Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 2, Month 1

Held on 26th August 2021 at 2 pm
Via Microsoft Teams

M I N U T E S

Present	Ahluwalia, Jag	(JA)	Non-executive Director
	Blastland, Michael (Chair)	(MB)	Non-executive Director (Chair)
	Fadero, Amanda	(AF)	Non-executive Director
	Graham, Ivan	(IG)	Deputy Chief Nurse
	Jarvis, Anna	(AJ)	Trust Secretary
	Midlane, Eilish	(EM)	Chief Operating Officer
	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development
	Powell, Sarah	(SP)	Deputy Clinical Governance Manager
	Screaton, Maura	(MS)	Chief Nurse
	Seaman, Chris	(CS)	Quality Compliance Officer (Minutes)
	Smith, Ian (Part 2 only)	(IS)	Acting Medical Director
In attendance	Hurst, Wayne (part meeting)	(WH)	Head of Nursing, Cardiology
	Pai, Sumita (part meeting)	(SP)	Consultant Microbiologist
	Sheares, Karen (part meeting)	(KS)	Consultant, Thoracic Medicine
Apologies	McCorquodale, Chris	(CMc)	Deputy Chief Pharmacist
	Palmer, Louise	(LP)	Assistant Director for Quality & Risk
	Posey, Stephen	(SP)	Chief Executive
	Raynes, Andy	(AR)	Director of Digital & Chief Information Officer
	Webb, Stephen	(SW)	Deputy Medical Director and Clinical Lead for Clinical Governance

Discussion did not follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.

Agenda Item		Action by Whom	Date
1	**APOLOGIES FOR ABSENCE**		
	The Chair opened the meeting and the apologies above were noted.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions. The following standing Declarations of Interest were noted: • Michael Blastland as Board member of the Winton Centre for Risk and Evidence Communication; as advisor to the Behavioural Change		

Agenda Item		Action by Whom	Date
	by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration, as a freelance journalist reporting on health issues and as an advisor to Bristol University's Centre for Research Quality and Improvement. • Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd. • Jag Ahluwalia as: CUH Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer; Programme Director for East of England Chief Resident Training programme, run through CUH; Trustee at Macmillan Cancer Support; Fellow at the Judge Business School – Honorary appointment and am not on the faculty; Co-director and shareholder in Ahluwalia Education and Consulting Limited; Associate at Deloitte and Associate at the Moller Centre. • Ian Wilkinson as: Hon Consultant CUHFT; Employee of the University of Cambridge; Director of Cambridge Clinical Trials Unit, Member of Addenbrooke's Charitable Trust Scientific Advisory Board, Senior academic for University of Cambridge Sunway Collaboration and Private Health Care at the University of Cambridge. • Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH; Chair of the NHS England (NHSE) Operational Delivery Network Board; Trustee of the Intensive Care Society; Chair of the East of England Cardiac Network and an Executive Reviewer for CQC Well Led reviews. • Amanda Fadero as a Trustee of Nelson Trust, a charity predominantly supporting recovery from drug and alcohol addiction with expertise in trauma informed care for women; Associate Non-Executive Director at East Sussex NHS Healthcare Trust. • Maura Screaton as a director of Cambridge Clinical Imaging and with shares in some biotech companies.		
3	**COMMITTEE MEMBER PRIORITIES** Chair conveyed the concerns of the Clinical Decision Cell over the rate of cancellations due to increased pressures with headroom and continuing Covid related ECMO burdens within Critical Care. He invited the Chief Nurse to share her initial observations and considerations for the longer term output of Critical Care. She highlighted: • Matching staffing numbers with higher acuity was challenging and a complex issue, as recent rises in patient acuity had raised the skill set required. • CCA rostering/staff support/well-being issues already previously undertaken - she would be reviewing these, together with the Director of Workforce and Organisational Development before articulating the next steps. • She would like to understand better the objective metrics used on a day to day basis with regard to staffing before making further comment. In particular, how we articulate breaching compliance with staffing policy and what mitigating steps were taken in order to escalate before closing beds. Discussion: • AF remarked that the recent divisional illuminations had highlighted the stress and anguish clearly felt amongst some staff and asked what impact the numerous and varied interventions were having impact across the Trust.		

