

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 16th April 2024

Present:

Nicholas Brooks (Chair)
Margaret Carney
Joan Mathews
Manoj Kuduvali

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

In Attendance:

Megan Underwood
Mike Filek
Karan Wheatcroft
Jenny Crooks
Archie Samuel

Senior Executive Assistant (Minutes)
Head of Improvement & Transformation
Director of Risk & Improvement
Deputy Director of Research & Innovation
Clinical Audit & Effectiveness Manager

Apologies:

Julian Farmer

Non-Executive Director

1. Apologies for Absence

The apologies were noted above.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 9th January 2024

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

The Chair raised a point with regard to Radiology LOCSIPs and assurance – it was confirmed that this would come through QSEC and was on the business cycle. CQC IRMER report to come through QSEC and to the Quality Committee on an annual basis.

4. Patient Story

The Acting Director of Nursing and Quality (ADONQ) read the patient story.

5. Action Log: 9th January 2024

Item 1 patient story – this action was in relation to following up on the story once the patient had had their procedure. The item was completed and removed from the action log.

Item 2 quality dashboard and SOF – this action was in relation to the metric on complaints being resolved within 28 days. It was agreed that it would be added back onto the SOF. Archie Samuels and Jennifer Crooks to review with Laura Allwood.

Item 3 stroke annual report – this was on the workplan and will come back in a years' time. The item was completed and removed from the action log.

Item 4 surgical site infections – it was agreed between the Chair and the Medical Director (MD) that a report would come back in July 2025.

Item 5 quality strategy annual update – this action was in relation to the committee receiving assurance against the delivery of the priorities of the quality strategy. The action is to be discussed as part of the main agenda; therefore, the item was closed and removed from the action log.

Item 6 QSEC key assurances/risks report – this action was in relation to e-consent and the obstacles around implementation. Rollout of e-consent is as complete as possible within surgery, though there were a couple of residual concerns, relating to the availability of hardware in some areas. Medicine e-consent was progressing and already launched in some service lines. Consent forms have been withdrawn from outpatients for surgery and withdrawal from the wards is the next step. It was noted that work on e-consent was to be completed with an update to come back to the next meeting.

MK

6. Quality

6.1 Quality Dashboard

Changes have been made to the EPR checklist so that the discharge checklist which was at the end of the discharge checklist documentation has now been moved to the beginning to avoid any confusion for staff whilst completing the document. Facilities boards are now in place, with the senior nurses working with the digital team to ensure their visibility for ward managers in real time. This allows ward managers to check completion of flow sheets that may have been not completed timely on a laptop or monitor.

When the nutritional score exceeds two an automatic referral is sent to the dietetics team. Recently there have been slight delays due to sickness within the team. Work with EPR continues to ensure where automatic referrals are required based on a MUST score of 2, these are checked by nursing staff before the referral is made to the dietetic department. . Assurance was received that patients at risk were being referred.

Radiology alerts – currently a technological fix ensures the correct data are available to the teams. A dashboard detailing the nature of the alert provides patient and consultant level data. The dashboard enables the divisional management teams to monitor compliance and highlight non-

compliance. Further update to come back to the next meeting once the MD has met with the data team.

MK

VTE – improvement is required on 24-hour reassessment. The NICE guidelines require VTE prophylaxis to be reviewed by a doctor within 24 hours of admission. The initial assessment, when patients are admitted, is usually completed by ANPs or junior doctors. ADONQ and MD to liaise with VTE Clinical Lead to review VTE policies and modify as appropriate.

6.2 QSEC Key Assurances/Risk Report

CQUIN – awaiting Quarter 4 compliance for CQUIN. Discussions ongoing on whether CQUINs will be taken into next financial year and whether it be paused. The Trust will continue with the agreed CQUINs until confirmation is received from QSEC.

The Fuller enquiry was discussed at the Board of Directors and assurance was received outside of QSEC that all 17 recommendations have been met.

Duty of Candour – two serious incidents reported between April and December 2023, with 100% compliance with standards. MIAA is auditing the duty of candour within the hospital and the Trust will receive the report shortly.

