Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Quality and Risk Committee
Thursday 19 December 2024 – 14:00-16:00
Chair: Michael Blastland
(Quarter 3, Month 3)
via Microsoft Teams

Present	Role	Initials
Blastland, Michael (Chair)	Non-Executive Director	MB
Midlane, Eilish	Chief Executive	EM
Palmer, Louise	Assistant Director for Quality & Risk	LP
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
Wilkinson, Ian	Non-Executive Director	IW
Fadero, Amanda (joined 14:45)	Non-Executive Director	AF
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Hurst, Rhys	Staff Governor	RH
Monkhouse, Oonagh	Director of Workforce & Organisational Development	OM
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
In attendance		
Watson, Alice	Executive Assistant	AW

P A R T O N E

Item		Action	Date
1.	**Welcome & Apologies** The Chair welcomed all those present to the meeting. Apologies had been received from David Meek (DM).		
2.	**Declarations of Interest** There is a requirement that those attending Board Committees raise any specific declarations, if these arise during discussions. There were no new declarations of interest.		
3.	**Committee Member Priorities** The Chair referred to discussions relating to quality improvement at the CDC meeting on 13 December, noting the positivity and enthusiasm expressed. It was questioned how the many ideas put forward might be implemented. IS concurred that the meeting had been productive, but noted that there was nothing coming out of that meeting with the		

	capability to move the productive discussion to another forum, with the capacity for delivery. MS added that CDC was not a decision-making group and thus the progression of ideas was an issue which required further consideration. In respect of the particular actions raised at the 13 December meeting, such as those related to flow, these required to be channelled into the streams of work already in place, such as the Flow Programme. The recording of actions at CDC was also raised as an issue, as these were not being formally captured. IS considered that CDC needed to establish the value of the learning and carrying forward of ideas, versus the in-the-moment decisions, which had been the initial purpose of the group's set-up. LP highlighted the pertinence of the interplay between CDC and QRMG in decisions around quality improvement. The Committee **NOTED** the Committee Member Priorities.		
4.	**Ratification of Previous Minutes Part 1 (28.11.24)** The minutes of the 28 November 2024 Quality & Risk Committee (Q&R) (Part 1) meeting were agreed to be a true and accurate record of the meeting, and would be signed as such.		
5.	**Matters Arising – Part 1 Action Checklist (19.12.24):** *076 - National Cardiac Audit Programme data: To liaise regarding the inviting of relevant clinicians, and/or representatives from NICOR, to attend Q&R, to present and discuss NICOR report data.* MS updated the Committee that there was intention to invite Narain Moorjani to an upcoming meeting, to provide an example of the national cardiac audit programme and its use. To remain **OPEN**. *077 - AMS 2024/25 Report: To provide the Committee with a chart reflecting the long-term position.* Item due to be heard in December, but deferred to January 2025. To remain **OPEN**. *079 – To Provide a progress report on discharge summaries, digital position and pilot update in RSSC.* AR advised that a draft document had been produced which required to go via QRMG, prior to presentation to Q&R in February 2025. To remain **OPEN**. *080 – Discuss and review performance reporting and monitoring: Investigate when the Trust was last compliant and consider adjusting the trigger for action to three months instead of the current one or two months. Evaluate whether the reaction to fill-rate changes constitute a*		

