

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 9th January 2024

Present:

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

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

In Attendance:

Megan Underwood
Jo Shaw

Archie Samuels
Mike Filek
Manoj Kuduvali
Karan Wheatcroft
Sue Oakes

Senior Executive Assistant (Minutes)
Divisional Director of Nursing, Clinical Services (items 6.1, 6.4 & 8.2)
Research Audit & Effectiveness Officer
Head of Improvement (item 6.2)
Divisional Medical Director, Surgery (item 6.3)
Director of Risk & Improvement (items 7.1, 7.2 & 9.2)
End of Life Specialist Nurse (item 8.1)

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: 3rd October 2023

The minutes of the previous meeting were accepted and recorded as a true and accurate record.

4. Patient Story

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

5. Action Log: 3rd October 2023

Item 1 stroke annual assurance report – discussed under item 6 on the main agenda and removed from the action log.

Item 2 patient story – no additional information is currently available; to remain on action log pending a further report.

Item 3 quality dashboard and SOF – a further meeting (NB, SP, JM and PJ) has been held and work on the SOF remains in progress. To remain on the action log.

Item 4 quality dashboard and SOF/surgical site infections – discussed under item 6.3 of the main agenda and removed from the action log.

Item 5 QSEC key assurances/risk report/ NatSIPs/LocSIPs in radiology – report received and discussed under item 6.4 of the main agenda. Removed from the action log.

Item 6 Dr Foster dashboard/interpretation of data – explained under item 6.8 of the main agenda. Removed from the action log.

Item 7 therapies weekend working – to await the outcome of the business case. Removed from the action log.

Item 8 serious incidents update – RP explained the reasons for the decision, which was agreed with the ICB, to downgrade the incident from an SI. Removed from the log.

6. Quality

6.1 Stroke Annual report and Sentinel Stroke National Audit Programme (SSNAP)

Jo Shaw, Divisional Director of Nursing for Clinical Services joined the meeting to present the annual report of the stroke service and participation in the SSNA.

In 2022/23 the team cared for a total of 176 patients, including 50 requiring complex rehabilitation, compared with 154 in the preceding year.

Key service developments during the year included:

- A review of the SLA with LUHFT to enhance out of hours provision and strengthen collaborative working with LUHFT medical staff.
- Updating of the stroke protocol
- Introduction of mandatory e-learning for all clinical staff, with 85% compliance
- Potential stroke added as an indication for a MET call.
- Access to EPR on- and off-site for visiting staff.
- Appointment of a new stroke lead (Dr Amy Hill)
- Hannah Rooney to return to the team for two days per week to focus on training, education, audit and research.

The team has achieved the long-term ambition to participate in the SSNAP, starting in the next financial year. It is, however, recognised that

compared with dedicated stroke units in general hospitals for which the audit provides benchmarks, the LHCH service is currently unable to meet several of the NICE criteria. These include a dedicated unit with gymnasium and kitchen, and an on-site multidisciplinary team. Patients at LHCH are reviewed by the Stroke team with an individual plan of medical/therapy care outlined specifically for each patient. Once the patient is medically able to be transferred for rehabilitation this is progressed.

Report to come back in one years' time.

MU

6.2 GIRFT Programme Update

Mike Filek, Head of Improvement, joined the meeting to present the GIRFT programme Update.

Compliance continues to increase. Three main areas of focus for the next quarter are stroke, peri-operative care and lung cancer. Further updates will be provided in accordance with the Committee workplan.

The DONQS and the Committee thanked Mike Filek for his commitment in promoting GIRFT and commended the enthusiastic adoption of the recommendations by members of the Trust.

6.3 Surgical Site Infections

Manoj Kuduvalli, Divisional Medical Director for Surgery (DMD), joined the meeting to report on progress relating to surgical site infections after cardiac operations. In previous reports a wound infection rate of between 8 and 10% had been noted, with an upward trend attributable to the more complete case ascertainment introduced in mid-2023, and extension of surveillance to 30 days postoperatively,

Preliminary analysis of data collected by the SSI team led by Nicky Best, Infection Prevention Specialist Nurse, has been undertaken to assess possible variations in the incidence of infection among individual surgeons. The data were derived from the EPR. and the analysis subject to the following limitations:

- The outcomes – predominantly wound infections - are not risk adjusted, and it is known that several conditions including obesity, frailty and diabetes, as well as pre-, per and postoperative factors outside the control of the operating surgeon, affect the risk of infection.
- Denominators are small for some surgeons resulting in wide confidence intervals for individuals with lower numbers of cases.
- Wound clinic attendance provides information on the size of the problem but does not consistently disclose the infection site or its depth.

