

## minutes

### Quality Committee

#### Minutes of the Quality Committee Meeting held on Tuesday 9<sup>th</sup> July 2024

**Present:**

Nick Brooks (Chair)  
Claudette Elliott  
Margaret Carney  
Joan Mathews  
Ben Vinter  
Justin Ratnasingham

Non-Executive Director  
Non-Executive Director  
Non-Executive Director  
Director of Nursing and Quality  
Director of Risk and Corporate Governance  
Associate Medical Director, Clinical Services

**In Attendance:**

Megan Underwood  
Mike Filek  
Kirsty Dudley  
Neil Coulson

Senior Executive Assistant  
Head of Improvement and Transformation  
Divisional Director of Nursing, Clinical Services  
Consultant Anaesthetist

**Apologies:**

Manoj Kuduvali

Medical Director

**1. Apologies for Absence**

The above apologies were noted.

The Chair welcomed Claudette Elliot, Non-Executive Director and Ben Vinter, Director of Risk and Corporate Governance to their first Quality Committee.

**2. Declarations of Interest**

Claudette Elliot declared a Non-Executive Directorship at another organisation.

**3. Minutes of e-meeting held on: 16<sup>th</sup> April 2024**

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

**4. Patient Story**

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

**5. Action Log: 9<sup>th</sup> July 2024**

**Item 1** discussions were being held with the data and analytics team with regard to the quality and safety SOF dashboard. This item is ongoing and is to remain on the action log.

**Item 2** was in relation to electronic consent and the obstacles to its implementation. To be discussed as part of the main agenda. Item closed and removed from the action log.

**Item 3** related to electronic consent with an update to come back to the Committee. To be discussed as part of the main agenda, and accordingly closed and removed from the action log.

**Item 4** related to an update on radiology alerts. To be discussed as part of the main agenda, closed and removed from the action log.

**Item 5** updates on the Terms of Reference; these have been completed and the action removed from the action log.

**Item 6** updates to the business cycle in relation to surgical site infections – agreement was reached for this to be reported through the annual reporting cycle; accordingly completed and removed from the action log.

**Item 7** this was in relation to research updates being reported through Strategic Research Committee with quality or safety concerns to be escalated to Quality Committee. Amendments have been made to the workplan, and the item was closed.

## **6. Quality**

### **6.1 Quality Dashboard**

Nutritional score – EPR calculates the score automatically which explains why the scores continue to fluctuate. Sophie Barwise, Senior Insight Analyst, requests validation of the scoring from the Matrons, following this the performance data is updated. The ward level nursing parameter performance dashboard has now been established with the senior nursing teams able to view and amend those referrals that require attention.

MRSA – there has been a single MRSA bacteraemia. Following a review, the tissue viability team remains unsure as to how it was acquired. Their investigation is continuing.

Targets are set by the commissioners and based on the previous year's performance data. A target of zero for the Trust will most likely continue.

### **6.2 QSEC Key Assurances/Risk Report**

CQUINs – a document has been received from NHSE stating that CQUINs are not mandated for 2024/25 and would be included in the contracting arrangements between the ICB and Trust. Following discussions at QSEC it was agreed that the CQUIN of difficult conversations will not be included as the Trust has received feedback from patients highlighting that they have been included in conversations.

All other quality and safety CQUINs will continue to be reported through QSEC.

There has been a decrease in formal complaints; from the same period last year the Trust had 12 formal complaints for all three divisions, and in Quarter 1 there have been only three. The open communication clinics appear to be working extremely well with any concerns being resolved at that time. In Quarter 2 there has, so far, been one formal complaint.

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

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

For the benefit of Claudette Elliot, the Head of Improvement and Transformation gave a brief overview of the Quality/Equality Impact Assessments.

The QI process is to be migrated to an Office 365 application. It has been tested, and no risks have been identified except for financial; no equality issues have been flagged and it has been signed off by the divisions, the Director of Nursing and the Medical Director.