	significant trend. To discuss the issue further offline for deeper insights and strategies. ***Address the issue of the 'Safe' rating being marked as 'red' due to fill-rates of Healthcare Support Workers and determine if these fill-rates should form KPIs, or be monitored separately.*** MS confirmed that discussions had taken place and it had been agreed that Healthcare Support Workers would not be removed to ensure a 'green' rating. The Trust was considered safe in terms of staffing and the decision had been made to leave matters as they stood, but reconsider when the annual metrics were reviewed, in April 2025. To be **CLOSED**. *081 – Produce a report on the QUACS study findings: IS to speak with Samer Nashef (SN) about the QUACS study results, with the aim to prepare and present a report for the Committee on this matter, with a timeline to be determined.* IS advised that he had reached out to SN but had not yet received a response. Action to be raised again at Q&R in February 2025 and remain **OPEN**. The Committee **REVIEWED** and **NOTED** the Matters Arising – Part 1 Action Checklist.		
6.	**Quality & Safety**		
6.1	QRMG and SIERP Highlight and Exception Paper		
	LP presented the QRMG and SIERP Highlight and Exception Paper, which was taken as read. Highlights were as follows: • There were no formal escalations from QRMG or SIERP. • PSII was not noted as a formal escalation due to the new PSIRF Framework. • QRMG had been advised of three interplays which had affected Q3/Q4 metrics for 2023/2024 data, with necessary assurances provided. • One PSII had been commissioned in the month of November 2024 following an incident regarding clinical stabilisation of a patient following determination of death by neurological criteria (WEB54609). • There had been one incident graded as moderate harm or above in November 2024. This had been discussed at SIERP and statutory Duty of Candour was required. • There were four learning responses completed in November 2024. • There was one RIDDOR reportable incident which had been reported to the Health and Safety Executive. • The volunteer community continued to go from strength-to-strength.		

	• The PAT Dogs procedure had been finalised, and recruitment would now take place. The local Cambridgeshire coordinator for the PAT Dog Charity and the volunteer manager at CUH, were supporting. • Two inquests had been heard in November 2024. One of these (INQ2122-03 /INQ552) was a four-day inquest at which the Trust was represented by a barrister, and involved attendance by seven clinical members of staff. The Coroner had issued a Prevention of Future Deaths (PFD) report to the Department of Health and NHS England. Matters of Concern were as follows: ○ Hospital discharge notes were not uniform across Hospital Trusts. This carried the risk of essential patient information not being available to treating clinicians when a patient was received into a new clinical setting, leading to potential delay in providing lifesaving care and treatment. **Discussion:** AR referred to the PFD report, considering that much of the issue resulted from the configurability of the system. Progress had been made in Lorenzo, and the team had been focusing on this, in conjunction with the Record Standards Body. It was therefore pertinent that the paper came back to demonstrate work being undertaken, but in any event, there was a pilot underway in RSSC to achieve a more acceptable standard. LP wished to clarify that this did not relate to the discharge summary in the particular case, but rather, the circumstances around this and the wider learning. IW had been through the two inquests and considered they were well commented; he had nothing to add. EM queried the patient safety events, noting a reduction of approximately 20% and wished to ensure this was not a result of reporting 'fatigue'. LP considered that whilst the data was noted here, six-month trend data was more pertinent; no concern was expressed in relation to EM's question. The correlation between activity and incidents was highlighted, and it was acknowledged that this data was captured in the PIPR. The Chair suggested it may be useful to look at monthly activity data to see how the two months compared, as the numbers fluctuated from month-to-month. The Committee **REVIEWED** the QRMG and SIERP Highlight and Exception Paper.		
6.1.1	Intensive Care National Audit & Research Centre (ICNARC) – Internal Review April 2022 to March 2024		

	The Intensive Care National Audit & Research Centre (ICNARC) – Internal Review April 22-March 24 was taken as read. • LP provided background that the report had historically been heard at QRMG, with high-level assurance provided to Q&R that it had been received and reviewed. Last year had been a data period in which the Trust had not fallen within the national average which had therefore been highlighted to Q&R, who had requested this formal update. **Discussion:** The Chair sought assurance that the Trust had sufficiently timely awareness of the trends and once aware, that there was sufficient non-defensive curiosity about them. In addition, it was questioned whether the general claims about RPH's performance as a well-performing heart centre were sustainable, on the basis of the data. IS responded that there had been conversations about the results a year ago in the Critical Care Team, and they had responded early. By way of latest update, a letter had been received from NHSBT approximately three weeks ago, expressing concern at RPH's cardiac transplant results. That trend had been picked up by the team circa. nine months ago, and mitigations put in place prior to the letter arriving. IS highlighted that the Trust was held to a different standard to the other centres, due to previous good results, with a special category for heart transplants, meaning that a red flag was raised when RPH dropped to the national average. However, the team had already responded that they had picked up some trends and reacted, thus no complacency had been demonstrated. In terms of general cardiac surgery outcomes, whilst these had been outstanding in terms of performance, they were now rather more average. However, staff were checking their own results and there was action, thus IS was not concerned regarding issues of complacency. LP confirmed that the paper related to mortality from patients that came through Critical Care, for which outcomes were monitored. In relation to Cardiac Thoracic Surgery, it had been questioned how national audits could be used to try and compare and contrast and collate the information, which had been an action taken away for the Audit Team to consider. IW questioned how the expected percentage was calculated, and it was felt that the subject matter expert was needed to respond to such questions. IW considered that observed percentage was of primary importance. The Chair questioned of LP whether her impression was that the reflections on RPH's data input and ICNARC's risk measurement was that there were probable or satisfactory explanations for the levels		

