

## minutes

### Quality Committee Item 3

#### Minutes of the Quality Committee Meeting held on Tuesday 8<sup>th</sup> October 2024

**Present:**

Nick Brooks (Chair)  
Claudette Elliott  
Joan Mathews  
Ben Vinter  
John Morris

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

**In Attendance:**

Megan Underwood  
Mike Filek  
James Greenwood  
Sarah Barr  
Clare Quarterman

Senior Executive Assistant (Minutes)  
Head of Improvement & Transformation (item 6.4)  
Patient Safety Lead (item 7.1)  
Chief Digital Information Officer (item 8.2)  
Consultant Anaesthetist (item 8.2a)

**Apologies:**

Manoj Kuduvali  
Margaret Carney

Medical Director  
Non-Executive Director

**1. Apologies for Absence**

The above apologies were noted.

**2. Declarations of Interest**

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

**3. Minutes of e-meeting held on: 9<sup>th</sup> July 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.

It was highlighted that volunteers play a significant role within the organisation.

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

**Item 1** this action refers to discussions with regard to the SOF metric on venous thromboembolism prophylaxis. It was agreed that this will be discussed again in January with any recommendations to be submitted to the Board. The action was removed from the log.

**Item 2** this was in relation to a list of titles of CIPs being included within every report. The action was implemented and removed from the log.

**Item 3** this action was in regard to the possible cumulative effect of multiple CIPs, or of those crossing divisions. MF explained that this is fully covered cross divisionally through the QIA process.

**Item 4** this item referred to Further Faster currently being in the early stages and a checklist being underway for cardiology and respiratory. This action will be included with GIRFT updates in accordance with the workplan and was therefore closed.

## **6. Quality**

### **6.1 Quality Dashboard**

The DONQ noted that performance indicators were generally going well and drew the Committee's attention to certain areas.

Discharge summaries – the compliance for September had risen to 95% but the performance is inconsistent. There have been technical issues with the daily performance data in the nurse dashboard. Matrons across the divisions are working with the analytical team to ensure the correct data are being pulled through from the patients EPR.

Referral to dietitians – still inconsistently achieving the target but with an improving trend and reached 95% in July.

Pressure ulcers – the number of grade 2 ulcers have seemed to be high, but lapses in care remain rare and associated with minor harm, such as lesions under the patient's nose or behind their ear associated with nasal oxygen cannulae. All ulcers, irrespective of grade, are reviewed within 72 hours by the teams, together with documentation to ensure that appropriate care has been provided.

Two falls occurred in July 2024, but overall, the number has been consistent for each month at around seven or eight. High bed occupancy above 80%-90% and individual acuity are factors associated with an increased risk of falls. The Trust have discussed with Rambelguard if data can be extracted to show the numbers of falls prevented by use of the equipment.

VTE risk assessments and prophylaxis remains consistent with an improving trend. There have been no reported incidents of PE or DVT because of non-compliance with the VTE process.

The Quality Committee noted the dashboard.

## **6.2 Quality Strategy Update**

The current strategy remains in place whilst the priorities for 2025-2027 are being developed. Discussions with the clinical leads occurred during the recent away day and suggestions for incorporation in the new strategy were agreed, for presentation in January 2025.

The Quality Committee noted the update.

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

Formal complaints have been few in number – a total of seven in the last two quarters, and substantially less than in previous years during which the average has been about ten per quarter. Whilst this is obviously positive, the DONQ has asked the Patient and Family Support Manager (PFS) to have an in-depth look and to triangulate themes from quarters 1 and 2 to ascertain if an explanation for the remarkably low number can be identified, though considerable efforts are made to ensure patients' well-being and minimise the chances for dissatisfaction:

- Ward managers proactively liaise directly with patients and families when concerns are raised at ward or department level, and this process usually results in resolution without progression to a formal complaint.
- The number of bereavement meetings appears to be increasing; families find these very beneficial as they provide an opportunity to ask questions and raise any concerns over their relative's care.
- The improved communication between the cardiologist of the week and surgeon of the week has made a positive impact in ensuring patients are kept informed of their date for surgery whilst waiting in the hospital.
- The matron and ward manager open communication clinics are occurring regularly, greatly facilitating the ability of patients and families to ask questions about any concerns they may have.

The SSI report highlighted the difficulties in identifying the fluctuating statistics of both superficial and deep infections. The focus for the SSI meetings continues to be on the patient pathway before admission to hospital and through their journey from ward to theatre, in the main:

- decolonisation,
- hair removal
- theatre etiquette,
- antimicrobial Stewardship.

