ITEM 8C

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Minutes of the Healthcare Quality Assurance and Improvement Committee held on Thursday 10th September 2020 at 2.00pm via MS Teams.

Chair:

Dr L Thomson	Non-Executive Director (Chair)

Present:

Mr A Boyle	Non-Executive Director
Mrs M Lees	Chair, Area Clinical Forum
Mrs L McDonald	Non-Executive Director
Dr A Osborne	Non-Executive Director

In Attendance:

Dr J Burns	Executive Medical Director
Mrs K Cormack	Director of Quality
Mrs M Cranmer	Staff Partnership Representative
Mrs E Currie	Quality Programme Manager, Business Support
Professor K Currie	Professor of Nursing & Applied Healthcare Research, Glasgow Caledonian University
Dr M Devers	UHM Deputy Chief Doctor, Consultant Physician in Diabetes/Endocrinology
Mr E Docherty	Executive Director of Nursing, Midwifery & Allied Health Professionals
Dr L Findlay	Medical Director, South Lanarkshire HSCP
Dr J Keaney	Medical Director, Acute Division
Dr H Mackie	UHH Consultant Gastroenterologist
Dr A Mallin	UHH CT2-CMT Medicine
Mrs T Marshall	Nurse Director, North Lanarkshire HSCP
Mr P McCrossan	Head of Allied Health Professionals
Mrs L McInally	Senior Improvement Advisor
Mrs A Minns	Head of Evidence, Quality Directorate
Mrs L Thomson	Nurse Director, South Lanarkshire HSCP

Apologies:

Mr P Cannon	Board Secretary
Mr G Docherty	Director of Public Health
Mrs H Knox	Interim Chief Executive
Mrs N Mahal	Board Chairperson
Mrs C McGhee	Corporate Risk Manager
Mrs M McGinty	Head of Improvement
Mr R Peat	Interim General Manager, Bellshill Locality

1. <u>WELCOME</u>

Dr Thomson welcomed colleagues to the meeting and apologies were noted.

2. <u>DECLARATION OF INTERESTS</u>

There were no declarations.

3. MINUTES

The minutes from the meeting held on 22nd July 2020 were approved. The Committee also approved the minutes from the exception meeting of HQAIC held on 17th June 2020 regarding Care Homes.

THE COMMITTEE:

Noted and approved the minutes of 22nd July 2020. The Committee also noted and approved the minutes from the exception meeting of HQAIC held on 17th June 2020 regarding Care Homes.

4. ACTION LOG

The Committee discussed the action log from the meeting held on 22nd July 2020 and heard updates, including the Covid 19 consent documentation. Dr J Keaney advised that changes had been made to the documentation as discussed and he would share a copy of this at the November meeting. Dr J Burns noted that the Information Governance Committee have appointed a new Chairperson and further discussions were planned regarding the fair-warning system. The Committee discussed the action aligned to the Inpatient suicide item, noting that NHS Lanarkshire is part of a national pilot and involved in a Mental Welfare Commission pilot for suicide reviews to have an external assessment.

THE COMMITTEE:

1. Noted and approved the action log from the meeting on 22nd July 2020.

5. QUALITY PLANNING & PROFESSIONAL GOVERNANCE GROUP – HIGHLIGHT REPORT

Dr J Burns presented the Quality Planning & Professional Governance Group Highlight Report to the Committee, noting that Dr A Khan and Dr M Malekian were writing a paper regarding the Cumberledge Report to provide assurance on NHS Lanarkshire arrangements and governance relating to the issues raised in the report. Dr L Thomson requested a timescale for an update coming back to the Committee. Dr J Burns advised that an update would be available for the November meeting and she would request a gap analysis from Mrs C Gilmour. The Committee discussed the issue of patients being listened to and how best to quantify this. Dr J Burns and Mrs K Cormack will meet to discuss this, review themes to help provide assurance in terms of the NHS Lanarkshire position.

Dr A Osborne enquired regarding the Cytosponge procedure and the positive impact this could have on staff capacity and the current waiting list for endoscopy. Dr J Burns advised that it is a relatively new technique and not suitable for all patients, however will be of benefit to those who would have gone straight to test. Dr J Keaney advised that it is a more comfortable procedure for patients than a scope. It is being fast tracked nationally and NHS Lanarkshire will actively monitor the impact on waiting times. The Committee heard that upper GI surgeons will use the technique in a pilot to gather expertise in its use before roll out.

