

## Quality Committee Meeting

Item 6.1.3

# minutes

### Quality Committee meeting

held on 11<sup>th</sup> July 2017

#### Present:

David Bricknell  
Mark Jones  
Sue Pemberton  
Dr Raphael Perry  
Mark Jackson

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

#### In Attendance:

Lynda Robinson (Item 6.2)  
Peter Hannaford (Item 8.3)  
Debbie McEllenborough

Head of Business Transformation Group  
Resuscitation Officer  
Support Secretary

#### 1. Apologies for Absence

Marion Savill, Non-Executive Director

#### 2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest to declare

#### 3. Patient Story

The Director of Nursing and Quality read the patient story and the Committee commented on the optimistic attitude of staff at LHCH and how this had a positive effect on patients.

#### 4. Previous Minutes

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

#### 5. Review of Action Log

The Committee reviewed the Action Log and the following points were noted:- :-

**Action 1 Report on Medication Errors** – The data was now available in the Quality Report and would be closely monitored by the Committee going forward. Item complete and removed from the action log.

**Action 2. Metrics for Respiratory Patients** – The Committee had discussed this action in detail at the previous meeting. The Medical Director provided an overview of the current position in relation to data gathering of performance data for respiratory patients and the issues that had been raised. The Medical Director went on to say that a variety of KPIs were available nationally at organisational level but not for individuals. A review paper would be brought to the next Quality Committee meeting in October 2017 to include the current information that was available and what could be achieved going forward. **RAP**

**Action 3 – PPCI Call to Balloon** - Discussed under agenda item 6.1 Quality Report.

**Action 5 QIAs** – Discussed under agenda item 6.2 Cost Improvement Programme.

### **6.1 Quality Report**

The Director of Nursing and Quality presented the Clinical Quality Report and the Committee noted the following key areas:-

**Hospital Mortality Standardised Mortality Ratio** - data was discussed in detail in relation to rag ratings and the Committee were informed that targets were risk adjusted; numbers were small and the threshold for anything appearing as amber turning to red would be unusual, with the Trust currently performing as expected.

The Committee heard of a national methodology that was used by Dr Foster to collect data, given the case mix of procedures at LHCH it was not always a good measure or reflection of the Trust's performance. Work was underway in conjunction with a quality investigator from Dr Foster to review the groupings and take back more control.

Further discussion followed on how the small sample provided a variant report that would oscillate over and under the thresholds with the Trust continually aspiring to achieve the required targets.

In addition, the Committee were informed of a comprehensive and robust mortality review process in place following National Guidance on Learning from Deaths that had been issued earlier in the year. Although the percentage of reviews at the Trust screened by doctors within 7 days appeared low at 40%, the Committee noted the in-month slippage that would be monitored further at the next meeting. Mortality reviews completed by doctors within 30 days had achieved the target figure of 80%. Mortality reviews completed by nurses for the specified indicator had all been achieved.

In summary, the Committee noted that whilst a number of targets were rated amber this was a small variation around the standard and not a cause for concern at this level. However, as it was a public measure of the Trust's performance, resources had been put in place to ensure the Trust understood the implications of the Dr Foster data. In addition, new measures

from Dr Foster would enable the Committee to monitor patient safety and the sensitive issues around mortality.

**Emergency re-admissions** - The Committee reviewed the emergency re-admission rates and noted that performance for elective admissions was below the national average in-month and year to date, although non-elective admissions remained amber.

It was explained that various reasons contributed to re-admissions including infection following surgery and chest pain. A number of initiatives were underway to ensure the discharge summary was more informative and included a copy of the ECG that patients could produce at A&E. The Committee were appraised of work that was under way to further analyse the re-admission data ahead of making improvements by the divisions.

A further discussion followed on psychological support for patients who often experienced a lot of emotional anxiety and how to improve in this area. The Heads of Nursing had been asked to conduct a review of the Trust's psychology services to assess how this service could be offered Trust wide rather than for specific groups of patients.

**Medication Errors** – The Committee were informed this was the first time that medication errors had been presented by category. The Committee noted that although the numbers of errors were low, the data would be monitored closely to identify and target areas where improvements were required, to ensure inadequate administration did not lead to patient harm.

The Committee went on to discuss the importance of capturing data in relation to medication errors which would further prompt the Committee to review aspects of the Trust's administration procedures. The Committee requested clarification on the definitions of dispensing and administration. The Director of Research and Informatics confirmed the definitions would be built into the report going forward. **MJa**

A further discussion followed on auditing of medications in relation to distribution and storage. The Director of Nursing informed the Committee of a piece of work that was underway to enhance the administration of medicine systems. A meeting was planned to review procedures at the Trust and identify where improvements could be made on EPR. **SP/MJ**

In addition to the above, the Associate Medical Director for Medicine had driven forward measures to ensure TED stockings were prescribed in a timely manner by making improvements to the EPR system, resulting in an improvement in this area.

**VTE prophylaxis** – The Committee noted that VTE risk assessment on admission was consistently above target, although the target for the provision of appropriate VTE

Prophylaxis had not been met in-month, efforts to improve consistency continued.

**Primary call to balloon** – The Committee were informed that targets for Primary Call to Balloon had initially been set by Specialised Commissioners to ensure that patients were taken to hospital within 2 hours. The Medical Director had asked Commissioners to change the targets to a more achievable figure and a response was awaited. A further update would be available at the next meeting. **RAP**

**Patient Experience – Outpatient & Community - Outpatients** – This section contained one month's data; there had been a number of comments around waiting times and improvement work was underway to look at diagnostic appointments being better re-aligned with consultant appointment times.

## **6.2 Cost improvement Programme and Quality Impact Assessments**

The Committee received a further five Quality Impact Assessments (QIAs) for review, a number of which were admin related and thus had less of an impact on clinical areas.

