

Quality Committee

minutes

Minutes of the Quality Committee meeting held on 25th October 2016

Present:

Lawrence Cotter,
Mark Jones
Marion Savill,

Non-Executive Director (Chair)
Non-Executive Director
Non-Executive Director

In Attendance:

Dr Mark Jackson,
Dr Raphael Perry
Susan Pemberton
Joanne Shaw (Item 7.1)

Dr Gill Gow (Item 5.2)
Karen Wafer (Item 8.4)
Jim Davies (Item 5.3)

Tim Crowley
Debbie McEllenborough

Director of Research and Informatics
Medical Director and Deputy Chief Executive
Executive Director of Nursing and Quality
Lead Nurse for Patient and Family Centred Care
and Safeguarding
Chief Pharmacist
Cath Lab Manager
Deputy Chief Finance Officer

Mersey Internal Audit Agency (Observer)
Support Secretary

Patient Story

The Executive Director of Nursing and Quality read the patient story.

1. Apologies for Absence and Introductions

There were no apologies for absence to record.

The committee offered introductions and welcomed a representative from Merseyside Internal Audit Agency (MIAA) who was in attendance to observe the Committee as part of the well led review.

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest relating to agenda items.

Action

3. Previous Minutes

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

The Chair asked to be appraised on the following items:-

Smoking Cessation – The Director of Research and Informatics explained that circumstances had not changed in relation to funding being withdrawn by Public Health England (PHE). This issue had been raised at the Clinical Quality Performance Group Meeting (CQPG) attended by local Clinical Commissioning Groups (CCGs). At present the Trust was unable to take this forward without funding its own smoking cessation advisors and this was not financially viable given the current economic climate.

The Non-Executive Directors (NEDs) questioned how this affected the Healthy Liverpool initiatives and requested the DoN to discuss this with the CEO and contemplate drafting a briefing letter to be circulated to local councillors outlining the Trust's concerns and consider raising this and other priority issues when the Secretary of State for Health visited the Trust. **DoN**

The NEDs went on to express trepidation that a cut in funding for smoking cessation would put quality initiatives under duress. However, the NEDs received confirmation that nursing staff at the Trust were trained in basic smoking cessation and letters were sent to a patient's General Practitioner to follow up stop smoking initiatives within the locality.

4. Review of Action Log

The Committee reviewed the Action Log

Item No. 1 Medication Errors – this item was on the agenda

Item No. 2 Planned Utilisation of Service Line Reporting – The Director of Research and Informatics explained that a new internal role was due in post in January 2017. A recent national directive had been published and the Trust had a plan in place to address the objectives identified therein. The NEDs also commented that Service Line Reporting and benchmarking had been discussed at a recent Integrated Performance Committee meeting.

Item No. 3 Reflection strengthening of quality improvements and local audits in the Quality Strategy – this item was on the agenda.

Item 4 Quality Report – Re-admissions. The Director of Research and Informatics provided an update on the reporting of medical re-admissions and explained that further work was underway within the divisions to improve the quality of discharge data collected. In turn this would help to highlight specific areas and ensure patients were not discharged too soon following their procedures. The divisions would be asked to provide a more detailed report for the next Quality Committee meeting in January 2017. **MJ**

5. Quality

5.3 Quality Impact Assessments

The Committee received the Cost Improvement Programme (CIP) and Quality Impact Assessments (QIAs) report from the Deputy Chief Finance Officer (DCFO). The report provided an update on the CIP process and specifically the QIAs. The DCFO explained that the Trust was committed to the delivery of £3.7m for the financial year 2016/2017 although there was a short fall of £1.3m at the end of September 2016.

It was highlighted to the Committee that schemes under the de-minimus threshold of £25k did not require QIAs and progress was reported via a monthly report to ensure the CIP Steering Group had oversight of the CIP process.

The CIP Steering Group was due to be replaced by the Business Transformation Steering Group (BTSG) chaired by the Chief Finance Officer and would retain overall responsibility for reviewing and assessing the accuracy of the schemes.

