

Quality Committee Meeting

Item 10.2.2.2

minutes

Minutes Quality Committee meeting held on 27th April 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
Lynda Robertson (Item 6.3)

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
Chief Pharmacist
Head of Nursing and Quality for Surgery
Head of Nursing and Quality for Medicine
Deputy Director of Nursing and Quality
Complaints and Family Support Manager
Support Secretary

Gill Gow (Item 7.1)
Lisa Salter (Item 7.2)
Karen Wafer (Item 7.3)
Joan Mathews (Item 9.2)
Lisa Gurrell (Item 8.3- part)
Debbie McEllenborough

1. Apologies for Absence

There were no apologies to record.

Action

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest expressed relation to agenda items.

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

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

Item 1 – Emergency Re-admissions had previously been discussed at length at the Quality and Patient and Family Experience Committee and the Medical Director had agreed to share the action plan with the Committee. This item had been circulated with the papers although emergency re admissions would continue to be explored further within the Divisions.

Item 2 Report on Medication Errors – The Director of Research and Informatics to arrange for the number of incidents to be shown separately by ward each month for surgery and medicine. Work was underway on the one remaining indicator and data would be ready for the next meeting in July 2017. Item carried forward to the next meeting.

MJa

Item 3 –

Metrics for respiratory patients. The Medical Director had discussed current measures with a respiratory physician. A number of cystic fibrosis reports had been produced and information was also being collated from local and national cancer registers and these could be used as a measure of effectiveness.

The reporting of thoracic data was relatively new and not yet as sophisticated as cardiac data. A re modelled consultant dashboard was currently being trialled and could potentially be used to produce information for thoracic patients.

An explanatory report would be produced and presented at the next meeting.

RP

Peer Review (ITU) The Director of Nursing confirmed that the peer review (ITU) had been included on the work plan.

Item 4 Quality Report – PPCI Call to balloon – The Medical Director and the Director of Nursing and Quality had discussed the national targets to agree a more realistic figure. The Director of Research and Informatics went on to explain that this was a locally commissioned target of 120 minutes for call to balloon and the National target was 150 minutes. Therefore, as it was unlikely the Trust would achieve the 120 minutes target due to outside influences such as ambulance delays etc the Specialised Commissioners would be approached to remove the target.

Item 5 Quality Impact Assessments and Cost Improvement Programme – This item was on the agenda.

Item 7.2 - WHO Safety Checklist – Item on the agenda.

Item 8.1 – Benchmarking – The Director of Research and Informatics had shared details of benchmarking tools with the Non-executive Directors. This item was complete and removed from the dashboard.

Item 8.2 – Strategic and operational dashboard performance assignment thresholds - Present further report following start of new financial year in April 2017 – Item on the agenda.

6. Quality

6.1 Clinical Quality Performance

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

Mortality – There had been a number of significant changes contained in the recent National Guidance on Learning from deaths publication. All screening would need to be completed within 30 days. As time was not built into the working day to conduct screening this would be challenging for nursing staff.

The Medical Director had a meeting planned with the Associate Medical Directors to review the new guidelines, the screening process and timescales to ensure the Trust was compliant with the new requirements.

The Director of Research and Informatics explained that following further investigation with the data collection team there had been a change in how screening information was presented and going forward a more accurate view of the screening timescales would be presented.

Falls – Following a recent review 50% of falls had been classified as avoidable with the remaining 50% unavoidable. A number of specific departments had been targeted and improvements made, particularly on Oak ward. Further work was underway on Cedar and Birch ward to help focus on specific areas and times when falls occurred

A number of recurring themes had also been identified and these included:-

- Night sedation – a review was underway to address how else patients might be helped
- Continence
- High dose analgesics

Going forward the DoN would assess all falls, review the learning and identify what could be done differently and share with staff.

Incident reporting

Medications – A meeting had been planned with pharmacy to review incident reports and the display of medications.

Safe staffing levels – all staffing levels were rated as green. Although there had been a number of red flags in relation to the standard of having 2 registered nurses per shift. The wards were noted to be safe and staffing managed according to occupancy and reviewed on a daily basis.

