

Item 6.1.1b*

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 12th April 2022

Present:

Nicholas Brooks (Chair)
Sue Pemberton
Raph Perry
Julian Farmer

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

In Attendance:

Megan Underwood
Val Davies

Senior Executive Assistant (Minutes)
Chair

Apologies:

Karen O'Hagan

Non-Executive Director

1. Apologies for Absence

Apologies were noted as above.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 4^h January 2022

It was agreed that the e-minutes were accepted and recorded as 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 – Update reports to be added to workplan. Removed from the action log.

Item 2 – Quality Strategy – Discussed under agenda item 6.1. Further 6-monthly updates and annual report in October to be included in workplan. Removed from the action log.

Item 3 – GIRFT project – Discussed under item 7.2. Further progress reports to be included in workplan. Removed from the action log.

Item 4 – Quality Dashboard – Completed and removed from the action log.

Item 5 – Responsiveness of BAF risk ratings to reports and briefing papers – Informal conversations held with the Chief Governance Officer have concluded that the issue will be addressed by inclusion of the BAF 1 (Quality and Safety) report on the agenda of every Quality Committee. Removed from action log.

Item 6 – QSEC Key Assurances Report/Acute kidney injury – 3rd December 2021 – Discussed under item 6.2 and removed from the action log.

Item 7 – Dr Foster Dashboard – Minutes from the newly established Mortality Improvement Group will be received by the Quality Committee as a starred standing agenda item. The item was completed and removed from the action log.

Item 8 – Stroke Service Update – To be discussed at July's Quality Committee.

Item 9 – Annual Report Clinical Effectiveness Strategy – The Director of Nursing, Quality and Safety (DoNQS) to liaise with the Clinical Audit and Effectiveness Manager to determine the feasibility of returning to the format of previous years, in which all internal and external audits and responses to national directives were tabulated, in readiness for next year's report.

SP

Item 10 – Quality Risks – This item was completed (as in item 5 above) and removed from the action log.

6. Quality

6.1 6-monthly progress update Quality and Safety Strategy

Despite constraints imposed by the residual Covid-19 challenges which have resulted in slippage of the planned timelines and a lack of clarity over when some will be fully implemented (e.g., the medicines safety improvement plan), the report provided assurance on overall engagement in delivering the strategy. The process was being managed with regular meetings with the leads for each objective. A further progress report will be made to the Committee in July, and an annual report will be presented to the Committee and the Board of Directors in October 2022

6.2 QSEC Key Assurances / Risk Report – 4th March 2022

DoNQS highlighted the areas in red and amber, as follows:

Acute Kidney Injury – screening of cardiac surgical patients for risk of acute kidney injury remains low at 54%. A meeting is scheduled between Dr Al Rawi and the IT team to devise an IT solution to improving uptake of the tool and to include patients in the Medical Division undergoing contrast-based radiological procedures.

Radiology discrepancy reporting – key learning points are to be escalated from the radiology review meetings to the Ops Board

All other areas within the report were rated as green.

The DoNSQ informed the Committee of a notable improvement in dietician referrals in March, and of completion of work with the matrons and IT team to ensure accuracy of the data.

6.3 Clinical Quality Dashboard / Supporting paper

The DoNQS presented the new clinical quality dashboard to the Committee. The accompanying report provided assurance on progress with areas previously identified as requiring continuing focus or improvement: delirium assessment, medication incidents, screening for dementia, copies of discharge summaries to patients, nutrition, pressure ulcers, radiology alerts and serious incidents. In response to a question about a recent serious incident the DNoQS explained that this primarily involved a delayed referral from another trust, from which an investigation and report have been requested.

Members requested that for future meetings the dashboard be included with the briefing papers.

SP/MU

6.4 Annual Assurance Report Quality Committee

The report has already been approved at the March Audit Committee. Tracked changes were approved and deleted.

The report was approved by the Quality Committee.

6.5 Quality Committee Terms of Reference – For Approval

The chair outlined the new NSHE recommendations for certain roles currently delegated to NED champions to be moved to the respective assurance committees. For the Quality Committee this includes the end of life and resuscitation services. It was agreed that reports from these services should be added to the TOR and workplan. NB would continue to attend the action group meetings whenever possible.

6.6 Quality Committee Workplan 2022/23 – For Approval

As discussed in action point 7, the annual report and minutes from the Mortality Improvement Group will be added to the workplan.

MU

Aside from these amendments, the Quality Committee approved the workplan for 2022/23.

6.7 Quality Impact Assessments (CIPs) & Update Report

The closing report for the 2021/22 financial year cost improvement programmes QIAs and EIAs was presented by the Head of Improvement and Transformation.

Of the 32 schemes requiring assessment, 28 have been ratified (gateway 5) and those remaining are on course to be implemented within the next month. Preliminary evaluation in all schemes discounted the requirement full EIA.

Additional assurance activities in relation to the 2021/22 schemes to be undertaken in quarter 1 include:

- a lessons-learned review based on a sample of schemes for 2021/22
- review of a sample of QIA/EIA documents by the Trust's Equality Lead for an independent assessment of the equality impact assessments.

Planning for 2022/23 is in the early stages with no schemes currently ready for a QIA.

Members of the Committee agreed that the report provides acceptable assurance on the QIA/EIA process.

The Head of Improvement and Transformation left the meeting.

6.8 Dr Foster Dashboard

The Medical Director shared the Dr Foster Dashboard with the Quality Committee.

Members were satisfied with the dashboard which disclosed no unexpected new findings and had no specific comments or questions

6.9 Resuscitation Training

Current risks affecting the resuscitation service were outlined by the chair; in particular, the outstanding recommendations of the previous external review for a second resuscitation training officer (RTO), and for improved facilities for training. The situation is compounded by the current absence of the Resuscitation Lead, and compliance with mandatory training was below target at all levels in Q4.

