

Item 7.1.1.2

Quality Committee

minutes

Minutes of the Quality Committee meeting held on 10th January 2017

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
Linda Robertson (Item 6.2)

Karen Wafer (Item 7.2)
Neaka Cope (Item 9.1)
Debbie McEllenborough

Director of Research and Informatics
Medical Director and Deputy Chief Executive
Executive Director of Nursing and Quality
Head of Project Management Office and
Business Transformation
Cath Lab Manager
Deputy Divisional Head of Operations, Surgery
Support Secretary

1. Apologies for Absence and Introductions

There were no apologies for absence and the meeting was advised that the Director of Research and Informatics would join the meeting following their return from an event at Aintree Hospital.

Action

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest.

3. Patient Story

The Director of Nursing and Quality read the patient story. The Committee were informed that all concerns had been thoroughly investigated and it was important that less positive stories were shared with the Committee.

4. Previous Minutes

The previous minutes were agreed as a true and accurate reflection of the meeting and it was confirmed that that an in-depth discussion on sepsis had been recorded under Item 8.2 of the minutes.

The Chair mentioned the item that had been raised under any other business and the need to ensure that metrics for respiratory patients in general were not overlooked. The Committee went on to discuss the work currently under way with cystic fibrosis patients and how this was scrutinised externally. In addition, further work had taken place recently with the restructuring around the therapies department.

The Medical Director went on to say that it was difficult to track readmission rates for cystic fibrosis patients as they often presented periodically at the Trust if they felt unwell. The Medical Director agreed to have a conversation with one of the respiratory physicians to determine what measures were in place and what could be reported back to the Quality Committee.

RAP

The Director of Nursing mentioned a peer review that had recently been conducted in ITU and the Chair asked for peer reviews to be built into the Quality Committee workplan and quality assessments of respiratory patients to be included as an item on the agenda at a subsequent meeting.

SP

5. Review of Action Log

The Committee reviewed the action log:-

Item No. 1 Emergency re-admissions. The Medical Director advised the Committee that this topic had been discussed at the recent Quality and PFEC meeting on how to reduce re-admission rates. An action plan had been developed that identified a number of recommendations including:-

- Appending results of patient tests to their discharge summary
- Reviewing how a patients cardiac rehabilitation was delivered
- Provision of up to date leaflets to hand out to patients in relation to their recovery
- Improving advice line availability / or the process as to how advice is sought
- Improving TTOs and reducing superfluous and unnecessary information and details that were constantly repeated.

The readmission indicators had been provided by Dr Foster and the Chair commented on the data only being available up to April 2016.

The Chair asked for the action plan and information that went to the Quality and PFEC to be shared with the Quality Committee.

DMc

Item No. 2 Smoking Cessation – At a previous meeting the Committee had learnt that funding for smoking cessation had been withdrawn by Public Health England. The DoN confirmed that the Chief Executive would be prompting the need for this to continue as part of the CEO's influential work with the CVD Programme Board. Item complete and removed from action log

Item No. 3 Quality Impact Assessments – the issues previously identified had been raised at the appropriate forums. Item complete and removed from action log.

Item No. Missed assessment for dementia patient – this had been followed up by the DoN. Item complete and removed from action log.

Item 5.2 Report on Medication Errors – to be shown separately for surgery

and medicine and also broken down by wards. Item carried forward to the next meeting in April. **MJa**

Item 8 Medical Equipment – Raised at the last Board of Directors meeting in December 2016. Item complete and removed from action log.

6. Quality

6.1 Clinical Quality Performance

The Director of Nursing presented the report to the Committee and highlighted the key areas:-

Mortality – Hospital Standardised Mortality Ratio had seen an increase in July and the Committee were informed that even a small increase in mortality rates would alter the statistics significantly. Mortality reviews had been completed for all 21 deaths in July. 17 had been assessed as definitely not avoidable, three more had been scrutinised and it was confirmed there were no recurring themes.

The Chair had requested more information on the circumstances of the three deaths that had been scrutinised. The Medical Director provided an update on the following:-

Patient 1 was an elderly high risk surgical patient that had encountered problems with clotting after their anticoagulation medicine was stopped. This was normal practice before this type of procedure. However, the anticoagulant had been stopped whilst the patient was at Whiston Hospital and there was a gap before the patient was then started on low molecular weight heparin.

In conclusion, the Medical Director confirmed that the death was avoidable. The Divisions had fully investigated the issues and would always feed-back to the referring hospitals as part of the Root Cause Analysis process so that they are aware of the findings.