Waiting lists – an important risk and major source of complaints. Discussions have been held to put a process in place for patients on the waiting lists to be contacted on a regular basis.

SEND (Special Education Special Needs & Disabilities) – a report had been requested but is not applicable to the Trust. A LD (Learning Disability) engagement event for ACHD patients is to take place in June, with Non-Executive Directors being invited.

SSI update - MDT into SSIs and audits of practice to continue as part of the normal PSII process.

QSEC to review their terms of reference.

The Quality Committee noted the report.

6.3 Annual Quality Assurance Report

The report has been received at Audit Committee and there were no further comments.

6.4 Quality Impact Assessment (CIPs) and Update Report

Mike Filek, Head of Improvement and Transformation joined the meeting to present QIA and CIP update report.

The report indicates a high degree of compliance with the process, and 30 of 35 proposed schemes have received full approval. Assurance has been received from external auditors that is robust and teams complying as expected.

In response to a question, MK explained that it is rare for schemes to fail a QIA as few risky proposals are submitted. However, the ADONQ

highlighted a scheme relating to lower cost food provision that had been rejected after advisors noted that this would result in poorer quality.

The MD highlighted that the CIP process was fully embedded within the Divisions.

6.5 Dr Foster Dashboard

MK presented the Dr Foster Dashboard.

The Trust were in a good position with regard to HSMR and SMR.

6.6 Quality Committee – Terms of Reference

There were two points without bullet points – to be amended, otherwise the Quality Committee accepted the Terms of Reference.

MU

6.7 Quality Committee – Workplan 2024/25

Stroke Sentinel Audit is part of annual report, items to be joined together.

Surgical Site Infections to be an annual report.

The Quality Committee approved the workplan for 2024/25 subject to these minor changes.

MU

6.8 Mortality Improvement Group Minutes – 13th December 2023

The Quality Committee noted the minutes.

An observer from Telstra Health attended the last Mortality Improvement Group meeting. Feedback was received with regard to involvement and knowledge of those within the group.

7. Patient Safety

7.1 PSIRF implementation update

Karan Wheatcroft, Director of Risk and Improvement (DR&I) joined the meeting to present PSIRF implementation update.

Implementation reports have been presented regularly to the Quality Committee, and this was the final update due to PSIRF being fully embedded within the organisation.

PSII's will come through the Board of Directors and organisational learning has been scrutinised by the Audit Committee.

From a Quality Committee perspective PSIRF is now business as usual with any further updates to come through other committees.

8. Clinical Effectiveness

8.1 Clinical Audit and Effectiveness Strategy Annual Report

Jennifer Crooks, Deputy Director of Research (DDR) and Archie Samuels, Research Audit & Effectiveness Manager (RAEM) joined the meeting to present the annual report.

The strategy was due for review at the end of 2023 but has been delayed on account of several changes in the team and a review of the CAE

portfolio in collaboration with iDigital and the Deputy Chief Digital and Information Officer.

The DDR confirmed that the team had met some of the key requirements outlined in the strategy, but further work was to be completed in terms of effectiveness and ensuring the service evaluations are in one central location.

Since the strategy was first published a significant amount of work has been completed, specifically the registration process for new projects and the introduction of new technologies.

It is anticipated that the new strategy will be published over the coming months.

There have been a number of changes relating to data analytic support, the first being one of the job titles being changed from Clinical Audit Effectiveness Officers to Information Analysts. Efficiencies were being explored to release resources for other work. Dr Matt Shaw is now working alongside the audit team as the Lead for Data Analytics and Research. An appointment with an interest in IT systems, data analysis and artificial intelligence has been made; the calibre of the applicants was outstanding.

The Quality Committee noted the report.

8.2 GIRFT Annual Report

Mike Filek, Head of Improvement and Transformation joined the meeting to present the GIRFT annual report.

Nine GIRFT reports were identified that were relevant to the Trust. Four of the nine have been worked through to completion to the stage at which the Trust is satisfied with the level of implementation of the recommendations.

Detailed progress updates on each speciality are to come back to July's meeting.

Recommendations that apply to the Trust are progressing well at 81% compliance.

