Portsmouth Hospitals NHS
NHS Trust

Clinical Effectiveness & Mortality Review Steering Group

Minutes of meeting held on Tuesday 19th May 2015
Meeting Room, Trust HQ, F Level

Attendees:	Code A	Chair Vice Chair Consultant Surgeon Renal & Transplantation Clinical Audit Assurance Manager Head of Nursing CHAT Coding Manager Assistant Information Manager Dr Foster Dr Foster
In attendance:		Consultant Geriatrician Consultant Neonatologist Director of Medicines Optimisation & Pharmacy
Apologies:		Information Services Manager Head of Information Services Head of Nursing, MOPRS Consultant Renal & Transplantation Head of Nursing ED Nurse Consultant ED
Minutes:		PA to Medical Director / Director of Workforce

No	
1.	**Welcome & Apologies** Apologies were noted.
2.	**Review minutes and actions of previous meeting:** The minutes of 21st April 2015 were agreed as an accurate record. 2) Minutes April 2015.doc
2a	The items on the action grid were updated.
3.	**Mortality Review** MOPR&S Mortality Report – Code A RP outlined a summary of the deaths within MOPR&S from June 2014 – November 2014. There was a huge step down in the level of mortality in MOPR&S in June 2013 which was due to increased cross boundary working with Southern and Solent which meant patients were in the right

	place for their needs and not hospital. Year on year there has been an increase of around 9-10% of episodes going through MOPR&S with the mortality rate since 2013 at around 10%. Around 1.8% (4 patients) died in the rehabilitation beds (F1, Ark Royal or Cedar Wards) and two died on medical wards under the care of MOPR&S. 2.3% of all MOPR&S deaths in the period died on outlying wards (A6, C5, E8 and D4) compared with between 1.0% and 1.68% within the previous six month period. The department looks at deaths by day of admission between once and twice a year and there appears to be no statistical difference to be of any significance. On the deaths of day of the week (for 1st June – 30th November 2014) Thursday, although not statistically significant, is showing an upward trend and the department will keep this under review. One patient from a nursing home was admitted and subsequently died in hospital, this was preventable and this has been taken up with the GP and nursing home direct. The Gold Standard framework is important to the department but when first implemented was not taken on board by any of the community providers in Hampshire. Good care plans are now in place with patients expressing their wish of not coming into hospital to die. The department has areas of good practice such as: • Most admissions could not have been prevented (one exception) • 73% of patients have a consultant review more than three times a week • Appropriate placement for patient (2.3% could have been placed in a more appropriate setting) • Correct action in deteriorating patient (91%) • Management of patients identified at risk of dying (communication, ceiling of management and referrals to End of Life Care/Palliative Team) 3a) MOPRS Mortality Report February 201 SH thanked Rachel for her presentation. The group agreed this is how mortality reviews should be undertaken in each CSC and SH asked this document be circulated to all CSCs for information. **Action:** Code A SH circulated a draft template with some initial questions for the CSCs to consider when presenting at the meeting. All were asked to feedback as soon as possible any amendments. **Action: All** The group went through the alterations to the electronic mortality review tool and SE undertook to unsure these were completed. **Action:** Code A JR invited members of the group to a workshop being organised by Dr Foster in July along with other Trusts regarding mortality. SH thanked JR and responded that the Trust would like to take up the invitation.
3b	**Issue of Death Certificates** SH briefed the meeting on the issuing of death certificates. It will now be a requirement for a Junior Doctor to liaise with their Senior Consultant on what to put on death certificates before it is signed off. This will be more time consuming but the Trust is accountable and needs to ensure the correct

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	cause of death is documented.
3c	**Stroke Mortality Alert** SH reported on the recent mortality alert relating to hospital acquired pneumonia and the increase in the last quarter of the previous year, deaths have increased and the relative risk is higher. TC was asked to keep a watch on the trends going forward. 3ci) aspHAP_stroke_quar 3cii) aspHAP_stroke_quar 3ciii) aspHAP_stroke_year Stroke.ppt
4.	**Dr Foster Reports (standing agenda item)** There was no HSMR data available this month. The Trust's published SHMI of 107.52 is a slight drop from the previous quarter of 107.9 and we are within expected range but it is the in-hospital deaths that are pushing this up. The HSMR for the same period was 99.59 with in-hospital deaths at 101.9. Out of hospital deaths increased the SHMI by 5.62 TC referred the group to page 2 of the report which looked at the rolling 12 month SHMI scores shown by their published quarters. There has been an upward trend which appears to be starting to drop slightly. When looking at the quarterly figures for the last three years a seasonal effect is evident and we can also see a dramatic drop from 2014/15 QW1 To 2014/15 Q2. The palliative care coding has improved and we are now in the middle banding compared with other Trusts. We are also in the upper middle quartile for the palliative coding of deaths and this has shown an improvement since the previous publication. TC referred to the SHMI by diagnosis group data which shows four of the SHMI groups above the upper 95% control limit. There are no groups over the 99.8% control limit and this marks a great improvement over the previous quarter. SD reported on the recent coding audit that had been undertaken for CCF. 28 patients had been identified dying with a primary diagnosis of CCF or after having a nephrectomy performed. Three sets of notes were not found but all episodes reviewed found the coding to be correct. Nothing therefore was found untoward. 4) SHMI to Sep 2014.pdf
5. a)	**Audit Reports** Pharmacy – **Code A** AC went through the progress made since the last report. The Pharmacy department has had an internal restructure of posts in order to improve quality of services and service development.