At this point in the year, relatively few CIPs have been identified, but this is very much a changing situation and is monitored closely. By the time of the October meeting the value of identified CIPs is expected to be higher.

Within the portfolio, there are 64 schemes with 17 being at Level 3 with others scheduled to be ratified at July's Finance and Performance Group. As of 14<sup>th</sup> June 2024, QIA compliance was as follows:

- Corporate – two schemes have been completed with two in progress.
- Clinical Services – two have been completed with nine in progress.
- Medicine – eight were in progress.
- Surgery – one has been completed with six in progress.

The Chair observed that the titles of several schemes pointed to the potential for impacts on safety and quality, including theatre establishment, critical care skill mix, savings on catering, junior doctor establishment and changing IV potassium to Sando K. The proposal for mexiletine to be prescribed by the patients' GPs seemed contrary to the recent board strategy to avoid placing additional burdens on primary care.

JM explained that theatre establishment would not affect actual staffing levels and therefore did not require an in-depth QI assessment.

JR explained that the IV potassium CIP was a clinically led improvement project that reflected new research-based guidelines on the target level of potassium in post-operative cardiac patients, and assured the Committee that potassium levels would continue to be monitored and managed appropriately.

The catering CIP applies to facilities for the staff and public, not to the patient menus.

JR informed the Committee that the mexiletine prescribing arrangement had been agreed by Dr John Morris in discussion with primary care. Its

cost is explained by its limited application to a small group of patients with inherited cardiac disease.

The possibility of a cumulative effect from multiple CIPs in a single division or area of activity was discussed. It was noted that the divisions should pick up any cumulative effects through their regular meetings. The Chair commented that this requires further thought.

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With regard to cross divisional programmes, it was conceded that though small in number these could prove challenging to assess.

From a divisional point of view, the triumvirates are aware of all schemes, can triangulate when progress is being made and identify the fail safes. Check and challenge accountability meetings are held with the different service lines with multiple leaders who will discuss all schemes and highlight any safety risks.

The Committee accepted these assurances from the Director of Nursing and the Divisional Medical Director for clinical services.

#### **6.4 Mortality Improvement Group Minutes**

The Quality Committee noted the minutes.

#### **6.5 Surgical Site Infections (SSI)**

The initiative to reduce SSIs, which commenced two years ago, was presented and discussed.

The Trust is evaluating the possibility of adapting new criteria for diagnosis of superficial infections, this is in its infancy at the present time with the TVSN monitoring progress. From a patient harm perspective, deep infections, such as mediastinitis, are recorded, investigated and reported to the matrons and heads of nursing to ensure that learning is shared. Over the last five months there has been a decrease in deep infections.

The underlying causes of SSIs are being looked into by different teams including microbiology, tissue viability and infection control, working together to ensure all systems and processes are in place to prevent, as far as practicable, post-operative wound infections.

During the last year, there has been an audit of staff movement in and out of theatres. The number of people entering the operating theatre is kept to the minimum to reduce infection.

Audits of theatre temperature have been performed to ensure an appropriate and consistent temperature is maintained.

Ventilation is a potential source of infection and concerns within theatres have been raised and escalated to the Estates department. The business case for replacement of the old ventilation systems is in preparation.

Work is ongoing to ensure adequate hair removal prior to surgery in association with an audit of hair removal equipment.

A trial of a special bra for female patients is in progress, in the expectation that if weight can be kept off the post-operative sternum it will heal better, and the infection risk will be reduced.

### **6.6 e-Consent**

The surgery division has removed all paper-based consent forms and moved solely to e-consent.

Cardiologists are committed to adoption of e-consent and are working to ensure the processes work for them and for their patients. Dr Vishal Luther, ACCIO for Medicine has received approval to proceed with hand-held devices, to enable consultants to complete the consent form in a more accessible way. The division has committed to this being rolled out by the end of 2024.

### **6.7 Knowsley Place Quality Visit**

A question was raised with regard to 'cold chain' medications. It was explained that this relates to medications that need to be temperature controlled, such as insulin.

The Quality Committee noted the report.