Mixed Sex Accommodation Breaches

There had been three mixed sex accommodation breaches in March 2017, six in February 2017 and one in January 2017. To date there had been none during April 2017. The HoN and

Quality explained that clinical discussions were often made to ensure patient safety was not compromised over the need to segregate patients in order to avoid a mixed sex accommodation breach.

Claims

All complaints had been acknowledged and responded to within the agreed timeframe.

VTE Prophylaxis

The target for the provision of appropriate VTE had not been met this month. Efforts to improve consistency continued and these would be addressed with input from the Operational Board and the Divisions.

Call to Balloon - Primary PCI 120 minute - internal target had not been met recently. An Audit during January – March 2017 had highlighted issues with ambulance delays etc. The DoN and Quality also mentioned the target of 120 minutes was an internal target and the national target was 150 minutes.

Sepsis – Rated green for two of the indicators. The appropriate taking of blood cultures prior to antibiotics being given required improvement as did the year to date percentage of patients receiving at least one sepsis antibiotic within one hour. However, it was noted that 95% of patients did receive their antibiotic within 3 hours (which was the national standard).

Education continued to address the points mentioned above, raise awareness of the symptoms and ensure staff remained vigilant. In addition, further development of EPR was underway to enable further supportive care documentation to monitor key aspects of sepsis.

Patient and Family Experience

The Committee acknowledged the excellent results that showed the Trust consistently scoring high in all of the categories. The response rate had seen a slight slippage due a reduced number of patients completing the survey on birch ward.

The Committee went on to discuss the outpatient experience work and the need to continue to look at how patients flowed through different departments when they attended for pre-arranged tests or appointments. The Medical Director confirmed that conversations had been held with consultants regarding ward rounds and clinic times to ensure that where possible clinics started on time.

Quality Priorities

- **OT referrals for frail patients** – development work continued on EPR to enable staff to make OT referrals and performance should improve going forward.
- **Aortic Surgery Patient Follow Up** – patients contacted by telephone following discharge to address any issues or questions. The Committee discussed increasing the

target from 75% to 90% The Director of nursing agreed to discuss this with the staff member who leads the service.

The Committee commented on the good work undertaken in this area and commended the Advanced Nurse Practitioners for their achievements.

Mortality – work continued to improve the screening timescales. A briefing had been presented at a recent Executive meeting, an action plan developed and discussions taken place at the Operational Board meeting to ensure learning from deaths was shared with staff.

6.2 *Quality Improvement Strategy and Item 6.2a (Appendix)

The Committee received Item 6.2 and Item 6.2a for information only.

6.3 Quality Impact Assessments (QIAs)

The Quality Committee received the paper presented by the Head of Project Management Office and Business Transformation. The QIAs had been reviewed by the Medical Director and Head of Nursing and Quality or their delegated deputy. In addition, the Chair of the Quality Committee had also held a separate meeting to review all the completed approved QIAs with the Head of PMO & BT and the DoN.

The Committee reviewed details of the following QIAs:-

QIA Reference No. 1 – Nursing Review, Clinical, Medicine and Surgery. – The Director of Nursing talked through the nursing review QIA and explained that most of the savings would be realised by staff leaving or moving to other jobs. A larger scheme in Coronary Care had been agreed following a review of the levels of patient care required. A new dependency tool had also been introduced to assess safe staffing on the unit. The Director of Nursing explained that these were one off savings and no further reductions in nurse staffing were proposed currently. The DoN went on to say that a reduction in nursing numbers in CCU had been agreed at the Operational Board meeting and it was confirmed there would be no impact on the quality of patient care.

The Chair mentioned previous concerns that had been raised with Cedar ward and how a reduction of a further 2 nursing staff could impact on the quality of nursing on the ward. The DoN confirmed that following investment on the ward there had been a significant improvement. Regular meetings were held and following a recent Excellent Compassionate Safe (ECS) assessment the ward had since achieved a green rating.

The Head of Nursing and Quality had joined the meeting to present another item and confirmed the skill mix on the ward had improved and an Advanced Nurse Practitioner was also in post. Positive feedback had been received from both patients

and their families and previous concerns had been successfully addressed.

QIA Reference No. 4 – Procurement Programme (theatres and Perfusion non-pay workstream) There was a risk identified that medical staff would not be comfortable with a change to the products utilised in theatres and this would be monitored by the Quality Committee.

