

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 11th October 2022

Present:

Nicholas Brooks (Chair)
Sue Pemberton
Julian Farmer
Margaret Carney

Non-Executive Director
Director of Nursing, Quality & Safety
Non-Executive Director
Non-Executive Director

In Attendance:

Megan Underwood
Justin Ratnasingham
Mike Filek
Danny Forrest
Helen Martin
Ben Murray

Senior Executive Assistant (Minutes)
Divisional Medical Director, Clinical Services
Head of Improvement of Transformation (item 6.2 only)
Chief Pharmacist (item 6.7 only)
Risk & Safety Lead (item 8.2 only)
Trust Sepsis Lead (item 6.6 only)

Apologies:

Raph Perry

Medical Director

1. Apologies for Absence

The apologies were noted as above.

The Chair welcomed Margaret Carney to her first Quality Committee meeting.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 12th July 2022

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

4. Patient Story

The Director of Nursing, Quality and Safety (DONQS) read the patient story and provided its context by outlining the new collaboration with Broadgreen Hospital. The arrangement is similar to those with other Trusts, which were established during Covid to provide support for liver cancer and vascular surgery. It involves the provision of critical care for specialist orthopaedic surgery when this is not available at Liverpool University Hospitals (LUHFT) and is focussed on patients who have been on the waiting list for more than two years. The operations, by LUHFT colleagues, are timed to minimise the risk of cancellation of procedures on LHCH patients.

5. Action Log

Item 1 –Discussed as part of the main agenda. Completed and removed from the action log.

Item 2 –Discussed as part of the main agenda. Completed and removed from the action log.

Item 3 – QSEC report has been deferred and will be discussed at January's meeting.

Item 4 – The stroke service review is being led by Hannah Rooney and a further update will be brought to January's meeting.

6. Quality

6.1 Clinical Quality Report

On-going issues with the performance dashboard, the associated SPC charts and the overlap of data with the QSEC key assurances report were discussed. SP is working with the informatics team and will consider the practicality of reorganising the quality committee agenda, possibly to combine the quality and QSEC reports as a single item.

The following quality indicators were discussed:

- Delirium risk assessment once a day during August and September was 60.9% and 53.9% respectively, against a target of 90%. Completion of the assessments remains a high priority for the ward managers.
- Sixteen falls during August, two of which were avoidable. The lead for falls has visited each area to highlight prevention methods with ramble guards in place for patients at risk. Falls awareness week was held in September, with the trial of yellow blankets, slipper socks and locker bags.
- Radiology alerts with a response document on EPR – 81.7% achieved in August against a target of 95%.
- Five clinical claims in August but with no significant trend over the last 12 months.

SP

HR/SP

SP

- Primary PCI 90-minute door to balloon time - 89.9% in August against a target of 95%. The 150-minute target for call to balloon time was achieved in only 50% of cases and the progressive downward trend on the SPC chart over the last two years was noted with concern.
- Screening for malnutrition - performance has been improving progressively since January to reach 91.2% in September
- Patient receipt of their discharge summary - improved in September. SP assured the Committee that essentially all patients are being given a copy of their summary on discharge, and that the reported figures reflect poor documentation.

6.2 Quality Impact Assessments (CIAs) & Update Report

The Head of Transformation and Improvement joined the meeting to present the CIA report.

Of the 88 schemes being tracked only 36, representing 84% of the total value, require a CIA. Half (19) have progressed to the final stages of the assessment, of which the majority have been approved.

Putative savings from the schemes are not retracted from the budget until fully approved and implemented.

In response to a question about the large number of schemes under the value of £15k not requiring a CIA, MF explained that the policy is based on a subjective view that balances the need to consider safety and equality against the generation of an excessive administrative burden.

The Committee noted the report and accepted assurance on the CIA process. It was accepted that the slow progress in approving some schemes, whilst being a financial risk, has no adverse impact on the safety and quality component of the Board Assurance Framework (BAF).

6.3 QSEC Key Assurances / Risk Report – 9th September 2022

Consent – a further consent audit revealed only slight improvement. Members of the Committee indicated their concern, having noted the recent serious incident in which a patient had been anaesthetised before it was realised that they had not consented to the intended procedure.

SP outlined the on-going efforts to ensure compliance with the consent protocol and assured the Committee of her expectation that roll-out of the procedure-specific e-consent process, initially for surgery, from November would largely resolve the issue.

