

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 4th January 2022

<p>Present: Nick Brooks (Chair) Sue Pemberton Raph Perry Julian Farmer Karen O'Hagan</p> <p>In Attendance: Megan Underwood Mike Filek Jenny Crooks Hannah Rooney</p>	<p>Non-Executive Director Director of Nursing, Quality and Safety Medical Director Non-Executive Director Non-Executive Director</p> <p>Senior Executive Assistant (Minutes) Head of Improvement and Transformation (item 6.2 only) Associate Director of Research & Innovation (item 8.1 only) In-Hospital Therapy Lead (item 6.5 only)</p>
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1. Apologies for Absence

There were no apologies to record.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 19th October 2021

It was agreed that the e-minutes were a true and accurate record.

4. Patient Story

The Director of Nursing, Quality and Safety read the patient story.

5. Action Log

Item 1 – GIRFT update Critical Care – To be rescheduled for a future meeting. The Head of Improvement and Transformation is leading the

GIRFT project with the Deputy Medical Director; a workplan is being devised and progress will be presented throughout the year at Operational Board. The reports will be included in the Quality Committee workplan to ensure assurance is received.

MU/SP

Item 2 – Stroke Service Update – Discussed as part of the main agenda (item 6.5) and removed from the action log.

Item 3 – Quality Strategy – Discussed with item 6.1.1 on the main agenda. Further updates to be reported to the Committee in April and July with an annual report in October.

SP

Item 4 – Clinical Quality Report: Radiological alerts – Discussed with main agenda (item 6.1.6: Areas for improvement). Removed from action log.

Item 5 – Clinical Quality Report: Nutrition – Discussed as part of the main agenda (6.1.10). Removed from the action log.

Item 6 – Clinical Quality Report: Discharge summaries – Discussed as part of the main agenda (6.1.1). Removed from the action log.

Item 7 – Dr Foster Consultant Focus and Functionality – Discussed as part of the main agenda (6.4.1). Removed from the action log.

6. Quality

6.1 Quality Dashboard

Members of the Committee endorsed the use of SPC charts (as presented to the Board of Directors in December) for the new performance dashboard. The Chief Digital Information Officer (CDIO) is leading the work in liaison with the DoNQS, who will update the Committee on progress towards its full implementation.

SP

JF raised questioned the “no impact” and “acceptable assurance” statements in the Impact on BAF section at the head of the report, despite documentation of areas of concern. The DoNQS explained that it was not considered, from the executive perspective, that the concerns in the quality dashboard had a significant impact on the BAF, but it was agreed that the issue should be discussed outside the meeting with the Interim Chief Governance Officer.

SP/NB/JF

The Committee discussed the areas of concern identified in the quality dashboard (excluding those considered in the QSEC assurance report, item 6.3).

Delirium

The DoNQS assured the Committee that risk assessments are being performed three times a day in patients assessed as having an altered mental state, and that the apparently poor performance reflects challenges in transferring data from the EPR to the dashboard.

The data is reviewed on a weekly basis with the Ward Managers and the Matrons' audits demonstrate that the assessments are taking place.

The Digital Team is working to resolve the problem which should be completed by the April meeting of the Committee.

Falls

There has been an increase in unobserved falls. The matrons and heads of nursing are focussing on the issue which concerns mainly Birch and Cedar wards. KO asked if the restricted visiting related to Covid-19 precautions might be contributing to the problem but accepted that the current arrangements were essential to prevent cross infection. The DoNQS was satisfied that falls risk-assessments were being completed and that the range of preventive measures, as previously reported to the Committee, were being complied with.

Primary PCI

The problem, which is affecting trusts nationwide, of increasing delays in the admission of heart attack patients for PPCI has been discussed by the Committee on numerous previous occasions. The MD reiterated that the most adversely affected patients are those requiring transfer from other trusts, rather than the those brought directly to LCHC by the ambulance/paramedic teams. High-level discussions are continuing and the PPCI protocol is being revised by Dr Clare Appleby. Options being considered are for more rigorous discussion with referring trusts on the suitability of patients for transfer and the possibility of thrombolysis when excessive delays are unavoidable.