Patient 2 was a Primary Percutaneous Coronary Intervention (PPCI) and had died post Coronary Artery Bypass Grafting (CABG). The patient had received a successful stent but had thrombosed twice. The review identified that a coagulant was used for 12 hours and possibly this could have been administered for at least 24 or 36 hours. The Medical Director informed the Committee that this had been discussed at length at the angioplasty meeting.

Patient 3 – had received by-pass surgery and spent a length of time on ITU due to an infection on the left side of the chest. This would be further discussed at the next audit day and the learning from this shared with staff.

The Committee were informed that the new mortality review completion rate was now measured at 30 days and improvement efforts were on-going. The message was clear to staff to conduct the reviews in a timely manner and this would be closely monitored. The Medical Director was planning to meet with staff to discuss the new process and length of time to complete the reviews and also to randomly select patients that were not screened to ensure nothing had been missed.

C-Diff

One case had been identified in December that was not shown on the report and investigations were underway.

Falls Pressure Ulcers

Seven falls had been reported in November 2016. The Director of Nursing and Quality had asked for Brompton and Papworth to share their falls data with the Trust to help identify themes and work towards reducing falls.

Further work was also planned to look at innovative ways to help reduce falls by providing patients with alarms etc. when they were mobile on the wards. A more detailed analysis would be brought to the meeting once complete.

Pressure Ulcers

The Committee commended the continued high standard across the Trust on meeting targets in this area.

Incident Reporting – following a rise in incident reporting when the new system was first implemented this had now levelled out and it was apparent that some areas needed encouragement to report incidents. Going forward specific areas would be targeted to help improve the number of incidents reported.

Medication Errors

The number of medication errors reported in November was more than expected. The medication errors leading to harm to patients was very small with

- 19 recorded as minor or no harm
- 0 as moderate harm
- 0 as severe harm or death.

Improvement work continues to reduce the number of errors.

Safe Staffing

In light of the recently published safe staffing guidance from the National Quality Board there was a renewed focus on care teams and care hours per patient day rather than ratios of staff to patients. Information from the Trust would be shared with Brompton and Papworth and outputs from a recent pilot in relation to care hours per patient day were yet to be published.

The Chair asked about the average fill rate for nurses per day and the Director of Nursing and Quality explained that percentages were lower when staff were off sick and staff were moved around or worked in different ways to ensure safe staffing. The wards were noted to be safe and staffing was managed according to occupancy and reviewed on a daily basis by the Heads of Nursing and Ward Managers.

Mixed Sex Breaches

There were no missed sex breaches for the month of November 2016.

VTE and PPCI

The Trusts target for the provision of appropriate VTE prophylaxis given was not met for the month of November 2016. Efforts to improve consistency in this area continued with a development expected in EPR to prompt doctors to give

the appropriate VTE prophylaxis with the required timeframe. The Medical Director confirmed that this had been discussed in detail at the last Operational Board meeting in December 2016 and plans were underway to split out the information by Division and by Wards to identify where there were delays.

PPCI – Call to balloon

The Committee discussed the internal target of 120 minutes for call to balloon and how this had originally been set by local Commissioners and was not a National target. Therefore given the National target for call to balloon was 150 minutes it was highly unlikely the Trust would achieve the target of 120 minutes.

MJa

The Medical Director informed the Committee that regular meetings were held in relation to ACS and the main delays included:-

- Delays with assessing patients at local A&E Departments
- Patients attending A&E independently
- Delays with secondary transfer of patients to LHCH

The Chair asked if the Medical Director and Director of Nursing and Quality could discuss the issues and look at what options were available to improve the figures or agree a more realistic internal target.

Sepsis

For patients with indications of sepsis, the appropriate taking of blood cultures prior to antibiotics being given was below target although the percentage of patients receiving at least one sepsis antibiotic within one hour had been met in the month of November 2016

RAP/SP

The Medical Director explained that a change to EPR next Wednesday 18th January 2017 would see an improvement to align the timings for the blood cultures together with the printed label prior to antibiotics being given.

Patient Experience – Inpatient

Response rate indicator for the current month was slightly below target as Birch Ward had a high number of patients and was unable to promote the completion of the in-house survey by patients and their families due to increased activity on the ward

Quality Priorities – Patient Experience (Outpatient)

This continued to show an improvement and the Chair asked to see the number of patients included on the graph going forward.