Whilst the raw data suggested the existence of significant variations in SSI incidence between different surgeons, a first attempt at adjustment, based on known risk factors, largely eliminated the differences. MK informed the Committee that a further analysis of data collected from July 2022 to June 2023 aims to generate a full risk-adjusted model from which to construct control charts to enable the rates of sternal wound infection associated with individual surgeons to be determined.

The SSI steering group has developed an extensive action plan and audit programme to address all possible sources of SSI and to explore the potential for further benchmarking with comparable cardiac surgery centres and, eventually, to extend the work to include thoracic surgical patients.

The Committee congratulated MK on this innovative project which has the potential to make significant cost savings and improve patient safety and experience. It was agreed that a follow-up report would be prepared in about 12 months, for presentation to QSEC and the quality committee in Q2 2025.

MK to bring a follow-up report in July 2025.

6.4 Radiology NATSIPs/LOCSIPs

Jo Shaw, Divisional Director of Nursing for Clinical Services, joined the meeting to discuss a report from radiology on progress in the implementation of NATSIPs and LOCSIPs.

NatSIPs/LocSIPs relating to CT-guided lung biopsies have been operating in the department for a year. In an audit of 80 procedures carried out in Q2 (2023) ward information was missing in 36% and radiology information in 42%; specifically, allergy information was omitted from 43% of proformas. In response to the findings the proforma has been modified, with the introduction of mandatory fields, together with an action plan to ensure compliance with the NATSIPP/LocSIPPS requirements. The Committee noted the report and the actions taken to ensure future compliance.

MU/MK

Completion of the action plan and monitoring of procedures in Quarter 3 to be reported back to QSEC.

6.5 Quality Dashboard – SOF

The areas of significant concern are the continuing failure of responses to radiology alerts (for which the mitigating actions previously discussed at the Board and Quality Committee remain in place) and the call to balloon time for primary angioplasty. SP outlined the actions of the data team to resolve the challenges associated with alert reporting, and RP informed the Committee that although the delays in the admission of patients for primary angioplasty are unacceptable, the overall performance of the Trust, in part attributable to consistent achievement of the target for admission to balloon time, is in the top quartile nationally.

There were no further questions or comments.

6.6 Quality Strategy Annual Update

The Committee received assurance against delivery of the priorities of the Quality Strategy. An update will be provided for July 2024.

Work on the new strategy, led by Dr James Greenwood, is in progress and the draft document will be discussed at consultation forums with a view to finalisation by December 2024.

The Committee noted the outstanding performance reported in the annual update.

JM

6.7 QSEC Key Assurances / Risks Report

Assurances were noted and discussed in the following areas:

The Fuller inquiry - the Trust is awaiting assurance from LUHFT on completion of the 17 required actions relating to the mortuary. A report is anticipated in February 2024. Once received, this will go through the normal governance processes.

Electronic consent – there have been obstacles to implementation, but rollout continues. Further audit is planned.

Work on implementation of NatSIPs is progressing.

An action plan to address the few issues identified from the otherwise outstanding results of the 2022 adult in-patient survey is in progress.

Communication – still the predominant cause of complaints. Whilst the introduction of voice recognition software (EPRO) has speeded up the transfer of information to GPs, RP explained that the anticipated saving in secretarial time has been limited by the continuing necessity for editing.

JR/JS

The Quality Committee noted the QSEC report.

6.8 Dr Foster Dashboard

The Medical Director (MD) took the committee through table on the main drivers of mortality and explained the funnel plot to the new members.

6.9 Mortality Improvement Group Minutes – 13th September 2023

The Quality Committee noted the minutes.

7. Patient Safety

7.1 Incidents, Complaints and Claims (IICC) Report

Karan Wheatcroft, Director of Risk and Improvement joined the meeting to present the report on IICC for Qs 1 and 2 2023/24 as compared with the preceding two quarters. It was explained that Q1 – Q2 spanned the transition from reporting on Datix to InPhase and that with the introduction of PSIRF in October, future reports will present enhanced data on learnings and improvement.

Incident reporting has remained consistent over the transition to InPhase. The top five categories of the 1037 incident reports: administration processes (including clinical record keeping); medications; communication; and slips, trips and falls, together with documentation of the extensive learning and actions were noted.

Three serious incidents, one of which remains under investigation, have been discussed previously and at the Board.

Concern was expressed over the increase in complaints compared with 2022/23, (total for the whole of 2022/23 26 vs. 24 in the first two quarters of 2023/24). KW pointed out that that the total number remains relatively

low. It was also acknowledged that the majority are not upheld or only partially upheld, and that all have been discussed with the relevant divisions and reviewed by the quarterly NED complaint panel with no concerns over their management having been raised. All responses have been in line with the duty of candour. SP stressed the importance of the rapid response to informal concerns by the patient and family support team, of which there were 197, in minimising the number of formal complaints. The situation will continue to be monitored and reported to the Committee in compliance with the workplan.