QIA Reference No. 6a – Radiology General – Workforce Redesign – There were several risks identified regarding staff morale, staff leaving the organisation and the impact on staff salaries given the new arrangements. The Committee were informed of discussions underway with staff regarding new ways of working to ensure they were fully engaged and supported. Newly qualified staff would be recruited from Summer 2017 and waiting times for patients would be monitored and communicated to patients. The impact of the redesign would be monitored by the Quality Committee.

QIA Reference No. 6b – Therapy Skill Mix Review – There was a potential patient safety risk identified by the Committee if insufficient therapists were available to complete initial assessments or maintain an on-call rotas. This in turn could affect clinical effectiveness and quality outcomes. The Committee was informed that regular assessments would be undertaken in therapies to identify and address any potential concerns. This item would be monitored by the Quality Committee.

QIA Reference No. 10 Non-Pay Savings Schemes – Medicine Division – The Non-Executive Directors asked for clarification on the saving of £115k from Service Line Reporting analysis and clinical consistency changes. The DoR & I explained that savings would be made around reliability and standardisation of practice and putting processes in place to adhere to the same products. Staff had warmed to this initiative with good acceptance regarding the use of an electronic integrated care pathway system.

The Divisional Head of Operations for Medicine would complete a separate QIA if the proposed changes impacted on patients.

QIA Reference No. 12 – Advisory Board

The Director of Research and Informatics explained that the Trust had 4 programmes of work that included:-

- Cardio Vascular Round Table
- Electronic Health
- Clinical Investment
- Health Care Innovation

The Advisory Board gather and synthesise data and present it in a way the Trust could look at making savings or introduce new ways of working.

The Trust was looking to discontinue 3 of the programmes and continue with only one of the initiatives. This would realise a saving of £40k per annum.

The Committee were informed that 19 QIAs had been quality assessed and signed off. The remaining 10 CIP schemes without QIAs would be progressed and any new schemes developed to bridge the current £75k gap in the 2017/18 Cost Improvement Programme and would follow the required QIA process.

QIA Reference No. 14 Workforce Restructure -

The Chair asked for further clarification around the restructure and it was explained that the Trust was moving to a more dynamic workforce with the ability to transfer staff to other departments as and when required. Any impact on staff and services would be picked up by the People Committee.

The Committee were informed of 10 outstanding QIAs that were currently being worked on in readiness for the Business Transformation Steering Group in May 2017 and for review at the next Quality Committee in July 2017.

LR

The Head of PMO and Business Transformation explained that a number of the QIAs would be subject to mid-term reviews and any new QIAs or changes that impacted on quality would be reviewed and reported to the Quality Committee. It was agreed that as the Business Transformation Group reviewed the QIAs on a regular basis the Quality Committee would receive reviews on a 6 monthly basis and a highlight report would be produced following the mid-term reviews performed by the BTSG.

LR

In conclusion the Committee were satisfied with the level of detail in the QIAs, mitigation of the risks, timescales for review and formal follow up.

The Chair thanked the Head of PMO and Business Transformation and her colleagues for producing the QIAs and asked for a further update to be presented at the next meeting in July 2017.

6.4 Quality Priorities 2017 / 2018

The Quality Committee received the paper for information and noted the recommendation in the paper for follow up calls for 50% of complex aortic patients as the local indicator for audit purposes for 2016/17 and the recommended quality account priorities for 2017/18.

7. Patient Safety

7.1 Medicines Policy Annual Report

The Chief Pharmacist presented the Medicines Annual Report to the Committee and explained that the report aimed to provide the Quality Committee with assurance that monitoring of the Medicines Policy within the Trust was appropriate and that medicines were handled according to the law and current safe practices.

The Chief Pharmacist went on to explain that several of the action plans included in the 2016 Medicines Annual Report required developments in EPR. Good progress had been made with all aspects of the EPR system and further work was underway to develop processes for anticoagulation drugs and instances where second or witness signatures were required as a checking process. Further improvements were expected once the new initiatives had been implemented.

The Non-Executive Directors referred to the safe storage of medicines and some of the issues that had been identified particularly on Birch and Cedar ward following an audit in January 2017.

