

## minutes

### Quality Committee

#### Minutes of the Quality Committee Meeting held on Thursday 12<sup>th</sup> January 2023

**Present:**

Nicholas Brooks (Chair)  
Sue Pemberton  
Raph Perry  
Margaret Carney  
Julian Farmer

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

**In Attendance:**

Ruth Gaunt  
Karan Wheatcroft  
Jo Shaw

Senior Executive Assistant (Minutes)  
Director of Risk & Improvement (item 6.8 & item 9.2 only)  
Divisional Director of Nursing, Clinical Services (item 8.5 only)  
Consultant Radiologist (item 8.5 only)

Marousa Ntouskou

**Apologies:**

**1. Apologies for Absence**

The apologies were noted as above.

**2. Declarations of Interest**

There were no declarations of interest to record.

**3. Minutes of e-meeting held on: 11<sup>th</sup> October 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.

**5. Action Log: 11<sup>th</sup> October 2022**

**Item 1** – Emergency readmissions. Discussions have been held with the divisions and a verbal update provided to QSEC. To be included in future key QSEC assurance reports to the Quality Committee.

**Item 2** – Significant progress has been made in relation to in-patient rehabilitation of stroke patients. Funding has been allocated for additional band-4 staff to provide rehabilitation at weekends. Hannah Rooney to present an update for April 2023.

HR

**Item 3** – The DONQS is working with Alex Garbett, Head of Information, on the metrics to be included in the new quality dashboard. The proposals will be shared with the committee for discussion prior to a report to the Board of Directors.

SP

**Item 4** – Surgical site infections. Discussed as part of the main agenda; accordingly, this item completed and removed from the action log.

**Item 5** – Pharmacy aseptic audit. Assurance report on completion of recommended actions to be received by the Committee for the April meeting.

SP/DF

## **6. Quality**

### **6.1 6-monthly progress update on Quality and Safety Strategy**

The Committee noted the outstanding progress on the Quality and Safety Strategy. Improvements in swallowing assessment in stroke patients, tracheostomy care, and the reduction in medication incidents with the introduction of CLM were considered particularly impressive.

Regular review of the dashboard by the DONQ with the relevant executive lead takes place to ensure no loss of momentum.

### **6.2 Mortality Improvement Group Annual Report**

The Committee received assurance from the annual report, noting that the risk-adjusted mortality (HSMR), though still above 100, has been falling progressively and is now consistently within the expected range. The improvement is mainly a reflection of more appropriate and accurate coding which has been facilitated by the inclusion in the group of a consultant from Telestra Health (formerly Dr Foster). The main driver of the HSMR continues to relate to very sick patients on acute pathways, notably myocardial infarction.

### **6.3 Mortality Improvement Group Minutes – 14<sup>th</sup> September 2022**

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

### **6.4 Clinical Quality Dashboard**

Delirium assessment and management. The DoNQS reported verbally that whilst the regular (three times daily) assessment of patients with an

altered mental state was not consistently being documented, the assessments are being carried out and there is no risk to patients. Efforts are being made to educate the nursing staff, particularly on wards with a high turnover, to ensure complete documentation.

VTE risk assessment – this has fallen but is improving in response to education and an early return to target is anticipated.

Patient safety incidents –reduced slightly, probably due to the reduced number of patients during the festive period.

Falls – high number of falls recorded in December despite the improvement work. Two could have been avoided but the others were judged to have been unavoidable.

Primary PCI – this national problem is driven principally by the pressure on the ambulance service. Work with NWAS is ongoing, with the intention of maximising the number of patients brought direct to the Trust rather than to the nearest A&E necessitating onward transfer. Patients who are admitted to A&E departments for whom PPCI is likely to be delayed are now receiving thrombolytic therapy before transfer.

The number of deaths for this year is down from the 223 reported for 2021/22, currently 135 on entering the last quarter. The high number of deaths in the winter of 2021 associated with out-of-hospital cardiac arrests and high-risk transfers for PPCI was not replicated during November-January.

Completion by the nursing staff of the Malnutrition Universal Screening Tool (MUST) is still inconsistent. Education sessions are being undertaken.