The DCFO then went on to say that 6 schemes were yet to be scoped, 4 schemes required QIAs and 2 schemes already had QIAs approved. These were:-

Same day admissions - this realised quality and financial benefits although there were also some key risks identified around capacity and support.

Theatre efficiency – highlighted improvements and savings in relation to pay and non-pay financial benefits, E-rostering, scheduling and 7 day working.

The DCFO explained the implications around staff consultations and how this affected timescales and the implementation date that was scheduled for March 2017 (following the consultation exercise).

A discussion followed on the processes, the point where schemes were presented to the Quality Committee and concerns were expressed about the timeliness of schemes to realise their potential savings and achievability within the required timeframes.

The Chair re-iterated the concerns of the Committee and a requirement to ensure robust processes were in place and savings made in a timely manner without impacting on patient safety and quality. The DoN informed the Committee that these concerns would be raised at the next BTSG meeting. As this was a recurring theme the chair asked for the process and timeliness of QIAs to be brought to the attention of the Board of Directors at their next meeting.

DoN

The Chair thanked the DCFO for attending the meeting and providing a comprehensive report. The DCFO left the meeting at this point.

5.1 Quality Report

The DoN presented the Quality Report to the Committee and highlighted the key areas.

Mortality – The committee noted that the number of observed in hospital deaths for all surgery admissions was higher than expected and it was explained that this may be due to lack of risk adjustment. Deaths were monitored and subject to mortality review. The number of deaths was

monitored and would be examined to ensure the trend did not remain elevated next month and that once risk adjustment had taken place rates were within normal limits.

Mortality Reviews - The Committee discussed the timely completion of reviews within 30 days and the work that was underway to tackle the back log. From 1st October 2016 there would be a change to the process with 6 consultants screening all deaths. The majority would entail a rapid review with a small minority receiving a detailed review. Following the reviews the focus would be on strengthening organisational learning and sharing the outcomes with staff across the Trust.

The Committee received assurance surrounding the review process and confirmation that there was no direct link between the screening consultant and the consultant under review. The Chair also commended the mortality review process and the high quality of reports that were produced.

Falls – The Committee received an update on recent initiatives to reduce the number of falls on four wards (Birch, Cedar, Elm and Oak). Benchmarking had been carried out with Papworth and Brompton hospitals and this showed there fall rates were considerably higher than that of the Trust.

Pressure Ulcers – The Committee commended the continued high standards across the Trust on meeting targets in this area.

Infection prevention – The Committee commented on the superb efforts in this area that showed exceptional performance and asked for the Infection Prevention team to be commended on their high standards of patient care.

Mixed Sex Accommodation – no breaches were recorded for the past month. Again the Committee praised the good work that had been done to achieve this.

Clinical Claims – The Committee were informed of a National Report that would be presented to the next Risk Management meeting regarding how claims would be processed going forward and how premiums would be calculated following an assessment of the Trusts safety culture.

VTE and PPCI – The Trusts target for the provision of appropriate VTE Prophylaxis had not been met and efforts to improve consistency in this area continued. So far this year the national call and door to balloon standards were being achieved.

Dementia Assessment – The Trust had not met the required dementia assessment for the month of September 2016. One patient had been missed and this would be followed up by the DoN. **DoN**

Patient Experience

- Inpatient – The results for inpatient responses and indicators was outstanding
- Outpatient – One patient had made a suggestion for a visual sign to be available for people with hearing difficulties rather than staff calling out names.

Sepsis – The indicators showed that appropriate taking of blood cultures and

the percentage of patients receiving at least one sepsis antibiotic within 1 hour was below standard. The Medical Director explained that numbers were low and this would affect the percentages if only one patient did not receive their required treatment in the required timeframe and work continued to improve this.