THE COMMITTEE:

1. Noted and approved the Quality Planning & Professional Governance

Group highlight report.

6. NORTH HSCP SUPPORT, CARE & CLINICAL GOVERNANCE GROUP - HIGHLIGHT REPORT

Mrs T Marshall presented the North HSCP Support, Care & Clinical Governance Group highlight report and updated the Committee on key areas including the restructure currently underway in the Partnership. North will retain 6 localities, with 2 main units and will be reviewing their Support, Care & Clinical Governance Group structure accordingly. The Committee heard that the North HSCP Significant Adverse Event Review Group are in the process of appointing a new Chairperson. The paediatric service is experiencing staffing issues at present and these are being addressed, while recovery work is ongoing regarding outpatient services and planned care. The Sexual Health service is recovering following the impact of Covid 19 and it is anticipated that NHS Lanarkshire will see an increase in unplanned pregnancies; this will continue to be monitored. Mrs T Marshall advised the Committee that an inspection was completed in Shotts Prison looking at the safety and security of staff, Infection Prevention and Control and human rights. No recommendations were made from the inspection and NHS Lanarkshire recognise the hard work and effort of all the staff involved. The partnership has recruited to a complaints post and this will help with the provision of complaints reporting to provide further assurance at future meetings. Arrangements are being made for Quality Week 2020 involving Mental Health Services and work is planned to create videos, discuss improvement work and look at whether the triangle of care is transferrable to other services.

Mrs L MacDonald enquired regarding the support mechanisms in place for significant adverse event reviews in North HSCP. Mrs T Marshall noted that the partnership does not have a Risk Facilitator post, however they are reviewing current arrangements to try and identify funding to support this work. Dr L Thomson requested the Committee receive an update on this risk at the November 2020 meeting.

Mrs K Cormack offered to provide significant adverse event review training to any new staff North HSCP colleagues recruit to the Risk Facilitator post.

Mr E Docherty advised that he is keen to see the triangle of care system used across the organisation.

THE COMMITTEE:

1. Noted the North HSCP Support, Care & Clinical Governance Group Highlight Report.

7. CASE-NOTE REVIEWS

University Hospital Hairmyres

The Committee welcomed Dr H Mackie and Dr A Mallin from University Hospital Hairmyres (UHH) who attended the meeting to present their mortality case-note review report. A mortality review team was established to review the inpatient deaths associated with Coronavirus at UHH. 57 patients were identified with Covid-19 listed as their cause of death between 28th March and 31st May 2020 and all deaths were reviewed using the standard NHS Lanarkshire mortality review forms and IHI 3x2 Matrix and global trigger tool. The deceased group of patients were compared to a survivor group of 51 patients discharged from UHH after a diagnosis of Covid-19 disease between

5th April and 22nd April 2020.

The Committee heard that the patients in the mortality group were found to be older and frailer with a male predominance. The report identified that communication with families was done well, with active discussions around end of life care noted. 75% of relatives were given the opportunity to visit if a patient was end of life. Anticipatory care planning was generally done well with 100% of patients in the mortality group having a documented plan and 78% of those who survived having an anticipatory care plan completed.

Dr L Thomson enquired regarding hospital discharge letters and cause of death. Dr A Mallin advised that UHH had recently switched to using the HEPMA system and there has been an improvement with regard to immediate discharge letters. She noted however that cause of death was not always recorded on the patient notes. Dr J Burns commented that it was disappointing we do not have an electronic patient record to complete the full patient frailty score for frail patients. Dr A Osborne asked about the demographic analysis, BAME community and involvement of the palliative care team. Dr A Mallin advised that ethnicity was not included as nothing new of interest came out of the review, very small numbers. The Committee heard that very few patients were seen by the palliative care team during the pandemic, possibly due to deterioration of patients being so rapid.