The Quality Committee noted the clinical quality dashboard.

## **6.5 QSEC key issues/assurance report – 2<sup>nd</sup> December 2022**

Radiology alerts – persistent issues in reporting relate to cross-matching data with the EPR and are the subject of ongoing work. For assurance purposes the MD explained that the alerts are monitored, and reminders sent when no action has been taken within 28 days; currently the timely response rate has been improving. Members of the Committee remain anxious for the reporting issue to be resolved and for the data to continue to be monitored as an index of quality.

The Quality Committee received assurance.

## **6.6 Quality Impact Assessments (CIPs) and Update Report**

The Quality Committee noted the report and had no further comments.

## **6.7 SSI Update**

The Medical Director shared a presentation on surgical site infections.

**RAP**

Monthly surveillance data are received but reported approximately 3 months behind reality.

For the month of October, 15 patients were identified as having an SSI, of which 3 were deep sternal infections. Most SSIs present after discharge from hospital, but the new system should collect all significant cases. Currently it has not been possible to obtain comparable information from other cardiothoracic centres with which to benchmark the incidence of SSIs.

It was agreed that 6-monthly updates would be presented to Committee.

RP

## **6.8 Patient Safety Incident Response Framework (PSIRF)**

The Director of Risk and Improvement provided the Quality Committee with a high-level overview of the new Patient Safety Incident Response Framework.

Members of the Committee sought further information and reassurance on the impact of the new framework on the existing LHCH approach to incident reporting, which already has a strong reporting culture, focus on learning, and assurance. The flexibility proposed by the PSIRF is likely to result in fewer incidents being reported externally, greater discretion in identifying serious incidents, strengthening of thematic analysis and involvement of the ICB in determining the overall strategy. It was noted that a significant programme of staff training will be required. MC asked if the new framework would initially run alongside the existing system, but it was explained that transfer to PSIRF in its entirety is mandatory.

The Committee accepted assurance from the existing progress and proposed timetable that transition to the framework, which includes reporting serious incidents to a new learning system - Learning from Patient Safety Incidents (LFPSI) – in place of StEIS should be in place by the end of the year.

## **7. Patient Safety**

### **7.1 Annual Report of Incidents, Complaints and Claims (IICC)**

This had previously been discussed at Board of Directors and Audit Committee.

The Quality Committee noted the report and had no further comments.

## **8. Clinical Effectiveness**

### **8.1 Clinical Audit and Effectiveness Strategy Annual Report**

The report had been discussed at January's Audit Committee.

The Quality Committee noted the report and had no further comments.

### **8.2 Critical Care GIRFT**

Actions are close to completion, and it was recommended that reporting should be closed, and incorporated into business as usual.

The Quality Committee noted the report.

### **8.3 End of Life Annual Report**

Sue Oakes joined the meeting to present the End-of-Life annual report which provided comprehensive information on activities, service developments and key achievements during the last year. Highlighted issues were:

Experience of the team at LHCH differs from that of other palliative care teams: the higher proportion of non-cancer patients, the high number in critical care for whom no preliminary contact would have been appropriate, the shorter time from admission to death or recognition that EOL was imminent, and with many deaths being sudden.

Despite limited consultant palliative care cover as compared with national commissioning guidance, audits and surveys have shown consistently high levels of EOL support from the specialist team, a 75% increase in out of hours calls for advice and positive feedback from families.

EOL education is a high priority with courses for all grades of staff from all relevant professional groups, with participation rates ranging from 71 to 90% in five priority areas. Unfortunately, face to face sessions are often cancelled due to difficulties in releasing staff, though e-learning continues to be available.

Despite the extensive provision of training, the NACEL audit (see also item 8.4) reported a widespread lack of confidence among ward staff working during the Covid pandemic over caring for patients at the end of life. A gap analysis has been undertaken on staff perceptions, and to ascertain what training, and the best mode of delivery, they considered would be useful. The end-of-life team have been working with the education team to develop e-learning packages for mandatory training. A significant issue is the time for the ever-increasing burden of training.

The DNOQS and members of the Committee congratulated the team for their excellent work in challenging circumstances and their consistent focus on training and improvement. The report was accepted as providing a high level of assurance on the quality of the service.