Agenda Item		Action by Whom	Date
	• The Chief Nurse acknowledged that it had been a difficult time for all organisations across the NHS but in terms of what she had seen both in Critical Care and ward areas, there was recognition that it had been hard but also that we as Execs and committee members acknowledged this. Ward areas reported that getting back to their normal teams gave a great sense of relief but she felt that CCA was a bigger issue and that we needed to consider triangulating the context of the comments to ensure these were taken in context. For example 'not getting breaks' - she felt more objective measures were needed and intended to embed the Safecare/red flags tool (a best practice initiative aligned to national policy about early warnings of when things are not going quite right, eg, missed breaks, going off work late, unable to deliver care they would normally). Regular red flag reports would enable closer monitoring and allow a more agile response. Staff comments could be more easily triangulated in comparison to red flag reports. • The Director of Workforce and Organisational Development reminded the Committee of the staffing difficulties within CCA prior to the pandemic. During the pandemic staff were redeployed into CCA with some remaining in CCA but not all staff were not redeployed back immediately. Now with the full release of redeployed staff, overlaid with Covid absences this had compounded staffing issues. There would naturally be a range of experiences reported with some staff enjoying a positive experience whilst others had found CCA a very scary place to be. She reported that another staff survey was approaching which would give timely feedback but in the meantime the Trust had taken the opportunity to support line managers who perhaps understandably had prized clinical expertise over line management during the pandemic crisis. The band 7s had been on away day development line management sessions and there was ongoing band 6 development as part of the compassionate and collective leadership programme. • Chair considered that as NEDs rely on the data, when seeing anecdotal evidence it is sometimes difficult to judge how seriously to take this. He queried whether there was anything in the short term pressures that the data did not capture; he would be more reassured if there was more triangulation of evidence. • The Deputy Chief Nurse considered that part of the answer for context was that areas of CCA was still in both Covid and ECMO surge and many staff had barely left this environment for 18 months. This presented a polar opposite with other parts of the organisation who were trying to recover and move beyond Covid. This should be important context as to why there was mixed feedback. • He added that clinical walk arounds were a valuable opportunity to gather staff feedback on positive progress (new 4th floor clinical assessment room, new educational nurse, band 6 CCA development) and believed this was the way to reflect anecdotally on positive experiences. He considered that leadership and accessibility, including NEDs made a big difference and this was where you would experience something that couldn't otherwise		

Agenda Item		Action by Whom	Date
	be quantified. He reported that he and Amanda Fadero had a scheduled walk around on 6th September where vital context could be gained; they would be sure to visit CCA so AF could witness this for herself.		
4	**MINUTES OF THE PREVIOUS MEETING – 26th August 2021**		
	The Quality & Risk Committee approved the minutes of the previous meeting held on the 26th August 2021 and authorised these for signature by the Chair as a true record.		
5 **5.1**	**MATTERS ARISING AND ACTION CHECKLIST PART 1 26th August 2021** **VTE Assurance Update** Wayne Hurst joined the meeting to assist the Committee understand the fall in compliance with VTE assessments. The Committee noted the pre-circulated document and the following points were highlighted by WH: • Patients who required an overnight stay were required to have a VTE assessment in line with NICE guidelines. • Continued monitoring of compliance was reported nationally via UNIFY and internally via PIPR. • Non-digital Trusts submit data based on a random 30 patients however Trusts with electronic patient records (EPR) were required to submit data live from the system on all hospital admissions. • From June RPH had moved to reporting as an EPR Trust. • RPH monthly admissions were in excess of 1100 patients therefore the confidence interval with only 30 patients had given false assurance. • VTE related incidents had not increased. • Downward trajectory from 2017 (21) to 2020 (11) evident. • Monitoring was against per 1000 bed days; excluding 2 Covid related spikes in relation to coagulopathies incidents have remained consistently low. • Further patient education on VTE and associated equipment continued along with the monitoring of VTE associated medication and interventions. • The VTE scrutiny panel saw all incidents and these had all been low or no harm incidents. • 85% compliance in wards – link trainers and manual screening of clinical indicator provided daily monitoring. • CCA – a daily reassessment of risk required. VTE link consultant had driven forward improvements from 40 to 60% of the 24 hour requirement from admission. Digital systems had been improved to facilitate easier input of completed assessments. • Daily CCA risk assessment compliance was at 16% however this was considered a formality of incomplete paperwork and there was reassuring evidence of ongoing care and treatment. Dr Ahluwalia raised the following: • How had 'green' wards achieved their success – WH advised that surgical wards had been more proactive with assessments and were sharing this within the Link Group. Pre-assessment pathways often allowed VTE assessments to be done within the 7 days prior to admission, which improved compliance rates. • Risk of VTE to Covid patients was greater than to the average patient therefore further assurance was required that these		