Professor K Currie thanked Dr H Mackie and Dr A Mallin for the presentation and report and enquired regarding whether there is an opportunity for the 3 NHS Lanarkshire acute sites to come together to compare data beyond mortality and capture even more learning for the organisation. Dr J Keaney noted that the case-note review reports will be shared with the Acute Clinical Governance Committee in November 2020 for further discussion and analysis.

Mrs L MacDonald asked regarding whether early intervention has an impact on patient outcome, whether 100% of patients had indicated their preferences and what percentage of patients presented with gastrointestinal symptoms. Dr A Mallin replied that 100% of patients in the review had a decision documented and some patients had presented with loss of appetite and diarrhoea.

University Hospital Wishaw

Dr J Burns presented the SBAR from University Hospital Wishaw (UHW) regarding their mortality case-note review. The Committee noted that 52 consecutive deaths were reviewed for patients admitted to UHW in February 2020 to identify any gaps in the quality of care and areas for potential improvement. UHW has started a second mortality case-note review of 50 cases, i.e. 25 Covid 19 deaths and 25 non Covid 19 deaths. This review began in August 2020 with 30 cases allocated to clinicians for review. A full report will be provided to the next meeting in November 2020.

University Hospital Monklands

The Committee welcomed Dr M Devers from University Hospital Monklands who provided an update on progress regarding their mortality case-note review. Dr M Devers noted the different approaches the 3 NHS Lanarkshire acute hospitals had taken to their case-note reviews, highlighting the benefit to the organisation from the breadth of learning being captured as a result. 50 consecutive deaths were reviewed using the global trigger tool, 25 from Covid 19 and 25 non Covid 19. Together with Dr S Chohan and Mrs C Andrews, they reflected on how previous case-note reviews had focused on elderly patients, therefore younger patient deaths were less well captured. The

Committee heard that the Treatment Escalation Limitation Plan (TELP) was a very helpful tool for staff and patients and this was used to review whether the patients were expected to survive. A matrix was developed based on the TELP figures, allowing groups to be identified. Dr M Devers advised that the involvement of patient safety fellows, Mortality & Morbidity leads and representation from multi-disciplinary staff was excellent. The data was finalised in August 2020 and there were concerns regarding Category 1s. It was noted that a full report will be submitted to the Committee for the November 2020 meeting.

Dr A Osborne thanked Dr M Devers for the report and enquired regarding treatment escalation and whether it will be part of the final review to look at whether the correct judgements were made in terms of treatment escalation. Dr M Devers advised that age is the greatest risk factor and co-morbidities, therefore the TELP was very helpful and clinicians were having communication by telephone with patient's relatives, so noted it was a very different environment they were working in and to make shared decisions. The Committee recognised very challenging judgements being made by staff, even with the support of the TELP and that staff always endeavoured to involve the patient and their family. Dr A Osborne asked whether judgement calls have been subject to scrutiny, to which Dr M Devers replied that on some occasions of over treatment, but not under treatment.

Mrs K Cormack commended the work completed by colleagues and noted hospital onset Covid 19 infection was being investigated as a SAER on at least one site. She highlighted the importance of ensuring standardisation of what is reported as SAER across the 3 sites to provide more information for learning going forward.

Dr L Thomson thanked colleagues for their excellent presentations and reports, noting the time, work and effort dedicated to complete this valuable work and capturing the learning for the organisation.

THE COMMITTEE:

1. Noted the mortality case-note review updates from University Hospital Hairmyres, University Hospital Wishaw and University Hospital Monklands.

8. QUALITY STRATEGY IMPLEMENATION PLAN 2020-2021

Mrs K Cormack provided a verbal update regarding progress to date of the Quality Strategy Implementation Plan 2020-2021. The Committee heard that the plan has been moved onto the LanQip system to improve efficiency, accuracy and quality of reports. An update report will come to the Committee in November 2020. Internal Audit have completed an audit of the Implementation Plan and their report is expected soon. Verbal recommendations include ensuring that a completed date is specified against all completed actions and ensuring any overdue actions are given a new target date. Mrs K Cormack confirmed that these recommendations have been actioned and she will now be working with Internal Audit to support their review of the Healthcare Quality Assurance & Improvement Committee.