NATSIPS 2 remains an area of focus specifically around intercostal drain insertion and compliance in radiology. Further work is required on LOCSIP documentation to ensure standardisation for this procedure is across all wards and includes the radiology department.

The Quality Committee noted the report.

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

Mike Filek joined the meeting to present the QIA report.

A CIP overview was provided with the following being highlighted:

- There is a divisional target for 2024/25 is £ £4.8m
- As of 6th September schemes to the value of £3.7m (77% of target) identified
- Unidentified gap of 23% £1m, a further £1.3m (28%) in development/not fully matured.
- No QIA risk currently noted.

The QIA and EIA information is to be shared with the Integrated Performance Committee.

Discussions were held at the previous meeting with specific areas being identified that could potentially have a quality impact. A question was raised with regard to mexiletine prescribing being handed over to GPs, against the background of ongoing plans to reduce workloads within primary care. The drug is expensive due to it not being in widespread production as it is only used for patients who cannot tolerate other anti-arrhythmic drugs. Although progressing through the Trust's process, it is not yet a transacted scheme and is yet to be agreed with primary care.

#### **6.5 Telstra Health Dashboard**

Despite a slight upward rolling trend in SMR and HSMR, both indices remain within the expected range: the latest HSMR (for April 2024) was 89.9 and, for the rolling 12-month period 107.1. Corresponding values for SMR (all diagnoses) were 86.2 and 104.7.

For myocardial infarction, the in-hospital relative mortality rate remains significantly higher than in the peer group at 151.6, though well below the peaks, averaging 180, up to 2022. Previous investigation by the Mortality Improvement Group has demonstrated that the higher mortality in this diagnostic group is driven mainly by the Trust's unique policy of accepting direct admission of exceptionally high-risk patients with out of hospital cardiac arrest, combined with the inevitably incomplete coding of comorbidities (i.e. risk factors) in these patients.

The Quality Committee noted the report as providing good assurance on the Trust's mortality statistics.

#### **6.6 Mortality Improvement Group Minutes – 12<sup>th</sup> June 2024**

The Quality Committee noted the minutes.

#### **6.7 Quality Committee Workplan 2024/25**

To be resolved separately with MU and DDON.

#### **6.8 Mortality Review and Improvement Annual Report**

The report included the continuing surveillance of SMR and HSMR (as detailed in 6.5). The analytics team has developed a dashboard to allow raw mortality to be viewed live online. Between April 2023 and March 2024, the total (across both medicine and surgery) raw death rate was 1.5% against the target of 1.5%. CUSUM curves for cardiac surgery and PCI were in the middle of the expected range and, for surgery closely

aligned with the EuroSCORE risk estimation. Individual operator CUSUM curves are no longer monitored by the MRG but reported separately to the divisions. The Committee was informed that none of the outcomes for individual surgeons or operators falls outside the expected range but a policy exists, and has been utilised in the past, for individuals that fall outside the statistical confidence levels.

VTE performance, compliance with the sepsis bundle, the surgical site infection group, and initiatives on stroke management, all contribute to the objectives of the group in reducing mortality.

The report provides assurance on the existence of a comprehensive mortality improvement plan which includes processes to investigate causes of deaths and develops initiatives to prevent deaths and focus on organisational learning.

The Quality Committee accepted assurance from the report.

## **7. Clinical Effectiveness**

### **7.1 Deaths on the waiting list**

Dr James Greenwood joined the meeting to update the Committee on the work he is leading on waiting list deaths.

Concern derives from the long waiting lists, and particularly on deaths that occur whilst patients are awaiting surgery.

A dashboard has been developed to monitor deaths of patients who are waiting for:

- First attendance
- Diagnostics
- Treatment following first attendance
- Follow-up
- Community appointment

The dashboard is user friendly, with the ability to drill down into consultant level data, service lines and time on the waiting list. The Committee strongly approved of the initiative and in response to discussion, JG confirmed that it has the potential to provide information on equality and diversity, to ensure that no patient groups are disadvantaged.

Deaths among patients waiting to be seen or treated rose to a peak of 963 in 2023, though the largest category was of out-patients awaiting follow-up. These outpatient deaths have declined rapidly during the first six months of 2024. Of those on the in-patient waiting list, 16 died between January and December 2023: 12 under the medical, three under the surgical and one under the clinical services division.

Processes to contact patients at appropriate intervals while waiting are now established to ensure that any who might be deteriorating can be reviewed by the responsible consultant.

Dr Greenwood is due to hold a meeting with the divisions for the final road test of the dashboard, which is then to be adopted by the triumvirates.

The Quality Committee noted the report and congratulated JG on the progress of the initiative.

