

Item 6.1.3.2 Quality Committee

minutes

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

Present:

Nicholas Brooks
Mark Jackson
Mark Jones
Sue Pemberton
Marion Savill

Non-Executive Director (In the Chair)
Director of Research & Innovation
Non-Executive Director
Director of Nursing & Quality
Non-Executive Director

In Attendance:

Lisa Gurrell

Manoj Kuduvalli
Lesley Hughes
Lynda Robinson

Megan Underwood (observing)

Patient & Family Support Manager
(Item 7.1 only)
Associated Medical Director for Surgery
Executive office Manager (Notes)
Head of Project Management Office
(Item 6.2 only)
Executive Office Assistant

1. Apologies for Absence

Apologies for absence were noted from Raph Perry.

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest to record.

3. Patient Story

The Director of Nursing & Quality (DoNQ) delivered the patient story.

4. Previous Minutes

The following amendment was noted:

Item 7.1 Measures and Reporting of Respiratory Metrics: The Chair requested that the final paragraph be removed as there had been no agreement to arrange for enhanced review of the existing data. Members of the Quality Committee (QC) agreed and the minutes would be amended accordingly.

5. Review of Action Log

The Chair referred to the following items not incorporated within the Action Log:

Item 6 Page 3 CQUINS:

Offering advice and guidance to GPs was still under review with the Medical Director (MD) and cardiologists currently engaged in the pilot. The DoNQ reported that the 80% target was not being met within the required timeframe. The MD will be transferring responsibility to the consultants to embed the process within the cardiology division.

Clinical Utilisation Review: Issues with misleading information had been highlighted. The Trust is currently on target. It was reported that the value of this CQUIN stood at £625k. Whilst some clarity was required around the targets, negotiations had concluded and an agreement had been reached.

Item 1 Discharge by 12 Noon: It had previously been reported that the discharge lounge was no longer being used. The DoNQ confirmed that patient discharge was now managed effectively by the wards; the action had therefore been discharged and would be removed from the Action Log.

Item 2 Clinical Quality Performance: Family Experience. "Did staff have the necessary skills to deliver the care" score had reduced. The DoNQ confirmed that the information provided was incorrect and there were no concerns relating to the family experience figures. The item had therefore been discharged and would be removed from the Action Log.

Item 3 Quality Impact Assessments Update Report: Main agenda item 6.2 referred. The item had therefore been discharged and would be removed from the Action Log.

6. Quality

6.1 Clinical Quality Performance Report

The DoNQ presented the Clinical Quality performance report and the salient points were noted as follows:

Mortality:

- HSMR data had reduced (latest figures supplied by Dr Foster March 2018)

- The target of 80% of mortality reviews completed within 30 days of allocation had been achieved. It was noted that the Mortality Review Team had a further member, identified by the MD.

The surprisingly low level of PCI complications (MACE) between October 2016 and March 2017 was questioned. The Director of Research & Innovation (DoRI) would review the accuracy of the report.

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Infection Prevention and Emergency Re-Admissions:

- 1 CDiff within Critical Care; LHCH acquired but no lapses in care were identified. It was noted that work was being done within the network on bowel management.
- 1 CPE; hospital acquired. Patient samples were submitted for testing and the source was identified in a line tip on routine culture of the line. No cross infection was identified.

Incident and Medication Errors:

- Reported patient safety incidents stood at 115 YTD; none had resulted in severe harm or death.
- 16 medication errors reported in month, 50 year to date. Data on the detail of the medicine errors was still awaited.

Radiology Alerts and Dementia Find/Assess/Refer:

- Radiological alerts with a response document reported amber stood at 92% within the month and 98% for the year. The committee noted that the process was being developed through the divisional dashboards and the informatics team. Radiological alerts relating to requests from junior doctors were also reported to the responsible consultant.

PPCI:

- The primary PCI (120 mins) internal target call to balloon was reported red at 76.3% in the month, 75% YTD. The national 150 minute target was also red YTD at 86.7%. Commissioners had requested a review to be reported to the November 2018 meeting. It was noted that the main cause was ambulance delays which in the main are beyond our control; however, the Trust would continue to engage with the service. The Chair requested that the MD provide an update to the next meeting.
- Sepsis: Training in ward areas, changes in the EPR system and the continuation of the education programme have resulted in an improvement in sepsis prevention and management. The improvement work is on-going.

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Discussions followed in relation to the effectiveness of the sepsis bundle and screening programme; the committee noted that further improvement was expected in the coming months.

Quality Priorities: Delirium, Complex Mental Health, Frailty:

The committee noted that the information was still being compiled; the DoNQ would provide a report to the next meeting.	SP
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CQUINS:

The DoRI informed the committee that the advice and guidance examples referred to on page 14 were not implemented until quarter 2 and progress was being made.

The remainder of the report was noted.

