

minutes

Quality Committee

**Minutes of the Quality Committee Meeting
held on Tuesday 11th July 2023****Present:**

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

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

In Attendance:

Megan Underwood
Karan Wheatcroft
Mike Filek
Danny Forrest
Kirsty Dudley

Senior Executive Assistant
Director of Risk & Improvement
Head of Improvement & Transformation
Chief Pharmacist
Critical Care Business Manager

Apologies:**1. Apologies for Absence**

There were no apologies to note.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 18th April 2023

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.

The patient story recounted, overall, a highly satisfactory experience but raised a number of issues in relation to food. This was disappointing and unexpected, since much emphasis has been applied to the management of mealtimes, the availability of snacks and food quality. SP assured the Committee that the issues were being addressed.

5. Action Log: 18th April 2023

Item 1 rehabilitation for stroke patients—to be discussed at October's meeting.

Item 2 quality dashboard – this action was closed and removed from the action log.

Item 3 quality impact assessment – this action has been implemented and was removed from the log.

Item 4 mortality improvement group minutes/waiting list management – this action is to be added to October's agenda.

Item 5 nutrition annual report – this action is to be added to October's agenda.

Item 6 therapies weekend working – this action links to item 1 and is to be added to October's agenda.

Item 7 Quality Committee effectiveness review – this action is to be confirmed.

6. Quality

6.1 Quality Dashboard and SOF

The new dashboard is still under development and should be available for October's meeting. However, the Committee commented favourably on the presentation and accompanying narrative.

The dashboard was presented, and the following areas were highlighted and discussed:

- Radiological alerts – The Medical Director (MD) continues to work with Alex Garbett, Associate Director of Data and Analytics on the data extraction to enable responses to alerts to be taken from the EPR. For assurance, the current weekly manual checks will continue over the period of transition to the new system.
- VTE risk assessment – the decline in this metric has been discussed at QSEC and the Operational Board. Dr John Morris has presented an overview on the tracking of thrombotic episodes, their prevention and actions being undertaken to follow patients after discharge. The current 'VTE risk assessment' metric is actually a composite of risk assessment on admission and the implementation, where appropriate, of prophylactic measures, and is derived from a review at 24 hours. It is proposed to refine the data in the new SOF by separating screening and prophylaxis.
- There have been no grade 3 pressure ulcers since February 2022.
- Nutrition: though still below the 90% target, a steady improvement trend in referral of high-risk patients to the dietician has occurred following intensive efforts by the ward managers.
- SP explained that the erratic achievement of the nationally mandated metric 'complaints responded to within 25 working days' provides a misleading impression of the reality. All complaints are acknowledged within the first few days, but thorough investigation may take longer than 25 days (the mandated national metric); in these circumstances the complainant is contacted, and a

completion date negotiated. NEDs commented that, based on experience from the quarterly complaint reviews, the system is thorough, fair, and efficient.

- No further discussion took place on the longstanding problem of ambulance related delays in admitting patients with heart attacks for primary angioplasty, but the 'call to balloon' time will continue to be monitored.

6.2 QSEC key assurance / risks report

- Data on two CQUIN targets for treatment of non-small cell lung cancer (Commissioner 2 CQUIN10 and a local CQUIN) are not yet available but will be received by QSEC in September.
- Referrals to the Mental health liaison team have been increasing with the total number referred in 2022 already exceeded in the first quarter of 2023. The clinical services division is to undertake a deep dive to determine if additional resources are required to sustain the service.
- Readmission within 30 days of PCI (and surgery) – the Committee noted the proposals for 30-day follow-up.
- Data quality (response to a question) – previously the Trust double-checked NICOR submissions, but this is no longer possible due to insufficient analyst time. However, the data are lifted automatically from the procedural report on EPR.

6.3 Quality Impact Assessments (CIPs) and Update Report

Mike Filek, Head of Improvement and Transformation joined the meeting to present the update on quality impact assessments.

As of June, 12 of 29 schemes have been fully approved.

MF described a recent focus on training, with feedback being sought on how to enhance collective understanding of roles and responsibilities.

A post-project evaluation of several schemes was presented to the Finance and Performance Group to provide assurance and lessons learnt and will be included in the next Quality Committee report.

The Quality Committee accepted good ongoing assurance on the QIA process.

Mike Filek left the meeting.

6.4 Dr Foster Dashboard

The HSMR and SMR continue to be within expected limits, with the rolling average less than 100 over the last 12 months. Drivers of mortality remain the same as in previous analyses – principally high-risk myocardial infarctions (coded as 'diagnostic imaging of the heart') and deaths in first 24 hours of admission.

RP explained that the diagnostic group 'rest of arteries and veins' with a relative risk of 360, applies to the small number of, mainly emergency, vascular surgery procedures undertaken in the Trust.

