

minutes

Quality Committee Item 3

Minutes of the Quality Committee Meeting held on Tuesday 14th January 2025

Present:

Claudette Elliott
Margaret Carney
Joan Mathews
Ben Vinter

Non-Executive Director
Non-Executive Director
Director of Nursing and Quality
Director of Risk and Corporate Governance

In Attendance:

Debbie Ellison
Archie Samuels
Susan Oakes
Marousa Ntouskou
Mike Filek

Senior Executive Assistant (Minutes)
Research Audit & Effectiveness Manager (Item 9.1)
Palliative Care Specialist Nurse (Item 9.2)
Consultant Radiologist (Item 9.3)
Head of Improvement & Transformation (Item 6.4)

Apologies:

Nick Brooks (Chair)
Manoj Kuduvalli

Non-Executive Director
Medical Director

1. Apologies for Absence

The above apologies were noted.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 8th October 2024

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

4. Patient Story

The patient story was deferred to the next meeting.

5. Action Log: 8th October 2024

Item 1 Quality Dashboard – VTE. This item is discussed under item 6.1 on the main agenda and removed from the action log.

6. Quality

6.1 Quality Dashboard

Joan Matthews, Director of Nursing and Quality noted that performance indicators were going well.

The delirium risk assessment in August and September highlighted the commentary as excellent. Risk assessments are completed on admission and remain above 95%. Further work is needed on the risk assessment that is required once a day, when a patient shows signs of delirium. A Ward Manager dashboard has been developed with the BI team and is working well. Issues arise when a patient is admitted and then is moved. The time element lapses for the risk assessment to be completed. A meeting has been arranged with the BI team and the matrons to explore a digital correction to the EPR record risk assessment that enables staff to identify a missing risk assessment and enable amendments to be made in real time.

The numbers of Pressure Ulcers with lapses in care remain low. These are reviewed at the Executive Group Meeting on a weekly basis. The risk assessment has been changed within EPR, to now incorporate the recording of moisture damage to ensure, potential harm to patients is actioned.

Discharge summaries on the day have greatly improved and are just above 95% performance target. A digital fix has been added to the patients EPR discharge checklist which enables pharmacy technicians to add in that they have given the discharge summary to the patient.

MUSDT referrals to dieticians is improving month on month in the main this is due to ward managers and matrons checking the referrals made at ward level in real time.

VTE is an assessment that is completed on admission and then again within 24 hours. This ensures that it is picked up for patients who are moved after admission. Assessments are above 95% on admission.

Prophylaxis is recorded if a patient requires mechanical or therapeutic intervention depending on their risk assessment. Patients who are identified as high risk are prescribed medication or TED stockings until their VTE risk assessment has returned to normal.

Formal complaints remain very low. Matrons and Ward Managers maintain communication with anyone who has an informal concern. There are 16 formal complaints now as one has just been removed due to the patient now wishing to pursue. At the end of Q4 last year, there were 40 formal complaints received. The complaints procedure is highlighted on all wards, to ensure patients and families are aware of the Trust procedure to contact the Patient and Family Liaison Team.

CE - The performance dashboard data is recording for September, and we are in January. The question was raised as to why the SOF could not be more up to date.

Action: performance data to be aligned to real time.

BV/JM

The Quality Committee noted the dashboard.

6.2 Quality Strategy Update

The priorities for the Quality & Safety strategy were discussed at the Clinical Leaders away day at the end of last year. A meeting is in place this week to meet with the Patient Safety Lead to discuss the priorities identified by the clinical leaders and to ensure the document is ready for approval by the end of March by QSEC for 2025-2027.

The committee noted the impact to the PSIF priorities and framework. The review would mean it would be later than it would normally be to align it with the quality strategy.

The Quality Committee noted the update.

6.3 QSEC Key Assurances/Risk Report

The delirium target was showing as 68% and should be 90%. The matrons are working with BI to ensure the correct data is captured.

EPRO PSII update will be going to the next Digital Excellence Committee. There is a further PSII for a patient who was transferred from another hospital. Multiple organisational response is ongoing, and an update will be brought to the meeting.

Formal complaints remain low in number. 3 were received in quarter 2 and have all been closed.

In the reporting period compliance with the Duty of Candour was achieved 100% of the time.

All annual reports have been presented. Digital consent has helped to mitigate some risks of incomplete consent processes in the trust, but further work is still required.

There have been issues regarding staff having to change from BLS to ILS. There was a small dip in resuscitation mandatory training for ILS as the system in HR wasn't aligned. More sessions have been added so performance should come up. This hasn't impacted any incident relating to patients and resuscitation practice.

The annual pain report had been presented and a number of policies had been approved.