5.2 Report on Medication Errors

The Committee received the report presented by the Chief Pharmacist and it was explained that medication incidents generally fell into one of three categories

- Dispensing incidents
- Prescribing incidents
- Administration incidents

The Quality Committee was informed that the Safe Medication Practice Committee met monthly and reviewed all incidents reported via the Trust's incident reporting system (Datix). The length of the meeting had been reduced to an hour to improve attendance by both ward managers and medical staff and the Chair received confirmation that a log of attendees was recorded.

The Chief Pharmacist explained that prescribing errors had shown a slight increase and this could be due to the new reporting system.

Each error was reviewed and possibly reclassified if it was considered that harm or potential harm could have occurred. The reclassification process of the Safe Medication Practice Committee enabled incidents of note to be discussed which may have gone unnoticed and helped to identify trends.

The trend analysis was sent to the three clinical divisions on a quarterly basis to enable learning points to be discussed. Going forward the Quality Committee would also receive a summary of the Safe Medications Report and Medicine errors that was presented at the Divisional Meetings.

A safe medication strategy was also being developed at the request of the Medical Director.

The Committee noted the positive progress that had been made and asked for the table that summarised the total number of incidents reported to include a breakdown by incidents each month by both medicine and surgery. The Director of Research and Informatics agreed to take this forward with the Information Team for inclusion in the Quality Performance Report.

MJa

5.4 Quality Governance Review

The Executive Director of Nursing and Quality presented the Quality Governance Report. The report provided a final update against the areas of improvement identified in July 2015 against the requirements of the Quality Governance Framework (QGF) that had now been superseded by the Well Led Framework.

Strong progress had been made in all areas identified for improvement as demonstrated within the report and this provided assurance to the Quality Committee that significant steps had been taken to address areas where

improvements had been highlighted.

The Committee was asked to receive the document as a closing report in respect of progress made and note that the QGF had now been superseded by the Well Led Framework. An external review was underway and would report to the Board of Directors in March 2017.

DR&I

The Chair commented on the clear and concise information contained in the report and there was a request for the data quality plan to be circulated to the Committee separately.

6. Clinical Audit and Effectiveness

6.1 NHS Boards and Clinical audit Papers

The Director of Research and Informatics presented the Self- Assessment against Clinical Audits that provided the Committee with an updated action plan in relation to the self-assessment undertaken against the updated Healthcare Quality Improvement Partnership (HQIP) publication.

The action plan demonstrated good progress and performance made since July 2016 against 10 standard questions. The key areas to note were:-

Question 4 – Are the Trusts clinical audit cycles comprehensive, timely and outcome focussed? –

- Clinical engagement was being addressed
- Dashboards in use to support audit cycles and outcomes
- Use of hierarchy and prioritisation process for CQFP development
- Divisional input required to improve identification of priorities.

Question 5 – What proportion of approved clinical audits had been completed to time and budget?

- Clinical engagement was again being addressed
- Divisions were progressing well and closing gaps
- Quarterly meetings with the Divisions had been set up and provided opportunities to review the requirements for specific pieces of work

The committee noted the content of the report and progress being made against the action plan.

6.2 Clinical Audit and Effectiveness – Annual Report

The Director of Research and Informatics presented the Clinical Audit and Effectiveness Group (CAEG) Annual Report. The paper provided an update to the Quality Committee on the progress and activity of the (CAEG) between 1st April 2015 and 31st March 2016.

The paper outlined the key achievements and highlighted the following:-

Safe from harm objective – partially met. Feedback on previously approved technology was requested and followed up by CAEG to gain assurance that patient care was safe and effective. An audit had been undertaken in two of the four new technologies approved and 2 were still to be followed up.

Committee self-assessment and review – The findings indicated that

attendance had shown an improvement and it was suggested that this be discussed with the CEO so that she may encourage this to be increased further.

Participation in Clinical Audits - Appendix 1 and 2 were taken from information published in the Quality Account (March 2016). The outcomes of reviews and gap analysis had all been addressed. On reflection it was recommended that this item would be rescheduled to return annually to the Quality Committee following the next update in March 2017.