The DoNSQ outlined the measures in progress or already adopted to mitigate the situation:

- appointment of an interim Resuscitation Training Officer
- support for the development of additional in-house instructors to provide appropriate training to specific areas of the Trust with greater flexibility in timing

- a new trajectory for training with 206 BLS, 60 recertification ILS and 48 full day ILS sessions available for Q1 and Q2. If all sessions are filled compliance should increase to 95%.
- the RTO to monitor mandatory training compliance, attend audit days and ensure that instructors maintain their skills and have completed their General Instructor Course
- the purchase of extra mannequins, facilitated by a recent large donation, which will be based on the wards, thereby mitigating the problem of not having a designated training room and reducing the need for staff to leave their departments for training.

Flyers have been circulated to all Heads of Departments with awareness being raised in both Gold and Silver Command

The Committee commended the commitment to these improvements.

7. Clinical Effectiveness

7.1 Mortality Review Annual Report and improvement plan

The Medical Director presented the mortality review covering the period December 2020 to November 2021 but with updated information covering the subsequent three months, together with details of the mortality improvement plan.

The key issues from the annual report:

- though persistently greater than 100 throughout the year, the risk adjusted (SMR and HSMR) mortality rate is declining
- the higher-than-expected mortality (both risk and-adjusted and in comparison, with peer group trusts) is being driven mainly by the unrestricted policy, unique to LHCH, of accepting direct admission of patients with out of hospital cardiac arrest (OOHCA). In these patients and others admitted acutely, there is inevitably incomplete collection – and consequently coding - of co-morbidities
- the mortality reduction strategy has been strengthened by the establishment of the mortality improvement group, set up in collaboration with Telestra Health (formerly Dr Foster), which meets monthly and reports to the Ops Board
- introduction of the Medical Examiner post
- progressive implementation of GIRFT recommendations
- use of the learning from deaths process to improve clinical systems
- rigorous performance management: notably use of CUSUM curves for individual cardiac surgeons, none of whom were outliers. The MD explained that a comparable analysis for device implantation would not be meaningful because of the rarity of deaths relating to these procedures
- Development of improvement plans for all three clinical divisions, though it was noted that whilst clear timelines were set out by clinical services these are less well, if at all, defined for medicine and surgery
- Appointment of a new VTE lead and continuing focus on application of care bundles across a range of interventions

Based on discussion of these issues, members of the Committee agreed that acceptable assurance was received in the following areas:

- The rigorous multi-layered processes involved in the scrutiny of and learning from deaths, the comprehensive measures to reduce mortality and the reliability of the data
- The higher-than-expected mortality is a reflection of causes other than from any deficiencies in the standards of care within the hospital.

7.2 Annual Report re GIRFT Report Actions and Progress Update

The MD presented an update on progress with the GIRFT programme and informed the Committee that with the addition of a litigation GIRFT there are now eight best practice reports applicable to LHCH from which assessment for gaps and action plans are developed. The report detailed excellent progress with deep dives and implementation of best practice reports. Feedback from the regional GIRFT implementation manager has been of exemplary practice. In certain areas, notably pathology, which is provided by Liverpool Clinical Laboratories, where there is reliance on external parties, it may not be possible to complete the gap analysis because of competing priorities. The Committee also noted reservations over the feasibility of participation in the recommended Infection in Critical Care Quality Improvement Programme because of the onerous requirement for data collection, though mitigations are being explored.

Members of the Committee noted the good progress with clear and appropriate actions.

7.3 Annual Report Medications Safety

The Chief Pharmacist was congratulated on their sustained commitment to medications safety, and members noted the excellent record and new initiatives in monitoring and learning from errors over the course of the year. The Chief Pharmacist explained how introduction of the closed loop system for drug dispensing and administration could be expected to eliminate common human errors in dispensing and administration.

Key to this continued progress is actual reporting of medication incidents. Identification of issues and corrective action plans to prevent harm/potential harm to patients can only be achieved if there was awareness of incidents and this, together with “safety through learning” has been a key component of the Trust’s new Quality and Safety Strategy.

In the last 12 months, out of 280 reported incidents, 273 resulted in no harm, six in minimal harm and one in moderate (short-term) harm. Two major safety concerns had been discussed at previous meetings of the Committee: a never event in which a patient was connected to medical air instead of oxygen and an incident involving a controlled drug. Both were followed with RCAs and prompt implementation of actions to prevent recurrence.

The report was reported as providing partial assurance, but the Quality Committee considered that it provided acceptable assurance and recommended the change.

The DoNQS thanked the Chief Pharmacist for his leadership.

The Chief Pharmacist left the meeting.

7.4 MIAA Secure Health Messaging – actions completed

Committee members were pleased to note the positive response to the MIAA audit. Measures in the action plan, which includes a detailed Standard Operating Procedure, and which should be implemented in full by the end of the month are considered to cover all possible eventualities. Retrospectively, outstanding alerts up to three years old have been identified, reviewed by the AMDs and the responsible clinicians, and urgent cases acted upon.

Rigorous assurance that secure health messages are being opened, actioned, and documented is to be provided to the Operational Board.

8. Compliance and Regulation

8.1 SUIs

There was nothing of significance to note; only a minor update on the actions of most recent incident (technical issues during and internally proctored case) since presented to Board of Directors in April.

8.2/8.3 Quality Risks and BAF 1 review

The most up to date BAF was discussed by the Committee. The DONQS considered that full implementation of the refreshed quality and safety strategy could be expected to bring all assurance levels to within the risk appetite.

9. Date and Time of Next Meeting

Tuesday 12th July 2022, 11.00am-1.00pm, Research Meeting Room/MS Teams