The Quality Committee noted the report.

6.4 Quality Impact Assessments (CIPs) and Update Report

Mike Filek, Head of Improvement & Transformation joined the meeting to present the QIA report.

MF advised that steady progress is being made with no concerns or alerts to draw to the committee's attention.

A CIP overview was provided with the following being highlighted:

- CIP 24/25 target £10.6m
- Divisional target for 24/25 £4.8m

- Central target £5.8m
- Quarter 3 targets to 31st December have identified 100% and transacted 75%

Progress:

- Divisional Schemes – 90% identified, 63% transacted
- Central Corporate Schemes – 100% identified, 82% transacted

As of 31st December, QIA Compliance, 82 schemes have been identified, with 43 requiring QIA of which 31 are complete. 72% of schemes have been quality assessed and compliant with the process. They have been signed off by the Divisions, the project lead, the Medical Director and the Director of Nursing. The remaining schemes are amber as they are in the process and progressing towards full sign off.

After sign-off, schemes are taken back to Finance and Performance Group were operational and clinical colleagues are able to have oversight and final feedback in terms of whether there are any concerns about the schemes progressing.

No new schemes less than £25k have been added to the Hopper Tracker since the previous update.

A full list of the schemes was included in the appendix.

Central Corporate Schemes are newly reported as historically they didn't impact staff or services and were purely transactional.

The meeting discussed the impact from a protected characteristics perspective.

Action: it was agreed MF would bring an example at the next meeting after a conversation with NB.

MF

The meeting discussed the quality control and overview of EIAs in general. The understanding was that they sat with People Committee.

Action: it was agreed this would be followed up with Jane Royds, Chief People Officer.

MF

The Virtual Ward scheme had not been approved and was still in process.

Action: the status and an update would be emailed to the chair.

MF

The Quality Committee noted the report.

Mike Filek left the meeting.

6.5 Mortality Improvement Group Minutes – 11th September 2024

The Quality Committee noted the minutes.

JM advised that all in-patient deaths are reviewed by the Deputy Director of Nursing and Quality. If a nursing review would assist the Mortality Review Group (MRG) process, then they are allocated. The majority of in-

patient deaths occur within Critical Care or from patients from PPCI, so a nursing review would not be appropriate or applicable. Therefore, there are a reduced number of nursing mortality reviews required.

6.6 Surgical Site Infections Update

The Director of Nursing and Quality shared a presentation from the Medical Director to give an overview of surgical infection rates, variables, historic data, and actions to improve.

If a patient develops a surgical site infection it can have considerable long-term effects on physical and mental health, finances, and body image.

SSI account for 19.6% of healthcare infections and are among the most preventable.

Cardiac patients fall into this risk factor. Patient factors include BMI, diabetes, age, smoking, altered immune response, nutritional status, colonisation with *Staphylococcus aureus* and co-morbidities.

There are a number of task and finish groups which have looked at groups of patients before they are admitted, pre-op bathing, hair removal. Peri-operative indications looking at surgery, length of surgery, surgical technique, correct antibiotic prophylaxis, body temperature, blood glucose levels, oxygenation, theatre environment, theatre equipment and instruments, antisepsis at the surgical site, scrub technique and ventilation and air quality. Then post operatively, dressings, dressing changes and wound care (inpatient and community).

Prevention is minimised wherever possible. Following compliance with SSI prevention bundle along with optimal theatre conditions and post operative wound care. Prompt recognition and early intervention and treatment should an SSI be identified.

There is an SSI Group which is multi-disciplinary: Consultant Surgeon, IP, TV, HON, Matrons, CCA, Theatre and information team who review the available data, consider existing evidence base and new recommendations, develop and monitor audit programme and develop and oversee an ongoing action plan.

A new system was introduced in July 2022 enabling comprehensive surveillance and data collection on all patients having cardiac surgery. The system has been refined and improved and additional information collected over 23/24. Follow up of patients and recoding of their wounds and any associated issues after discharge is performed using a platform that allows patients to upload photographs which are reviewed by the tissue viability nurses. Patients can also be offered advice and seen in clinic if required.

Graphs of surveillance data, SSI by site and where and when SSIs are diagnosed were shared with the meeting. The majority of SSIs are diagnosed after the patient has been discharged therefore the more robust and comprehensive surveillance and follow up systems that have been introduced are highly likely to have increased the number of infections detected.

All severe infections now have a post infection review to assess if there is any learning that can be identified.

Although the rates of SSI fluctuate there appears to have been a reduction in the more severe types of infection over time. July 22-23, there were 28. This has reduced down to 5 between July 24 and October 24. If a patient is readmitted an InPhase is now put in so the patient's pathway can be looked at in detail.

