Royal Papworth Hospital
NHS Foundation Trust

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

Held on 26th January 2023, 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
	Fadero, Amanda (left 16:07)	(AF)	Non-Executive Director
	Jarvis, Anna	(AJ)	Trust Secretary
	McCorquodale, Christopher	(CMc)	Staff Governor
	Midlane, Eilish	(EM)	Chief Executive
	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development
	Palmer, Louise	(LP)	Assistant Director for Quality & Risk
	Raynes, Andy	(AR)	Director of Digital & Chief Information Officer
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
	Webb, Stephen	(SW)	Deputy Medical Director and Clinical Lead for Clinical Governance
	Wilkinson, Ian (left 16:07)	(IW)	Non-Executive Director
In attendance	Shillito, Elizabeth (left 15:24)	(ES)	Theatre Matron
	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
Apologies	Hodder, Richard	(RHo)	Governor

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.

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1	**APOLOGIES FOR ABSENCE**		
	The Chair opened the meeting and apologies were noted as above.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement that those attending Board Committees to 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 by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration, as a		

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	freelance writer and broadcaster. The Chair advised that he was Co-Chair on a review of impartiality of BBC coverage of taxation and public spending. • Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd; CIS UCQ is a trademark for health and car IT courses established under consultancy ADR Health Care Consultancy Solutions Ltd. • Eilish Midlane as: Chair of C&P Diagnostic Steering Group; Holds an unpaid Executive Reviewer Role with CQC; as Director of CUHP; Voting Member of ICB. • Jag Ahluwalia as: Employee of 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. • 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; Consilium Partners is a specialist health consultancy working wit health and care organisations to help them plan, improve and deliver successful and sustainable futures. Interim CEO role St Barnabas and Chestnut Tree House Hospices for 6/12. • Maura Screaton as a director of Cambridge Clinical Imaging and has shares in some biotech companies. • Richard Hodder as Deputy Chair, Clinical Policies Forum, NHS Cambridgeshire and Peterborough ICB.		
3	**COMMITTEE MEMBER PRIORITIES** The Chair raised that there had been a request from Performance Committee held on the morning of 26th January to review PIPR Safe and Caring. To be discussed in agenda item 6.3.		
4	**MINUTES OF THE PREVIOUS MEETING – 22nd December 2022** The minutes from the Quality and Risk Committee meeting dated 22nd December 2022 were agreed to be a true and accurate record of the meeting and signed.		
5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 - from 22nd December 2022** The Committee noted the pre-circulated document, which was updated, with key points to note as follows: • 016: On the agenda. To be closed. • 025: Action to be closed. ICB meetings are currently evolving and		

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	IS/MS/SW to bring information to the Committee when relevant. • 031: In progress. To be closed. • 032: Focus on near misses to be held in March. All other actions are on the agenda, for discussion at a future meeting, or closed.		
6.	**QUALITY AND SAFETY**		
6.1.1	**QRMG and SIERP Highlight and Exception Paper** The Committee noted the pre-circulated document, with discussion as follows: • The Committee noted that there were no escalations from the QRMG and SIERP meetings held since last reported. • The Committee noted the Digital Clinical Safety Officers Report Q3 and requested further information regarding the misrouting of results. The Committee noted that further information is in the full report and that no harm was reported. AR informed the Committee that this is on the digital risk log and this is being identified and managed. Statement to be given on future Highlight and Exception papers stating that no harm was reported where relevant to give assurance to Committee. • The Committee noted that EPR remained one of the top three risks and suggested to AR that the variety of issues raised should be logged to inform procurement of a new system, in particular misrouting of results. AR stated that this has been the focus of discussions with Dedalus and would be part of any ongoing evaluation test criteria. • AR informed the Committee that the Trust is recruiting a new Chief Allied Health Professional Information Officer and that the Trust has a significant cohort of digital clinical information officers currently in place. • The Committee queried the two new RIDDOR reportable incidents reported to Health and Safety Executive during December 2022. Are staff members not using equipment correctly? How many incidents is the Trust having that are not reportable? The Committee noted that investigations are ongoing but that both incidents related to one bariatric patient. A triangulation has been sought between these incidents and non-compliance in mandatory training and none was found. However, the incidents have highlighted the requirement for a review of bariatric patient care, including equipment processes and training, to ensure the safety of staff and patients.		
6.1.1	**Serious Incident Executive Review Panel (SIERP) minutes (221206, 221213, 221220)** The Committee noted the pre-circulated documents.		
6.1.2	**SUI WEB 44419 Lung Cancer Incidental Finding** The Committee noted the pre-circulated document, with discussion as follows: • IW sought clarification regarding the radiology images in the Lessons Learnt section of the report. LP stated that this would be clearer in the full report and that she would ensure the action plan		