	observed. LP responded that this was the impression gained and there were three notable factors: • a different auditor, and method of capture lacking clarity; • the risk adjustment model had been changed; and • there were some patient cases and deaths in the period. MS did not feel that data input was a concern. It was felt that the appropriate way forward was to invite Dr Lenka Cagova to an upcoming Q&R meeting to provide further detail around the issues raised. OM raised the merit of asking the professional group/STA the questions posed by the Chair at today's meeting, and queried whether there was a national framework to refer to. **ACTION**: LP and MS to consider the most appropriate Q&R meeting for Dr Cagova to attend, and extend the necessary invitation. The Committee **NOTED** the Intensive Care National Audit & Research Centre (ICNARC) – Internal Review April 2022 to March 2024.	**LP/MS**	
6.1.2	Serious Incident Executive Review Panel (SIERP) minutes (05/11/24, 12/11/24, 19/11/24, 26/11/24).		
	The Committee **NOTED** the Serious Incident Executive Review Panel (SIERP) minutes (05/11/24, 12/11/24, 19/11/24, 26/11/24).		
6.1.3	Trust-wide Consent Audit (TRU-139) for 2024/25		
	The paper was taken as read. The Committee **NOTED** the Trust-wide Consent Audit (TRU-139) for 2024/25.		
6.1.4	Trust-wide Mouth Care Audit (TRU-150) for 2024/25		
	The paper was taken as read. MS suggested that Dietitian Assistant, Gemma Bibby, should be invited to attend a future Q&R meeting for a focussed session on the work undertaken, and progress made, in relation to mouth care. **ACTION**: Gemma Bibby to be invited to attend an upcoming Q&R meeting for a focussed session on mouth care, work undertaken and areas of progress. Committee **NOTED** the Trust-wide Mouth Care Audit (TRU-150) for 2024/25.	**MS/KMB**	
6.2	SSI Quality Monitoring Dashboard		
	MS presented the SSI Quality Monitoring Dashboard. The following highlights were of note:		

	• The scorecard was reporting an inpatient and readmission rate of 4.2%, but this was shown as 3.8% in the narrative, which would be corrected. The 4.2% rate was noted to be encouraging. • For October and November, a rate of approximately 3% had been reported. • In in terms of the environmental dashboard, good, embedded practise around the significant items would continue, such as decontamination of surgical instruments, administering antibiotics and application of Octenisan using pre-op decolonisation. • In relation to IPC audits, which were on-the-spot check audits around hand washing, and ANTT cleaning of equipment, were areas which were noted to be 'amber' and 'red'. This offered reassurance that audits were being properly conducted and results were real, rather than corrected. • There was now significant focus on the Critical Care environment and equipment. Failures related to evidence of cleaning (such as stickers), or delayed cleaning following patient use. This was not considered cause for concern. **Discussion:** AF requested an update relating to the cultural aspects of the workstreams further to the SSI Summit. MS advised that an update had been provided last month, but relayed that the challenge remained in relation to the door openings in theatres, together with the footfall. Figures had improved in the latest audit, but were still not optimum. MS had requested to know action being taken and plans for improvements, with specifics around the staff groups with whom it was difficult to engage, so support and assistance could be offered. AF further raised a key theme arising, which had been discussed at Board, regarding patients being transferred into RPH, to which a significant number of events related. It was questioned whether this was going to be a quality priority in the year ahead, or whether a thematic review might be undertaken. LP responded that quality account themes were already being scrutinised, and there was also the PSIRF plan around the data. Of the five key elements around incidents, one related to patient pathways, which had not yet been a focus but would be a high priority, going forward. The Committee **REVIEWED** the SSI Quality Monitoring Dashboard.		
6.3	M.abscessus Dashboard (Nov 2024 data)		
	MS presented the M.abscessus Dashboard (Nov 2024 data). The following was noted: • Two new patients WEB54338(5) & WEB54645(6) were reported in November (samples taken in October 2024).The first patient was under the care of the Lung Defence Team and had a positive sample during their first inpatient admission to RPH; the second patient was under the care of the CF team and had had multiple		