MJa

The Chair commended the results of the family and inpatient experience scores

Quality Priorities – Frailty, Aortic Surgery, Complex Needs and Enhanced Care

The Director of Nursing explained that good progress had been made amidst the challenges of documenting and extracting the required information. Some education was required around tick boxes for OT referrals for patients determined as frail as incorrect boxes had been selected and resulted in the target not being met.

6.2 Quality Impact assessments (CIPs)

The Head of Project Management Office and Business Transformation presented the report and informed the Committee that concerns regarding the timeliness of completion of schemes had been fed back to the Business Transformation Steering Group following the last Quality Committee meeting in October 2016.

The Non-Executive Director asked how the Quality Committee would receive assurance that schemes were being completed in a timely manner and following the correct process.

The Head of Project Management Office and Business Transformation explained that a number of steps had been put in place that included:-

- The completion of a number of audits
- A Tracker created to monitor progress
- Schemes would be logged against a matrix for 2017/2018 to drive forward the number of schemes that would be delivered.
- A Project Management Officer had been recruited to co-ordinate the process that would be overseen by the Head of PMO & BT

The Head of PMO & BT went on to say that some schemes had not been deemed as viable for 2017 and other new schemes had since been identified. The Quality Committee would receive a list of all the schemes at the beginning of the new financial year in April 2017.

LR

6.2(a) Appendix 1 – QIA Offensive Waste

The Chair asked for clarification on the Offensive Waste Quality Impact Assessment and the Head of PMO & BT explained that a review had been undertaken as the Trust was required to comply with both environmental and waste legislation. Failure to comply could result in the Trust being prosecuted and fined up to £50,000 by the Environmental Agency.

A successful trial had been undertaken in Cath Labs to ensure the department was clear on the disposal of clinical and non-clinical waste and that it was labelled appropriately. Spot checks had been carried out to ensure compliance and that waste was segregated correctly.

Training and education had been provided as staff did not realise that non-clinical waste was disposed of at a premium if it was incorrectly labelled as clinical waste. The introduction of clearer waste disposal instructions would realise a recurring saving.

6.2(b) Appendix 2 – QIA Bloods Protocol

The Head of PMO & BT explained that a review of the pathology protocol for Critical Care had been undertaken and this had identified that in some instances too many blood tests were being carried out unnecessarily and had resulted in an unnecessary overspend. A new protocol had been developed and a number of savings had been identified that were reflected in the QIA document.

6.2(c) Appendix 3 – QIA Head of AHP Schemes

The QIA was taken as read and no issues were raised.

7. Patient Safety

7.1 Annual report on incidents, complaints and claims

The Director of Research and Informatics presented the paper that had previously been presented to the Board of Directors at the meeting in December 2016.

The D of R&I explained that the paper highlighted the change from Prism to the new Datix reporting system and the under reporting of near misses.

The Committee were informed that reporting of near misses would be discussed at the next audit meeting and comprehensive data on near misses would be included on the dashboard.

7.2 WHO Safety Check List (Cath Labs)

The Cath lab Manager presented an update on the WHO safe procedure checklist. The assurance target for the WHO checklist was set at 95% and Cath labs were compliant for the month of October 2016

Previous outstanding actions had been addressed with further developments completed or commenced as planned. The mandated data set would be reviewed and a further 11 fields would be incorporated in the check list going forward. The Cath lab manager had spoken with the audit team and the EPR documentation would be reviewed from December 2016 and be presented next time in line with PCI data.

The Cath lab manager explained that National Safety Standards for Invasive procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) implementation work was on- going and would become a framework that the CQC would benchmark the Trust against. In addition it would also underpin the development of the team and patient safety culture. The Cath lab manager would be the Trusts lead for Natssips and Locssips.

The Chair thanked the Cath lab manager for attending the meeting and asked for a further paper to be presented at the meeting in April 2017 by medicine, surgery and clinical services on progress with NatSSIPs and LocSSIPs to provide assurance that this would be fully implemented by Sept 2017. In addition broader work around patient safety the use of HALT, cultural survey data and patient safety incidents would also be included.

HoNs/KW

8. Key Reports

8.1 Benchmarking annual report of quality outcomes

The Committee received the report from the Director of R&I. The report summarised the opportunities used by the Trust to benchmark clinical outcomes. The Committee discussed the merits and values of benchmarking and the benchmarking sources used by the Trust namely Dr Foster, National Cardiothoracic Benchmarking Collaborative (NCBC), National Audits Report and the Clinical Reference Group (CRG) Dashboard for specialist services.

The Committee were informed that the Trust was making use of all appropriate opportunities

The paper identified difficulties with benchmarking and the need to ensure data collected by everyone involved was of the highest standard. The high quality of

the Trust data would also be more beneficial in light of the Sustainability Transformation Programmes (STPs).

