

# minutes

## Quality Committee

### Minutes of the Quality Committee Meeting held on Tuesday 3<sup>rd</sup> October 2023

**Present:**

Nicholas Brooks (Chair)  
Sue Pemberton  
Julian Farmer  
Margaret Carney  
Justin Ratnasingham

Non-Executive Director  
Director of Nursing, Quality & Safety  
Non-Executive Director  
Non-Executive Director  
Associate Medical Director, Clinical Services

**In Attendance:**

Megan Underwood  
Karan Wheatcroft  
Sue Sutton  
Ria Carter

Senior Executive Assistant  
Director of Risk & Improvement  
Out of Hospital Therapy Lead (item 6.6 only)  
(item 7.1 and 7.2 only)

**Apologies:**

Raph Perry

Medical Director

**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: 11<sup>th</sup> July 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.

There is to be a follow up to the story once the patient has had their procedure.

SP

**5. Action Log: 11<sup>th</sup> July 2023**

**Item 1 stroke annual assurance report** – this is to be added to January 2024 agenda.

**Item 2 mortality improvement group minutes 11<sup>th</sup> January 2023** – discussed as part of the main agenda; this item was closed and removed.

**Item 3 therapies weekend working** –discussed as part of the main agenda; this item was closed and removed.

**Item 4 quality committee effectiveness review and annual report** – effectiveness report to be developed and submitted to January 2024's Audit Committee. Item was closed and removed.

**Item 5 quality impact assessments and CIP update** – post-project evaluation from FPG to be circulated to the committee; this item was closed and removed.

## **6. Quality**

### **6.1 Quality Dashboard and SOF**

The Committee noted the following highlights: sepsis management has fallen below target only once in the last 12 months; no serious incidents, and no never events or pressure ulcers >grade 2 due to lapses in care in previous 3 months. Excellent performance in dementia, delirium and FFT metrics. Referral to dietician of high-risk patients on special cause improvement trend though still below 90% target. Falls are infrequent and continue to be within expected variation but additional measures, including increased use of Rambleguard equipment and bathroom watch continue. The discharge summary metric is showing special cause improvement, and the 95% target was achieved in July. Failures reflect mainly absence of documentation, and staff education remains the focus for matrons and ward managers.

The response to complaints within 25 days has significantly underperformed in recent months; as noted previously when investigation takes longer the timescale is invariably negotiated with the complainant and all incomplete complaints are monitored regularly. Legitimate reasons for delay include the need for additional information, complexity, and involvement of another division or organisation.

Action: DONQS and NB to discuss with the data and analytics team if a more useful metric can be devised, as part of a further meeting to refine and finalise the quality and safety SOF dashboard.

The VTE risk assessment, was consistently below target for eight months but exceeded 95% in July and August. The Committee was informed of continuing educational efforts to ensure completion of the assessments and prescription of prophylactic measures when appropriate.

Radiology alerts with a response document continues to perform below target. Work continues on the digital solution (tracking with automatic reminders etc) but in the meantime the medical and divisional directors continue to review a patient-level rolling report to ensure that responses occur within 28 days.

**SP/NB**

There was nothing further to report on the consistent failure to achieve the target times for primary angioplasty.

The Chair raised the reoccurrence of CDIFF in the last 12 months, noting that though only six cases, there is no room for complacency.

The incidence of surgical site infections has remained constant since the start of detailed collection, at around 10%. JR explained that the majority are superficial and affect the vein donor sites. Improvement can be anticipated with the more widespread uptake of endovascular vein harvesting; to date two surgical assistants have been trained in the technique. Multiple patient-related factors are known to be associated with the risk of sternal wound infection; these include diabetes, higher BMI and urgent procedures.

The Associate Medical Director for Surgery will present a report on surgical site infections to the next Quality Committee in January 2024.

The Chair and DONQS are due to meet with the data and analytics team prior to January's meeting to discuss – and hopefully to finalise – the SOF quality and safety indicators.

## **6.2 QSEC key assurance / risks report**

The pressure ulcer CQUIN has been achieved only partially year to date due to incomplete documentation resulting from failure of the EPR system to issue prompts. This has been addressed and improvement is anticipated.

NATSIPs/LOCSIPs: the DONQS explained that documentation of chest drain procedures has been inconsistent. This is being addressed by communication with the doctors; the insertion document is being reviewed and an additional removal form is to be added.

Additional focus is required on the embedding of NATSIPs and LOCSIPs in radiology. The Divisional Medical Director for Clinical Services has met with the radiology team, and this will be followed up by a further report to the Divisional Board in November, to QSEC in December, and fed back to the Quality Committee in January.

An overview of waiting list management was reported to QSEC for review by the Integrated Performance Committee and for assurance to the Executive team. Whilst the focus of the work has been on administration, members of the Quality Committee discussed the desirability of deriving metrics for the SOF indicators to provide assurance on adverse outcomes – deaths and emergency admissions – among waiting list patients. This will be explored with the data and analytics team in November.

## **6.3 Quality Impact Assessments (CIPs) and Update Report**

The post-project evaluation (item 6.3 July minutes and action log) scheduled for presentation to the Committee was not included with the reports and will be forwarded to the NED members after the meeting. (Post meeting note: the report has been sent out and no comments have been forthcoming).

SP/MK

MU

MF

The Committee noted the good progress since the previous update: of the 32 schemes that require a QIA, 25 (78%) are fully approved (previous update: 12 out of 29 (41%)) by the Executive Medical Director and Executive Nursing Director or deputy. No impact, either positive or negative, has been identified.

