

Quality Committee

Item 3

minutes

Date of Meeting: 10th May 2016
Time: 12.30
Venue: Boardroom

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

In attendance: Shirley Cummings, Project Management Office (Item 7.2)
Dr Gill Gow, Chief Pharmacist (Item 12)
Dr Mark Jackson, Executive Director of Research and Informatics
Christine Mars, Sister Cath labs (Item 5.2)
Sarah Moreton, Interim Cancer Services Advisor (Item 9.1)
Sue Pemberton, Executive Director of Nursing and Quality
Dr Raph Perry, Medical Director
Hannah Rooney, Neuro Physiologist (Item 6)
Dr Nik Sharma, Stroke Consultant (Item 6)
Julie Tyrer, Tissue Viability Specialist Nurse (Item 9.2)
Tony Wilding, Chief Operating Officer (Item 7.2)

Debbie McEllenborough, Support Secretary (Minutes)

1. **Apologies for absence**

There were no apologies received.

2. **Declarations of interest relating to Agenda Items**

Mark Jones expressed a declaration of interest in relation to Item 9.1 on the Agenda as a family member was due to receive treatment at the Trust.

3. **Minutes of the previous meeting held on 8th March 2016**

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

4. **Action Log**

All outstanding actions were included on the Agenda.

6. Stroke Update

Following a previous meeting, the Committee had requested a member of the stroke team to provide a verbal update on the stroke service at LHCH. The Committee welcomed two members of the stroke team; Dr Nik Sharma and Hannah Rooney.

It was explained to the Committee that although the service was not judged against national performance, the stroke service benchmarked itself against 10 criteria. The criteria had been adapted from the Stroke National Audit Programme (SNAP). Since February 2015 the stroke team had overseen the criteria indicators and introduced changes to drive forward improvements.

One of the initiatives addressed how data was collected and work was undertaken to look at improving data capture and ensuring the correct data was accurately recorded. More regular and reliable ward rounds were introduced together with input from the stroke advanced nurse practitioner. The stroke team also focussed on discussing every patient as part of the Multi-Disciplinary Team (MDT) meeting. Interactive MDT sessions were also introduced with the patient to assess and measure progress against the indicator and also to discuss their care plans. This helped to achieve the targets set for the criteria.

The stroke team went on to say there were three challenging areas:-

- **Indicator 1 - Brain imaging within 24 hours.** Most stroke patients at LHCH experienced a stroke during a procedure and were then too poorly to go for a scan. Teaching was underway to educate junior doctors on early imaging and last quarter had seen an improvement with an increase to 90%. Documentation was also being reviewed to assess patients who had been ventilated and to screen patients who had been suspected of having a stroke.
- **Indicator 4 - Formal Swallow Assessment.** This was to assess how well a patient was able to swallow and if they were well enough to eat and drink. A new SALT role had been introduced within the Trust and the new staff member was keen to be actively involved.
- **Indicator 10 - Onward Referrals to Local Stroke Service.** This was difficult to follow up for patients outside the immediate area. A new onward referral document had been created for those patients discharged from LHCH to ensure they received appropriate stroke follow up in their locality. The Trust also ensured that, on transfer, when patients were

repatriated the Trust provided accurate information pertaining to their stroke.

The Committee were also informed of competency based stroke training that had been delivered to staff on Elm Ward, POCCU and Critical Care. This had been well received and further training dates were planned.

The Executive Director of Nursing and Quality informed the Committee of the positive feedback that had been received from patients and families on Elm Ward. The stroke team had made significant improvements and were commended by the Committee for their achievements. Going forward the stroke team was asked to prepare an annual report for the Committee to review on a yearly basis.

5.2 WHO Safety Check List – Cath Labs

The Committee received the report that was taken as read and presented by Christine Mars, Sister, Cath Labs. The report provided an update on checklist completion. The Committee were informed that the check list omission data had been reviewed for a six month period rather than the previous 7 day snapshot and the findings would be presented at the cardiology audit day.

