

minutes

Quality Committee

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

Present:

Nicholas Brooks (Chair)
Sue Pemberton
Raph Perry
Andrew Lang

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

In Attendance:

Megan Underwood

Senior Executive Assistant (Minutes)

Apologies:

Julian Farmer

Non-Executive Director

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: 12th April 2022

Julian Farmer to be added to the attendance list of the minutes, otherwise it was agreed that the e-minutes were accepted and recorded as a true and accurate record.

MU

4. Patient Story

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

5. Action Log

Item 1 – This item was to be discussed as part of the main agenda and, accordingly, was closed and removed from the action log.

Item 2 – The Director of Nursing has liaised with the Clinical and Audit Effectiveness Manager and informed the Committee that a paper, which includes tabulation of all the audit activities in the Trust, is to be presented to the Audit Committee on 19th July 2022 and can be shared with Quality Committee members. The Chair was satisfied with this response and the action was removed from the log.

Item 3 – This item was completed and removed from the action log.

Item 4 – This item was completed and removed from the action log.

Item 5 – This item was completed and removed from the action log.

6. Quality

6.1 Clinical Quality Dashboard

The areas of concern were listed within the report and were discussed as follows:

Delirium

As one of the quality priorities for 2020/21 that was carried over to 2021/23, there has been a significant focus on delirium, and the first two indicators - risk assessments on admission and repeated assessments should the patient develop delirium - have progressed well. The third indicator: for daily assessment of patients with an altered mental state rather than delirium has proved to be more problematic. Discussions have been held with the Informatics team in relation to the wording of the dashboard. Nevertheless, gradual improvements have been confirmed by the matrons: in April the divisions were reporting compliance at 25%, in May 36.7%, in June 48% and in July 76%.

DONQS to review the dashboard for clarification of the wording with the Informatics team and the Chief Digital Information Officer.

SP

MU to liaise with the Director of Risk Improvement on providing the Non-Executive Directors with access to the Clinical Quality Dashboard on Athena.

MU

Medication incidents

The DNOQ explained that this dashboard will always display as red in order to encourage the reporting of medication incidents. Introduction of the closed loop system has been associated with a reduction in administration errors. Targeted work is focussed on educating diabetic patients and allowing them to be involved in administration of their own insulin.

Blood cultures

The trend has been favourable, and the target (96% within 24hrs preceding first antibiotic administration) has been achieved for six of the seven months up to May 2022.

Discharge summaries

The patients are receiving copies of their summaries, but documentation needs to improve and is being monitored by the Matrons and Ward Managers.

Nutrition

Documentation of screening for malnutrition has been improving over the last five months and reached 95% in May 2022. Of those referred all are receiving a care plan and concerns or issues are raised at the daily safety huddle. The DNOQ reiterated the effectiveness of the nutrition group. Review of facilities boards was underway.

Falls

The number of falls causing harm (none during last 12 months) and those considered to have been avoidable remains very low. Most unavoidable falls have occurred in patients who were non-compliant for a variety of reasons, e.g., reluctance to ask for help and attempting to use the bathroom without assistance. The focus is on prevention, with education beginning in outpatients and continuing on admission; and use of falls prevention equipment and surveillance. Every fall is reviewed by the ward managers and matron.

Radiological alerts

An apparent sharp increase in alerts without a documented response in May was caused by an IT issue following a recommendation in the MIAA audit that resulted in duplication, with alerts being sent to the consultant as well as to the requester. The problem has been escalated to the Chief Digital Information Officer who is to liaise with the EPR team and Informatics. The Medical Director oversees the process to ensure the RARs are being completed.

Emergency readmissions

The emergency readmission target up to 30 days after an elective admission to LHCH is set at less than 6% and current figures are broadly in alignment with this. For non-elective (emergency and urgent) primary admissions, the readmission rate is averaging about 12% though the figures for the last four months on the dashboard – up to November 2021 – were between 9 and 11%. Reasons for readmission were discussed and, though there is no national benchmark for comparable trusts, the MD considers that the LHCH rate is no greater than expected. However, he acknowledged that the true figures may be an underestimate because most readmissions are to other hospitals, and there is no reliable system to inform LHCH.

The Medical Director is to liaise with the Divisions to obtain up-to-date information for a report to be presented to the Quality, Safety, Experience Committee (QSEC) in September and to be reconsidered by the Quality Committee in due course.