The Chief Pharmacist explained that a senior technician now visited the wards on a regular basis to monitor safe storage, a senior pharmacist reviewed Cedar ward and improvements had been made on Oak ward. Further audits during February 2017 and March 2017 had also indicated improvements.

The DoN had met with the Chief Pharmacist to review the issues and assess the storage areas on every ward. The DoN also confirmed that although drugs were not always locked away in the correct cabinet they had, at all times, been stored in a locked room.

Further work was in hand to address reasons why medicines were not locked away and left out and these included:-

- A review of stock to make any adjustments to ensure there was not too much stock being held which impacted on the ability to store safely.
- Ensure tidiness of storage and medications stored alphabetically.
- Ensure medicine cabinets at the bedside were reviewed frequently and any medications not required were removed.

The Non-Executive Directors were informed of a robust training programme put in place around the administering process and how Learning and Development had included a module in my PACT. All nurses were mandated to read the Medicines Policy and ensure 2nd signatories and witness signatures were collected when required. In addition, training videos were available together with e-learning material.

A number of changes had also been implemented on EPR to help with the safe administration of medicines.

In conclusion, a number of action plans had been developed to monitor progress and ensure actions generated the required improvements across specific areas. Re-audits would occur in future when actions had been completed.

The Chair commented on the comprehensive level of detail contained in the audit and the action plans in place to mitigate any risks.

7.2 WHO Safety Check List Audit - Surgery and progress on NatSSIPs & LocSSIPs

The Committee received the report from the Head of Nursing and Quality for Surgery. The audit had been completed for 100% of patients in March 2017 and was fully compliant for each section of the checklist. The audit had shown an improvement against the previous month with further work underway to ensure 100% compliance was achieved at all times and that all patients had been seen and checked. Staff had been provided with feedback if elements of the checklist were found to be incomplete.

The Chief Clinical Information Officer (CCIO) was working closely with the matron to review data, how it was collated and subsequently presented. Further discussion at a divisional level had also taken place.

The Non-Executive Directors were informed that all nursing vacancies in the department had been filled.

NatSSIPs & LocSSIPs

Discussions had taken place across the Divisions in relation to national, regional and local safety standards. Each division had identified a list of procedures that would require safety standards to be written using the NHS England template.

Learning and Development had also been asked to support safety standards to ensure staff had the relevant training and understood the importance of putting the standards into practice.

In conclusion, the Committee noted the content of the report and received assurance Surgery were compliant with the checklist and that a further update would be available at the next meeting in July 2017.

7.3 WHO Safety Check List Cath labs audit and progress on NatSSIPs & LocSSIPs

The Committee received the paper presented by the Head of Nursing and Quality for Medicine. The paper showed compliance rates had met the target of 95% for the last quarter and Cath labs had achieved 100% for March 2017. Currently the minimum data was being audited.

In addition, changes to EPR had helped with reporting requirements and a new Care Cube system was due to be piloted in May 2017 and this would further provide additional checks and levels of reporting.

The HoN for Quality and Medicine went on to say that good progress had been made within EPR to implement changes to

improve the checklist process. In addition, the Care Cube project would also realise additional benefits and the reporting requirements were under development by the IT Team. A number of site visits had been arranged for other organisations to see how the Trust had made improvements in this area and to review the innovative use of Care Cube.

NatSSIPs & LocSSIPs

As previously mentioned under item 7.2 a lot of work had been undertaken to ensure the Trust had all the NatSSIPs and LocSSIPs elements in place and complete by September 2017.

Both Cath labs and Surgery had taken a standard approach to achieve the requirements in relation to national, regional and local safety standards.

8. Clinical Effectiveness

8.1 *Mortality Review annual report (to include review of cusum curves)* This paper was for information only. Since the report was completed there had been a slight change due to the new guidance in relation to learning from deaths therefore an updated report would be presented to the Board of Directors meeting in May 2017.

8.2 Strategic & Operational Dashboard Performance Assignment threshold

This paper was for information only. However, the Committee were informed that an e-coli indicator would now be included in the document for the coming year.

82a Draft Clinical Quality Performance Report

The draft dashboard was included to show the Quality Committee how information would be presented at the next meeting in July 2017. This was well received by the Chair and Non-Executive Directors.