The 10-year CNST data on claims were noted without comment except that KW confirmed that they include the costs of actions that have been defended successfully.

The Quality Committee accepted assurance that mitigation to prevent harm to patients and staff, by the reporting of and learning from incidents, complaints, claims and patient experience events continue to be monitored through the governance structures within the organisation.

7.2 PSIRF Implementation Update

The Quality Committee received the paper on progress with implementation of the PSIRF together with an informative presentation on its impact on organisational learning as compared with the previous incident response framework.

8. Clinical Effectiveness

8.1 End of Life Annual Report

Sue Oakes, Palliative Care Specialist Nurse joined the meeting to present the End-of-Life Annual Report.

The Committee commended the outstanding service delivered by the team, and the commitment to EOL training across the Trust in all aspects of care of the dying patient, with participation rates of between 88 and 94%.

The referral pattern has been evolving, with a decrease in in-patient and increase in out-patient referrals and increasing numbers of phone calls from the community. As noted previously, the service is unusual as compared with acute general hospitals in the relatively high proportion of non-cancer diagnoses and deaths that were not anticipated, many of which occur in critical care. This is reflected in the NACEL audit, which included only 19 eligible patients over the three-month period of data collection, of which only 16 could be analysed. The audit, with above average scores in three domains and two comparable to the national average, provided limited assurance; of some concern were the results of the staff survey which, despite the high uptake of training, reflected a widespread lack of confidence in delivering care at the EOL.

The possibility of extending the NACEL data collection in order to obtain a more accurate assessment of the key issues was raised, and SO informed the committee that this was being explored in discussions with JM.

Internal monitoring of the end-of-life dashboard also disclosed areas of poor documentation, particularly relating to symptom control, though

closer examination of the records indicated that in most instances appropriate care had been provided.

Discussion centred on recognition that the EOL service, with its small specialist palliative care team and limited medical support, and without assistance with administration or audit is highly vulnerable to absences from maternity leave, sickness, and retirement. The team is collaborating with the Northwest Strategic Clinical Network and C&M palliative and End of Life Care Programme on the CNS role, with the aspiration of extending the on-site service to 7-days per week.

The Quality Committee accepted assurance on the EOL service but noted the risks imposed by the small number of specialist nurses and medical and administrative support in the face of the changing workload and expectations. The constraints are to be escalated to the Divisional Director of Nursing for Clinical Services.

Sue Oakes left the meeting.

JM to bring an update back to the next meeting.

8.2 CQC IRMER Report

Jo Shaw, Divisional Director of Nursing for Clinical Services (DdoN) joined the meeting to present the 2022/23 report on IRMER related incidents in compliance with the CQC requirements.

The Trust recorded a total of 171 incidents on Datix relating to diagnostic imaging: three were of inadequate checks prior to imaging resulting in unintended exposure, and ten of incorrect patient, incorrect protocol, incorrect demographics or images not being transferred to PACS. None met the requirements for a report to the CQC, though members of the Committee commented that any incident involving imaging of the wrong patient or requiring additional exposure should be regarded as serious. All have been investigated internally, and a series of actions and mitigations have been identified, including the adoption of a new management system, which will enable Quality Standard for Imaging (QSI) accreditation and provide evidence for future CQC inspections.

Utilisation of mobile scanners has increased significantly with implementation of the Targeted Healthy Lung Project. The Trust supports the external providers with the standard protocols, SOPs, incident reporting and investigation, and audit.

The Quality Committee accepted assurance from the proposed measures to reduce the risk of incidents.

Jo Shaw left the meeting.

9. Compliance and Regulation

9.1 Serious Incidents

The Quality Committee noted the report (which had previously been discussed at the BOD).

9.2 Quality Risks / BAF 1 Review

MU

KW highlighted the following points with regard to BAF 1.

- The BAF is being updated for discussion at the next meeting of the BOD.
- The report format has been adapted with the introduction of InPhase.
- Reprioritisation of the capital programme is taking place following the increased allocation from the ICB, which will enable additional capital spending in-year. The business case for new anaesthetic machines has been signed off; lifts and fire doors are longer term programmes,

JM

The Committee agreed that BAF1, with its residual risk of six in compliance with the minimalist risk appetite, remains consistent with the evidence submitted.

Departure of Medical Director and Director of Nursing and Quality

The Chair thanked Raph Perry and Sue Pemberton on behalf of the Committee for their outstanding contributions to quality and safety in the Trust over so many years. Best wishes were recorded to Raph for his retirement, and to Sue for her new appointment at the Countess of Chester Hospital.

10. Date and Time of Next Meeting

Tuesday 9th April 2024, 11am-1pm, MS Teams