Surgical site infections (SSI) - information on SSI has, historically, been incomplete but this should be rectified with introduction of a new electronic system. The current rate of SSI is at least 5%, which is higher than for other trusts. Investigation by the SSI group, which reconvened after Covid, has revealed poor compliance with the SSI prevention bundle. An audit

RP

programme and action plan have been developed and will be reported to January's meeting of the Quality Committee.

6.4 Dr Foster Dashboard

No emerging issues were reported, and the Committee raised no new concerns.

6.5 Mortality Improvement Group Minutes – 13th July 2022

The Quality Committee received the minutes. There were no questions or comments.

6.6 Sepsis Annual Report

Ben Murray, Trust Lead for Sepsis, joined the meeting to present the annual Sepsis report.

The KPIs for antibiotic administration have improved, with recent figures showing full compliance within three hours and the one-hour target missed only marginally. This has been achieved despite toughening of the performance objectives by bringing forward the clock-start from opening of the sepsis bundle to completion of the screen. Since many clinicians have not been using the bundle, the change also results in more cases being documented. Acquisition and timeliness of blood cultures prior to antibiotic administration and rates of screening require further improvement. All areas receive monthly reports with weekly review of the data to improve awareness.

The actions derived from the MIAA review have been completed.

Education led by the outreach nurses continues to be delivered to all training grades. Progress is being made with changes to EPR flowsheets with the help of Andrew Hirrell (Deputy EPR Manager), with the aim of underlining the urgent time-sensitive nature of reacting to changes in MEWS and highlighting deterioration to the medical and ANP teams. The September figures show good performance in achievement of performance targets: blood cultures within 24 hours preceding the first antibiotic at 94.7%, and antibiotic administration within one hour at 94.7% and 100% by three hours.

The Quality Committee congratulated the Sepsis Lead, the microbiology nurse specialist Felicity Kempson, and their colleagues on their tireless work which is finally delivering notable progress in the management of sepsis.

Dr Ben Murray left the meeting.

6.7 Quality Aseptic Audit – Pharmacy

The Chief Pharmacist (DF) joined the meeting to present a recent MHRA/NW quality assurance audit of the aseptic service together with the department's response.

The aseptic unit is a sterile zone housed within the pharmacy department. All processes including cleaning schedules, product preparation, compounding and checking, gowning, and monitoring are covered by standard operating procedures (SOPs).

The unit compounds sterile products for inpatient use which currently include:

- IV insulin syringes
- IV iron infusion
- total parenteral nutrition
- paravertebral infusions
- intrathecal diamorphine
- IV dobutamine

The audit identified areas of concern and concluded that the unit's operation was posing a risk to the quality of medicines prepared within it. Failure to meet the audit requirements could result in enforced closure. For the Trust this would mean products would have to be purchased from a third party at higher cost, or that ward staff would have to prepare medicines with resulting time away from clinical care and the potential for errors and microbial contamination.

The areas of non-compliance together with an action plan and timeframes for completion were included in Appendix 2

DF explained that to date the pharmacy department has had an excellent record for both the quality of aseptically prepared products and adherence to robust process and monitoring requirements; despite the findings of the external audit, the unit was fully compliant with its internal KPIs for 2021/22. He took the Committee through appendix 2 in detail, explaining that many of the failings related to a requirement for more rigorous documentation than has been previously required. Action plans were in place with many already implemented and those remaining with completion dates by December 2022. The department is confident that all remedial actions will be taken to ensure the continued safe running of the unit and that there is no immediate operational risk to patients or the Trust. A further briefing will be provided to Quality Committee in due course.

DF/SP

Questioned over the possibility that patient harm might not be identified in a RCA or mortality review, DF informed the Committee that suspicion of a contaminated medicine could be investigated retrospectively by batch testing.

The aseptic Lead is due to retire in 2023. The post has been advertised and the vacancy included in the risk register for pharmacy.

The Quality Committee accepted assurance that all necessary actions were being undertaken to maintain the safety and quality of the pharmacy service.

The Chief Pharmacist left the meeting.

7. Clinical Effectiveness

7.1 Annual Report – GIRFT Reports, Actions and Progress Update

The Head of improvement and Transformation, MF, attended to present the GIRFT annual report.

After the initial inspection by the national GIRFT team, the process for implementation includes a review of the national best practice reports, assessment of the service for relevant gaps, formulating improvement plans and monitoring progress.

The Committee noted and discussed the following issues.

There are eight GIRFT national best practice reports applicable to LHCH services. The Trust is addressing 168 headline recommendations that were broken down into a further 405 sub-recommendations.

Seven of the eight services have made good progress, with cardiology, respiratory medicine and critical care having largely completed their improvement actions in line with all practicable recommendations.

