

## Quality Committee

### Item 3

## minutes

**Date of Meeting:** 1<sup>ST</sup> September 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)  
 Mark Jackson, Director of Research and Informatics  
 Sue Pemberton, Director of Nursing and Quality  
 Raph Perry, Medical Director  
 Debbie McEllenborough, Support Secretary (Minutes)

#### 1 **Apologies for absence**

There were no apologies for absence.

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

There were no declarations of interest to record.

#### 3. **Minutes of meeting held on 20<sup>th</sup> July 2015**

The minutes of the meeting held on 20 July 2015 were reviewed and the Chair requested clarification of the following points to be included:-

- **Item 13 – Mortality Review**
  - Referenced the End of Life Care Strategy and the Director of Nursing explained that an update on Palliative Care will be received by the Committee in 2016.
  - The Medical Director confirmed that a meeting was planned to review the early discharge of patients from POCCU and the appropriate use of beds and patient flow.
- **Item 24 – Sepsis Update.** The Medical Director confirmed that results from the recent Sepsis Audit will be available at the next Quality Committee meeting in November 15.
- **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.

#### 4. **Matters Arising**

The Chair requested an update on 'Readmissions' and the Executive Director of

Research and Informatics explained that work is currently underway with a locum cardiologist and community nurses to review data relating to readmissions. A report would be available to present at the next Quality Committee meeting in November.

**5. Action Log (All)**

The Committee discussed the outstanding actions and the items updated accordingly:-

**No. 13. Item 6.1 Review of re-admissions** – discussed under matters arising.

**6. New Terms of Reference**

The Committee reviewed the updated Terms of Reference and the following amendments were requested to the document:-

**Section 8 Quorum** – The Chair or Vice Chair, plus one other member of the Committee must be present.

The Committee went on to discuss Equality and Diversity and it was agreed the section is to remain in the Terms of Reference for consideration in all aspects of the Committee's work.

**7. Updated Work Plan**

The Committee received the Work Plan and the following changes were requested:-

- Cusum Curves to be presented in May 2016
- Mortality Review to be a separate item and an update provided at every meeting.
- November items to be spread more evenly throughout the year

**8. Receive Minutes of Operational Board Group**

The Committee were informed the minutes are in draft format and awaiting approval.

**Patient Story**

The Director of Nursing and Quality read a patient story and informed the Committee that the patient's comments had been conveyed to the relevant wards together with the patient's gratitude for the efforts of all concerned with their recovery.

**9. Quality Report**

The Director of Nursing and Quality presented the Clinical Quality Performance to Month 04 to the Committee and the main items noted included:-

**Mortality** – work is underway to improve the timeliness of completion of mortality reviews for divisions and this will be further enhanced by the introduction of Consultant Job Planning to allow surgeons to complete reviews within 28 days and urgent reviews within 14 days. Learning from reviews is to be shared at audit days and cascaded to the nursing staff. The Executive Director of Nursing and Quality confirmed mortality reviews for nursing have improved.

**Hospital Standardised Mortality Ratio (HSMR)** – rated green with no concerns

**C.Diff** – 1 case reported in July, currently under review

**Falls** – 8 falls in July, slightly above target although LHCH are performing within the trajectory for 2015. All falls are subsequently discussed at the daily Safety Huddles. (It was noted the number of falls reported on the graph on page 4 had been transposed).

**Pressure Ulcers** – no new avoidable pressure ulcers reported in July

**Patient Safety Incidents** – new system to record and track safety incidents is being implemented across the Trust end of Dec 2015 / Jan 2016.

**Medication Errors** – The Committee asked for reassurance on the quality of data in relation to medication errors and received assurance that robust processes and procedures are in place to track and monitor medication errors by the:-

- Use of PRISM
- Medication Safety Thermometer
- Medication Errors Safety Committee (identify best practice and propose recommendations)
- Continual monitoring of medications by the pharmacy team
- Missed-doses 1 day Audit presented to Quality and Patient and Family Experience Committee

**Mixed Sex Accommodation Breaches** - 6 breaches recorded in July as patients could not be transferred to other wards from POCCU. A new discharge lounge is due to be implemented at the end of September to improve patient flow.

**Complaints** – the number of complaints remains low with all complaints acknowledged and responded to within the agreed number of days.

**Serious Incidents** – one serious incident mentioned at the last meeting under review

**VTE** – VTE Risk Assessment on admission has been consistently above target this year.

**VTE Prophylaxis** – pressures continue with achieving targets although it was noted that a third of all cases reported were due to poor data quality. Actions have been identified and will be taken forward by the new Divisional Heads and results reported to the Operational Board.

**Patient Experience – Inpatient** – Response rate low due to technical problems with iPads. This was corrected as it should have been 42%.

**Quality Account Indicators** – Timeliness of patient discharge requires improvement and the Listening into Action (LiA) project is working alongside the Care Support Team to facilitate this.

**Speak Out Safely** – Campaign underway to ensure that patients their families and carers are aware of the processes in place to speak out safely. The Executive Director of Nursing and Quality is working in conjunction with the EPR team to ensure this information is captured on the system electronically.

**Safe Quality Care** – The criteria for vulnerability of patients has been implemented on EPR. Training is on-going to identify the appropriate actions to be taken when a vulnerable patient is identified and development and communication of a specific care plan to meet their needs is underway.

**CQUINs** – Actions to improve Clinical Digital Maturity previously put on hold due to insufficient resources is now continuing after additional EPR resources were approved by the Executive Team.

In summary the Chair requested the Chief Pharmacist to articulate assurance on

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Medication and for the Medical Errors Committee Annual Report to be presented to the Quality Committee in March 2016.

