

Quality Committee**Item 3****minutes**

Date of Meeting: 17TH November 2015
Time: 09.00 am
Venue: Boardroom

Present: Lawrence Cotter, Non-Executive Director (Chair)
 Mark Jones, Non-Executive Director
 Marion Savill, Non-Executive Director

In attendance: Shirley Cummings, Project Manager (Item 10)
 Danny Forrest, Deputy Chief Pharmacist (Item 7.1)
 Mark Jackson, Executive Director of Research and Informatics
 Sue Pemberton, Executive Director of Nursing and Quality
 Raph Perry, Medical Director
 Lisa Tierney, Theatre Managers (Item 19.1)
 Karen Wafer, Cath Lab Manager Theatres (Item 19.2)
 Debbie McEllenborough, Support Secretary (Minutes)

Patient Story

The Executive Director of Nursing and Quality read a Patient Story and confirmed that appropriate feedback would be provided to the relevant wards and staff.

1. Apologies for absence

Debbie Herring, Executive Director of Strategy and Organisational Development.

2. Declarations of Interest Relating to Agenda Items

There were no declarations of interest to record.

3. Minutes of meeting held on 1st September 2015

The minutes of the meeting held on 1st September 2015 were reviewed and the Chair asked for changes to be made and the following items were reworded:-

Item 26 – Cusum Curves

An update to be provided at subsequent meetings for surgeons reported as being outside of the confidence intervals and not maintaining the full complement of procedures. It was confirmed that one surgeon at the Trust was currently restricted and another two were being performance managed.

Item 10 – Cost Improvement Programme (CIPs) and Quality Impact Assessments

The Committee articulated concern that QIA savings had already been identified and budgets reduced accordingly, prior to the Committee receiving assurance and establishing there would be no adverse effect on quality. The Chair requested details of the savings that had already been identified be made available and submitted to the Committee.

Item 12 Benchmark Review of Quality Outcomes

The Director of Research and Informatics informed the Committee that benchmarking possibilities would be available for the next Quality Committee meeting in November 2015.

4.

Matters Arising

There were no matters arising.

5.

Action Log (All)

All outstanding Actions were on the agenda

6.

Receive Minutes of the Operational Board Group

The Committee received the approved minutes from the Operational Board Group meeting held on 24 July 2015

8.

Review of Incomplete QIAs 2015/16 and Update on Workforce Related Projects.

The Committee received a presentation from the Project Manager that included a CIP Quality Impact Assessment Status Report and a CIP QIA update. Additional information was provided on the major workforce related projects:-

- **Consultant Job Planning** – A meeting was planned with Allocate on 30th Nov 2015 to commence with the implementation of an electronic Job Planning system, Zircadian. All job plans would be uploaded and analysed for effectiveness. System training would be provided for Consultants and it was planned to use the same system for revalidation.
- **Workforce Utilisation** - Revised rates of pay were being introduced to encourage Bank versus Agency usage with mid-month Bank Payroll introduced from November 2015.
- **Agenda for Change Maximisation Review** - All HR policies were being reviewed to maximise effectiveness, together with a review of on call arrangements. This had been effectively put on hold until after concerns by Junior Doctors in relation to this were resolved.

The Committee received confirmation that contingency and back up plans were in place pending the results of the ballot held for Junior Doctors and the potential for industrial action.

Next steps for QIAs were to:-

- Establish the PMO working closely with Finance to identify CIP schemes for 16/17 in preparation for the CIP
- Deliver QIA (project documentation) training sessions to ensure qualitative information
- Ensure QIAs were completed in a more timely and controlled manner (2 week turnaround)
- Ensure all PMO Dashboard Projects followed the Project Governance, ie QIAs / Project Initiation Documents (PIDs)

In conclusion, risks/issues relating to the major projects mentioned above were to be addressed monthly via highlight reports and revisited on a monthly basis. The Committee commented on the need to ensure the same information is not reported to multiple Committees. It was therefore recommended that any issues impacting on quality were presented to the Quality Committee at subsequent meetings.

7. Quality Report

The Executive Director of Nursing and Quality presented the Clinical Quality Performance to Month 06 to the Committee and the main items noted included:-

Mortality Reviews – work continued to improve the timeliness and completion of mortality reviews for Divisions and this would be further enhanced by the introduction of Consultant Job Planning as well as clear Key Performance Indicators (KPIs).

The Committee expressed concern that targets were not being met for mortality reviews. In addition, the Committee were informed the Care Quality Commission perceive the completion of mortality reviews and the learning from them as standard practice. The Chair asked for this to be investigated further and elevated to the Board of Directors.

Following the last Quality Committee, the Executive Director of Nursing and Quality again re-iterated that mortality reviews for nursing had improved.