### **6.8 Radiology Alerts**

The Committee discussed the on-going efforts to ensure that radiology alerts are actioned appropriately.

When an incidental finding is reported on an x-ray or scan an alert is sent to the requesting clinician. Sometimes the alerts have not been sent to the correct person, to someone who is not working in the Trust, or to a junior doctor.

A dashboard has been developed and will go live in Summer 2024. It will provide accurate information on the recipient of any alerts, and actions undertaken. The Divisional Medical Directors are responsible for ensuring that actions are undertaken, and that the response document is completed appropriately.

Assurance was received that alerts are being reviewed on a weekly basis.

## **7. Clinical Effectiveness**

### **7.1 GIRFT Update**

Mike Filek joined the meeting to present the GIRFT update.

A new programme of reports on best practice called Further Faster is aimed to reduce the number of long waiters. It is currently at an early stage, with a checklist underway for cardiology and respiratory; an APOM checklist is to follow and will be shared with the GIRFT team in Quarter 2. The Head of Improvement and Transformation will report back to the next Quality Committee.

### **Stroke**

The Trust is currently non-compliant with 7/7 working for therapies and SALT. This is under review and the outcome will be presented to the Operational Board and the triumvirates for further reflection. A band 6

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was appointed to the SALT team in January 2024; improvements have been noted in weekend referral to screen time, and an audit is planned for August 2024.

Mitigations are in place for physiotherapy. A demand and capacity workforce review is in progress, for completion in November 2024, which will inform planning for the 2025/26 financial year.

### **Surgery**

Day of Surgery Admission (DOSA) is to be the key priority. GIRFT recommends this to be the default practice for all thoracic and cardiac surgical patients, irrespective of their complexity.

The Trust's DOSA performance pre-covid was around 35% compliance, the Trust appears to be an outlier in comparison to other cardiac units. This in the main is due to the limitations imposed by the estate, with only Aspen suite available and able to take five or six patients. The senior nurse team and the Director of Nursing assured the Committee that further options were being explored to improve the DoSA performance.

### **Radiology**

The division is currently addressing the following:

- Provider to Provider (P2P) risk
- Supporting the CAMRIN review
- High levels of staff sickness

The Committee noted the continuing progress in compliance with the GIRFT recommendations.

Mike Filek left the meeting.

## **7.2 Resuscitation Annual Report**

Kirsty Dudley, Divisional Director of Nursing, Clinical Services joined the meeting to present the resuscitation annual report.

The report focuses primarily on staff compliance with mandatory training and the utilisation of DNAR forms and ceilings of care.

Mandatory training figures remain below target. The divisions have been working with the learning and development team to improve compliance. Last year ward staff were moved from a requirement for basic life support (BLS) to intermediate life support (ILS); this caused some confusion within the system. The REACT course has been implemented in the catheter labs, which is more relevant to their specific clinical environment. This training is not currently pulled through the ESR and requires manual entry.

Bespoke sessions continue and there have been no cancelled sessions during the last 12 months, but staff shortages and sickness remain common themes for non-attendance. Drop-in sessions have been introduced every Friday afternoon whereby any staff member can drop in to critical care for a BLS update. Figures have improved, and this will continue for the remainder of the year.

Previous incidents have highlighted instances of confused leadership of the resuscitation teams. This has been an area of focus and there have been no incidents during the last 12 months.

More structured handovers and the MET are established and have been associated with reduced numbers of cardiac arrest calls.

In the next quarter there is to be a review of the MET team calls out and their impact on reducing the number of patients being readmitted to critical care.

357 DNARs and ceilings of care orders have been documented on EPR during the year and all have been reported in the system. Current issues include documentation of DNAR orders for patients transferred from another Trust with a DNAR, and the different systems between primary care and secondary care, necessitating paper forms ('lilac forms') to be passed between organisations. Work is ongoing with primary and secondary care to streamline the system and the Trust may participate in a new initiative being piloted, called I Care and Share, across Merseyside.