The department have participated in the NHS Benchmarking of Pharmacy Services with the outcome currently unknown. There were six local audits undertaken and completed by pre-registration graduates during the year 2013/14. All actions have been implemented as a result of five of the audits.

As part of the PHT quality contract 2014/15 there are four areas audited on a regular basis:

1. **Medication incidents that result in moderate/severe harm/death:** ***Monitor/No increase – based on 13/14 outturn medication incidents that result in moderate/severe harm/death***

   There were 18 medication incidents which resulted in moderate/ severe harm/ death. (15 moderate harm incidents and 3 severe harm and so did not meet the target to remain at or below the 2013/14 outturn of 11.

   The number of moderate / severe harm incidents reported is affected by many factors including 3 incidents identified from Coroner's reports and 1 from recoding from other classifications (e.g previously coded as treatment/ procedure). The definition of moderate harm (amber grading) has also been updated on our Datix system in line with NRLS and so includes short term rather than long term harm. Therefore for 15/16 it has been requested that the Quality indicator be reviewed to represent a reduction in % harm caused by reported medication incidents. Reporting is to be promoted so that near miss reporting is increased and pharmacist interventions are captured on Datix to enable more effective learning across the organisation.

2. **Medicines Reconciliation:** ***The provider will report the number and % of medicine reconciliations completed by pharmacists within 48 hours of admission.***

   A one-day audit was carried out in May which identified that the pharmacy team completed medicines reconciliation & appropriate queries resolved within 48hrs on 83.7% of possible drug charts. The monthly data collected for medicines reconciliation within 24hrs in Quarter 4 remains above the regional average at 86.3%.

3. **Antimicrobial Prescribing:** ***The provider will provide assurance to the commissioner of a whole system approach to effective antimicrobial prescribing stewardship.***

   Work continues since the antibiotic point prevalence study which was carried out in June 2014, which showed an improvement in effective antimicrobial prescribing and reduced variation against clinical guidelines. The annual point prevalence study is due to be repeated again in June 2015.

4. **Omitted Doses:** ***The provider will report the number and % of inappropriately omitted doses due to a drug not being available or a reason not being documented.***

   A trust wide re-audit was carried out in March and were very similar to, with a very slight reduction in omitted doses due to drug not available and doses not signed for but with a very small increase in reason not documented.

Total Number of Inappropriately Omitted Doses	Missed doses audit March 2015 (No. of doses prescribed = 8073)		Misses Doses Audit June 2014 (%)
	Total missed doses	% of total	
Reason is not documented	232	2.87%	2.52%
Drug not available	98	1.21%	1.25%
Total	330	4.09%	3.77%

These results are to be analysed further in more detail to assess the relative importance of omitted drugs recorded, identify any themes and classes of drugs omitted. Omitted doses reported via Datix are also to be reviewed in conjunction with these results to identify any trends. Individual ward audits are to be requested and reviewed to identify good practice and share at the Medication Safety Committee.

5a) CESG Specialty Reporting Pharmacy I

AC was thanked for her report.

5b) NICU – **Code A**

HJ reported that since the last report to the group there has been progress in:

- National Neonatal Audit Programme with marked improvement in ROP screening rates and two year follow-up with continued good performance against other standards.
- Neonatal Survival Rates – these have shown excellent outcomes compared to National and Network (level 3 unit) rates.
- The department have participated in the National Neonatal Audit Programme with anonymised data submitted quarterly direct to BadgerNet database which is used by 179 neonatal units in England and Wales.
- The department has an active local clinical audit programme and HJ reported on the summary of last year's activity. For NICE guidance the department are fully compliant in the Interventional Procedures (347) Therapeutic hypothermia with intracoporeal temperature monitoring for hypoxic perinatal brain injury (May 2010).
- The department is partially compliant for both Clinical Guidelines (98) Neonatal Jaundice May 2010 as the department are not meeting some standards on postnatal wards and new jaundice management record development to improve care and compliance with standards, particularly on postnatal wards. Bilirubin meter now in use and a re-aduit will be undertaken shortly.
- Clinical Guidelines (149) Antibiotics for early-onset neonatal infection August 2012 is only partially compliant and there is an action plan in place for this and another audit is planned for