There are a number of actions and ongoing projects to reduce SSI including an audit programme and feedback on SSI prevention infections. Prophylactic vacuum assisted closure for high-risk patients. Surgical bras, antimicrobial sutures, theatre environment monitoring, endoscopic vein harvest and benchmarking with other Trusts.

AS advised that there is a surveillance programme that the Infection Prevention Team are hoping to join. They have contacted research for support on collecting the data.

The Quality Committee noted the report.

7. Patient Safety

7.1 Incidents, Complaints & Claims (IICC) Annual Report

Ben Vinter, Director of Risk and Corporate Governance presented the IICC annual report to the meeting and highlighted the following:

- Incident reporting, learning from incidents, complaints and claims and improving the safety culture, remains a priority for the Trust.
- The number of incidents and trends remain consistent with the top 5 themes being administration processes, medications, health & safety, medical devices and communication.
- Swarm discussions, rapid review and MDT reviews continue to be undertaken with a focus on learning, improvement and just culture.
- There was 1 incident classified as fatal harm, which is being investigated as a PSII in quarter 2.
- There were 3 RIDDOR reportable incidents in the first two quarters.
- The team are working on developing a module in InPhase to include how learning comes from incidents.
- There were no concerns or actions from the coroner's cases that were closed in quarter 1 and 2.
- Issues raised through Freedom to Speak Up were largely related to systems and processes, health and wellbeing, working practices and staff values and behaviours.
- Patient engagement events have been held and further are planned on listening and how we act and respond to patients.

The Director of Nursing and Quality confirmed that an OOH node was an 'out of hospital' node on the PAC system. This is where staff are looking to see external radiological images.

A number of appendices had been included to be helpful to give an understanding about the building blocks the team used for the report.

The Quality Committee noted the report.

8. Governance

8.1 QSEC Terms of Reference

The Quality Committee approved the QSEC Terms of Reference.

9. Clinical Effectiveness

9.1 Clinical Audit & Effectiveness Strategy Annual Report

Archie Samuels, Research Audit & Effectiveness Manager (RAEM) joined the meeting to present the annual report.

The Clinical Effectiveness Strategy is still to be ratified once the Research Department Strategy is completed. Timescales are sitting with the Medical Director.

Action: Medical Director to confirm timescales.

Archie Samuels left the meeting.

9.2 End of Life Annual Report

Sue Oakes, Palliative Care Specialist Nurse joined the meeting to present the annual report and highlighted the following:

- There has been an increased number of patients supported by the palliative care team on the wards.
- 73% of the patients are non-cancer.
- There has been an 18% increase in the last financial year in bereavement calls and follow up support.
- Numbers of calls to Marie Curie for advice out of normal working hours are consistent with previous years.
- 32% increase in the number of documented end-of-life phone notes which highlights the support given to community patients. With a total time spent of 87 hours.
- Proportionally LHCH has more deaths on a Saturday, 29.73% versus 11.99% nationally, it is not clear as to why this is. It has been looked at in more detail but nothing specific or pattern has been found. This will continue to be monitored, and the Medical Director has asked for it to be part of the MRG process.
- Training is ongoing and e-learning remains positive.
- From a team point of view, the last financial year was difficult in terms of staff leaving and sickness but there has been an increase in number to the team and generally the feedback is positive.

JM noted a good and positive report. It is a small team who do amazing work. The DONQ has regular meetings with the team. Families who have had some form of access to the team, come back regularly with question or for support as they can't access it outside in primary care. The Palliative Care team offer palliative support to patients and their families.

There have been challenges releasing staff for training. One of the challenges has been the use of individual care plans and as noted in the report, there was another drop in the last financial year. Teaching has been ongoing and there has now been an improvement from previous years to 53% for doctors using the individual end-of-life care plans and the

nurses end of life flow sheets is at 71%. The number of nurses flow sheets tends to reflect the number of end-of-life patients.

There are still issues outstanding including the end-of-life care plan, but the dashboard has been updated.

Action: poor performance of end-of-life care plans to be recorded in performance matrix of the Divisions.

Another challenge has been the Advance Care Plan. The Trust Advance Care Plan has been in place for several years however it is used infrequently. A way forward is still being explored.

The Quality Committee noted the report.

Sue Oakes left the meeting.

9.3 CQC IRMER Report

Marousa Ntouskou, Consultant Radiologist joined the meeting to present the IRMER annual report for the period from April 2023 to March 2024 and the inspection of the Radiology Department in July 2024.

CQC is the competent authority in England for enforcement of the Ionising Radiation (Medical Exposure) Regulations 2017. The Regulations state that every exposure needs to be justified and optimised to ensure that the benefit for the patient outweighs the risk.