The Chair commented on the extensive amount of good work that had been undertaken in this area and asked for the CAEG to be commended for their efforts.

7. Patient and Family Experience

7.1 Patient and Family Experience Annual Report

The Lead Nurse for Patient and Family Centred Care and Safeguarding presented the report to the Committee. The key points to note were:-

- The Trust had facilitated four engagement events during 2015 / 2016 held at Llandudno, Isle of Man, Liverpool and Chester.
- The events were designed to capture feedback on patient and family experience and how patients would like services to improve with a focus on family centred care
- The events had all been supported by representation from the Executive Team, Non-Executives, Governors and clinical staff.

The report also brought together the outcomes from the evaluation of the Trusts' patients and their family experiences of care in the Trust. The results were excellent and during 2016/2017 the Trust would continue to build on this success to ensure they were working together with patients and their families as equal partners in care.

Additional initiatives underway included:-

- Piloting the Care Cube System (scheduling solution for patient flow) on Holly Suite
- Replacing the Cath Lab scheduling system with status at a glance.
- Improvements to scheduling
- LINQ – Trialling - reduced length of stay (no antibiotics)
- Injectable monitoring devices

The committee commented on the outstanding information and results that were reflected in the report and the remarkable level of energy required continuing with the high standards. The Lead Nurse for Patient and Family Centred Care and Safeguarding left the meeting at this point

7.2 Patient and Family Support Team Complaints – 6 Month report

The Executive Director of Nursing presented the quarter one and quarter two complaints activity report for 2016/2017. It was explained that the Trust had received a total of 165 complaints through the Patient and Family Support Team. Of these contacts 97 were for advice and support and 68 informal concerns. The main themes included:-

- Waiting time for surgery appointments
- Shortfalls in communication
- Referral enquiries
- Concerns related to car park charges

36 formal complaints were received and the main themes included

- Clinical care including nursing care
- Communication
- Waiting times
- Referral processes

Of these 36 complaints

- nine remained under investigation
- three remained on hold awaiting full details

Of all the complaints closed following investigation:-

- 16 complaints were considered upheld/partially upheld and required action/learning
- Seven complaints were not upheld, meaning they did not require any corrective action or learning
- One complaint was withdrawn

A table within the document demonstrated the number of complaints received, trends and grades for Q1 and Q2 2016/17. Recurring trends were highlighted and it was indicated if complaints were well-founded and requiring action. The number of complaints was also broken down by Division.

The DoN confirmed that learning from complaints was fed back to staff at the organisational learning events, through the Divisions and if appropriate at one to one meetings with staff. All complaints were discussed in the respective governance committees and learning would be embedded Trust wide. Going forward any actions developed as part of the process would be prioritised within the divisions and plans were underway to audit the outcomes of these actions.

The Committee commented on the rigorous review and extensive report and received assured on how complaints were dealt with and how the learning was fed back to staff as mentioned above.

7.3 Safe Staffing Review – 6 Month report

The Committee received the report for information that had previously been presented to the Board of Directors. There were no additional comments made.

8. Key Reports

8.1 ECS annual report

The Executive Director of Nursing and Quality presented the Excellent Compassionate and Safe (ECS) Annual Report. The report described the assessment process undertaken to monitor clinical standards on the ward. The

Committee were informed that following the first assessment in October 2015 results showed that two areas did not meet the outcome of green status.

Further assessments were carried out in March and September 2016 and all areas were rated green. Actions had been identified following the assessments and would be monitored by the Divisions.

There would be another round of assessments starting in November 2016 and plans were underway to include areas such as Pharmacy, Radiology and Medical Engineering as part of the assessment process.

Once an area had received three consecutive green ratings they would be eligible to apply for ECS Gold Status.

The Committee commented on the excellent paper and the stringent demands required achieve Gold Status.

In conclusion, the Committee received assurance of the good practice highlighted and the plans to address the areas identified for improvement.