	attendances at RPH since 2019, with one inpatient admission in 2019. Relatedness studies had been requested, results of which had revealed that one case had related to the outbreak cluster - WEB54338(5) . Detailed analysis of that patient was underway, but no obvious route of entry had been established. • A plan was underway to roll-back from many of the mitigations currently in place, but risk assessments would take place at every point. **Discussion:** The Chair referred to the patient with M.abscessus related to the outbreak cluster - WEB54338(5), noting few opportunities for this to have been contracted at RPH, although outpatient appointments would have been attended prior to admission. MS confirmed that further investigations were ongoing, adding that the Outpatients department had strict safety measures in place. The Chair questioned whether MS was sceptical about the likelihood of patients contracting M.abscessus in Outpatients. MS noted that vulnerable patients were cared for in a specific part of that department, so agreed she would be sceptical, as the chances of exposure were remote; this was a lower-risk environment. IS concurred that these patients were relatively isolated during their time in Outpatients. It was recognised that simply having positive sputum once, did not equate to an infection, which required the observation of clinical deterioration. A specimen taken at bronchoscopy was far more reliable than a specimen taken from expectorated sputum, as was the case here. A full investigation was underway and progress would be monitored, with care. The Chair questioned whether there was any evidence to suggest there might be a continuous, or new, source of infection, or whether the infections were getting through the Trust's protective measures; neither IS nor MS expressed concern in this regard. MS was confident that sufficient scrutiny of the particular patient's individual case was underway. The Committee **REVIEWED** the M.abscessus Dashboard (Nov 2024 data).		
	Numbers 6.4, 6.5, 6.6 and 6.7 not used on agenda.		
6.8	PPI Minutes		
	The PPI minutes were taken as read. The Committee **NOTED** the PPI Minutes		
6.9	**Performance**		
6.9.1	Performance Reporting: PIPR M8		

	MS presented the Performance Reporting: PIPR M8. The report was noted to be light, due to the recent Q&R session. Highlights were as follows: • In November, there had been one PSII commissioned by SIERP (PSII-WEB54609). • There had been one confirmed moderate harm incident. • In respect of harm-free care, there would be a focus on pressure ulcers in January. • Supervisory sister time was noted to have improved, the value of which was acknowledged. **Discussion:** AF was concerned to note the level of performance in respect of responsiveness; there was a need to consider this in preparing for next year. The Committee **NOTED** the Performance Reporting: PIPR M8.		
7.	**Risk:**		
7.1	Board Assurance Framework (BAF) KMB presented the BAF. • Progress notes on page 74 reflected previous comments regarding SSI rates, which had stabilised. The Committee **NOTED** the Board Assurance Framework (BAF).		
7.1.1	Appendix 1: BAF Report The Committee **REVIEWED** the BAF report, Appendix 1.		
7.1.2	Appendix 2: BAF Tracker The Committee **REVIEWED** the BAF tracker, Appendix 2.		
8.0	**Governance and Compliance**		
8.1	Quarterly Account Progress Reports Q2 24/25		
	LP presented the Quarterly Account Progress Reports Q2 24/25. • The reports comprised a Q2 update with part of Q3 included. • The three quality accounts were progressing positively; diabetes in particular. • Food and nutrition was also performing well, with the mouth care audit playing an important role. • Volunteer Patient Safety partners were active in both of the above. • Delerium/dementia had taken longer to progress, but in respect of delirium, this had received more oversight, with review of guidance and recognition of what might be actioned in order to improve quality.		