The Committee noted the marked reduction in risk-adjusted mortality during the last 12 months which has coincided with establishment of the Mortality Improvement Group.

MF

6.5 Mortality Improvement Group Minutes – 8th March 2023

The MIG minutes were noted.

In response to discussion on deaths while on the waiting list, RP explained that the majority occur, as would be expected, in the sickest patients - i.e., those in the P2 and P3 categories - but the individual causes of death was currently difficult and, in many cases impossible, to ascertain as they most often occurred outside a hospital setting. Further analysis, with separation of patients waiting for a clinic appointment and those waiting for a procedure is to be undertaken and reported in October.

Further discussions to be had at October's meeting.

6.6 Surgical Site Infections – progress update

RP presented the update on surgical site infections since the introduction of comprehensive surveillance, performed by IP nurses, which resulted in recognition that the incidence was substantially (approximately 2-fold) higher than had previously been reported in the previous GIRFT submission. The incidence is averaging about 8%, without discernible improvement during the last 18 months, though deep – difficult to treat and potentially dangerous - infections are infrequent.

The SSI group is focussed on cardiac surgery but in due course will include devices (pacemakers and implantable defibrillators). Thoracic surgery is not tracked though the infection rate associated with thoracotomy is generally low.

Continuous monitoring of the major components of care for the prevention of SSI: pre-operative screening for MRSA (90%) skin decolonisation (92%), antibiotic prophylaxis prior to surgery (99%), skin preparation (100%), hair removal (61%) and dressing undisturbed for 48 hours (95%) is in progress together with action plans for improvement and a standardised approach to prevention and treatment of SSIs.

A multidisciplinary review has identified issues in the operating theatres, including etiquette, the number of people present during operations, and the wearing of theatre clothes and footwear outside the theatre environment. These are being addressed. The theatre ventilation system is being updated.

A team, including their director of infection prevention, from Papworth Hospital has been invited to visit in September 2023.

The Committee noted the report.

7. Clinical Effectiveness

7.1 Annual Mortality Review and Improvement plan (April 2022 – March 2023)

The Committee discussed the main conclusions of the report:

- The monthly SMR and HSMR (risk-adjusted) mortality rates for the trust have been consistently within expected limits and the rolling averages of both indices have been less than 100 for the entire 12-month period.
- The overall raw (i.e., non-risk-adjusted) mortality rate for the year was marginally below the 1.5% target at 1.34%, compared with 1.69% in 2002. Medicine was 1.22% and surgery 1.64%.
- No significant day to day variation – in particular, no increased mortality over weekends.
- All cardiac surgeons' (mortality) and interventional cardiologists' (mortality and complications) CUSUM curves are within the expected range.
- Further improvements in data quality
- Further enhancements in the learning from deaths from MRG focus on organisational learning, and introduction of the medical examiner.

The report highlighted the trust-wide policies to improve patient safety and reduce mortality. On-going work includes further analysis of 30-day mortality, monitoring of deaths on the waiting list, improvements in data quality and review of divisional mortality improvement plans.

Members of the Committee noted the report and commended the outstanding results and work of the MRG.

7.2 Annual Report Medications Safety

Danny Forrest, Chief Pharmacist joined the meeting to present the annual medications safety report (April 2023 to March 2024).

The Medicines Safety Committee receives weekly reports from the Medication Incident MDT and reports annually to QSEC and the Drug and Therapeutics Committee. The report focussed on reporting and learning from incidents, the introduction of processes to minimise the risk of errors, and staff training. A highlight of the year's activities was the introduction of the closed-loop administration system, which narrowly missed out on first prize at the HSJ awards.

Incident numbers were between 14 and 32 per month, with an annual total of 253, marginally down on the previous year. Notably, the majority were classified as 'no harm' (208) or 'near miss' (41), with three 'low harm', one 'moderate harm' and none with 'significant harm'. The report provided details of all incidents in the harm category, all of which had been discussed at the Medicines Safety Committee, the divisional meetings and QSEC. Errors were categorised as prescribing (73), administration (64), dispensing (30), controlled drug stock discrepancies (30) TTOs (28) and other (23), and within each category a subdivision into common themes was cascaded via sharing and learning, safety huddles, corporate communications and safe medicines bulletins, and further incorporated in training, EPR enhancements and working practices.

Administration errors during 2021-22 accounted for 32% of the total as compared with 25% in 2022-2023, an improvement that coincided with the introduction of the closed loop system. Prescribing errors, however, have remained static at 29% compared with 26% in 2021-22.

The Committee noted the main on-going areas of concern: failures of an independent second check for high-risk drugs and delayed or omitted medications. Members also commented on the poor attendance at the Safe Medication Practice Committee and were informed of efforts to improve attendance by focussing on potential clashes with other committees and seeking additional or alternative clinical members.

