all domains. All patients had been cohorted on one ward to ensure continuity of care, and competency based staff training was delivered three times a year. The EPR had been updated to ensure data were collected and consultants were exploring how the information could usefully be shared with patients and for any correlation with specific procedures.

Going forward the team would continue with data collection, review the indicators and set rehabilitation goals. Additional funding had been secured for SALT assessments.

The Quality Committee commended the enthusiasm and achievements of the stroke team. It was agreed that a validated scoring of stroke severity would be included in the next report.

8. Clinical Effectiveness

8.1 Mortality Review Annual Report and Review of Cusum Curves

The Medical Director presented the paper that summarised the performance for the

year to December 2017, and reviewed the measures in place to ensure mortality was kept as low as possible. Consultant outliers continued to be performance managed according to the existing policy and robust plans were in place to improve organisational learning. The MRG process was being improved in line with national guidance and learning from deaths had been implemented.

The total number of deaths in the Trust had increased between 2013 and 2017. A notable increase in deaths after cardiac catheterisation was driven by the management of acute MI in patients admitted after out of hospital cardiac arrest (OHCA). Emergency angiography, with no options for subsequent angioplasty or surgery was a common finding in these very ill patients among whom the mortality was high.

The crude (i.e. non-risk adjusted) surgical mortality at around 2.9% had increased from the end of last year. There had also been an increase in comorbidity, but no alerts had been triggered, and no issues had been highlighted through the Mortality Review Group. It was accordingly considered that these outcomes were within acceptable statistical boundaries and not a reflection of systematic problems.

In view of the increasing acuity and complexity of the patients presenting to the Trust the MRG planned to reassess the baseline mortality rate. The present overall rate of 1.6% was unlikely to come down to the 1.3% target. Once the new baseline was established the aim would be for a reduction of 10% by 2020.

The GIRFT review of cardiothoracic surgery had highlighted a number of apparent differences between LHCH and other comparable trusts, notably stroke, return to theatre for bleeding and coding of post-operative complications. Plans were in place to address these issues which would then be reviewed by the Committee.

Cardiac surgery and Cardiology risk adjusted CUSUM curves were reviewed every 6 months, reported to the Divisions and reviewed at Divisional Governance Meetings. The data were also reviewed at the quarterly cross division Quality & PFEC meeting.

In 2016 two cardiac surgeons had breached the local 90% confidence limits for expected mortality although both were within the 95% nationally-defined criteria. The surgeons were being managed according to the Trust's policy; one had returned to within the confidence limits of expected performance and the other was on a trajectory of improvement.

No individual operator performance issues were identified among cardiology procedures.

A discussion followed on the apparent correlation between in-hospital mortality for lung cancer patients and the number of operations carried out by individual surgeons. It was explained that these figures were within the boundaries of chance variation but would be kept under review.

A report on organisational learning and learning from deaths was to be presented to the Board of Directors in May 2018 for consideration of the criteria for reporting and the level of detail required.

In summary, the Quality Committee noted the current position with regard to mortality, the high level of scrutiny reported in the paper, and took assurance from the on-going work.

10. Compliance and Regulation

10.1 SUIs – None to report

10.2 Quality Risks

The Director of Research and Innovation provided an overview of the Quality Risks.

The main highlights included:-

- The clinical decision support system within EPR (Multum) not being suitable for UK use was a static red and rated 16.
- Medication errors - improved administration via EPR was a static amber and rated 10.
- Delays in reporting of histopathology samples from lack of reporting capacity and consequent delays in the scheduling of urgent cancer care. Accreditation had been renewed but the service still required improvement and remained amber and rated 12.
- The Secure Health Messaging risk had reduced following a review of the backlog of alerts by the Medical Director that identified no outstanding issues. This risk had reduced from a rating of 12 to 8. Although the Divisions had requested further improvements to ensure that individuals were putting the alert on the EPR system, this would be discussed further at the Operational Board meeting.

11. Date and time of Next Meeting

24th July 2018 – 12.30 – 14.30 Research Meeting Room