The Chair went on to commend the good performance across the Trust, specifically the low mortality rates and went on to acknowledge the low instances of pressure ulcers and infections and agreed to write and thank both the lead nurses involved.

#### **10. Cost Improvement Programme (CIPs) and Quality Impact Assessments (QIAs)**

The Committee received a presentation from the Project Manager outlining the LHCH Project Framework and explained the various processes in place that are supported by additional check points to review the feasibility, risks and benefits of each of the developments. A new monthly CIP Steering Group chaired by the Chief Executive had been introduced with managerial and clinical representation. The Committee were informed that QIAs for clinically focussed schemes and those over £25k in value are submitted to the Head of Nursing for Quality and Corporate Services for sign off or subsequent discussion with the Heads of Nursing. The Director of Nursing and Quality confirmed all QIAs that impact on nursing are reviewed by the DoN and the Heads of Nursing and Quality.

The Committee were informed of three major projects currently under development:-

- Consultant Job Planning
- Workforce
- Admin Review

The Committee requested that monthly progress updates are provided at the Quality Committee meetings going forward.

Further details were provided in relation to the four divisions (Surgical, Medicine, Corporate Services and Clinical) together with an update for each including

- Number of schemes identified
- QIAs received by the Project Management Office
- QIAs signed off by Heads of Nursing and Quality
- Schemes requiring a full QIA by Heads of Nursing
- QIAs requiring additional information

The Committee expressed concern at the number of outstanding Quality Impact Assessments that had not been assured by the Committee. A date was subsequently agreed for completion of all the outstanding QIAs by 30<sup>th</sup> September 2015 with an exception report to be submitted to the Executives if this was not achieved.

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.

The Committee went on to review the Quality Impact Assessments and the following points noted:-

- The QIAs included generic statements concerning patient safety /

experience and clinical effectiveness and the Committee were informed that additional work is on-going and QIAs would be updated regularly as developments progress and more information becomes available.

- Check points and monthly reporting will take place as projects progress to highlight changes and identify risks.
- A disconnect with items on the Corporate Risk Register was identified and the Executive Director of Research and Informatics agreed to work together with the Project Manager and Executive Director of Strategy and Organisational Development to address any training issues and ensure standard procedures are followed for the recording / reporting of risks and that issues in QIAs are aligned to the corporate risk register.
- The Project Manager to ascertain the status of the QIA for Job Planning.

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In conclusion the Committee raised the impact of specific QIAs on staff morale and requested this be considered going forward.

The Chair expressed thanks to the Project Manager and Executive Director for Strategy and Organisational Development for their effort and time taken to produce the documentation.

## **11. Review Progress of Clinical Audit and Effectiveness Strategy**

The Executive Director of Research and Informatics presented the Annual Report and progress and activity of the Clinical Audit and Effectiveness Group between April 2014 and 31<sup>st</sup> March 2015. The Committee were informed that the CAEG continues to function well although there are still issues with attendance despite efforts to improve this. The main reason for non-attendance was usually due to last minute clinical commitments.

### **11.1 Clinical Audit Progress and NICE Adherence**

The Executive Director of Research and Informatics explained the report provided additional information in relation to audit work and recommendations by the Audit Committee to improve attendance at the CAEG and the impact of the changes. The Committee received assurance that audit and effectiveness activity at the Trust continued in accordance with the Trust Clinical Quality forward plan 2015/16.

The Director of Research and Informatics provided an update on the following Appendices and the Committee were informed of the items RAG rated as red.

### **11.2 Appendix A LHCH Clinical Quality Forward Plan 2015/16**

- **Consultant Appraisals** – not started
- **Fasting Re-Audit** - No audit data received for Cath Labs

### **11.3 Appendix B LHCH Quality Compliance Reporting Template**

- **Near misses** – Evidence of timely reporting, triangulation of other information incorporated into analysis and also the demonstration of learning across the organisation from near misses. Request made by the Clinical Commissioning Group to provide information bi-annually to coincide with LHCH reporting timescales.
- **National Staff Survey; Review quarterly actions** – information to follow

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.
13. **Patient & Family Experience Annual Report**  
The Executive Director of Nursing and Quality presented a report that provided an update on performance against the KPIs determined and agreed by the Board of Directors in relation to the Patient and Family Experience Vision 2013-16.
- The Committee were informed of a number of key areas within the report:-
- **Parking** – is expensive and long stay passes were not always available
  - **Signage** - is poor across the site and new signage has been agreed and is due to be presented to the Board of Directors
  - **Availability of Family Rooms** – New Cherry Ward open with family room and work is underway to look at suitable family rooms for Maple Ward
  - **Discharge Planning** – Two Listening into Action groups were undertaking improvement work on discharge. Survey information showed an improvement in this area
  - **Personal TV / Radios** – Revisit provision of personal TVs etc. for patients
14. The Committee received assurance around the work that continues to ensure the Trust provides excellent and outstanding levels of patient care.
- PLACE Self-Assessment**  
The Committee received a report that provided results of the Patient-Led Assessments of the Care Environment (PLACE) that are a self-assessment of non-clinical services which contribute to the environment in which health care is delivered. The areas for improvement highlighted by the teams during the PLACE Assessment within the Trust included:-
- **Well-being of Patients** – individual TV and Radio access for all patients
  - **Curtains** - not closing on Elm and Birch ward. Clips to ensure privacy have been ordered for the curtains and delivered to the wards.
- The Trusts overall average for 2015 shows an improvement of 1.3% on last year's figures.
- The Quality Committee were asked to note the results of the recent PLACE assessment and the recommendations relating to improvement work required to meet the new standards across the organisation.
15. **SUIs and Risks**  
None to report
16. **Date and Time of Next Meeting** 17<sup>th</sup> November 2015 from 09.00 – 11.00, Boardroom