In response to a question concerning the time from inception to rollout of a CIP, it was explained the CIPs do not have to wait for FPG approval prior to implementation, although the group can raise queries. Schemes can be actioned once the Medical Director, Deputy Director of Nursing or DONQS have signed off on the quality impact. Accordingly, delays are unusual, and progression to stage 3 is normally rapid.

The appendix provided a list of all schemes over £25k and their stage in the approval process. Other schemes are below £25k in value.

#### **6.4 Dr Foster Dashboard**

The Committee noted the progressive fall in risk adjusted mortality (SMR and HSMR), which has been consistently below 100 for the last 18 months. The key drivers of mortality have remained consistent, as previously discussed by the Committee: diagnostic imaging of the heart and heart failure, which are largely accounted for by very high-risk patients with acute myocardial infarction, many with out of hospital cardiac arrest, for whom the imaging discloses no prospect for successful coronary intervention.

The 'rest of respiratory (diagnostic/minor)' was not understood by the Committee, but JR explained that the RR of 196 reflected only 10 patients and would accordingly be associated with large confidence limits. MC and JF requested further clarification of the columns in the 'drivers of mortality' slide for the next meeting of the Committee.

RP

#### **6.5 Ockenden Action Plan Progress Report**

The DONQS reported progress on the updated action plan developed from the Ockenden review and recommendations. None of the recommendations reflected major departures from the existing quality and safety governance in the Trust, but all actions have been completed with the exceptions of board assurance on safe staffing for disciplines other than nursing, simulation training and consultant ward rounds. Good progress is being made in these outstanding areas.

The Committee noted the report, and there were no additional comments or questions.

#### **6.6 Therapies Weekend Working**

Sue Sutton joined the meeting to present her report on the introduction of the weekend rehabilitation service.

The enhanced service commenced in December 2022 with funding for a single band 4/5 physiotherapist to work on Saturdays (on a rotational basis and paid as overtime). Between December and August 435 patients (the majority on Cedar and Oak wards) were treated, and 92 were discharged over the weekend rather than having to wait to be reviewed on the Monday. On three occasions the support worker, having recognised

early signs of deterioration, escalated patients for urgent chest physiotherapy or outreach review.

The Committee approved of the conclusion that the service is a valuable enhancement but, for comparison, asked how many patients had been discharged over the weekend during the six months prior to its introduction. SS undertook to obtain these data. It was also noted that the scheme falls short of the ideal 7-day rehabilitation service (as in the original business case) and did not include the treatment of stroke patients. SS explained that expansion to a 7-day service would require a new business case and, moreover, that staff shortages from sickness and maternity leave were currently challenging. Nevertheless, the Committee fully supported the ambition to establish a 7-day service in order to bring LHCH in line with its peers. In the meantime, the Saturday service will continue. A new in-hospital therapy lead is due to commence in October.

SS/SP

Sue Sutton left the meeting.

## **6.7 Mortality Improvement Group Minutes – 14<sup>th</sup> June 2023**

The Quality Committee noted the minutes.

## **7. Patient Safety**

### **7.1 Patient Safety Incident Response Framework: update and plan**

Karan Wheatcroft and Ria Carter (risk management lead nurse) joined the meeting to provide the Committee with an update on implementation of the PSIRF. Of the six previously identified and discussed phases, five are complete and the final transition phase is in the process of planning. There is an expectation that monitoring during the first six months after implementation may result in the need for revisions or adaptations to ensure that learnings from the existing system are not lost.

The Committee noted the assurance provided by the progress report.

RC led the Committee through the detailed Trust policy which is based on the National guidance but tailored to the existing framework of the Trust and an analysis of previous incidents.

### **7.2 Patient Safety Incident Response Framework: policy**

The draft PSIRF policy sets out its purpose and scope; oversight, roles and responsibilities; the existing strong LHCH safety culture; the introduction of patient safety partners; the approach to health inequalities; the processes to be followed after an incident including reporting, engagement with patients, families and staff members; cross system incidents; processes following deaths; complaints and appeals.

The draft policy has been reviewed by the ICB.

The Quality Committee commended RC on her work and approved the framework which will now be resubmitted to the ICB for final sign-off.

Ria Carter left the meeting.

## **8. Compliance and Regulation**

### **8.1 Serious Incidents Update**

An incident from Q1 associated with the death of a patient had been reported to StEIS but was subsequently downgraded by the incident review team. The chair questioned this decision on the basis of the narrative summarised in the report, which appeared to document a series of failings. JR was not familiar with the case. The DNOQS agreed to obtain more detail and forward the information to the chair.

SP

The Quality Committee noted the report.

## **8.2 Quality Risks / BAF 1 Review**

Risk registers were migrated to Inphase in July 2023.

An update is in progress for consideration at the next meeting of the Board of Directors, but no changes have been made to BAF1, with a residual risk of 6 against the target of 6, corresponding to the Board risk appetite of minimalist and providing acceptable assurance.

The Committee noted 14 risks in other parts of the register with residual scores of 12 which relate to quality and safety, in particular concerning recovery, delivery and waiting lists with the ongoing industrial action, theatre staffing constraints and operational challenges. All high-risks are reviewed regularly by the risk management committee with each division to test mitigations and action plans.

The Quality Committee noted the report and assurance from BAF 1.

Karan Wheatcroft left the meeting.

## **9. Date and Time of Next Meeting**

Tuesday 9<sup>th</sup> January 2024, 11am-1pm, MS Teams