8.2 Sepsis Update Report

The Committee received the Sepsis Update Report from the Medical Director. The paper summarised the current practice and recent audit results in relation to the recognition and treatment of sepsis according to the new NICE guidelines issued in July 2016. These guidelines contained new definitions and risk stratification tools for patients with suspected sepsis. There had been two revisions of guidelines within the last 18 months.

The Medical Director explained the difficulties experienced with meeting the KPIs and challenges experienced with recording the required information on EPR in a timely manner. In addition the number of patients with sepsis was low and this would reflect relatively low percentages if the prescribing of sepsis was mistimed when recorded on EPR. The MD went on to say that patients who were severely ill did receive the treatment they required.

The MD went on to say that there would be a number of planned changes to current practice in response to the new guidelines:-

- Introducing a sepsis screening tool
- New sepsis awareness campaign to educate staff about the new sepsis definitions
- Introducing the sepsis screening and management pathway into EPR.

The Committee went on to discuss a number of concerns with

- how the data was captured on EPR
- the integrity of the data
- the need to establish a more robust method of capturing the correct information
- how the information was being audited and could this be done differently.

In conclusion, the Committee felt that they required further assurance of the Trusts plans to improve the management of sepsis and the Chair asked for sepsis to be raised at the next Board of Directors meeting in November 2016.

8.3 PLACE Annual Report

The Committee received the report for information that had previously been presented to the Board of Directors. There were no additional comments made other than the results were excellent.

8.4 WHO Safety Check Lists – Cath labs Update Report

The Committee received the update report from the Cath Lab Manager who explained that the assurance target for the WHO Safety Checklist had been set at 95% and a recent audit from June 2016 - September 2016 had shown that all compliance rates were above the 95% target.

The Committee were informed of a number of outstanding actions and the work that was underway to address these including the auditing of mandatory fields. Improvement plans were also in place with the proposed introduction of care cube within cardiology and the resultant significant improvements that would be realised for the auditable output.

The Cath Lab Manager went on to praise the use of HALT in Cath labs with nurses, Junior doctors and non-clinical members of staff who were all encouraged to speak out to prevent potential patient harm.

In summary, the Committee were informed that compliance was good and that further plans would offer additional quality assurance through more detailed audits.

The Committee noted the good work that had been achieved to date and looked forward to receiving the next update at the meeting in January 2017. The Cath Lab manager left the meeting at this point.

8.5 Medical Equipment Maintenance

The Committee received the report presented by the Director of Research and Informatics and were informed that the document had previously been reviewed at the Risk Management Meeting in October 2016.

The Committee expressed a number of concerns in relation to:-

- Quality implications for patients if equipment was not serviced regularly
- Logistical problems of servicing equipment (if equipment was in use at that time)
- The frequency of equipment replacement

It was also brought to the attention of the Quality Committee that following a recent NED walkround several issues were raised around:-

- Difficulties with maintaining a large and diverse range of equipment
- Replacement of key personnel (due to pending retirement)
- Age and profile of hospital / equipment

As a result of the comments above, the Committee felt that they required further assurance that medical equipment was being adequately maintained or replaced in a timely manner and asked for this issue to be raised at the next

Board of Directors meeting in November 2016.

9. Compliance and Regulation

9.1 SUIs

There were no Serious Untoward Incidents to report

9.2 Quality Risks

Sepsis - mentioned under Item 8.2

Secure Health Messaging (SHM) – used to identify abnormal radiology findings. The system was being improved and a number of enhancements introduced. SHMs would be posted to doctors and consultants via Allscripts inbox and SHM Icons.

10. Receive minutes of Operational Board (for information)

10.1 Approved minutes 27 05 2016

10.2 Approved minutes 01 07 2016

11. Any Other Business

The Chair mentioned thoracic medicine/surgery, patients that were on the cancer pathway, referral timings and if these types of patients and their quality aspects needed to be discussed at the Quality Committee. The DoN agreed to follow this up with the Executive Directors to determine where this was addressed.

11. Date and time of Next Meeting:

10th January 2017, 12.00 – 15.00 (Boardroom)

DoN