

Board of Directors

Item 6.2.2

Subject: Annual Assurance Report - Quality Committee 2021/22
Date of meeting: Tuesday 26th April 2022
Prepared by: Sue Pemberton, Director of Nursing and Quality
Dr Nicholas Brooks, Non-Executive Director & Quality Committee Chair
Presented by: Dr Nicholas Brooks, Non-Executive Director

BAF Ref	Impact on BAF
BAF 1	To provide assurance that the Quality committee has met its terms of reference in 2021/22.

1. Executive Summary

This report provides assurance to the Board of Directors on the performance of the Quality Committee. It summarises the Committee's activity for the financial year (April 2021–March 2022) and outlines how it met its Terms of Reference (TOR) and achieved its key priorities.

At the onset of the Covid-19 epidemic it was decided to avoid physical attendance and all the Committee's meetings were carried out remotely on Microsoft Teams.

The purpose of the Quality Committee is laid down in its TOR; in summary, it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, and clinical risk management. The report identifies the core issues discussed and debated and the assurances received. It also highlights where improvements are required for 2022/23 to strengthen the assurance on quality for the Board of Directors.

The report confirms that the Quality Committee has fully delivered its TOR responsibilities in 2021/22.

2. Background

The Trust has four assurance committees of which the Quality Committee is one. The Committee operates through a work plan derived from its terms of reference.

The Trust is rated outstanding by the CQC. No onsite inspections have taken place throughout 2021/22, but the Trust has had virtual reviews with the Trust's CQC lead.

3. Main Priority and Objective

The role of the Quality Committee is to provide the Board of Directors with an independent and objective review of quality governance. The main priority is to review and scrutinize assurances that the Trust's strategic priorities for quality improvement are identified, implemented, and monitored.

4. Duties and Responsibilities

The Committee exists to promote safety and quality in patient care and experience, and to help to identify priorities and risks arising from clinical care and treatment on a continuous basis.

4.1 Quality Strategy

The Committee received the Trust's updated Quality and Safety Improvement Strategy (2021-2024), which had been delayed due to the pressures from Covid, in January 2022. It had previously been received by the Board of Directors. Assurance on delivery of the strategy is scheduled for all future meetings of the Committee after this date.

4.2 Quality Impact Assessments (QIAS) relating to cost improvements

Assurance on progress with completion of QIAs for cost improvement programmes (CIPs) was received at every meeting during the year. CIPs are also assessed for any potential impact on equality.

The Committee received quality reports via the Quality and Patient and Family Experience Committee (QSFECC) and a Quality dashboard which provided assurance on all domains of quality at every meeting.

4.2.1 Mortality

At its meeting in October 2021 the Committee received the mortality review annual report. It was noted that high unadjusted mortality rates were attributable to Covid patients transferred to LHCH critical care combined with a consequent reduction in the number of low-risk elective patients. At this meeting the Medical Director informed the members that regular meetings with the Dr Foster team have proved helpful in understanding the Trust's HSMR which has been consistently above 100, although there have been no recent alerts of mortality exceeding the expected range. A senior consultant from Dr Foster presented to the committee on the measurement of mortality, which included a review and analysis of the Trust's results.

The Medical Director informed the Committee at its meeting in January 2022 that a new mortality improvement group had been established which was deemed to be a valuable step forward towards improving insight into the interpretation of mortality data. The minutes of the mortality improvement group will be distributed with the Committee papers for information, together with a brief note of ongoing actions.

4.2.2 Quality Dashboard

The Trust's quality dashboard was reviewed at every meeting. Indicators within the quality strategy include the incidence of pressure ulcers, falls, infections, mortality data, medication errors, mortality reviews and sepsis. The Committee received assurance from the QSEC key issues report that all quality indicators are discussed, monitored, investigated where necessary, and the learning shared.

Good progress in ensuring a low incidence of pressure ulcers, falls and infection rates was noted. Sepsis screens, and escalation and treatment within the target time frames have also improved but further effort is required.

4.2.3 Stroke Service Quality & Annual Assurance Report

The stroke service performance, presented to the Committee via the QSEC key issues report in July 2021, documented 100% compliance with the internally set key performance indicators. The Associate Medical Director for surgery shared a presentation which had been updated since the original response to the GIRFT report with further evidence of the consistently low rate of stroke associated with cardiac and aortic procedures against international comparisons. It was noted that agreement had been reached with Liverpool University Trust to instigate weekly ward rounds from a stroke consultant. Outstanding objectives were to develop a seven-day service, ensure a therapy presence in follow-up clinics, and for all patients to be nursed together in one clinical ward together with upskilling the nursing teams in that area. In a follow-up report, received in January 2022, the in-hospital therapy lead reported

that the stroke protocol had been rewritten and an E-learning package was being developed for inclusion in mandatory training. The policy for stroke patients to be nursed together in Cedar ward with enhanced therapy was to have been implemented in January 2022 but has been delayed while part of Cedar is still required for the care of Covid positive patients, though patients with strokes are nursed within that area whenever possible.

4.2.4 GIRFT Report Actions & Progress Update

The on-going GIRFT action plan has been progressing well within the surgical division, although certain sizeable elements have taken time to implement. The cardiology GIRFT was being dealt with on a regional basis, with data from the Wirral still outstanding. The Medical Director presented the annual GIRFT update paper to the September Board. This included progress with the recommendations of the cardiology GIRFT and Critical Care GIRFT.

In relation to the Liverpool Lung Cancer service, the Trust was compliant with all areas. GIRFTs for radiology, intensive care and pathology are ongoing. A new GIRFT on Litigation and Medical Negligence is being assessed. Once published, the Medical Director will bring these reports to the Committee.