## **8. Compliance and Regulation**

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

The BAF continues to be tracked in line with the Board of Directors' assessment of its risk appetite.

The report includes the single high-scoring risk in BAF1 which relates to the MR waiting list capacity. It was noted that 20 high rated risks (scoring over 12) also impact indirectly on quality and safety.

BV reported on the ongoing activity with regard to the financial profile of the system.

The Quality Committee noted the report.

### **8.2 PSII update**

The Chief Digital Information Officer (CDIO) joined the meeting to present an update on progress against the learning and actions highlighted by the Patient Safety Incident Investigation (PSII) relating to EPRO and Digital Communications, which had resulted in a cohort of letters not being sent to the intended recipients.

Nine actions relating to the software and applications were identified, of which three are complete and the remaining six, with three tied to a wider system upgrade, are scheduled to complete by 5th November. Areas for improvement and lessons learnt for future IT projects have been derived from inadequate governance of the EPRO project, insufficient representation within the stakeholder group, shortcomings in testing, insufficient training of users, and the high level of staff turnover during the project with resulting poor handovers and communication.

It was noted that the Trust introduced EPRO alongside several other changes which relied on a complexity of interfaces. The training of staff was highlighted as not being as robust as it could have been, and it was acknowledged that testing and monitoring should have taken place before adoption and implementation.

Henceforward projects will be tracked and managed by the Digital Excellence Committee which is chaired by the Medical Director. The report provided details of the action plan, including a review of the EPRO SOP which has been signed off, and provided assurance on progress against the majority of the remaining requirements.

The Quality Committee noted the paper and the wider action plan.

### **8.3 Learning from external reviews**

#### **Infected Blood Inquiry**

Dr Clare Quarterman, Consultant Anaesthetist joined the meeting to present a summary of the recommendations of the Infected Blood Inquiry and to explain the implications for the Trust.

A deep dive of the processes at LHCH was undertaken including a review of the consent process. The Trust is fully compliant with the Transfusion 2024 self-assessed checklist on patient blood management, transfusion laboratory safety, and information technology.

The Trust already complies with most of the recommendations in the main report. Tranexamic acid is used routinely in cardiac surgical patients, but discussions are to be held to consider expanding its indications for thoracic surgery.

The transfusion service is provided by Liverpool Clinical Laboratories (LCL) and the Trust has, accordingly little influence on the recommendations for staffing. Assurance has been received that the service meets all the requirements, and LCL staff attend the regular Hospital Transfusion Team and Transfusion Committee meetings. Education and training is overseen by the National lead employer to ensure that mandatory training is completed by all staff, including those on medical rotations.

All recommendations of Serious Hazards of Transfusion (SHOT) reports are reviewed by the HTT and HTC and the Trust adheres to the requirements on incident reporting via Inphase (and previously DATIX) and where appropriate reports to the MHRA and SABRE.

The Trust has an effective tracking system to ensure 100% compliance with the requirement to record the fate of every unit of blood. An electronic, closed-loop system is to be introduced that will revolutionise the process and with additional technology-based checks further improve the safety of transfusion.

The Quality Committee noted the report and the proposed actions to share the recommendations of the Inquiry with the consultant team, explore the wider use of tranexamic acid in thoracic patients, continue the Trust's participation in the National Comparative Audit and review the compliance with transfusion related mandatory training among rotating medical staff.

#### **Thirlwall Inquiry – review of inquiries.**

The Committee discussed the summary prepared by BV, of a review carried out by the Thirlwell Inquiry on recommendations from seven previous statutory inquiries, between 2010 and 2020, into events in hospitals or other healthcare settings and/or those relating to the safeguarding of vulnerable individuals.

The Chair reminded members that recommendations of all relevant inquiries are routinely subjected to a gap analysis and action plans implemented. It was agreed that the Trust has an excellent record of compliance with the wide-ranging recommendations in the inquiry reports, in particular over leadership, governance, transparency, risk management and the relations between managers and clinicians.

The themes and learning in the report will provide valuable points of reference to ensure they are embedded in the new Quality Strategy.

**Any Other Business**

The Quality Committee took the opportunity to consider a question from the chair of the Audit Committee at its recent meeting, on a proposal to audit clinical care pathways.

The unanimous view was that this would not be an appropriate addition to the Committee work plan since LHCH forms only one part of the pathways (e.g. acute coronary syndromes, pacemaker implantations, heart failure, valve disease and endocarditis etc) and it would be more appropriate for this to be monitored by the system/commissioners. It was emphasised, however, that the quality outcomes of these tertiary services are fully covered by the Committee's terms of reference.

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

Tuesday 14<sup>th</sup> January 2025, 11am-1pm, MS Teams

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