- Patient Pathway Programme
- Finance Team Structure
- EPR Analyst Post
- IT – 3<sup>rd</sup> Party Maintenance
- Medical Staffing Review – Medicine Division

The Committee were informed that all five QIAs had been quality assessed and signed off by the Medical Director and Director of Nursing and Quality and had been reviewed by the Business Transformation Steering Group in March and April 2017.

The remaining five CIP schemes without QIAs would be progressed and any new schemes to bridge the current £66k gap in the 17/18 CIP would follow the required QIA process. **LR**

It was anticipated that the five outstanding CIP schemes would be presented to the Quality Committee for assurance at the October meeting.

The Committee noted the content of the report and assurances provided in relation to workforce changes in EPR with the team now displaying a positive approach and a change in culture. This in turn had reflected on outcomes and the team were now performing well and achieving expected deliverables.

## **7. Patient and Family Experience**

### **7.1 NHS National Patient Experience Results**

The Director of Nursing and Quality presented the report that

showed the Trust had come second in the country for overall care with the Trust improving on last year's results.

The Committee were informed of slight differences between the top and second place and this included the scoring around emotional and psychological support. The Director of Nursing and Quality went on to say it had been noted by new ward managers recruited from another Trust how much time nursing staff at LHCH spent at computer screens to update patient records and capture information.

The Committee went on to discuss other distractors for nurses and expectations and demands on their time during the working day.

As a result of the aforementioned, work was underway to explore the use of hand held devices and connectivity to Allscripts to help free up nursing time to spend with patients. In addition, as mentioned previously, the Director of Nursing was looking at the provision of emotional and psychological support for patients and also informed the Committee of the 'What Matters to Me Boards' that had been installed above each bed. In addition, Ward Managers also spent less time in the office and more time on the wards to help support staff.

In conclusion, the Committee noted the report had addressed short falls from the previous year's excellent performance and the Trust was acting on this to make further improvements.

## **8. Key Reports**

### **8.1 \*Safeguarding Annual Report**

The Committee noted the Safeguarding Annual Report for information only as the document had recently been reviewed by the Board of Directors.

### **8.2 \*Complaints Annual Report**

The Committee received the Complaints Annual Report for information only.

### **8.3 Resuscitation Annual Report**

The Committee received the Resuscitation Annual Report presented by the Resuscitation Officer. The report focussed primarily on staff compliance with the use of Modified Early Warning Scoring (MEWS) system. The key highlights discussed included:-

- **MEWS** - The standard of 95% for observations recorded having a MEWS score correctly documented according to policy, was narrowly missed with the audit showing a compliance rate of 94.9%.
- **'Critical Care Outreach Team – Patient Outcomes'**, records all clinical interventions for the team and demonstrated that in the vast majority <90% the patient's condition improved. When the patient could not be effectively treated on the ward they were

transferred to Critical Care.

- **DNACPR order** – improvements being made on EPR to ensure all sections of the order were complete. Individual doctors and consultants had been targeted to help raise awareness.

The Committee went on to discuss the National Cardiac Arrest Audit Report covering 1<sup>st</sup> April to the 30<sup>th</sup> September 2016. The report compared individual hospitals with grouped comparisons on survival outcomes of in-hospital cardiac arrests. The information was broken down by presenting rhythm, age, location etc. Attention was drawn to a summary of the main results which showed observed survival to hospital discharge of LHCH patients. The Trust's results were above the national average in terms of patient survival to hospital discharge.

This NCCA Report, also specifically by risk adjusted comparative analyses, compared LHCH with three other Cardiothoracic Hospitals (five last year). The results showed that whilst these cardiothoracic hospitals were submitting varying data quantity samples there were no major differences shown in reported survival rates and reported cardiac arrests.

In conclusion, the Committee noted the content of the report and the need to ensure they had sufficient understanding of the charts. Going forward the Resuscitation Officer would engage with other NHS Organisations to share information and conduct benchmarking exercises to help improve the Trusts knowledge and comprehension of the data.

## **9. Compliance and Regulation**

### **9.1 Equality and Inclusion six monthly report**

The Committee received the report and commented on the excellent patient information booklet that had been issued. The Committee also heard of work that was underway with MerseyCare following an Executive to Executive meeting to review psychology training and how the Trust was going to explore this initiative.

### **9.2 Quality Risks**

Secure Health Messaging – Several improvements had been made to the radiology alert system. The Divisions were monitoring individual consultants to ensure timely responses to alert messages. Further improvements would be realised once the new version of Allscripts was installed in Sept/Oct 2017.

### **9.3 Never Event and Serious Incidents update**

The Medical Director provided an update on a recent serious incident from a second CT scan that had not been acted upon following a serious finding. A Root Cause Analysis had been performed by the Divisions. The learning had been shared with staff and alerts were being closely monitored by the Divisions to ensure they were addressed in a timely manner.

The Medical Director went on to provide a further update on a recent never event where an incorrect piece of equipment had

been used during a procedure. Actions had been put in place to ensure correct processes were followed and the check list had been changed to reflect this. There was no harm to the patient.

## **10. Receive Minutes of Operational Board for Information**

### **10.1 Operation Board**

The minutes were received for information, there were no further comments.

\*10.1a Operational Board Minutes - February 2017

\*10.1b Operational Board Minutes - March 2017

\*10.1c Operational Board Minutes - April 2017

\*10.1d Operational Board Minutes - May 2017

## **11.2 Receive Minutes of Business Transformation Steering Group for information.**

The minutes were received for information, there were no further comments.

\*11.2a BTSG Minutes - April 2017

\*11.1b BTSG Minutes - May 2017

## **Any Other Business**

**Date and Time of Next Meeting 24 Oct 2017 10.00 – 13.00**