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	wording is strengthened. SW stated that lessons learnt are very important to the Trust and that the recommendations will ensure that we would do our best to ensure that it never happens again.		
6.1.3	**A Focus Review of Patient Incidents and Harm** LP led the Committee through a pre-circulated presentation, with points to note as follows: • The aim of the presentation is to provide the Committee with a focus review of patient safety incidents and any associated harm. • The Committee has noted and discussed in previous meetings the apparent emerging theme of a deterioration in relation to some basic essential aspects of process of care. The Committee asked for an assurance report and any recommendations for next steps. • The Committee noted that of the 2993 patient incidents recorded in the period from January to December 2022, 36 were reported as a harm level of moderate harm or above, with 3 graded as severe harm. • 99% of the recorded incidents were graded as near miss, no/low harm. • Top five incident types: o Medication/medical gases/nutrition (494) o Treatment and procedures (385) o Pressure ulcers (376) o Administration – admission/discharge/transfer/waiting list (348) o Accidents – slip/trip/falls and other related incidents (193) • The Committee noted the deep dive into each of the top five incident types included in the presentation. • Throughout 2022, patient feedback on Friends and Family Test (FFT) Surveys remained high at 96.7% and above. 16,513 compliments were received through FFT surveys, cards, emails and letters. The Trust received 58 formal complaints with no referral to the PHSO, and the data from Model Health System continues to demonstrate that the Trust is in the lowest quartile for national comparison. • The Committee noted the recommendations of next steps, as follows: • Further assurance of current work plans: o Quality & Risk Reports – Quarter 3 for 22/23 will be reported in February. o Quality Accounts for 22/23 has a clear focus on harm free care. o Continuous Care Records Audit is underway. o Health & Safety self-assessment and benchmarking review planned for March regarding compliance. o Policy and Procedure – task and finish group to be set up for clinical review of all policies/procedures related to care. o IR(ME)R Improvement Action Plan underway. All CQC required submission met. • New programmes of work and roles to be embedded in 23/24: o National Patient Safety Strategy roll out. National Patient Safety training for all roles (level 1) and clinical roles (level 2). Investigators to have dedicated training (levels 3-5) to		

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	enhance investigations, report writing and approach to future investigations. Further focused training on Just Culture and Human Factors to be rolled out. o Making Data Count – embedding new ways of reporting using statistical process control (SPC) and clearer data sets to aid assurance and monitoring of compliance. o New Posts – Head of Quality Improvement and Transformation and Patient Safety and Governance Lead. • The Committee discussed SPC charts and noted their potential to improve understanding in short term changes in data. However, the Committee asked whether it might gain false reassurance from the data, in particular if not interpreted correctly. LP advised that the Trust could add its target and tolerance to the charts. • The Committee noted that education in the proper use of SPC is necessary to ensure teams to be able to read, analyse and comment on the data provided. • The Committee agreed that the data should be triangulated with patient experience, safer staffing, narrative, investigation information and stresses within the Trust. • The Committee discussed the benefit of also looking at areas of no and low harm to try to drill down and change them in a positive way. • The Committee agreed that there appeared to be no evidence of deterioration as presented in this data. • The Committee noted that the annual report will contain more information on incidents and the annual Safer Staffing report will also be presented to the Committee. • The Committee requested that the presentation be sent to Performance Committee members prior to the next meeting for their information and reference.		
6.1.4	**Surgical Site Infection (SSI) Dashboard** The Committee noted the pre-circulated document, with discussion as follows: • This is preliminary data as patients can present later and results will go into a later quarter. • The Trust will be reporting to UKHSA that the overall percentage of inpatient admissions with SSIs post CABG surgery for quarter 3 has increased to 7.1% from 4.8% in quarter 2. • For the Trust's internal monitoring for all inpatients and outpatients who have developed an SSI, total for quarter 3 was 8.6%, which is a decrease from 11.8% in quarter 2. • There has been an increase in patients with Organ Space SSIs from 0 in quarter 2 to 2 patients in quarter 3. • The Committee noted that the Trust had a total of 1.6% in quarter 3 for post valve SSIs, with one deep and one superficial. The overall figure for inpatient and community patients for sternal wounds post valve surgery had increased to 4.9% in quarter 3, from 2.6% in quarter 2. • The Committee noted the information on monitoring and auditing activity and noted that the Theatre Matron, Elizabeth Shillito, has been key to driving improvements in theatres. • The Committee shared its frustration at the increase of SSIs in		