RP

6.2 Quality Impact Assessments (CIPs) & Update Report

The Director of Risk and Improvement joined the meeting to present the update on Quality Impact Assessments.

Members of the Committee noted the slow progress, under oversight by the Finance and Performance Group, in identifying and progressing the CIPs in Q1 with none of the 25 schemes having (as of 1st July) completed the process. The Director of Risk and Improvement informed the Committee that the Head of Improvement and Transformation is exploring the potential for increased automation to reduce the delays.

The report summarised a review, by the Trust's equality leads, of the QIA and EIA processes for eight of the 32 schemes in the 2021/22 programme. It was concluded that a need exists to enhance the assessments in relation to the EIAs, none of which identified a potential impact on individuals with protected characteristics. The Committee noted the plans to extend training and to recommence the post-project evaluations with the aim of assessing the success or otherwise in achievement of the anticipated benefits, and learning lessons.

The Committee accepted assurance from the process.

The Director of Risk and Improvement left the meeting.

6.3 QSEC Key Assurances / Risk Report – 10th June 2022

The amber-rated assurances within the document had been discussed as part of agenda item 6.1.

The Committee received the Q4 complaints report. No issues were raised, and assurance was taken from the pro-active approach to patient concerns, the rigorous process of investigation of complaints and the quarterly NED review panel.

The IICC report for Q3 and Q4 combined with the annual report was received. There were no outstanding issues and it was noted that all serious incidents are notified to the Committee and discussed as their investigation progresses.

In response to a question from a new member of the Committee the DONQ described the learning process, which is applied to all deaths, incidents, complaints, and claims.

6.4 Stroke annual assurance report

The In-Hospital Therapy Lead joined the meeting to present the Stroke Service Assurance Report for 2021/22, which included an update (requested by the Committee January 2022) on progress in achieving the recommendations from the earlier service review.

Service demand increased from 104 strokes in 2020/21 to 119 in 2021/22. Length of stay also increased slightly from 27 to 30 days.

Of greatest concern to the Committee is that the average rehabilitation input has fallen from 42.3 to 10.1 hours per patient. HR explained that this

has resulted from depletion of the small rehabilitation team by sickness, study leave, and non-clinical responsibilities, compounded by the increasing demands of caring for complex patients with hypoxic brain injury following out of hospital cardiac arrest. There has also been a requirement to accompany ward rounds which has further depleted the time available for direct patient contact.

To address the issue, a business case is being prepared to provide rehabilitation cover at weekends, therapy notes are being expanded to include recommendations on functional ability, and there is a plan to teach rehabilitation to nurses and other members of the therapies team.

Members of the Committee noted the progress on recommendations of the 2021/22 review, which included the following actions:

- Service Line Agreement (SLA) with LUFHT - amended to include out of hours provision and strengthen collaborative relationships with LUFHT medical staff to ensure consistency and understanding of the service - in process of agreement.
- Stroke Protocol - updated and on the intranet with associated communications to raise awareness.
- Mandatory training package - went live in March 2022, for all clinical staff on recognising, referring, and escalating; as of mid-June compliance was at 81% with a positive trajectory.
- 'Potential Stroke' - now an indication for a MET call (Medical Emergency) which requires urgent review from a specialist team and timely protocol initiation
- Visiting clinical staff - now have access to EPR both on- and off-site allowing clinical records to be reviewed and updated.
- Training sessions facilitated by consultant intensivists and the stroke network for ANP's and doctors to increase awareness of protocol and processes.
- Increased psychology provision across the organisation accessible to the stroke MDT included in the business case
- Progress with the National Stroke Sentinel Audit Programme (SSNAP) - the Clinical Effectiveness team is building a programme to pull data from EPR for direct input to SSNAP.
- The Stroke Steering Group has undertaken a review of the Terms of Reference to establish stronger governance, chaired by the Head of Nursing and with membership expanded to include a consultant clinical intensivist.
- The Stroke Team was involved in the cardiac surgery GIRFT review
- Peer review by the National Stroke Network drew positive feedback
- LHCH inclusion in the Thrombectomy Oversight Group of the regional stroke network to facilitate transfer of patients to Walton for thrombolysis.

The number of incident reports on Datix was similar to last year: a total of 19 (vs. 22); the main themes related to administration, diagnostic performance failures, 'processes' – including a delay in referral and absence of cover over the bank holiday – and communication. Improvement is anticipated with introduction of the MET process and mandatory training.