The Trust has responded to recommendations to introduce Martha's rule with the introduction of Call 4 Concern to support patients or their families to escalate concerns over the management of clinical deterioration to the outreach team or, in the absence of the team, to the tier 1 doctor.

The Quality Committee received and noted assurance from the report.

Kirsty Dudley left the meeting.

### **7.3 MRG process assurance**

Dr Neil Coulson (NC), Consultant Anaesthetist joined the meeting to brief members of the Committee on the current MRG process.

The presentation had been requested at the most recent meeting of the Board of Directors following a discussion on mortality governance that was prompted by a report from the MRG.

A national requirement is for all deaths in the Trust to undergo a review. The process begins with Medical Examiners who review the deaths and highlight any initial concerns. They then liaise with the families to assist their understanding of their relative's treatment in the Trust.

Every death is initially screened by a senior nurse, and then by a consultant, trained in the Royal College of Physicians methodology, to identify the possibility of avoidability and to possible learning. Identification of potential avoidability is followed by a full review, based on a national protocol. The deaths are reported to the Mortality Review Group, where a final decision is agreed on avoidability or not, and full reviews are discussed.

Membership of the MRG includes a consultant from each division along with other healthcare professionals. The group decides what has been learnt from the reviews, irrespective of avoidability, and possible measures to be adopted to prevent future errors.

The cases are then compiled and brought to audit day for discussions and with actions being agreed.

Key changes have followed the introduction of InPhase, which came with only a basic mortality module. NC worked with the developers, to build a bespoke system to conform with the Trust's requirements. A section allows for recording of the MRG minutes, who was present, finalised avoidability decisions and a summary of discussions of cases to be presented at audit day.

Tasks can be generated for allocation to a specific person, with an email notification to alert the consultant to the requirement.

Data extraction and analysis is now an easier process with clearly defined search parameters such as cause of death and avoidability, resulting in a reduced administrative burden.

A SharePoint page for learning has been developed and presentations are uploaded to provide access at any time.

The report included several illustrative examples, and NC presented the learning from a patient who had died from haemorrhage. There was no bleeding protocol in place and the consultant looking after the patient didn't feel they were getting accurate information over the telephone. A protocol has been developed, led by trainees in surgery; it is easy to follow and includes a structured document for escalation to a consultant together with recording of actions following the conversation.

NC highlighted common themes relating to avoidability:

- Failure to rescue – complications that are developing but not recognised or managed correctly. A lot of education has been undertaken and regular teaching session for surgical trainees have been introduced, with cases presented from the MRG.
- Failure to escalate – staff managing patients overnight failing to escalate problems, receiving, or suspecting they are receiving incorrect advice and attempting to manage the patients by themselves. An escalation policy is in preparation.
- Management on critical care, for which education is being enhanced.

The Committee congratulated Dr Coulson on the outstanding work of the MRG, and took assurance from the robust processes in place, the improvements since the introduction of InPhase, and the continuing work on sharing the learning.

Neil Coulson left the meeting.

## **8. Compliance and Regulation**

### **8.1 Quality Risks and BAF 1 Review**

Of the two highest scoring risks within the organisation, one relates to CMR waiting times. Whilst primary oversight lies with the Integrated Performance Committee, it was emphasised that delays in diagnostic imaging have important implications for quality and safety.



There are 19 rated risks scoring over 12 and these are reviewed at each Risk Management Committee meeting.

The Committee received and noted the report.

A question was raised in relation to oversight by the assurance committees of the safer waiting list initiative. The Audit Committee is currently reviewing the TOR and roles of the committees, their reporting to the Board and tracking the completion of the actions. An update on safer waiting list management is to come back to the next meeting and the Chair of the Trust has requested a further briefing on this topic to the Board of Directors.

The Risk Management Committee reviews all risks, and the divisions are reviewing all long waiters. It was noted that two new consultant posts have been appointed.

## **8.2 Serious Incidents**

The Quality Committee noted the report.

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

Tuesday 8<sup>th</sup> October 2024, 11am-1pm, MS Teams