Discharge Summaries

The Matron's audit revealed that the checklists, which include confirmation that the discharge summary has been given to the patient, were not being completed consistently. Documentation is, accordingly, being monitored by the DoNQS.

Nutrition – referral to dieticians

Performance was better than displayed on the dashboard. The discrepancy is partly an issue of data quality related to the transfer of EPR information to the dashboard, but also to patients who were fasting pre-procedure being inappropriately designated as needing a referral to the dietitians.

Radiological Alerts

The response rate for November was recorded at 73%.

The Committee was updated on implementation of the actions recommended in the MIAA audit. Responses to alerts are reported weekly at Executive Group Meetings and the associate medical directors are monitoring the situation and sending reminders. Radiological alerts have been added to the business cycle of divisional boards to ensure

scrutiny on a monthly basis. The Radiology department is also working to ensure the data are being handled correctly.

Pressure Ulcers

Two grade three pressure ulcers were recorded during November. Both were investigated, with construction of a timeline of events which disclosed incomplete documentation of the interactions with the MDT in one case.

Emergency readmissions

The data on the performance dashboard were from March 2021 and will be updated by the digital team.

The Committee accepted assurance from the quality dashboard but noted that data quality and capture had been identified as a significant issue in connection with certain areas of concern, prompting the question as to the reliability of the dashboard in areas of apparently good performance. The DoNQS expressed confidence, based on close involvement with all aspects of quality and safety within the Trust, that whilst further development of data recording was on-going, the Committee could be assured that important issues are not being overlooked.

6.1.1 Quality & Safety Strategy – 2021-2024

This was discussed as part of agenda item 6.1.

6.2 Quality Impact Assessments (CIPs) & Update Report

CIP planning remains behind target but, of the 31 schemes that have been identified, 25 have passed through Gateway 4 and 24 have completed the final stage of ratification by the FPG. The final scheme will be discussed at January's FPG meeting.

No triggers necessitating a full EIA have been identified.

The Committee accepted excellent assurance over the quality and equality governance of the CIP process. The financial risk is managed within the Finance team.

6.3 QSEC Key Assurances Report – 3rd December 2021

Shortage of anaesthetic practitioners - this has previously been raised at the Board of Directors. The plan is to amalgamate both surgical and medical practitioners into a single team under the Surgical Division. Advertisements have been published, and interviews planned.

Fasting – improvement work continues in both Surgery and Medicine. 'Sips to sends' has been introduced whereby patients are encouraged to have sips of water until being collected for their procedure. Admission letters are being revised for accuracy and ambiguity. A further report will be discussed at February's QSEC meeting.

Acute Kidney Injury (AK) – audit data collected pre-pandemic had been discussed at the last QSEC, where it was noted that risk screening was performed in only 46% of patients. The Committee noted the value of the assessment in that 13.8% of recognised high-risk patients went on to require renal replacement therapy, compared with 1.6% of those designated to be at low risk. Leadership has been taken over by Amy Hill and the DoNQS will ensure that the data is incorporated in the clinical quality dashboard.

SP

NICOR ACHD report – in response to a question from the chair, the MD confirmed that the report covers outcomes as well as data quality and completeness and, accordingly, enables benchmarking against other centres. The report has been discussed at both the Liverpool and Northwest ACHD Partnership Boards.

6.4 Dr Foster Dashboard

The Committee strongly approved of the formation of the Mortality Improvement Group as a valuable step towards improving insight into the interpretation of mortality data.

The minutes of the Mortality Improvement Group will to be brought to the Quality Committee for information and an assurance report will be discussed at future meetings. The Business Cycle will be updated.

MU

The MD shared the Dr Foster Dashboard with the Committee.