Smoking Cessation– the Committee considered the target figure of 50% as low and asked for consideration to be given to adjusting the target upwards to enable more smokers to be offered smoking intervention advice. The Committee were informed that the smoking cessation service was funded by an external agency and under threat. A meeting was planned with Public Health to ascertain whether the service would continue.

Stroke – Diagnosis discussed with patient and family – again the Chair commented on the low target of 80% and recommended that all patients and their families should have a conversation if the patient had suffered a stroke. The Executive Director of Research and Informatics agreed to follow this up outside the meeting.

MJ

Emergency re-admissions – Emergency re-admission rates were slightly higher than plan with only a fraction of re-admissions coming to LHCH. The Committee discussed how once patients had been discharged from LHCH they were outside of the Trust's expertise. Therefore, it would be difficult to have any influence or control over a patient's re-admission and reasons for this.

Mixed Sex Accommodation Breaches – There were 6 breaches in September. So far this year the issues had been with transferring patients in a timely manner from POCCU to another ward. Improvements had been made with the opening of the discharge lounge to advance the flow of patients. From 2016 the Trust would be financially penalised for mixed sex accommodation breaches.

VTE Prophylaxis – In September the Trust achieved the 95% target for appropriate VTE prophylaxis for only the second time this year. Improvement work had been undertaken in this area and would be monitored closely going forward. The Chair acknowledged the achievements that had been made in the area to achieve the targets.

Patient Experience – Recommended Provider – the friend and family test for Outpatients this month received a score of 85% which was below the target of 95%. The Committee discussed a number of issues and recommendations to help improve the score:-

- Improve communication with patients when consultants were running late or there was a conflict with emergency patients / mitigating circumstances.
- Offer an apology to patients if clinics were running late
- Vary appointment times for new patients and follow up patient appointments
- Encourage consultants to attend clinic on time

Quality Accounts

- **Timeliness of inpatient discharges by 12pm** – work continues in this area with the emphasis on pharmacy and the TTO process with many eventualities, queries and subsequent changes to a patient's prescription to consider. The Trust had recently agreed that 2 junior doctors would be available to attend the discharge meeting daily with pharmacy to ensure changes to prescriptions could be made at that time.

Two new discharge pharmacists due to start in Dec 2015 and timeliness of discharge should show improvements in January 2016.

The Committee commented on managing patient expectations, planning the day before and ensuring systems were in place for both pharmacy and the discharge lounge.

The Chair commended the admirable results in relation to infection prevention and pressure ulcers together with the acknowledgement within 3 days of complaints received by the Trust.

9. Annual Report on Integrated Incidents, Complaints, Claims (trends & learning)

The Committee received the report that provided an analysis of reported integrated incidents, complaints and claims (IICC). The paper detailed the learning and changes in practice from the analysis of IICC. The report highlighted all changes / learning that had been identified through the analysis of information provided by the Risk Management Department, Complaints Department and Legal Services Department.

The Director of Research and Informatics explained that following a decline in incident reporting from July 2014, which could be attributed to the current reporting system (which was difficult to use) and a busy period over the winter period, incident reporting was now increasing. Additionally, the Trust had entered into a procurement process and Datix had been selected to provide an integrated risk management system to support incident reporting. The new system was more user friendly and the Trust were confident that an increase in the number of incidents reported would be achieved.

The Director of Research and Informatics went on to say the Divisions had shown

some improvement although further improvements could be realised in surgery.
The top five reported incidents were:-

- Medical Equipment (137 incidents).- The Chief Operating Officer had already raised the frequency and backlog of equipment maintenance and a requirement for checks to be completed within agreed operational timeframes. User error had also been acknowledged as a concern and this was now included as part of staff training.
- Documentation (95 incidents)
- Drug / Medication (93) incidents
- Delay in monitoring or obtaining assistance (67 incidents) – this may be due to staff / patient ratio. The Executive Director of Nursing & Quality to look at specific details and provide feedback to the group.
- Communication Error or Omission (63) incidents.

SP

The top 5 incidents were taken to the Operational Board Meetings to discuss the learning and tease out any issues. The Patient Safety Group were also doing some work to further investigate one of the top 5 incidents and identify actions to achieve improvements in that area.

In conclusion, the Committee requested further information was provided on Medical Equipment with the number of incidents broken down by

- Equipment / fault
- Human error
- Details of maintenance backlogs (

MJ

The additional information would offer assurance to the Committee by evidencing that issues were being actioned and improving.