The GIRFT Lung Cancer report was published in April 2022. The lung cancer team was scheduled to commence its review in September.

Positive feedback over the many areas of notably good practice was received from GIRFT clinical leads following virtual site visits to cardiothoracic surgery and critical care in the previous year.

Following the site visit to surgery it was recommended that the Trust establish a pre-operative clinic which would include job-planned anaesthetic input (see also item 7.2) as this would be a platform for further development of the Day of Surgical Admission (DOSA) programme. Finally, doubts were raised on the accuracy of data on mitral valve surgery and a local review was recommended.

LHCH has raised a concern with the GIRFT team over reports from four trusts that had, apparently not had any strokes; this implausible claim has contributed to the designation of the Trust as an outlier.

Excellent feedback was received following the Critical Care site visit, though the GIRFT team identified four priority areas:

- non-participation in the Infection in Critical Care Quality Improvement Programme (ICQIP).
- a lack of critical care research
- A need for enhanced provision of renal replacement therapy
- the Guidelines Provision of Intensive Care Services (GPICS) 2 standard requirement for seven days a week cover for physiotherapy, occupational therapy, and pharmacy.

In response to these issues, the Trust has now enrolled onto ICQIP with a microbiology nurse specialist to ensure complete and accurate data collection; a clinical trial is in place supported by the research team, and investment was provided during the Covid emergency to increase renal

support with haemodialysis in critical care, enabling better and more cost-effective provision for patients already receiving chronic dialysis.

The following challenges and risks were highlighted to the Quality Committee:

- The Clinical Services Division has developed a business case for seven-day working for pharmacy and physiotherapy, but implementation has been delayed pending identification of funding.
- Litigation learning – the existence of long-standing cultural obstacles, with consequent delay in identifying and sharing themes from the Trust's five-year litigation review.
- Capital funding and estates constraints present a challenge to delivery of the patient dignity recommendations for radiology.
- Provision of DOSA dedicated staffing and area.

The Quality Committee congratulated the Head of Improvement and Transformation and their team on the excellent progress that has been achieved in implementing the challenging objectives.

7.2 Anaesthetic and Perioperative Medicine (APOM) GIRFT

Dr Melissa Evans is leading on the APOM GIRFT.

The report presented by MF outlines the Trust's position against 18 recommendations with 95 sub-recommendations. After gap analysis and exclusion of (sub)recommendations not applicable to the Trust, LHCH is already compliant with 34/64 (50%) and an improvement plan has been drafted.

The focus is on reducing variations in practice and improving care and outcomes in anaesthesia and perioperative medicine. This requires rigorous preoperative assessment, streamlined pathways to reduce the risk of cancellation and a proactive approach to managing co-morbidities. Key themes are for day case to be the default pathway and, when this is not feasible, for the development of care plans with effective perioperative assessment to facilitate timely discharge. Key to the plan is the further development of DOSA (see item 7.1) and the building of peri-operative teams.

The Committee thanked MF for his presentation and accepted assurance from the draft improvement plan, whilst noting the risk associated primarily by the need for redeployment and, potentially, expansion of the workforce.

8. Compliance and Regulation

8.1 Serious incidents March - September 2022

Four serious incidents have been reported during the six-month period since April. All are in the process of investigation and the members of the Committee had no questions or comments at this stage.

8.2 SI investigations and themes: Ockenden action plan

The Ockenden report was the outcome of an independent review of maternity services at the Royal Shrewsbury and Telford Hospital. It was received by the Board of Directors in April 2022 and a report on the actions relevant to the Trust was requested.

The Audit Manager and Risk Management Lead Nurse have reviewed all SI's, complaints, claims and the clinical audit plan during the last two years. The report demonstrates a rigorous process for the investigation and external reporting of, and learning from incidents and claims with, where feasible, audited action plans. The Quality Committee and Board receive a report on incidents, complaints and claims every six months and a complaints review meeting with NEDs is held every three months.

The Committee had no reservations in accepting assurance from the report.

8.3 Quality Risks

The report summarises the high-level risks to quality and safety (BAF1). Members accepted that it is consistent with the work of the Committee and that there are no new risks or updates affecting the BAF.

8.4 BAF 1 Review

This was discussed as part of the previous agenda item.

8.5 Quality Committee – Mid Year Assurance Report

The report has been approved by the Audit committee.

9. Date and Time of Next Meeting

Thursday 12th January 2023, 2.30pm-4.30pm, Research Meeting Room/MS Teams