The Committee discussed the need for continuous improvement and the dedication and eagerness shown by the D of R&I to keep driving this forward.

The D of R&I went on to say that benchmarking tools were improving and the Trust needed to remain diligent and work towards enhancing the linking up of electronic records and the setting of standards across the area. A new data tool had been identified and the D of R&I would share details of this with the Committee. In addition it would also be shared with the Divisions.

MJa

8.2 Strategic & Operational Dashboard Performance

Assignment Threshold

The Director of Research and Informatics presented the report that had previously been presented to the Board of Directors in July 2016. At that time a request had been made to check the trajectories and thresholds with the respective Assurance Committees.

The D of R&I had highlighted the measures which required the attention of the Quality Committee although given the close proximity to the start of the next financial year it was proposed that any changes agreed would be implemented from April 2017

Following discussion of the strategic and operational dashboard performance assignment thresholds with the executive team, a further report would be brought to the next Quality Committee in April 2017.

MJa

9. Key Reports

9.1 Cancer Services annual report (inclusive of the national cancer Experience survey)

The Committee received the report presented by the Deputy Divisional Head of Operations, Surgery. This was an interim report and the full annual report would be presented to the Committee in September 2017.

The Committee were informed of on-going discussions with the Cancer Network in relation to historical issues around data capture and the running of reports from the Somerset Cancer Reporting system managed by the RLBUTH.

The D of R&I had also tried to drive this forward following a meeting that was cancelled at short notice in December 2016. The resolution of the issues with the reporting of cancer data was high on the Trust's agenda and work continued to get a further meeting diarised and the concerns addressed.

The Committee reviewed the recommendations identified in the document that included the work currently under way by the Trust to develop a Cancer Strategy based on developments across the network. This would be presented to the Committee at a future meeting.

10. Compliance and Regulations

10.1 Equality and Diversity 6 monthly report

The Committee received the report from the Executive Director of

Nursing and Quality that was taken as read. The updated paper provided details of additional training that had been developed for staff including learning disabilities and dementia training. The appendices provided examples of what equality and inclusion looked like at LHCH and details of the Equality Impact Assessment and Analysis (EIAA) Toolkit.

10.2 Quality risks

Secure Health Messaging

The Medical Director provided a verbal update on the changes that had been made to the EPR system to focus the system user's attention on receipt of a Secure Health Message (SHM). In addition, training videos had been developed to take users through the process and how to progress a SHM. Going forward, comprehensive audits would be undertaken with regular feedback to individuals who were required to take corrective action. The mechanism for overseeing governance issues would be at the combined Quality and PFEC meetings.

In addition, a review of the backlog of SHMs had been undertaken and dealt with in EPR. From the 220 identified there were 22 messages that had not been addressed. The Medical Director had emailed out to these individuals and to date (apart from the incident already identified) there was no harm to patients identified

The system would improve further once the Trust moved on to a later version of Allscripts. Monthly audits would be completed, sent to the divisions and reported on at Quality and PFEC.

The Chair commended the good work that had been done by all involved in addressing the issues with Secure Health Messaging.

10.3 Serious Untoward Incidents

The Medical Director provided an update on a recent never event and informed the Committee that a report would be forwarded to STEIS and the CQC on 9th February 2017.

As a result of the event, an RCA would be completed. Access to the Knowsley Community patients' electronic records had been made available to Consultants with immediate effect to enable clinicians to review patient notes.

In addition, a Secure Health Message had not been actioned by a junior doctor and a patient with a suspected lymphoma had been overlooked. This had been addressed by making improvements to the SHM process on EPR.

The Medical Director had informed consultants of their responsibility as part of their job role to action SHMs in a timely manner and this would be audited going forward and the findings presented at the Divisional Meetings.

A further formal update would be provided at the next Quality Committee meeting in April 2017.

RAP

11. Receive Minutes for Information

11.1a Operational Board Minutes* - 30th September 2016

The minutes were received for information and there were no additional comments.

11.1b Operational Board Minutes* - 04th November 2016

The minutes were received for information and there were no additional comments.

11.1c Operational Board Minutes* - 25th November 2016

The minutes were received for information and there were no additional comments.

11.2 Business Transformation Steering Group (BTSG) Minutes*

11.2a BTSG Minutes* - 22nd September 2016

The minutes were received for information and there were no additional comments

12. Date and time of Next Meeting:

April 27th 2017 13.30 – 16.30 Boardroom