Agenda Item		Action by Whom	Date
	patients were assessed. Dr Shears joined the meeting and confirmed that bleeding and thrombosis rates had been audited in 30 consecutive patients transferred into RPH during both first and second waves of the pandemic. Thrombotic events and significant major bleeding issues had been noted on arrival. These patients were admitted straight to CCA. Active auditing continued however guidance changed regularly and was relatively evidence light. She acknowledged that the Metavision form indicating a VTE assessment wasn't always completed however the assessments were noted in medical ward round notes every day. Unfortunately Metavision was the feeder into the audit assurance. She confirmed that every VTE thrombotic event underwent a rigorous RCA and the last preventable VTE event was in December 2018. • WH confirmed that only 10 Metavision records were audited as part of the previous random selection of 30 patients audited. The Committee took assurance, despite not necessarily being recorded in the appropriate part of the EPR, that VTE assessments were being undertaken and appropriate treatment given. Chair noted the rarity of significant VTE events and concluded that standards were sufficient. The public profile of the hospital's efforts on this aspect was however something to be considered.		
5.1.1	**VTE Q1 Report presented to QRMG** The Committee noted the pre-circulated document in conjunction with the discussion above.		
6	**QUALITY**		
6.1	**Q1 Quality & Risk Report** The Committee noted the pre-circulated document.		
6.1.1	**Q1 Divisional & Business Unit Quality & Risk Reports** The Committee noted the pre-circulated document. Amanda Fadero commented that she found the divisional reports challenging to excavate any possible escalations from these. The Chief Nurse reported that the reports along with the ward to board process was under review and would include the process of escalation to QRMG and Quality & Risk so that areas of escalated concern were more clearly indicated. It was considered important to still have quarterly divisional presentations offering the opportunity for highlights and issues. Dr Ahluwalia expressed a healthy antipathy to just exception reporting as he considered the risk was that committees would only ever see the 'reds' without encouraging discussions about the 'ambers to greens'. He considered it was as important to focus on the achievements too. The Deputy Clinical Governance Manager recognised this and confirmed a review of reports was underway. The Chief Operating Officer said that as divisions already presented to Performance Committee, in the interests of clinical teams' time, it would be sensible to consider a shared event where different committees were able to attend. Chair suggested Quality & Risk could join the presentations at Performance Committee however there was concern that attendance at three sub-board committees in one day was a heavy burden and consideration of meeting rescheduling was requested. Another suggestion of a lunch time plenary sessions where divisions attended to present what they were concerned about / proud of could be		

Agenda Item		Action by Whom	Date
	considered and the Chief Operating Officer undertook an action to discuss further with the Chair of the Performance Committee. The need to celebrate success and articulate how RPH was continuing the 'outstanding' journey by continuing to push boundaries was acknowledged and the suggestion of using the CQC domains to focus self-assessments was made. It was also noted that scheduling to highlight workforce issues was being considered by Execs at present.	EM/AJ	
6.1.2	**Quality & Risk Management Group (QRMG) Exception Reports** The Committee noted the pre-circulated document.		
6.1.2.1	**SUI Webs** There were no new serious incidents to report. Dr Ahluwalia initiated a discussion on the categorisation of serious incidents, in particular near misses being at the low harm end of the scale. By definition all near misses produced no harm but he questioned whether this meant they should all be categorised as low harm. Learning from near misses was vital and he queried whether we should be doing more to learn from these. The Chief Nurse confirmed that all near misses were reviewed as to whether they met the criteria for being declared an SI but that a deep dive into near misses and the learning taken from these could be undertaken. All near misses were investigated with the same level as any other incident. She commented that there were reporting issues with the NRL system we needed to comply with but a new national patient safety framework due next year would offer an improved way of articulating the effects on patients. Dr Ahluwalia articulated that some near misses were associated with catastrophic failures of process but other near misses were associated with minor process failures and he was concerned that these were all graded the same. A different categorisation was needed as to the failing as opposed to the impact; a process by which those which were of trivial consequence but significant process failing could be highlighted. The Deputy Chief Nurse commented that incidents had to be graded for reporting (issue with NRL system referred to earlier) as a near miss but were given the same attention as any other incident. An incident was investigated, patient reviewed including any liaison with the family, learning was implemented and then as a last action a grading was assigned. To provide more assurance to the Committee it was agreed that a review of the near misses over the last three months would be undertaken, with the caveat from the Deputy Clinical Governance Manager that these could only be reported issues.	SP	
6.1.2.2	**QRMG Minutes (210713)** These were accepted by the Committee.		
6.1.2.3	**QRMG Draft Minutes (210810)** These were accepted by the Committee.		
6.2	**PERFORMANCE**		
6.2.1 **6.2.1.1**	**Performance Reporting/Quality Dashboard** **PIPR Safe – M04** The Committee noted the pre-circulated document. The Chief Nurse commented that the fill rate referred to rates that are reported to unify on a monthly basis. She added that to provide greater clarity, the Care Hours Per Patient Day (CHPPD) metric - whilst a good measure, work to look at demand put in the system against what was being measured was underway.		