THE COMMITTEE:

1. Noted the Quality Strategy Implementation Plan 2020-2021 update.

9. CARE HOMES UPDATE

Dr J Burns presented the Care Home SBAR to the Committee, noting that this captures the essence of all the work that has been done to date and provides a reminder of the background, including the three exception meetings that took place. There is now an opportunity to discuss progress in relation to the actions agreed and develop a narrative. Dr J Burns suggested that it would be helpful to tease out the detail around the key themes and lines of enquiry and the development of research in this field. It would also be important to complete mortality reviews of the patients when the episodes of care have been fully coded. The Committee heard about the coding process and noted that it may not cover all deaths but will provide a good benchmark for the period in question and it will be later in the year before the review can begin. Dr J Burns asked the Committee to note the work undertaken so far, agree that we proceed with developing the narrative and acknowledge the reviews will be later in the year.

Dr L Thomson noted the importance of advising the Board that this is a significant piece of work therefore it will be necessary to wait to receive a final report. With regard to the question of whether NHS Lanarkshire acted in accordance with guidance at each point and is there assurance around this, the answer is yes. Dr J Burns noted that further work was required with regard to patient and relative's feedback, how to collect this and cross reference with the key themes.

Mr E Docherty advised that it was important to ensure the Care Homes Assurance Group are linked into this work and the Care Inspectorate review will also capture some of this. Mrs L Drummond suggested her team can review the complaints data, however there was uncertainty regarding whether Care Home complaints are processed by the Care Home Inspectorate. Professor K Currie agrees with the key themes and asked whether NHS Lanarkshire should seek the Care Homes perspective, noting this might depend on the target audience for the final report.

Dr A Osborne advised she is content to note progress to date and suggested that it would be helpful to review the language used in the themes and stipulate more regarding the multi-agency approach taken including local authority, Public Health, Care Inspectorate. The Committee heard that the IJB had commissioned work to support the local authority and Partnerships and asked whether this could be linked to the work.

Mr A Boyle stated that he recognised this was a huge piece of work and highlighted that he was unable to view the timeline fully due to the limitations of Admin Control. Mrs E Currie will check whether there is any alternative way of accessing the timeline for members using Admin Control. Mr A Boyle advised on the importance of being clear on the purpose of the Care Home work and of capturing all available evidence and comments from those involved. He also highlighted the need to set expectations to the Board and Scottish Government regarding realistic timescales.

Dr J Burns advised the Committee that this will be a NHS Lanarkshire document, covering the period from February 2020 to mid June 2020 when accountability was shifting and the need to start recording issues and decisions became clear. Mr E Docherty added that the lines of accountability are understood and both he and Mrs T Marshall are clear on their actions throughout the period in question and the work supported by the Care Home Assurance Group. Mr E Docherty asked members to view this work as a

moment in time, then pass discussions to the assurance group to allow them to move forward on the multi-agency element.

Dr L Thomson confirmed that Mr P Cannon has been identified as the single point of contact for NHS Lanarkshire for the enquiry into deaths in Care Homes during this period. The Crown Office are gathering information and it is imperative that our review is linked in as much possible.

THE COMMITTEE:

1. Noted the Care Home SBAR and updates provided and agreed to sign off the narrative themes.

10. EXTRACT OF CORPORATE RISK REGISTER (CLINICAL)

The Committee noted the report submitted by Mr P Cannon and no questions were raised.

THE COMMITTEE:

1. Noted the Extract of Corporate Rick Register (Clinical).

11. ADVERSE EVENTS HIGHLIGHT REPORT

The Committee considered the Adverse Events highlight report presented by Mrs K Cormack, providing an introduction to the system and description of arrangements during the Covid 19 period. Mrs K Cormack advised that the investigation element was suspended due to reduced clinical capacity and was re-instated in June 2020, therefore staff are working hard to catch up. The Committee heard that there were 12 significant adverse event reviews (SAERs) in May 2020 and a huge effort was being made to get back on track with timelines. The reports also provided an overview of activity and highlighted the fact that causation codes 1 & 2 are for investigations that have been unavoidable or unpreventable. In terms of types of events in the last quarter, it was noted that some SAERs remain open. Robust action plans are in place for concluded SAERs to support learning and a standardised approach to SAERs is in place as detailed in the report. SAER by category information has been provided and this gives a different overview e.g. medication is low; could this area be under reported. The team have developed a way of assessing where delays are occurring including an alert process for delays. Mrs K Cormack further updated the Committee regarding the development of an Adverse Events Bulletin that provides information and learning from SAERs across NHS Lanarkshire and the 2nd bulletin will come out in October 2020.