19. World Health Organisation (WHO) Safety Checklist Annual Compliance Reports

19.2 Cardiac Catheterisation Laboratory (Cath Labs)

The Committee received a report on the Cath lab WHO Checklist and the Cath Lab Manager explained that the safer surgery checklist was being adapted across the UKs Cath labs. As a result, a specific Cath lab checklist had been developed and had been used by LHCH since September 2014. Patients (together with the Cath Lab team) were actively involved with the checklist that provided the patient with assurance their safety was key.

The Committee were informed that use of the checklist was audited via case capture and completion quality and a 7 day review was performed by an external reviewer. The audit identified a number of cases that were captured but omitted from EPR and these issues were being addressed. A number of improvement initiatives were also planned and a sub group had been set up to develop a more robust method of capturing data with on-going evaluation of the data captured to demonstrate compliance. This had full support from the associate Medical Directors and Clinical Leads with positive and encouraging feedback received so far.

The Quality Committee were asked to accept the report as assurance on

compliance with an understanding that the process was routine for every case (other than PPCI) and the data capture and audit process required further review to more robustly demonstrate compliance.

The Committee acknowledged that further work was required to put the infrastructure in place and provide assurance that quality information was being submitted.

The Chair thanked the Cath Lab manager for attending the meeting and presenting the report and asked for an update to be provided in Jan 2016.

19.2 Theatres

The Theatre Manager presented a report on the Theatre WHO Checklists and informed the Committee that as from April 2015 completion of the WHO Checklist had been included in the trust Quality Report as a Quality Indicator, reportable to the Commissioners on a quarterly basis. The Trust had set a target of 90% of all Checklists being 100% completed.

The inclusion of the Checklist as a Quality Indicator had been presented to theatre staff on audit day and the requirement for all elements to be completed and attention to detail (checked by Health Care Assistants) was reiterated at the daily Safety Huddle. Staff continued to monitor completion of the Checklist on a daily basis and results continued to improve.

A Checklist for emergency procedures had been compiled and would be entered onto EPR in October's cycle of change. This would enable the results for emergency and elective procedures to be identified and reported separately to the Commissioners.

The Checklist for cardiology and minor procedures required reviewing and linking to Athena. This work was on-going.

The Quality Committee were asked to accept the report as compliance with the required Quality Indicator as evidence of continuous improvement. Theatres would continue to monitor completion of the Checklist on a daily basis and compile monthly reports.

Again, the Chair thanked the Theatre Manager for attending the meeting and presenting the report and asked for an update to be provided in March 2016.

7.1 Audit and Assurance Processes which Review the Prescribing and Administration of Medicines.

The Deputy Chief Pharmacist presented a report that had been produced by the Trust's chief pharmacist to demonstrate the scope, range and variety of audits and processes conducted within the Trust to review and monitor prescribing and administration of medicines. The pharmacy department had an audit programme which covered legal aspects together with clinical aspects. The paper summarised the changes, presented the previous and current position and made recommendations to ensure the continued assurance of medicines management processes.

The report included a comprehensive and robust list of audits, processes and frequency. The committee were informed of an Action Plan that had been developed and was monitored by the Patient Safety Group in relation to missed doses. The Action plan was owned by doctors and consultants and the action plan will be discussed at the next divisional governance meetings.

The Committee were informed of the complexities with prescribing and the additional work required on EPR to support this, together with in-house training on EPR and prescribing tests for nursing staff.

The Committee expressed their concerns following results from the missed doses and clinical decision support (NG5) audits. However, they acknowledged the work currently being undertaken in this area and asked for a paper to be presented to the Board of Directors with a covering paper outlining the main issues and how these were being addressed.

10

Quality Outcomes - update

The Committee received a verbal update and presentation from the Executive Director of Research and Informatics on Quality Outcomes. Benchmarking outcomes were presented and explained together with the centile and ranking information. The Committee were informed that a range of measures were used including waiting times and examples were provided of areas requiring improvement.

The Committee were informed that benchmarking information would feed into next year's Trust Improvement Plan and work was underway to look at areas of improvement (including data issues) which will be key to moving the Trust forward into the 'area of excellence' by selecting areas of value to work on.

11.

Review of Re-admissions

The Committee received a report from the Director of Research and Informatics on re-admissions. The purpose of the paper was to present the results from a clinical audit of readmission within 30 days of discharge to two local DGHs.

The audit revealed that just under half of readmissions back to secondary care were potentially preventable and made recommendations to:-

- Implement a more rigorous clinical review/sign off of all available results prior to discharges (approximately 10% of the cases)
- Improve information - Better patient counseling-(20% of the cases) and specific mention of support networks (10% cases), might have helped prevent re-admission.
- Ensure adequate documentation at time of discharge (8.3% cases) to detail plans (to patient and next medical contact) to follow if patient developed a problem leading to the readmission.
- Prevention of premature discharge in appropriate cases - extension of the hospital stay or use of an intermediate care bed rather than discharge home (about 5% of the cases),

The Committee received confirmation that findings from the audit would be presented at medical and surgical audit days and actions followed up at the appropriate Governance Divisional Governance Committee meetings. The committee will receive an update report in 6 months' time – May 2016.