	October 2015. The department continues to perform well in neonatal survival rates compared to the national average and there has been consistent improvement survival rates for the past 15 years. NICU joined the Vermont Oxford network in 2013 and is the largest neonatal network in the world with over 60,000 very low birth weight babies <1500g reported annually. The department have had very low mortality and morbidity rates in 2013 compared to the whole network, European units and the 31 participating units in the UK. SH thanked Huw for this report.  5b) NICU CESG Specialty Report May
6.	**PbR Audit Report** This item will be discussed at the June 2015 meeting.
7.	**Update from Clinical Audit (standing agenda item)**
a	<u>ERP and the 2015-16 Information Schedule</u> DW reported on the Quality Contract which is the same as last year. Colorectal has risen for Quarter 3 and the Quarter 4 figures are awaited. The figures are currently: Incision of rectum – length of stay 8 target of 7 Colectomy – target of 5 currently 8 Same day admission of surgery for incision of rectum within target but is at 89-91% The group agreed to keep the contract with targets to stay as they are.  **ERP & the 2015-16 information schedule.**
b	<u>Trust Wide Forward Audit Plan</u> The Audit Plan had been circulated to all CSC Governance Leads to sign off. Last year two CSCs failed to sign off the plan and this had been picked up by our internal auditors. DW referred the group to page 16 relating to Surgery and Cancer's Audit Plan which is quite minimal. This has been discussed with the Chief of Service, Mr Yiangou who undertook to speak direct to those specialities who had not engaged enough in the process. **The plan was formally accepted by this group.** SH asked whether all the National Audits were included within the document. DW confirmed this was correct.

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c	Trustwide Forward Audit Plan 2015-16 - I PHT Quarterly Quality Report DW presented this report for noting having been discussed at Trust Board. To note: • SHMI was originally only partially compliant but this has now compliant. • Enhanced Recovery Programme – Hip replacement, Colectomy and excision of rectum did not achieve compliance with the length of stay target by the end of Quarter 3. • Discharge summaries was not achieved as the existing EDS has not proved to be able to provide a reliable discharge summary in time that is reasonable for medical, nursing and pharmacy staff. • Emergency Care Pathway – the Trust did not achieve the 15 minute arrival to assessment time with a Quarter 4 compliance of 89 minutes. 74.15_PHT_Quarterl y_Quality_Report_Qu
8.	**AOB**
a)	SH asked if there was a rolling programme of all National Audits as he was concerned that the Trust may be missing some. DW responded that Clinical Audit keep a separate track of national audits and there is an escalation plan if specialities do not complete. There followed discussion on the outstanding specialities who need to report into this group for clinical audit. SH undertook to speak contact CSCs direct. **Action: Simon Holmes** SH would like a separate rolling programme for the mortality review section of this meeting. A programme to be devised and sent out to all Governance Leads so they are aware of dates they need to report back to the meeting: **Action Liz Burroughs**
b)	There was further discussion on Death Certificates and SH outlined that Bereavement Services would have a list of all deaths, the Junior Doctor would then need to sign that they have seen the Death Certificate and sought senior advice about the cause of death. It will potentially slow down the current process but we need to ensure that the death certificate reflects the cause of death especially with patients that come into the hospital with several comorbidities.
c)	DW and Tracey Stenning have met with Perbinder Grewal about the NCPOD lower limb contract. Perbinder has agreed to put together a proper action plan on the back of his gap analysis and will be reported back to this group shortly. **Action: Derek Williams**
d)	Ian Cairns has successfully participated in the pilot stage of End of Life Care National Audit. The main audit starts in June to November to review retrospectively the May 2015 notes.
e)	DW reported that they have advertised for the replacement for Tracey Davies but unfortunately there was only one applicant who withdrew. Recruitment is on-going.

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f)	SH confirmed with DW that he was happy with the Clinical Effectiveness Steering Group Annual Report and could now be circulated. **Action:** Code A
	Next meeting date

Date	Time	Venue
Tuesday 23rd June 2015	14:00 – 16:00	Meeting Room, Trust HQ, F Level
Tuesday 21st July 2015	14:00 – 16:00	Meeting Room, Trust HQ, F Level

Passion & Pride