Agenda Item		Action by Whom	Date
	Amanda Fadero asked whether the Nursing Message of the Week (NMoW) had real impact. The Deputy Chief Nurse commented that anecdotally it seemed to, eg infection control messaging; however he and the Chief Nurse had already considered to undertake a deep dive on a random selection of NMoW to consider the impact. Positive feedback on NMoW had been received and PIPR seemed the most appropriate place to celebrate the success of the messaging.	IG/MS	
6.2.1.2	**PIPR Caring – M04** The Committee noted the pre-circulated document. The Deputy Chief Nurse confirmed that within the Friends and Family scoring, whilst the graph looked more dramatic a change between 0.1 and 0.3 was considered steady. National statistics were included as a quantifying benchmark. Fluctuations to recommendation rates between 99 and 100% were consistently above the national average and whilst the response rate was not reported nationally RPH continued to do this; all teams had worked hard to improve rates. It was suggested that some graphs would lend themselves to run charts to avoid unnecessary focus on minor perturbations. A review of charts and graphs to give a clearer indication of real points of concern was agreed.	IG	
6.2.1.3	**PIPR People, Management & Culture – M04** The Committee noted the pre-circulated document. The Chair commented on the huge improvement to the % compliance of the approval of rosters 6 weeks in advance. This was in part due to the striping out the non-shift rotas however a focus on roster approval compliance had been undertaken.		
6.2.2	**Monthly Ward Scorecards: M04** The Committee noted the pre-circulated document.		
6.3	**SAFETY**		
6.3.1	**Serious Incident Executive Review Panel (SIERP)** (210727, 210803, 210810) minutes The pre-circulated minutes noted above were received by the Committee.		
6.3.2	**Antimicrobial Stewardship Q1 Report 2021/22** The pre-circulated report noted above was received by the Committee.		
6.3.3	**Antimicrobial Stewardship – presentation** Dr Sumita Pai, Consultant Microbiologist and Antimicrobial Stewardship Lead attended the meeting to present the recent project – Antimicrobial Stewardship Surgical Division Ward Rounds at RPH. The background to the project was a focus on the UK's five year national plan to tackle antimicrobial resistance. The objectives were to: • improve patient safety by optimising use of antimicrobials through a multidisciplinary approach • empower medical staff and non-medical prescribers on appropriate antimicrobial prescribing • demonstrate a financial saving through reduction in inappropriate antimicrobial prescribing The methodology was: • Between 01.12.20 and 20.08.21 twice weekly ward rounds were held on surgical wards for surgical inpatients on antimicrobials, excluding transplant patients. • Review of 440 patients (509 antimicrobial prescriptions) Results:		