12. Secure Health Messaging – update on compliance

The Committee received a verbal update from the Medical Director on compliance with the Trusts Secure Health Messaging Service. It was explained that results continued to be disappointing. There was assurance that secure health messages were being sent following an alert however documentation was not always completed and the action taken was not subsequently recorded on EPR.

The Medical Director explained that the Associate Medical Directors and Divisions were re-engaging and communicating with staff to ensure the appropriate actions were followed. A further audit will be carried out in three months' time and presented to the Quality Committee in March 2016.

13. NHS National Patient Survey Results and Annual Assurance Report

The Committee received the report that provided an update on the key actions in relation to the results of the 2014 National In-Patient Survey.

The paper was taken as read and the Quality Committee were asked to note the work undertaken to address any shortfalls in the two key areas of slippage and note the key actions identified in appendix 1 of the document.

14. Patient and Family Support Team 6 Monthly Complaints Report

The Committee received the report that outlined concerns and complaints captured in Q1 and Q2 2015/16 and included the number of complaints received, trends and severity of complaint. This report provided assurance of the complaints management and process.

The Executive Director of Nursing and Quality explained that the learning from complaints will form part of the organisational learning with the Divisions and the learning will be shared through the Operational Board.

15. Excellent, Compassionate, Safe (ECS) – Annual Report

The Committee received the Annual Report and acknowledged it was to be presented to the Board of Directors. Areas of concern rated amber would be addressed appropriately and action plans would be monitored through the Divisional Governance Meetings

16. CQC Intelligent Monitoring Report

There was no update for this item

17. CUSUM Curves (Paper) / Mortality Review

The Committee Received a paper and presentation from the Executive Director of Research and Informatics on CUSUM Curves and Mortality Review.

The purpose of the CUSUM Curves paper was to provide assurance to the Quality

Committee on the performance of LHCH cardiac surgeons and interventional cardiologists from the latest CUSUM results. Surgeons outside of the CUSUM Curves were reported on for cardiology and there were no interventional cardiologists lying outside of their CUSUM curve. However the Committee were informed that the British Society of Interventional Cardiologists had yet to update their risk prediction model which was now some 10 years out of date and would be prone to the overestimation of expected risk.

One surgeon had been on restricted practice for CABG and combined procedures for the last six months and another two surgeons were being reviewed by the Audit Lead for Cardiac Surgery in accordance with local policy.

The Quality Committee were asked to receive assurance that performance issues of Consultants in high risk specialties was monitored and managed in accordance with locally developed performance policies.

The Chair asked for this item to be discussed further at the Board of Directors meeting on 24th November 2015.

18. Sepsis Audit Report

The Committee received a re-audit presented by the Medical Director to assess compliance with the sepsis order set in EPR and subsequent audit of sepsis care. The re-audit was conducted to measure the KPI and the quality of compliance with using the Sepsis bundle order set to establish if there had been any improvement and to identify where further work was needed to achieve compliance

Although the results were disappointing there had been small improvements made and the audit demonstrated that the change in antibiotic usage in line with implementation of new antibiotics had been successful.

A number of next steps were identified in the paper and these would be monitored going forward with further updates fed back to the Quality Committee via the Quality Report

The Quality Committee were asked to receive assurance that sepsis was being monitored through the infection prevention committee and the suggested next steps would form the basis of the action plan to address compliance with the sepsis bundle.

The Chair asked for this item to be discussed further at the Board of Directors meeting on 24th November 2015.

20. Long Term Strategy for Managing Multi Resistance Organisms

The Committee received the report that was taken as read. The paper highlighted key areas for the Trust to consider and adopt to ensure that the Trust kept patients safe and was able to continue to provide the highest quality of care in the coming years.

The Quality Committee were asked to note the report and consider the developments outlined and attendant costs which were outlined in appendix 1 and 2

21. SUIs and Risks – Never Event

The Committee received a verbal update in relation to a recent never event and were informed the investigation was near completion and the case manager would produce recommendations.

22. Any Other Business

The Chair asked for the:-

- Time of the meeting to be extended by ½ an hour to 2 ½ hours
- CUSUM Curves item to be submitted earlier on the agenda
- Papers to be produced ather than presentations.

23. Date and Time of Next Meeting

12th January 2016 from 09.00 – 11.30 Boardroom

.