The remaining active risk on the register is the inability to follow-up stroke patients and assess their level of recovery, without which the risks of and associated with stroke cannot be conveyed to patients during their consent for a procedure.

During Q4, five of the 10 internally set KPIs were missed due to the pressure on the department.

Members of the Committee congratulated HR on her sustained attention to detail, and her commitment and drive in developing and sustaining an effective and safe service. The challenges and unresolved issues and mitigations were discussed, and the Committee is anxious to receive follow-up on the rehabilitation time with patients and weekend cover. It was agreed that the report does not change the overall risk on BAF1.

HR

The In-Hospital Therapy Lead left the meeting.

6.5 Dr Foster Dashboard

The HSMR 12-month rolling average has remained above 1 though with a downward trend over the last 12 months and no recent alerts.

Investigation of coding by the Mortality Improvement Group has revealed generally reliable practice, with the exception of an issue over urgent transfers being coded as elective cases, which has resulted in several problems including an underestimation of expected mortality.

The approved minutes of the March Mortality Improvement Group had previously been circulated to the Quality Committee.

6.6 Mortality Improvement Group Minutes – 9th March 2022

The minutes of the Mortality Improvement Group were noted, and the Quality Committee had no further comments.

7. Clinical Effectiveness

7.1 Resuscitation Annual Report

The Critical Care Business Manager joined the meeting to present the resuscitation annual report. The Committee noted:

- demonstration of full compliance with the end-of-life policy which includes documentation of ceilings of care
- continued reporting to the national audit of all cardiac arrests to which the team was called
- The annual national report (NCAA) showed that the Trust lies above the national average for survival to hospital discharge in comparison with other acute hospitals and, most importantly, with similar cardiothoracic hospitals.

Risks to the resuscitation service were discussed at the April meeting of the Committee (see Quality Committee minutes, item 3; p 4 item 6.9). These relate mainly to training which fell off after the departure from the

Trust of the resuscitation lead, though part-time support is provided by the previous retired RTO and the Critical Care service lead will continue as the resuscitation manager. The plan to expand training opportunities by adoption of a team approach and utilisation of ALS accredited staff to train in their divisions is progressing, with 90% ALS compliance though only 65.8% and 85.2% respectively for BLS and ILS. Training is a recurrent item on all resuscitation committee agendas and the meetings are well attended.

Though the structure of the service differs from the recommendations of the national review carried out three years ago, notably in having establishment for only a single resuscitation officer and sub-optimal physical facilities for training, the Committee accepts that the mitigation measures that have been introduced provide assurance that the service remains safe and effective. The chair pointed out that the team approach to training could be more satisfactory than the standard model prescribed in the review.

7.2 GIRFT Critical Care Update

The report provided an update on progress in implementing best practice identified in the GIRFT report on Critical Care which was published in February 2021.

A gap analysis undertaken by the Clinical Lead and the Critical Care unit manager of the 17 GIRFT recommendations applicable to the Trust had found initial compliance with 13. Following introduction of an improvement plan, compliance has improved to 15.

The outstanding action that has not progressed is the 7-day rehabilitation service (as in item 6.4); this is a priority for the Trust. Further discussion is to take place on participation in the national Infection Control Quality Improvement plan (ICCQIP), and acquisition of additional renal support for critical care to enable haemodialysis to be carried out on the unit.

A virtual meeting with the GIRFT team in December 2021 identified many areas of good practice, including “an excellent collaborative approach...in the multidisciplinary team”.

8. Compliance and Regulation

8.1 SUIs

The Committee is well-sighted on serious incidents which are reported directly to all the NEDs as they occur and reviewed at every meeting.

8.2 Quality Risks

The Committee received the newly developed risk report which draws together the BAF1 – failure to maintain safety and quality and reduce harm – with the high-risk register of those scoring greater than 15, and 9, of 26 with a residual risk of 12 that have implications for safety and quality. These high risks are reviewed monthly by the Risk Management Committee and Divisional Boards.

8.3 BAF 1 Review

The BAF had been reviewed at the recent Board Strategy day and members of the Committee were happy to accept the existing risk scores and appetite for overall 'minimal' risk.

9. Date and Time of Next Meeting

Tuesday 11th October 2022, 11.00am-1.00pm. MS Teams/Research Meeting Room