Mr A Boyle enquired as to whether the report could make reference to patient support and staff experience of being involved in adverse events. Mrs K Cormack noted that staff support is referred to in the Duty of Candour regulations however it is not currently collected on Datix. This is an area that will be picked up going forward and an update will be included in the next report coming to the Committee.

Dr J Keaney advised that junior doctors are offered support if involved in any SAERs, however capturing this is difficult. Occupational health support is also available to staff who may require this. Mr E Docherty commented that this is currently high profile and there is a lot of good work in this area, so it is a question of how we can capture this, bring it to the fore and understand the

impact on staff. It was also noted that the staff hubs have been very helpful during the Covid 19 pandemic.

Duty of Candour Highlight Report

Mrs K Cormack presented the Duty of Candour highlight report to the Committee, advising that this is a quarterly report and is reviewed by the Quality Planning & Professional Governance Group. The Committee heard that Scottish Government released an overview report in August 2020 regarding the first year annual reports (2018 – 2019) across Scotland. Due to the late release of this report, the second annual report (2019-2020) had already been submitted therefore it was not possible to implement the learning. The main aspect highlighted for NHSL was the support given to staff was not detailed within the report (which does not mean it is not done). Mrs K Cormack confirmed that she will pick up on staff support and persons affected by incidents in future Duty of Candour annual reports.

THE COMMITTEE:

1. Noted the Adverse Events Highlight Report and the Duty of Candour Highlight Report.

12. SAFETY PLAN STEERING GROUP – ANNUAL REPORT 2019-2020

The Committee reviewed the Safety Plan Steering Group Annual Report 2019-2020 and heard that membership of the group and terms of reference have been reviewed to help provide renewed focus. Scottish Patient Safety Programme (SPSP) work has been hibernated during Covid 19, although some areas are being restarted as per guidance from Healthcare Improvement Scotland (HIS). HIS have requested NHS Lanarkshire share the Falls Strategy with them, being the first NHS Board to develop one.

Dr A Osborne thanked Mr E Docherty for a clear, succinct report. There was a brief discussion regarding the incidence of falls at Stonehouse Community Hospital and progress following the quality improvement support in place there which will be picked up as part of the falls strategy.

Mr A Boyle enquired regarding staff mental health and wellbeing and the importance of ensuring this is referenced and forms part of the organisation's safety culture. Mrs K Cormack stated that work is ongoing with National Education Scotland (NES) who are providing tools to assess safety culture relating to staff support and wellbeing.

THE COMMITTEE:

1. Noted the Safety Plan Steering Group Annual Report 2019-2020.

13. LANARKSHIRE INFECTION CONTROL COMMITTEE - ANNUAL REPORT 2019-2020

Mr E Docherty presented the Lanarkshire Infection Control Committee Annual Report 2019-2020 to the Committee and noted that this had already been presented at the recent Board meeting and he was happy to take questions.

Dr A Osborne commented that she felt this was a first class report and that the NHS Lanarkshire targets for eColi were very ambitious and wondered how realistic these were. Mr E Docherty stated that, looking at the previous 5 years, these should be reviewed and discussed further at the group.

Dr L Thomson commented that she would like to see some early wins with regard to hand hygiene. Mr E Docherty noted that an Infection Prevention and Control Breakthrough Collaborative was being established and meeting dates were confirmed.