4.2.5 Consent

The Committee received an update on consent at the April 2021 meeting as part of the QSEC key issues report. The re-audit for consent within surgery was presented and it was noted that despite the efforts following three previous audits performance had not improved. An action plan had been requested to include responsibility for individual consultants to take ownership of the process. At the meeting in July 2021, it was reported that the action plan had been partially completed and leads for consent in the divisions had been appointed. The Committee was also informed that an electronic consent process was being developed.

MIAA have reaudited the consent process and produced a set of recommendations which are being addressed. It is anticipated that most of the gaps will be covered by introduction of the electronic consent process.

4.2.6 Quality risks

The Committee received an update at all meetings on the current risks relating to quality and the mitigating actions in place to address them.

4.2.7 Clinical audit

The annual report from the Clinical Audit and Effectiveness Strategy was presented to the Committee in January 2022. It was noted that the scope of the strategy was comprehensive, and the Committee accepted assurance from the report's conclusions that the CAEG is working effectively, ensuring the processes for identifying, distributing, and facilitating baseline assessments against NICE guidance and relevant national audits are completed.

4.2.8 Infection Prevention

Infection rates were discussed at all four meetings of the Committee during 2021/22. In July 2021 the Committee received the DIPC annual report which highlighted the re-establishment of the surgical site infection group in response to the reduced target for MSSA infections, an increase in surgical site infections and issues with decolonization exposed in a recent audit. The Committee was assured, however, that the overall incidence of surgical site infections is low. In addition, a group has been formed to look at all aspects of IV cannula management as this is a recurrent source of MSSA. The number of MSSA cases remained within target for the year.

4.2.9 Sepsis

The key performance indicators in relation to compliance with sepsis screening and administration of

timely antibiotics were reviewed at all four Committee meetings during the year and the sepsis annual report was received in July 2021. The Committee received assurance that the sepsis group had been re-established, that a critical care microbiology and sepsis specialist nurse had been appointed, and that education for all clinical staff had been intensified. The Medical Director presented an improvement plan at the meeting in October 2021. MIAA have audited the sepsis pathway, and the recommendations are being actioned, including formalisation of the sepsis group into a committee with new TOR and a governance structure.

5.0 Additional assurances received

The committee received assurance of compliance with key performance indicators and, where necessary, improvement work in relation to:

- Secure health messaging
- Mortality reviews
- Incident reporting
- Infection rates
- Dementia screening
- VTE screening and prophylaxis
- PPCI call to balloon times
- Patient and family experience
- Complaints management
- Resuscitation outcomes and do not resuscitate (DNAR) compliance
- Radiology discrepancy reporting
- Acute kidney injury and improvement work

5.1 Annual Reports

The Committee received annual reports directly or via the Quality and Patient and Family Experience Committee for:

- Diabetes
- Medications assurance
- Drugs and Therapeutics
- Safe medications
- Mortality
- Infection prevention
- The CQC National in-patient survey
- Cancer survey
- Incidents, complaints and claims
- Complaints management
- Patient and family experience
- NICE guidelines and new technology appraisals
- Tissue viability
- End of life care
- Clinical audit and effectiveness
- Sepsis

5.2 Annual Quality Report

The Quality Report has been completed in accordance with statutory requirements, and forms part of the annual report.

6 External Regulations

The last inspection by the CQC was 2019. Since then, the Trust has had regular contact with the CQC in the form of relationship meetings, from which no issues have been highlighted.

7 Patient and Family Experience

The Committee has received assurance against the Patient and Family Experience measures via the national survey results.

8 Research and Development

The Assistant Director of Research and Innovation provided assurance to the Committee on progress with the revised research strategy that was published at the beginning of 2021. The strategy is to be refreshed to include a focus on health inequalities. Key stakeholder engagement is critical to the development of the strategy, which will be reported annually to the Quality Safety and Experience Committee.

9 Membership and Attendance

The TOR specify that membership of the Committee comprises three nominated Non-Executive Directors, one of whom will be chair and one vice-chair, and that at all meetings the Director of Nursing and Quality, the Medical Director, and the Director of Research and Informatics should be in attendance. A review of portfolios within the Executive team has replaced the Director of research and Informatics with a new structure, with a medical lead as Director of Research, supported by an Assistant Director of Research and Innovation. The Assistant Director of research will attend forthcoming quality committee meetings as required.

Position - month meeting occurred	Non-Executive Director (Chair)	Non-Executive Director	Non-Executive Director	Director of Nursing and Quality	Medical Director	Director of Research and Informatics
April 2021	√	√	√	√	√	x
July 2021	√	x	√	√	√ (AMD attended)	x
Oct 2021	√	√	√	√	√	x
Jan 2022	√	√	√	√	√	x

10 Equality and Inclusion

The Committee is due to receive an Equality and inclusion update in April 2022.

11 Priorities for 2022/23

Priorities for 2022/2023 include:

- Continued focus on improving sepsis documentation and management
- Continued reduction in infection rates and all harms
- Mortality reduction
- Consent improvement

12 Conclusion

Throughout the past twelve months the Quality Committee has received assurance on all aspects of

quality, including delivery, governance, and clinical risk management. The Committee met quarterly, on four occasions. Review of the minutes confirmed good attendance.

This annual assurance report, derived from the minutes of the meetings, confirms that the Committee has received assurance against the criteria of the TOR. Amendments, subject to Board approval, have been made to the TOR to highlight areas identified as in need of attention in 2022/23.

13 Recommendations

The Board of Directors is asked to

- (i) receive assurance that the Quality Committee has met its terms of reference, and to note the areas requiring improvement in Trust performance.
- (ii) Approve the revised Quality Committee TOR (reviewed and recommended by the Audit Committee).