The Committee discussed the figures that had been presented and were informed that the initial snap shot audit only looked at three fields that had been omitted. They included consent, patient identification and allergies. The Committee expressed their concern with auditing such a small number of fields and went on to discuss the need to have a minimum data set going forward and have evidence to support that the minimum data set had been fully completed. The Medical Director confirmed that Karen Wafer and John Morris would be asked to review the requirements for the minimum data set, criteria and to set Key Performance Indicators (KPIs). The committee would also like to understand the comparison of data collected in the checklists for both medicine and surgery.

RP

In summary, the Committee requested that the check list compliance information should be included in the dashboard and a six monthly update provided to enable the Committee to monitor progress and performance.

5.3 WHO Safety Check List – Surgery

The Committee received the report prepared by the Theatre Matron and presented by the Director of Nursing and Quality. The report identified that data collected had highlighted that theatres had not been fully compliant during the audit undertaken in February and April 2016. The Committee were also informed that compliance had not been achieved if any elements of the check list were not completed. To help improve compliance, awareness sessions were being held at theatre safety huddles, a new matron was in post and an education manager was to be recruited.

The Committee went on to say that confirmation of patient identity must be recorded for all patients. If it was not recorded there was no evidence to support that patient identity was confirmed.

The Committee discussed the importance of recording information and an urgent need to make immediate progress. The Chair requested that an action plan was developed that clearly showed how improvements would be made with specific emphasis on ensuring that theatres improved their compliance rate with recording patient identity. The Medical Director informed the Committee **RP** that Richard Williams - Theatre Lead would be asked to take this forward a drive through improvements.

The Chair asked for this item to be included on the BAF Key issues for Quality at the next Board meeting in May 2016.

7.2 CIP Quality Impact Assessments

The Committee received the final QIA/ PID for the financial year which was being submitted by the Surgical Division. All other QIAs over £25,000 had been signed off at a previous meeting. The outstanding project was to increase productivity in theatres.

To achieve this, the Chief Operating Officer explained that going forward the theatre matron would focus on clinical and governance aspects and a theatre manager would focus on the day to day management aspects and be accountable for managing all of the theatre lists. Better management of lists would lead to a reduction in unexpected overruns with staff shifts written to reflect the activity required. To improve efficiency and reduce overtime costs there would be a requirement for staff to work 8am – 8pm and this would provide a more structured approach than the current 8am - 6pm.

The Committee went on to discuss how the change to working practice and reduction in overtime payments would affect people's salary. The COO explained that work was underway together with HR to review workforce flexibility, ensure the correct balance of core staff was in place and to use overtime only when appropriate.

The Committee received confirmation that the risks were being addressed and new ways of working would need to be progressed via the staff consultation process and this was included in the report.

9.1 Cancer Services

The Committee received the Cancer Annual Report 2015/16 from Sarah Moreton, the Interim Cancer Services Advisor. It was explained to the Committee that data quality and collection was a challenge to ensure that information was accurately recorded and validated in a timely manner. There had been good engagement with the Clinical Team and data collected would be used to monitor how the Trust performed against national statistics once this data was published.

Various cancer details had been transferred onto the Somerset Cancer Database used by the Royal Liverpool Hospital. LHCH and the Royal were waiting on a draft sharing agreement to be ratified to enable LHCH to access the information. A meeting had been planned with the Cancer Manager lead to take this forward. Meanwhile validation of the information was conducted in conjunction with the Liverpool Lung Cancer Unit.

The Committee were informed that Public Health England had produced a feedback report for the North West following analysis of the data recorded on the Cancer Outcomes and Services Dataset. The results of this were included in Section 5 of the report. It showed how LHCH ranked against completion of the cancer data that was submitted. It was emphasised by the Cancer Services Advisor that this information did not reflect rankings for clinical care or treatment.