30.6 million diagnostic examinations used ionising radiation (29.2 in 2022/2023). There were an increased annual number of accidental and unintended exposures registered, which is a positive indicator of good patient safety culture.

There were 819 statutory notifications of significant accidental and unintended exposures across all modalities.

- Diagnostic imaging: 447 notifications
- 65% from CT (computed tomography) an increase of 22% from 2022/23
- 25% from XR.

Key trends and concerns identified in the annual report were identified as follows:

- An increasing number of staff groups are making referrals for ionising radiation examinations
- Ensuring all employer's procedures are in place to support staff and reflect the current practice
- Regular review of diagnostic reference levels and enabling operators to access these
- Maintaining an equipment inventory that includes all information mandated by the regulations
- Undertaking adequate testing of equipment
- Having up-to-date training records available as evidence of adequate training

Concerns and recommendations from the inspection in July 2024 for the LHCH Radiology Department were as follows:

- Improvement in the quality and availability of training records for staff
- Efficient use of valuable input from medical physics
- Mitigating actions
- Mobile CT Services

The report confirmed that the organisation provided evidence and assurance of compliance with IR(ME)R. The Trust had employer's procedures and there was good support from medical physics. The Inspectors felt there were shortcomings in the structure of its radiation protection governance arrangements in terms of the frequency and duration of its Radiation Safety Committee.

Not all mandatory documentation was in place at the time of the inspection. Documents such as the radiology referral guidelines were in development. Training records for duty holders were not complete and the training of non-medical referrers were still in development. The Inspectors were impressed with the clinical workbooks supporting the training of new radiographers in cardiology.

There was a recommendation about the clear governance structure and the frequency of the Radiation Safety Committee meetings. It was felt that an annual meeting was not enough and there was no medical staff representation. There was also a recommendation to broaden the number of staff involved in the relevant tasks to support compliance and quality improvement.

To take forward the recommendations, a quarterly Radiation Safety Meeting was established with a representation from all the teams. Recruitment has been challenging and broadening the number of staff involved in the relevant tasks to support compliance and quality improvement is still a work in progress.

Procedures, protocols, and the Quality Assurance Programme was in place and provided in advance of the inspection.

Referrals and referral guidelines are still a work in progress. The guidelines written by RCR, iRefer are not used.

Incidents are prevented by EPR only allowing trained medical and non-medical staff to refer a patient for a scan and vetting is a robust process in the department carried out by consultant radiologist and senior fellows to avoid inappropriate acceptance of a scan. The E-IR(ME)R training report is presented monthly in the governance meeting.

There were no concerns in the Research and Clinical Audits. The Department complied with all requirements. There were 11 radiation related incidents reported to IRS between July and December 2024. 1 was reportable to CQC's IRMER team due to the wrong patient being referred for a CT scan. Checks and procedures were followed but failed to identify the wrong clinical history. The incident was discussed in the Governance and REAL meetings and at the Radiology Audit Day. The

patient's safety questionnaire was revised to include clinical history of the patient to prevent it happening again.

Justification and Authorisation. All appropriately trained medical and non-medical practitioners are working under protocols which had been entitled to refer for imaging at LHCH. Specific codes are used for specific imaging examinations. Consultant Radiologists had been entitled to justify and accept the scan. The vetting policy is followed, training is provided to every new consultant radiologist or senior fellows. The vetting process is audited regularly. There are plans to train radiographers in the vetting process. The increasing demand and the low levels of staff have not allowed this.

Mandatory training and training for staff has been focused on.

This had been the first inspection from IRMER. The two inspectors that came were really positive. There were no regulatory actions to deal with. Actions and recommendations would be monitored through QSEC.

The Quality Committee noted the report.

Marousa Ntouskou left the meeting.

10 Compliance

10.1 Quality Risks / BAF 1 Review

Ben Vinter, Director of Risk and Corporate Governance presented the Quality BAF and Risk Report which continues to have a residual score of 6 against a target score of 6.

The high rated risk that pertains to quality is MR waiting times. This has been a consistent position for some time. There are 17 risks relating to quality situated across the Divisional risk registers scored at 12 or above. The team are meeting with each Division to ensure all the risks are in an accurate position.

BV, JM & MK have looked at the BAF and feel from a quality perspective that the position is accurately described and static.

The Quality Committee noted the report.

10.2 PSII Update

The PSII Update was presented to the committee.

The MRG had found the death was >50% avoidable therefore met the National PSIRF Priority for PSII. Comments will be reserved until the PSII is complete and learning from the case is published.

The Quality Committee noted the report.

11 Date and Time of Next Meeting

Tuesday, 8th April 2025

11am-1pm,

MS Teams