### **8.4 National Audit of Care at the End of Life (NACEL)**

SO proceeded to present the NACEL audit and outlined limitations of the process with respect to LHCH as compared with other acute trusts; these are attributable to the unique structure of the hospital and case mix:

- The relatively low number of deaths during the reporting period
- The absence of an accident and emergency department
- The disproportionate number of category 2 deaths – those that are not recognised as being imminent

- The high proportion of acute transfers of very sick patients who are the subject of prolonged life-sustaining efforts, thereby not falling into the category of deaths within 4 hours which are excluded from the audit
- The high proportion of non-cancer deaths

An alert was received which identified the Trust as an outlier for a higher proportion of category 2 patients - those among whom death had not been anticipated - with the implication that the deaths had resulted from poor care. However, the explanation for the findings, from an expert (internal) review of the five deaths in this category, provided no evidence of sub-standard care.

Other aspects of the audit, those relating to the quality of care and support for staff, were favourable, with performance scored higher than the UK average.

MC asked how the LHCH results compare with similar hospitals but SO explained that the results are reported anonymously.

The Quality Committee accepted assurance on the service.

Sue Oakes left the meeting.

## **8.5 CQC IRMER Report**

Jo Shaw, Divisional Director of Nursing for Clinical Services and Dr Marousa Ntouskou, Consultant Radiologist joined the Committee to present the CQC IRMER annual (2021-2022) report.

IRMER provide a regulatory framework to protect patients against the dangers from being exposed to ionising radiation within a healthcare setting. The regulations state that each individual exposure should be justified and optimised to make it as effective as possible and to ensure the benefits for the patients outweigh the risk.

Accidental or unintended exposures to patients are monitored through Datix and reported to the CQC.

Between 1<sup>st</sup> April 2021 to 31<sup>st</sup> March 2022 144 incidents were reported for Radiology: 14 (10%) were caused by inadequate identity checks prior to imaging, of which six were incorrect referrals that were identified prior to exposure taking place, and eight involved the wrong patient being imaged, an incorrect protocol being followed, incorrect patient demographics and images not transferred to PACS. Only one incident was identified as being reportable to CQC.

The CQC have made a wide-ranging list of recommendations and the following actions have been put in place at LHCH:

- Pause and check posters from SOR visible in imaging areas
- Review of protocols
- Recruitment drive – reduce time pressures
- Thorough induction training

- Audit of worklist errors – identifying training needs
- Image rejection analysis
- Development of monthly radiology governance review
- Quarterly radiology audit morning used to share learning from incidents
- Re-energise the PAUSE and check poster – use as a screensaver on Trust IT systems as a prompt for referrers

The Committee noted the commitment to reduce the number of incidents.

Jo Shaw and Dr Marousa Ntouskou left the meeting.

The CQC IRMER report is to be added to the workplan and brought back in one year – January 2024.

**MN/SP**

## **8.6 Ockenden Annual Report**

The Quality Committee noted the report without further comment.

## **9. Compliance and Regulation**

### **9.1 SUIs**

No incidents required discussion and the Committee accepted the report without further comment.

### **9.2 Quality Risks / BAF 1 Review**

The Committee noted that, following further implementation of actions in the quality and safety strategy, the residual risk score for BAF1 (quality and safety) has now met the target score of 6.

The report included two new high-risk scores.

- At the time the report was prepared, delivery of psychology service to the long Covid clinic was based on non-recurrent funding and, consequently, was delivered by temporary fixed term staff resulting in uncertainty over its sustainability and a score of 16. A subsequent proposal to the Executive team to agree to fund permanent posts in the service has, as of the date of the Quality Committee (12<sup>th</sup> January 2023) reduced the risk to 12.
- A new high-risk to the aging theatre ventilation system has also been reduced from 16 to 12 following maintenance work, with most of the challenges being resolved.

The risk associated with industrial action has now been incorporated into other risks and will be reflected in the next paper to the Board of Directors

The Committee agreed that the report is consistent with its work.

**10. Date and Time of Next Meeting**

Tuesday 11<sup>th</sup> April 2023, 11.00am-1.00pm, MS Teams

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