The Chair went on to ask about the Key Performance Indicators used for the cancer performance targets and the following definitions were provided:-

- **14 day** (GP referral 1st Outpatient Appointment) - from urgent GP referral for suspected cancer to first appointment
- **31 day** (1st definitive treatment) from diagnosis (decision to treat) to first treatment for all cancers
- **31 day (Subsequent Treatment)** from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery or radiotherapy)
- **62 day** (Urgent GP Referral) Adjusted - 62 day wait split between GP referral and consultant upgrade from suspicion of cancer to treatment (first treatment)
- **62 day** (Urgent GP Referral) – a patient received their first definitive treatment for **cancer** within 62 days of an urgent GP referral
- **62 day** (Consultant Upgrade) Adjusted
- **62 day** (Consultant Upgrade) - patients who received first treatment for cancer following a consultant's decision to upgrade their priority began treatment within 62 days of that decision.

The Executive Director of Nursing and Quality asked what improvements were being put in place in relation to the 62 day GP referrals and was informed that processes were being improved to track investigations and escalations. Further work was underway to look at how to improve the pathway and the Director of Nursing and Quality asked if this information could be included on the dashboard going forward. The Cancer Services Advisor then went on to explain that the breach re-allocation policy was also under discussion together with the National CQUINs 62 day wait, root cause analysis and how the impact of delays effected a patients overall prognosis.

The Committee was asked to note the performance and the recommendations going forward and was informed that LHCH would develop a Cancer Strategy based on developments across the Network

9.2 Tissue Viability Annual Report

The Committee received the report from the Tissue Viability Specialist Nurse. It was explained that the Tissue Viability Service was also committed to providing value for money and cost effective products for their patients. Appendix 2 of the document provided details of the forecasted costs savings for 2016/17.

Data relating to pressure ulcers continued to be collected monthly using the NHS Safety Thermometer with the Trust regularly achieving the target set of 1.84%

The Trust also used an internal system for monitoring pressure ulcer incidence. This continued to accurately monitor and record grade 2 and above hospital acquired pressure ulcers to identify local issues and identify appropriate actions. The number of pressure ulcers assessed as avoidable had nearly halved in comparison to the previous year and was very low compared to other hospitals across the region. Please see table below:-

Pressure Ulcer Data	2014/15	2015/16
Number of hospital acquired pressure ulcers	26	22
• Surgical Division	12	6
• Clinical Services Division	13	15
• Cardiology Division	1	1
Medical Device Related pressure ulcers	2	2
Grade 2 pressure ulcers	22	19
Grade 3 pressure ulcers	4	3
Assessed as avoidable	19	10
Assessed as unavoidable	7	*12

Superficial grade 2 pressure ulcers still presented a challenge and actions were being rolled out Trust wide and progressing well. A new campaign to protect 'heels' was launched in April 2016

The Director of Nursing and Quality went on to say that apart from the cost savings identified in the report, money would have been saved by patients not acquiring pressure ulcers. This was directly attributable to good nursing care, leadership and education.

The Committee commended the team on their continued hard work and efforts to consistently reduce the incidents of pressure ulcers throughout the Trust.

7.1 Quality Strategy

The Director of Nursing and Quality presented the Clinical Quality Performance Report to Month 12.

Mortality Reviews - the timely completion of reviews had improved and an exercise was underway to address the historical back log. The Committee discussed the target of 85% completed within 28 days. The Medical Director said that going forward there would be a clearer focus on expectations, including organisational and operational issues.

Infection Protection – MRSA – no cases reported
C.Diff – none reported this month
CPE – 2 cases reported this month, 1 LHCH acquired.

The Committee commented on the on-going good work in this area.

Falls and Pressure Ulcers – overall there was a reduction in the number of falls. The focus was now on high risk areas and Birch, Cedar, Oak and Elm ward were being reviewed. A meeting had been arranged with ward managers to promote good practice and the Director of Nursing would establish who the leaders were in this field across the region

Medication Errors – The number of medication errors reported in March was above the monthly target and rated as red. The next Quality Committee meeting in July 2016 would be provided with broad categories on dispensing errors and details of the impact, if any, that was having on patients. **GG**

Dementia assessment – Again the Trust achieved the targets for all three screening indicators with more than 95% of patients treated appropriately. Again the committee commented on the good work in this area.