8.3 Complaints 6 Month Report

The Director of Nursing and Quality presented the report and explained that a number of common themes had been highlighted in relation to communication and car parking. 28 formal complaints had been received, 2 of which were still under investigation.

Responses were always undertaken within the required timescales and staff often undertook home visits when dealing with families going above and beyond what was generally expected. In addition, the learning from complaints was also shared with staff.

A satisfaction survey had recently been completed in relation to the complaints service. Although the levels of response could have been higher they had improved with 80% of families providing a positive response with knowing who to complain to and whether they were supported.

Home visits had also been well received and communication issues had been discussed at a recent Operational Board meeting and an action plan developed. In addition, work was also underway to address how best to support family members particularly when there were known complex family issues.

The Committee noted the outstanding work that had been achieved in addressing complaints and asked for this to be fed back to the complaints team.

9. Key Reports

9.1 DIPC Annual Report

This paper was for information only.

9.2 Diabetes Annual Report

The Diabetes Annual Report was presented to the Committee by the Deputy Director of Nursing and Quality and it was explained that diabetes was a challenge across all NHS organisations with approximately 20% of the Trusts patients having diabetes. Patients often presented with undiagnosed diabetes and this had led to an increase in the number of referrals to the diabetes team. The Diabetes nurse specialists worked closely with consultants and GPs to maintain a patients' condition both prior to and following surgery.

The Diabetes Steering Group had maintained good representation at the meetings and met regularly to ensure Trust-wide coordination of all aspects of diabetes management. This, in turn, ensured high quality clinical care at all stages of the patient journey and promoted a positive patient and family experience.

To date the diabetes team had reviewed approximately 810 patients from April 2016 these included

- Referrals received from outpatients prior to admission
- From clinical areas as inpatients

All patients reviewed had a letter sent to their GP with future management plans if required.

Further work had been undertaken in conjunction with Learning and Development to implement bespoke online training and this had realised improvements and areas of good practice and generally raised awareness of diabetes across the Trust. EPR changes were constantly being progressed to ensure safe use of insulin. A Service Line Agreement with the RLUH was also being finalised and the team had worked closely with the Tissue Viability nurses to identify and treat diabetic foot ulcers.

In conclusion, the Committee commended the good work that had taken place to date by the Diabetes team and noted the work that was underway with L&D and the DoN to align training and undertake further comprehensive audits.

9.3 Quality Committee Annual Report

9.3a Quality Committee TOR item was received for information only.

10. Compliance and Regulation

10.1 Annual assurance report on compliance with the NHS constitution

The Committee received the paper that was taken as read and there were no issues raised.

10.2 Quality Risks

The Director of Research and Informatics provided a verbal update on the single quality risk that had been rated as red on the register.

The Committee were advised the risk was in relation to Secure Health Messaging (SHM) and additional reporting had been undertaken to ensure the SHM process had been responded to in a timely and effective way once a radiology alert was raised. Reports were produced from EPR to monitor progress, flag potential issues and provide assurance that SHM's had been actioned by the appropriate manager. Improvements were underway to further strengthen this.

10.3 Serious Untoward Incidents update

The Medical Director relayed a never event that had previously been raised at a recent Board of Directors meeting. Work had taken place in cath labs to tighten up procedures and working practices had changed and the learning shared with staff.

11. Receive Minutes for Information

11.1 Operational Board

11.1a Operational Board Minutes - December 2016

11.1b Operational Board Minutes - January 2017

11.2 Business Transformation Steering Group (BTSG) Minutes*

*11.2a BTSG Minutes 15th Dec 2016

*11.2b BTSG Minutes 16th Jan 2017

*11.2c BTSG Minutes 15th Feb 2017

*11.2d BRSG Minutes 16th Mar 2017

Any Other Business

- Since Quality Committee had a wide area of responsibility and covered many areas, the Chair asked for Respiratory Medicine to be included in the Committee's remit going forward and this would be added to the workplan as appropriate.
- It was the current Chair's last meeting and thanks were extended by the Chair to all members and attendees for their involvement and steer during his time in post. The Committee thanked the Chair for his guidance and professionalism and wished him well for the future.

SP

Date and Time of Next Meeting 11th July 17 08.30 – 11.30 Boardroom