6.2 Quality Impact Assessments Update Report

The Head of Quality Improvement (HoQI) was in attendance to present on the progress of the cost improvement programme (CIP) and quality impact assessments for 2018/19.

The improved position was noted with 41 CIP schemes identified requiring a quality impact assessment (QIA), 36 of which had been approved (full details were provided within the appendices). 5 QIAs were outstanding and 2 of these had QIAs prepared and were awaiting approval from the next meeting of the Business Transformational Steering Group 23rd July 2018. A further 3 schemes were expected to be completed over the coming months.

The committee had previously discussed the QIA for the Pulmonary Function department for which a retrospective QIA had identified an adverse impact on quality. A concern had been raised at the April Integrated Performance Committee about a retrospective QIA. Following a request to check the information, the HoQI reported that a trial had been undertaken in relation to the scheme prior to removing the funding, the QIA was undertaken at the point the agreement to remove the funding from the budget was made.

The committee noted the remainder of the report.

The HoQI left the meeting.

6.3 Quality & Patient Family Experience Summary Report:

The committee received the reports presented by the DoNQ with supporting papers that had been circulated under separate cover. The following salient points were noted:

11th May 2018: Clinical Quality Performance Report:

- A programme of work was underway to improve the response to radiological alerts.
- The improvement work around sepsis had been discussed previously within the meeting (page 3 refers)

Fasting Compliance:

- Reviewed at each QPFEC meeting. Separate action plans had

been compiled for the medicine and cardiology divisions where improvement on fasting guidance and communication was required. Further detail was reported within item 6.3a (page 4 refers) in relation to the letters produced within the patient administration system which would provide specific information around pre-admission fasting and audited to measure its effectiveness.

Discussions followed around the National Early Warning System (NEWS) tool which has been mandated for all Trusts. However, an internal audit had identified patients who would not have triggered alerts using the NEWS and a decision had therefore been made by the Critical Care Delivery Group that the Trust should retain the MEWS as being more appropriate for our patient groups. The decision had been communicated to NHS England and a letter had been received in return. The national team have indicated that to retain funding for the CQUIN the Trust should continue to use NEWS alongside its own internal system. Further discussion with the Commissioners is required.

NATSIPS and LOCSIPS:

- The divisions continued to develop standards and audit data will be presented to the Quality and Family Experience Committee (QPFEC) at its November 2018 meeting.

Diabetes Steering Group Annual Report:

- The inappropriate omission of insulin and taking responsibility of the point of care testing fobs remained as issues in the service but were being addressed by the specialist nurses. It was noted that a consultant cardiologist and representative from the Royal Liverpool & Broadgreen University Hospital (RLBUHT) attended the Diabetes Steering Group (DSG) but greater input from the diabetes service is required; an action plan was being compiled for consideration by the QPFEC at its meeting in September 2018.

The Terms of Reference for the DSG were under revision.

The committee acknowledged the improvements to date and the areas requiring further improvement.

Mortality Review Annual Report:

- Discussions were being held on the necessity to reset the mortality reduction target. This has arisen because of the increasing baseline mortality, due principally to the policy of accepting patients with out of hospital cardiac arrest for primary PCI. The Mortality Review Group will consider the issue and make a recommendation.

13th July 2018:

The CQUIN update, sepsis and fasting compliance had been considered

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under the previous item.

Discharge Delay:

- The committee noted that a pharmacist had been identified to accompany surgical ward rounds resulting in increased efficiency of the discharge process.

Daily cardiology ward rounds were yet to be fully agreed/established but the plan is for these to commence in September 2018.

The committee considered the supporting documents that had been circulated and no questions were raised in relation to the Q3 and Q4 DNACPR Bi-Annual Quality Compliance Report.

Committee members commended the Tissue Viability Service Assurance Report and the impact of the first Tissue Viability Nurse Consultant within the service.

The contents of both reports were noted.

The committee members confirmed that they were satisfied with the level of detail provided in the QPFEC summary reports.

6.4 Statement of Purpose – for approval

The DoNQ delivered the Statement of Purpose that had been updated to incorporate reference to vascular surgery. ACHD would also be incorporated into the statement and re-circulated to committee members.

6.5 Care Quality Commission – In-Patient Survey Results

The DoNQ presented on the outcome of the Care Quality Commission National In-Patient Survey results for 2017 highlighting the main areas of focus for 2018/19 namely:

- Pre-admission process; improvements to patient letters. Further work required on the Patient Administration System to support this.
- Changes to admission dates.
- Patient own medication process.
- Patient fluid intake recording.
- Emphasis on doctor/patient communication.
- Discharge process/communications. Ward rounds in Birch ward would commence September 2018, accompanied by a senior nurse. Patients to be prepared for discharge the day before and expected discharge timings to be communicated.
- Post discharge equipment requirements.

The patient and family experience vision would be reviewed to include pre-admission and post discharge actions and presented to the Executive Group for consideration; the final proposal would be presented to the Board of Directors (BoD).