MSA – 5 MSA Breaches this month all reported from Critical Care. A representative from Commissioning was coming in to the Trust to meet with the Director of Nursing to discuss the action plan to reduce these.

VTE – Target for the provision of appropriate VTE prophylaxis was achieved again in March. Efforts to improve in this area continued.

Patient and Family Experience – This continued to perform well and the outstanding work in this area was noted by the Committee.

Clinical Digital Maturity – a new IT strategy was planned.

Smoking Cessation – funding withdrawn end of June. A new system was in place for the onward referral of a patient by their GP. Continued to be part of the Clinical Quality Improvement process and the information was also included in the discharge summary.

Discharge Summary – Improvements continued to reconcile discharge summary with the correct patient. Developments were on-going to address IT issues. Both the patient and GP received a copy of the discharge summary.

8.1 Annual Report Mortality Review

The Medical Director informed the Committee that only minor changes to the paper had been made since it was presented at the Board of Directors meeting in April 2016.

9.3 Safeguarding Annual Report

The Executive Director of Nursing and Quality informed the Committee that only minor changes to the paper had been made since it was presented at the Board of Directors meeting in April 2016.

9.4 Complaints Report

The Executive Director of Nursing and Quality presented the Complaints Report. The Committee were informed that 65 complaints were received by the Trust between 1st April 2014 and 31st March 2015. This was a 25% increase in comparison to the 52 complaints received the previous year.

The reason for the increase may have been due to promoting awareness via posters throughout the Trust and the introduction of new information booklets.

In addition, more meetings were being held with families and there were key areas of improvements being addressed particularly in relation to patients from the Isle of Man. The Trust was working in conjunction with Nobles Hospital to help improve the patient experience.

The Director of Research and Informatics informed the meeting that although the current incident reporting system had a complaints module the new system was much improved and had a more user friendly reporting mechanism

The Committee queried the number of complaints that had been upheld and the Executive Director of Nursing and Quality agreed to follow this up with the Complaints Managers. **SP**

The Committee asked to see the information presented in a graph format going forward to see trends over a period of time.

In summary, the Committee received assurance that complaints management was robust and proactive and that all complaints were investigated appropriately. Actions and learning from concerns was managed appropriately through the Divisional Governance structures.

12. Update to Medicines Management Report – summary action.

At a previous meeting the Committee had received a report into medicines management issues. The report included copies of various audits and the Quality Committee had commented on specific areas. The Committee had subsequently requested the Chief Pharmacist to put together a summary of the actions to address the issues that had been raised.

The Committee reviewed the action plan outlined in appendix 1 and went on to discuss:-

- the reporting of missed doses and near misses
- how LHCH rated compared with other Trusts for reporting
- If staff knew what an incident was.

Going forward the Committee would like to receive some examples of incidents and an indication of what medicines were involved in the incidents.

The Chair mentioned the potential life threatening near miss that had occurred in Critical Care and the Chief Pharmacist agreed to provide a brief outline of the incident for the Director of Nursing and Quality to update the Chair. **GG/SP**

In conclusion, the Chief Pharmacist confirmed that medication management in the Trust was as safe as it could be, was auditable and robust and improvements would continue to be made.

10. Compliance and Regulation

10.1 Mortality update – all surgeons previously outside their cusum curves were now back within their expected levels.

10.2 SUIs – Never Event – The Consultant involved in the Never Event had their contract revoked and no appeal had been received by the Trust in relation to this. The Coroner's hearing was scheduled to take place in September 2016. Learning and sharing had been disseminated and the processes had been strengthened.

A discussion then followed on the theatre lists and how these were shared with staff. The Medical Director explained that good processes were common practice in theatres and the Associate Medical Director for Surgery was responsible for ensuring that surgeons followed the correct processes and procedures.

11. Operational Board Meetings

The Committee received Minutes of the Operational Board Meeting (for information)

Patient Story

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

13 Date of Next Meeting - the date of the next meeting was changed from 12th July 2016 to 5th July 2016 at 12.30 – 15.00 (Boardroom)