THE COMMITTEE:

1. Noted the Lanarkshire Infection Control Committee Annual Report 2019-2020.

14. FALLS PRESENTATION

Mr P McCrossan and Mrs L McInally delivered a presentation on Falls to the Committee, sharing information regarding the NHS Lanarkshire Falls Strategy which is aligned to the National Falls Strategy. The Committee heard of the multi-agency approach to the work and the need to create a culture of falls being everyone's business. To this end, work is underway to create mandatory falls training for all NHS Lanarkshire staff. Mr P McCrossan advised that the current falls register is an excel spreadsheet which is maintained by two healthcare support workers in the falls team, based in Coathill Hospital. The register holds the details of approx. 13,000 patients and the team are currently working with colleagues in eHealth to move this onto a more appropriate IT platform. Mrs L McInally advised Committee members regarding the falls pathway and work with ISD to complete a register analysis to produce data regarding Emergency Department attendance, admissions, demographics and age. Frailty is a key part of the conversation in relation to falls and the strategy outlines this as well as the links between falls, frailty and bone health. Mrs L McInally stated that the Scottish Ambulance Service (SAS) are using an electronic patient information form for complex patients with multi-co-morbidities and the data from these is being interrogated. It is hoped that a hospital falls collaborative will begin soon, however this has been delayed due to Covid 19. Additional next steps planned are to form sub-groups for the collaboratives, work on the electronic frailty index and implement the strategy.

Dr L Thomson thanked Mr P McCrossan and Mrs L McInally for the presentation, noting this is an excellent piece of work. Dr A Osborne also thanked colleagues for a fabulous presentation, superb work and highlighted the very clear vision statement, asking that the shift in unscheduled care forms part of this work. Mr A Boyle stated that he was delighted to see this piece of work progress, having worked with the Fire Service and understanding the importance of making every contact count and involving patients in the conversations. Mrs L McInally advised that the Public Partnership Forum (PPF) and Seniors Together group have been involved and the team plan to involve others going forward.

THE COMMITTEE:

1. Noted the Falls Presentation.

15. INFORMATION GOVERNANCE – HIGHLIGHT REPORT

The Committee noted the Information Governance highlight report and Dr JBurns advised that Dr R McKenzie has been appointed as the new Chairperson of the Committee.

THE COMMITTEE:

1. Noted the Information Governance highlight report.

16. EXCELLENCE IN CARE – HIGHLIGHT REPORT

Mrs I Lindsay presented the Excellence in Care highlight report to the Committee, describing the work underway in terms of data collection and analysis, developing a framework, quality measures, use of psychological safety tool with staff and assurance and improvement conversations taking place with staff. Mrs M Lees enquired regarding the structure of the groups and requested a flowchart be added.

THE COMMITTEE:

1. Noted the Excellence in Care highlight report.

17. SPSO – HIGHLIGHT REPORT

Mrs K Cormack presented the SPSO highlight report to the Committee. No questions were raised.

THE COMMITTEE:

1. Noted highlight report the SPSO report.

18. CARE OPINION – ANNUAL REVIEW

The Committee noted the Care Opinion Annual Review and stated that the paper had already been circulated at the recent Board meeting. No questions were raised.

THE COMMITTEE:

1. Noted the Care Opinion Annual Review.

19. COMMITTEE WORK-PLAN 2020-2021

The Committee noted the Work-plan and stated that any updates that were not available today will be carried forward to the November 2020 meeting and the work-plan updated accordingly.

THE COMMITTEE:

1. Noted Committee Work-plan 2020-2021.

20. ISSUES OF CONCERN – BY EXCEPTION ONLY

- Operational
- Safety
- Independent Sector
- Staffing

The Committee noted there were no issues of concern.

21. ANY NEW RISKS IDENTIFIED TO BE CONSIDERED FOR INCLUSION ON THE CORPORATE RISK REGISTER

No new risks were identified by the Committee.

22. ANY OTHER COMPETENT BUSINESS

Clinical Governance & Assurance – future Covid-19 Escalation Triggers Presentation

Dr J Burns presented the Clinical Governance & Assurance Covid 19 escalation triggers presentation, highlighting current trends e.g. there has been an increase in Covid 19 presentations among the younger age group, 20 – 39 years old. Modelling is ongoing to share information regarding short and medium term scenarios and an early warning system is in place.

Professor K Currie enquired regarding the potential impact on outpatient and other NHS services going forward. Dr J Burns advised that most services continue to feel a huge impact and this is ongoing. A range of services are using the Louisa Jordan facility to see patients face to face.

DATES OF MEETINGS DURING 2020 / 2021 AT 14:00 HOURS

a) Thursday 12th November 2020 via MS teams
b) Thursday 11th March 2021 via MS teams
c) Thursday 13th May 2021 via MS teams