Agenda Item		Action by Whom	Date

	• 25 did not require intervention
	• 477 AMS interventions included:
	  ○ adding a stop date for antibiotics
	  ○ stopping antibiotics
	  ○ change from intravenous to oral
	  ○ incorrect dosing
	  ○ therapeutic drug monitoring
	Antimicrobial use at RPH compared with Royal Brompton and Liverpool Heart & Chest over the last 18 months had shown to be similar to the latter but over the last few months there was less usage at RPH.
	A use of broad spectrum antibiotics, which can drive resistance, was also monitored and where not required a narrow spectrum antibiotic was prescribed instead.
	The project had:
	• received positive feedback
	• improved relationships and engagement
	• allowed regular case based teaching for junior doctors and ANPs on wards whereby teams were using antimicrobials more appropriately
	• reinforced guidelines
	The financial spend on antimicrobials had significantly decreased following the intervention of ward rounds. By changing from IV to oral alone had saved about £1,000 pm.
	Further identified areas for action/improvement were:
	• diagnostic stewardship for UTIs was already underway
	• vancomycin prescribing errors to be mitigated by introducing the use of an alternative drug
	• prevent hospital chest infections (common cause for starting antibiotics)
	• prepare a business case for a permanent AMS pharmacist to sustain the project
	Chair thanked Dr Pai for her presentation and considered that the overall project was yielding good results for increased patient safety and antimicrobial resistance in general.
	Discussion:
	• Chair advised caution if the development of a business case was based on the financial calculations shown, given this had been during a pandemic. Dr Pai drew attention to the fact that these figures related to Q1 19/20 prior to the pandemic and stated that the Trust's use of antibiotics had been noted as above average in 2019. She also added that the use of oral narrow based antibiotics had impacted positively on financial savings significantly.
	• The Chief Nurse commented that it would be good to correlate this to patient outcome measures such as SSI rates and chest infections, etc.
	• Dr Ahluwalia considered that this work could have far wider ranging consequences than just financial ones but was concerned that such considerations as changes in case mix and the priorities of admissions did not get adjusted for in an audit such as this. He considered that the physical presence on wards and the role modelling for juniors would have the biggest impact but these areas could not be measured. Similarly readmission		

Agenda Item		Action by Whom	Date
	rates would also be hard to quantify along with all sorts of benefits that were hard to capture in the short term. He agreed that the preventive measures were the best way forward. • The Deputy Chief Nurse thanked Dr Pai for this valuable piece of team work and offered his support to the business case. He reported that the c.diff panels regularly saw the value of the work of the AMS team and that changes to guidelines to antibiotic prescribing may go towards some way to explain the shift in numbers. He lauded the team's clinical excellence on the ward rounds and concluded this had made a real difference. He acknowledged that it was difficult to compare year on year but stressed that a financial year on year saving had definitely been seen; he wondered however, how sustainable this was and considered that funding to continue monitoring the use of antibiotics may be a better way of presenting the business case. • Dr Ahluwalia considered how much antibiotic prescribing would lend itself to automation with prompts from the EPR for best practice by default. Had this aspect been fully explored? Dr Pai confirmed that she had approached Digital to link prescribing from within Lorenzo to the guidelines however this was some way away. They had been able to introduce microguides made available on smart phones. Reducing the default 7 day prescription length would also be helpful in reducing antimicrobials and this was in progress. He considered there must be shared incentives for s/w developers and the Trust with both reputational and financial gains, which the latter may help pay for the development costs. • Chair suggested this should be added to the future Committee session on digital clinical safety		
7	**RISK**		
7.1	**Board Assurance Framework Report** This was accepted by the Committee. Chair asked the Trust Secretary whether the pressures on Critical Care and patient flow, discussed earlier in the meeting, had translated into higher ratings. The Trust Secretary reported that associated risks had as yet not been reassessed. The Trust Secretary did express concern where risks are attributed to more than one committee and whether these should be reviewed. The Chair agreed to discuss further with other Committee members pertaining to a specific R&D risk outside the meeting. Dr Ahluwalia referred to the incident concerning an insulin pump and lauded staff for their honesty and transparency, however asked to what extent we were able to design risks out of equipment to ease the burden on staff? The Chief Nurse agreed to investigate whether improved safety could be designed into this type of pump. An update would be included in the Digital focus at next month's meeting.	MB MS	
7.2	**Emerging risks** There were none to report.		
8	**WORKFORCE**		
8.1	**WRES Data Submission Paper** The Committee noted the pre-circulated document. The Director of Workforce and Organisational Development noted the following against the metrics: • Proportion of staff in different bands - some progress made but a		