Discussions followed around the discharge of patients and if there were any identifiable differences between discharge to home or transfer to other hospitals; it was noted that the process was the same for all patients, regardless of their destination, although the majority of patients were discharged to their homes.

Committee members noted that the covering paper provided a link to the full report.

The committee noted the results of the survey and progress made.

7. Key Reports

7.1 Annual Complaints Report

The Patient & Family Support Manager (P&FSM) was in attendance to present the Annual Complaints Report 2017/18 highlighting the salient points:

- 50 formal complaints had been received and at the time of reporting, 2 had not been investigated as consent from the patients for relatives to act on their behalf had not been received. To date, however, consent had been received from one of these, bringing the total investigated to 49.
- Eighteen complaints had been fully upheld; 9 were partially upheld and 21 were considered unfounded and requiring of no further action apart from a full explanation to the complainant. Of those that were upheld 4 graded low, 43 medium and 1 high.
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- The Trust worked in partnership with 3 other NHS organisations when requested.
- Quarterly complaints review panels, attended by non-executive directors, continued to be held
- Complaints satisfaction survey returns were favourable
- Total complaint contacts for 2017/18 stood at 358, 153 of which were informal concerns and were resolved before being formally escalated.
- The other 205 contacts were relating to requests for Advice/information. (these are detailed on the quarterly reports)
- Themes:
 - Appointment/procedure enquiries
 - Access to health records enquiries
 - General Information about the hospital
 - Enquiries about Robert Owen House/Charity
 - Car parking
 - Communication issues

The committee discussed the importance of open communication to patients and their families and how the Trust was working on a standard approach across the organisation, and piloted within the surgical division, to manage bereaved families. They also sought assurance that the proposed bereavement letters be personalised; the P&FSM agreed to circulate a copy of the standard letter to committee members for their

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information.

The committee members commended the work of the team in relation to the resolution of informal concerns before they were formally escalated and noted the assurance around the effective complaints process, management and procedure.

The P&FSM left the meeting.

8. Clinical Effectiveness

8.1 Review of Cumulative Summation (CUSUM) Curves

The Associate Medical Director (AMD) for surgery presented the CUSUM curve charts which were part of the internal performance management process for Consultant cardiac surgeons and interventional cardiologists. The committee noted that the targets within the Trust were more stringent than those posed nationally.

8.1.1 Surgery:

Discussions were held in relation to the charts and ways in which additional information e.g. visually comparable data would help to allow for committee members to receive assurance.

The AMD explained how surgical mortality monitoring was carried out over a 3-year period and produced bi-annually, and referred to the Performance Policy which sets out in detail the process for the assessment of performance.

It was noted that the MD had previously presented a CUSUM Curve report to the Board at its Development Day.

8.1.2 Medicine

The committee reviewed the observed and expected 30-day mortality CUSUM curves for all PCI procedures between 1st April 2015 and 31st March 2018. A discussion followed on the impact of primary PCI patients with out of hospital cardiac arrest and of other unidentified factors which should be considered when reviewing the data. It was noted that all PCI consultants were operating within or better than the predicted rate of major adverse events.

9. Compliance and Regulation

9.1 Serious Untoward Incidents

There were no serious untoward incidents to report.

9.2 Quality Risks

The DoRI reported on the following high scoring risks:

Clinical Decision Support Programme within the EPR system was not fit for purpose. Following lengthy discussions with Allscripts this has now

been recognised and the system will be adapted to meet the Trust's requirements. In the meantime the clinical support programme would remain disabled.

Speech and Language Therapy (SALT): There was considerable pressure on the current service; however, plans were in place to reinstate the service line agreement with the RLBUHT and a band 6 and 7 had recently been recruited, thereby reducing the risk to the service.

Anaesthetists Recruitment Programme: The shortage of anaesthetists continued to be a concern, the main cause being retirement of colleagues. Despite the recent appointment of two consultant anaesthetists, the Trust continued to explore all recruitment options although it was noted that this was also a national issue.

Histopathology Service: The committee noted that a plan was in place to improve the Liverpool Central Laboratory histopathology service following their loss of accreditation, due in part to prolonged turnaround times which had implications on the scheduling of urgent care.

The Chair invited committee members to raise any other business and the following was noted.

9.3 High Risk Referrals:

The AMD reported on the increasing number of referrals of patients who had been turned down for surgery elsewhere, often on more than one occasion. This was liable to have an adverse impact on mortality rates. Each case was considered within a high risk MDT meeting and it was noted that only a small number were rejected; accepted patients were presented with an informed choice. The high acceptance rate did raise the question as to why these cases were not undertaken by the original hospital.

The committee discussed the importance of capturing the data through the EPR system and the DoRI agreed to investigate the options and report the outcome to the next meeting.

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10. Date and time of Next Meeting

29th October 2018 – 13.00pm-15.00pm Research Meeting Room

All