6.4.1 Mortality Improvement Group – Approved Minutes

The minutes were noted with no further comments.

6.5 Stroke Service Update

HR (In-hospital Therapy Lead) presented her report on progress with enhancement of the service which aims to bring it up to the standard of provision for stroke patients admitted from the community to general hospitals.

Positive developments include:

- The stroke protocol has been rewritten, ratified and is now in use with evidence of benefit: this time last year 12 Datix's incidents were reported over a three-month period whereas during the last six months there have been none.
- An e-Learning package is being developed and will be discussed at the People Delivery Group with a view to its inclusion in mandatory training for staff involved in the care of stroke patients.
- Stroke patients are being nursed together ('cohorted') as far as possible (currently limited by pandemic measures) with a trial of enhanced therapy to commence on Cedar in January 2022.

- Reporting to the national sentinel stroke audit (SSNAP) is ready for implementation following changes to the EPR to allow electronic data capture.

An unresolved issue is the slow progress of the proposed SLA with Liverpool University Hospitals (LUHFT) over medical cover, remote access to the EPR by visiting consultants, and the appointment of an ANP in stroke medicine.

It was noted that the Board accords high priority and support for resolution of the outstanding issues, and it was recommended that the next meeting with LUHFT should be supported at senior clinical level.

It was agreed that the report provides limited assurance, and a further update is to be provided for the July meeting of the Committee.

HR/SP/MU

Patient Safety

7.1 Annual Report on incidents, complaints and claims (IICC)

The Committee noted the report and made no comments.

8. Clinical Effectiveness

8.1 Annual Report Clinical Audit and Effectiveness Strategy

JC, Associate Director of Research and Innovation, presented highlights from the report which included progress on the revised strategy that was published at the beginning of 2021. Members of the Committee commented favourably on the excellent and comprehensive scope of the CAEG strategy and accepted assurance from the report's conclusions, that "The CAEG is working well, ensuring the processes for identifying, distributing, and facilitating baseline assessments against NICE guidance and self-assessments against relevant National audits are completed. The introduction and implementation of new technologies are monitored and reviewed."

In response to a question from the chair, it was confirmed that the Committee would continue to receive an annual report summarising all the Trust's internal and external audit activities.

MU/JC

9. Compliance and Regulation

9.1 SUIs

The summary report had been requested by the Trust Chair following the recent number of serious incidents within the Trust.

All had been discussed previously by the Committee, but additional information was sought on two incidents:

Incident 3.8 – unwitnessed fall followed by death. Escalation had been slow throughout the day despite the patient having varying levels of delirium/confusion. The fall occurred as the patient attempted to get out of bed unaided. Since this incident outreach provision has been extended

to a 24hrs 7 days per week service; handover processes have been strengthened with replacement of the paper with an electronic document; escalation to intensivists will be actioned if concerns are not addressed and the medical emergency team has been established and is readily available to assist with deteriorating patients.

Incident 3.2 – post-operative patient suicide. Questions were raised over recognition of the patient’s delirium. The enquiry had determined that the suicide could not have been predicted, and this had been accepted by HM Coroner. All possible means to minimise future risk have been considered, and an SLA with MerseyCare has been secured for a mental health nurse to work in the Trust alongside the psychology and safeguarding teams.

Further reports, with updates on incompletely investigated serious incidents will continue to be submitted to the Committee as according to the TOR and workplan.

9.2 Quality Risks

Following the decision of the Chief Governance Officer, the Quality Risk report now focusses on the principal area of responsibility of the Committee: BAF1 - Failure to maintain safety and quality for the longer term. It was agreed that this is appropriate but the opportunity for further discussion on assessment of the risk levels, to take place outside the committee, was requested.

JF/SP/NB

10. Date and Time of Next Meeting:

Tuesday 5th April 2022, 11.00am-1.00pm, Research Meeting Room/MS Teams

The Chair thanked Karen O’Hagan, who is leaving the Trust, for her valuable participation in the work of the Committee.