Agenda Item		Action by Whom	Date
	need to sustain and grow this. • Likelihood of disciplinary had deteriorated but numbers were so small that only one would make a significant difference. Assured that checks and balances were in place to avoid any form of discrimination. Concerns with medical staff noted, which mirrored national position, would be a focus of future initiative to identify any potential problems. • There is no greater likelihood of white staff being shortlisted than BAME staff. Nationally the introduction of the disparity ratio has supported indicators 1-4 (Appendix 2). • There was an increased trend for bullying, harassment and discrimination however there was no difference in the experience of BAME staff with this indicator. • Indicator 7 - perception of equal opportunities for career progression showed a sharp decline between 2017 and 2019 by both white and BAME staff. The Director of Workforce and Organisational Development found this difficult to quantify and suggested this could be down to one or two examples of poor recruitment practice losing the Trust of staff, combined with the time period of the pre and post hospital move, balanced with the overall number of opportunities given the small size of the Trust. Any of these could translate in a 'not fair' belief. General loss of faith in the promotion process was considered very complex. • 'Fair recruitment' work being undertaken looked at evidence based research and would hopefully support understanding. Discussion: • The Chief Operating Officer asked whether the move from sampling some to all staff made a difference. The Director of Workforce and Organisational Development did not feel that this had added to the issue in this instance. • Dr Alhuwalia had the following thoughts: o He considered that perception could be troublesome as this had the potential to affect the mind sets and attitudes of many. o Should we venture outside conventional strategies for recruitment to encourage better relationships with disenfranchised community networks? The Director of Workforce and Organisational Development considered that reaching out to the communities that supported RPH throughout the pandemic would be a good starting point.		
8.1.1	**WRES Report Appendix 1 - Workforce Race Equality Standard Action Plan 21/22** The pre-circulated document noted above was approved by the Committee. This would be forwarded to the Board for ratification.		
8.1.2	**WRES Report Appendix 2 – Regional Data pack explanatory guide** The pre-circulated document noted above was received by the Committee.		
8.2	**WDES Data Submission Paper** The pre-circulated documents were received by the Committee. Whilst the data highlighted issues, these were not to the same degree as with WRES. The Director of Workforce and Organisational Development commented that encouragingly the WDES group had grown in confidence in recent months.		

Agenda Item		Action by Whom	Date
	The following analysis for metric 2 was queried**:** *The data shows disabled staff are more likely to be appointed in comparison to non-disabled colleagues.* This error would be amended. It was apparent that the data gaps which were quite substantial in some areas, could thwart any meaningful intervention as no assumptions could be made. The confidence to declare a disability and/or ethnic background was considered key however some comparison with the staff survey where staff were asked to declare *a long term condition* might be more realistic with the wider population.		
8.2.1	**WRES Report Appendix 1 - Workforce Disability Equality Standard Action Plan 21/22** The pre-circulated document noted above was approved by the Committee. This would be forwarded to the Board for ratification.		
9	**ASSURANCE**		
9.1	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		
10	**POLICIES**		
10.1	**Cover paper for DN832 Policy on the use of Bacteriophages** The Committee noted the pre-circulated document.		
10.1.1	**DN832 Policy on the use of Bacteriophages (ratified at DTC)** DN832 was ratified by the Committee.		
10.2	**Cover paper for DN331 Purchasing for Safety** The Committee noted the pre-circulated document.		
10.2.1	**DN331 Purchasing for Safety (ratified at DTC)** DN331 was ratified by the Committee.		
10.3	**Cover paper for DN485 FCSC Operational Policy** The Committee noted the pre-circulated document.		
10.3.1	**DN485 FCSC Operational Policy (ratified at QRMG)** DN485 was ratified by the Committee.		
12	**RESEARCH AND EDUCATION**		
12.1	**Research**		
12.1.1	**Minutes of Research & Development Directorate Meeting** There were none.		
12.2	**Education**		
12.2.1	**Education Steering Group minutes** (210813) These were accepted by the Committee.		
13	**OTHER REPORTING COMMITTEES**		
13.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** There was no escalation from CPAC however a review of the agenda was noted		
13.2	**Minutes of Clinical Professional Advisory Committee** (210722) These were accepted by the Committee.		
13.2	**Minutes of Safeguarding Committee** (210816) The Committee accepted the minutes of the Safeguarding Committee.		
14	**ISSUES FOR ESCALATION**		
14.1	**Audit Committee** There were no issues for escalation from Part 1.		
14.2	**Board of Directors** There were no issues for escalation from Part 1.		

Agenda Item		Action by Whom	Date
15	**ANY OTHER BUSINESS** There was no further business and the meeting closed at 16.05 hrs.		
	Date & Time of Next Meeting: **Thursday 30th September 2021 at 2.00-4.00 pm, via Microsoft Teams**		

……
Signed

……
Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee
Meeting held on 26th August 2021