The current focus areas were highlighted as follows

Stroke

- Psychology – aim to improve the provision of neuropsychology to patients who suffer stroke.
- Stroke specific therapies – improved speech and language therapy – in particular swallow screen/assessment and stroke specific physiotherapy under review.
- CT perfusion – clinical lead and regional ISDN lead have identified funding to support increased access to CT perfusion.

Lung Cancer

- Progress on GIRFT recommendations was being monitored through the Trust Cancer Board.
- Future plans for developing pre-habilitation - there is a cross over with the GIRFT perioperative workstream.

Anaesthesia and Perioperative Medicine (APOM)

- Remaining improvement areas were tasks that cross between divisions and these include:
 - DOSA
 - Enhanced recovery and enhanced care
 - Pre-habilitation
 - Pre-operative/SDM
- Proposal to strengthen governance was approved in principle in Quarter 4.
- Progress meeting has been planned for Quarter 1 to agree priorities and workstream leads.

GIRFT has launched several new documents; they support implementation of the current recommendations and enable providers to benchmark of their data against the Model Hospital.

Mike Filek left the meeting.

8.3 End of Life team update

The end-of-life report that was presented at January's meeting raised several concerns.

After the meeting the ADONQ met with the end-of-life team to gain an understanding of the concerns and regular meetings have been undertaken with Sue Oakes.

Assurance was received with regard to no complaints being received from patients managed by the end-of-life team. Staff experience has been rectified with over 130 colleagues recruited for training. The number of patients on end-of-life care is small and the ADONQ has requested comparative data to CCU, ACU, ITU and ward. A glitch in the system had resulted in 9 ward level patients being listed incorrectly as receiving end-of-life care.

9. Compliance and Regulation

9.1 NHS Constitution: Compliance Report

Waiting list times and waiting list initiatives to be emphasised for the next board report.

9.2 R&I Governance: MHRA/good clinical practice regulation

Jennifer Crooks, Deputy Director of Research (DDR) and Archie Samuels, Research Audit & Effectiveness Manager (RAEM) joined the meeting to present their report on preparedness for an MHRA inspection.

The DDR noted that this report is included in the business cycle for the Operational Research and Innovation Committee to ensure SOPs and policies are reviewed and kept up to date.

A Good Clinical Practice (GCP) gap analysis has been undertaken, and areas for improvement have been identified i.e., policies and training. A streamlined SOP reference matrix is in place. It includes a competency framework and a training rota to provide assurance on the knowledge and experience of the team.

An electronic trial management system has been validated.

The department has improved systems for logging and tracking samples and with Pharmacy accountable for medicines reconciliation.

The single outstanding SOP, to ensure staff are fully informed of their specific responsibilities during an inspection, will be drawn up when the Trust is notified of an impending MHRA visit.

The report was noted, and the Committee discussed and clarified its role in relation to research governance.

Incidents involving research will be processed through the PSIRF.

An MHRA inspection will remain on the risk register. Escalations from the Operational Research and Innovation Committee go to the Strategic Research Committee, and reports and minutes are shared with the Operational Board.

In summary, it was agreed that research updates will continue to be reported through the Strategic Research Committee, Operational Research and Innovation Committee and Operational Board. Quality concerns should be brought to the Quality Committee. It was agreed that oversight of research practice regulation would be removed from the Quality Committee Terms of Reference.

MU

Jennifer Crooks and Archie Samuels left the meeting.

9.3 Quality Risks/BAF 1

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

A full update of the BAF and risk appetite for 2024/25 was being undertaken for presentation to Board of Directors at the end of April 2024.

The BAF risks were being reviewed, however, for Quality (BAF 1) the risk appetite remains minimal with little change being made or considered.

PSIRF implementation is to be removed as an action as this is business as usual and will be shifted to assurance.

The Quality and safety strategy refresh will take place during 2024/25.

Work on the new CQC assessment framework by the DR&I and ADONQ to continue.

The Quality Committee noted the report.

Karan Wheatcroft left the meeting.

9.4 Serious Incidents

The Quality Committee were sighted on the letters incident and will be updated as and when information is received.

10. Date and Time of Next Meeting

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