The Committee noted the report with its high-level of assurance and commended DF on his leadership and commitment to the on-going work on medicines safety.

Danny Forrest left the meeting.

7.3 Resuscitation Annual Report

Kirsty Dudley, Critical Care Manager joined the meeting to present the resuscitation annual report, which focussed on training, DNAR orders and ceilings of care and the National Cardiac Arrest Audit.

Training

Since the post of resuscitation training officer was not renewed, training has been organised on a team approach led by the critical care education team, with ALS-trained staff members in each area being encouraged to attend a General Instructor Course to obtain certification to train across the organisation. The lack of a dedicated training room remains an issue but has been addressed by bespoke training, where necessary, by the resuscitation lead within wards and departments and during audit days.

The target for BLS and ILS (Basic and Intermediate Life Support) training is 95%. Between April 2022 and April 2023 BLS has been varying between 72 and 87%; for ILS, which is now the minimum requirement for registered nurses, there has been progressive improvement from 66% to 86%. ALS certification has varied between 88 and 95%. Sufficient training slots exist for the targets to be achieved but the trajectory may be compromised because of non-attendance caused by sickness and short staffing.

Resuscitation and ceiling of care orders

A national mandate exists for documentation of decisions on resuscitation status and ceilings of care. An audit by the palliative care team confirmed full compliance with this documentation in the EPR. Two patients during the year with DNAR orders in place received inappropriate CPR. Both cases were subjected to internal investigation following which greater emphasis on this aspect has been included in training sessions.

National Cardiac Arrest Audit

Every cardiac arrest call is validated by the resuscitation and clinical audit leads for entry into the national database. In the most recent audit (April 2022 to December 2023) the proportion of cardiac arrests patients surviving to hospital discharge was above average for acute hospitals and, more significantly, than in similar cardiothoracic hospitals.

KD reported that the MET call system is now firmly embedded in the Trust and that automated defibrillator devices have been purchased for six non-clinical sites.

The Quality Committee noted the report which provides good assurance on the resuscitation service.

Kirsty Dudley left the meeting.

8. Compliance and Regulation

8.1 Serious Incidents Update

Six serious incidents were reported to STEIS in 2022/23 and all have been investigated to a conclusion, with identification of learning opportunities which have been disseminated and, where feasible, identified as being appropriate for audit. One SI, reported in Q1, is under investigation. RP assured the Committee that, whilst full investigation may take several weeks, all SIs are immediately assessed for anything requiring urgent preventive action.

The Quality Committee noted the report.

8.2 Quality Risks / BAF 1 Review

Karan Wheatcroft, Director of Risk and Improvement joined the meeting to present the quality risks and the BAF 1 review.

It was agreed that the direct risks to safety and quality, currently graded as being consistent with the risk appetite, align with the work of the Committee.

KW explained that the roll-out of InPhase will improve triangulation of the risk registers with the BAF by tagging all risks graded >12 in the registers to the relevant section of the BAF.

KW further reminded the Committee that all risks in the BAF rated greater than 12 are discussed quarterly by the Risk Management Committee at which actions and mitigations are challenged; the risks are also reported monthly through Operational Board providing the Divisions with the opportunity to highlight, inform and update on risks.

8.3 Patient Safety Incident Response Framework

KW presented a paper on the Trust's progress in the six phases of the transition from the existing Serious Incident Framework to the PSIRF, and reiterated the main intention of the framework to focus on learning from all incidents through direct reporting to NHSE and clustering of common themes. Catastrophic incidents will automatically trigger an external investigation irrespective of any internal actions.

The implementation is being led by the Risk Management Lead Nurse, supported by the Director and Deputy Director of Nursing, the Director of Risk and Improvement, the Trust Patients Safety Lead, the Divisional Directors of Nursing, the Quality Improvement Lead, the head of Risk Management and the Risk Team.

Work on phase 2 (diagnostic and discovery) has been completed since the April meeting of the Quality Committee, and significant progress has

been made on phases 3 (governance and quality monitoring) and 4 (the Patient Safety Incident Response Plan). This has included the agreement on local definitions of incidents requiring a PSII report. Phase 5 (curation and agreement of policy and plan) is in the early stage of development.

Transition from the NRLS/STEIS reporting system to the new Learning from Patient Safety Incidents (LFPSE) process is on course to be implemented with the new InPhase system within the required timescale.

The Quality Committee were assured that the development of the process is on course for implementation by the deadline.

Karan Wheatcroft left the meeting.

9. Governance

9.1 Quality Safety Experience Committee Terms of Reference – For Approval

The Quality Committee approved the Terms of Reference.

10. Date and Time of Next Meeting

Tuesday 3rd October 2023, 11am-1pm, MS Teams