	• In relation to dementia, a professional development role had been appointed by way of support, and it was hoped this would aid progress. **Discussion:** MS highlighted the benefits of the Patient Safety Partners and the usefulness of the service they provided. MS also wished to offer brief overview of the long list of issues to be addressed in the next year, which would be brought to the next Q&R meeting. • In respect of responsiveness, and comments made by AF, it had been felt that consideration should be given to harm reviews of the RTT pathway; a process had been developed but only used by Oncology. • Discharge assurance was a further significant topic and an area requiring improvement; a workstream was already set up, but increased focus was needed. • Equality and diversity of patients would also be pursued, linking in EDS2. • Stroke and re-enablement had been discussed, particularly in relation to work being undertaken to enhance the stroke pathway. There had been investment in resource, and progress would be monitored. • CQC and compliance assurance and self-assessment programme would be commenced. • Virtual care, virtual ward and looking at those as a quality improvement had also been considered. OM referred to the health inequalities and EDS2, which was being reviewed. Feedback had inferred this lacked adequate infrastructure, governance, leadership and oversight, which required attention. Data gathering was considered key. An outstanding Board Development Session would inform the issue. KMB advised that this had been arranged for February 2025 but required to be moved due to competing priorities. Necessary conversations would need to be had to secure a suitable date for all, in the near future. AR stated that matters were improving; a Data Quality Group had been set up which was making good progress in a number of areas, including Scan for Safety (point of care scanning), which would improve data quality as part of the new Digital strategy. This, and other initiatives, including those around Population Health, were seeing headway being made. The Committee **REVIEWED** the Quarterly Account Progress Reports Q2 24/25.	**KMB**	
8.2	**Internal Audits:**		

8.2.1	None were available.		
8.3	**External Audits/Assessment**		
8.3.1	None were available.		
9.	**Policies and Procedures**		
9.1	ToR011 – Terms of Reference (ToR) for QRMG		
	LP advised that the only change requested to be clarified, related to the Medicine Safety Group, which fed into the Drugs and Therapeutic Group. Due to the expertise in that group, procedures would be received rather than re-reviewed; this was already in the ToR. The Committee **APPROVED** the ToR011 – Terms of Reference for QRMG.		
10.	**Research and Development**		
10.1	Minutes of Research and Development Directorate meeting (11/10/24).		
	The Committee **NOTED** the minutes from Research and Development Directorate meeting.		
11.	**Other Reporting Committees**		
11.1	Escalation from Clinical Professional Advisory Committee (CPAC).		
	There were no escalations from the Clinical Professional Advisory Committee.		
11.1.1	Minutes from Clinical Professional Advisory Committee (21.11.24)		
	The Committee **NOTED** the minutes from the Clinical Professional Advisory Committee.		
12.	**Areas of Escalation and Emerging Risk**		
12.1	Audit Committee There was nothing to report.		
12.2	Board of Directors There was nothing to report.		
12.3	Emerging Risks There was nothing to report.		
13.	**Any Other Business**		
	MS advised of the need to meet with KMB in order to map out the next year's reports and where the annual reports would fall. These were acknowledged to be loaded towards the end of the year due to the dependency on data coming from the end of the financial year. **ACTION**: MS/KMB to meet, to map out next year's reports. The Chair sought the Committee's views regarding the levels of assurance reported to the Board. It was considered that: • In respect of safety, QRMG was good, despite a 'red' rating. • Good levels of assurance and good quality accounts were noted.	**MS/KMB**	

	• Whilst assurance could not be received in respect of SSI outcomes, progress was being made, and a good system of governance was in place. • The position relating to M.abscessus was considered satisfactory in respect of assurance. • When considering ICNARC, it was agreed that as a Board, further assurance was required regarding the quality of mortality surgical outcomes/long-term trends relative to peers. LP reiterated that the mortality related to all pathways going to Critical Care. The Committee **REVIEWED** the items raised under Any Other Business.		
	Date and time of next meeting: Thursday, 30 January 2025, 14:00-16:00 – Microsoft Teams.		

Signed…….

Dated …….