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	quarter 3 after an improvement in quarter 2 and discussed the continuation of the programme of work. The Committee acknowledged that some workstreams and practices had not yet been fully embedded and that when there had been a reduction of audits, incidents of SSI appeared to increase. The Committee noted that the Trust was increasing communication regarding compliance on areas such as environment, ANTT, etc, and that this message was more powerful as SSIs had increased when compliance had slipped. • The Committee discussed the importance of reviewing where the gaps are compared to the Trust's peers and acknowledged the benchmarking work already undertaken with Barts and Liverpool, and also acknowledged the Trust may have a higher footfall in theatres than some of its peers. The Committee noted that the Trust was in the early stages of undertaking audits regarding footfall, not only through corridors in theatres, but also in terms of interruptions of the operating theatre. JA asked whether the Trust had reviewed weekday vs weekend footfall and was advised that work had been undertaken on looking at themes when reviewing harm on patients with SSIs and no theme was apparent as yet. • Additionally, the Committee noted the ongoing work regarding the ventilation system, which is compliant, but is being discussed in the newly formed Ventilation Safety Group. • The Committee acknowledged the improved data that was available to inform reasons why SSIs are increasing. • The Committee acknowledged the amount of work that had been undertaken to improve SSIs throughout the Trust to date. • The Committee acknowledged that it may take a few months for new trends to be clarified and for improvements to be made, but would continue to review the evidence at meetings.		
6.1.5 **6.1.5.1** **6.1.5.2**	**CQC IR(ME)R Inspection Update** **Appendix 1: Action Plan relating to Improvement Notices** **Appendix 2: Action Plan relating to Final Report** The Committee noted the pre-circulated documents. • As discussed in previous Committee meetings, the Trust had received two Improvement Notices following a CQC IR(ME)R inspection on 2nd November, and a copy of the Final Inspection Report. • The Trust was required to ensure compliance to the Improvement Notices by 20th January and had sent an action plan and evidence to the CQC on 16th January. At the date of the meeting, no response had been received from the CQC. • The Trust responded to the Final Report on 9th December offering clarification on areas that it believed were factually incorrect in the Report. The action plan relating to the Final Report was sent on 9th January. The CQC confirmed receipt on 12th January and acknowledged that the plan was 'good, with most milestones complete or almost complete'. • The Committee commended the Trust on its response to the inspection report and Improvement Notices.		
6.1.6	**Safeguarding Committee Minutes (221202)**		

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	The Committee noted the pre-circulated document.		
6.2	**Patient Experience**		
6.2.1	**Patient Story** Theatre Matron, ES, gave a verbal patient story to the Committee with points to note as follows: • The patient story concerned a patient with a history of rheumatoid arthritis. They had a chest x-ray and were advised to present to A&E the next day where the patient was found to have pneumothorax. The patient was treated and referred to RPH for decortication. • The patient was first on the theatre list and reported they felt they were prepared well by the ward staff in the morning. The patient said that the two porters who came to collect them were in good spirits and chatted to them all the way down to theatre which helped to take their mind away from the operation. • On arrival in the department the patient commented about how calm the atmosphere was and was particularly impressed with one of the SCPs who was extremely kind and kept talking to them during line insertions and prep, playing music on her phone to relieve the patient's anxiety. • When the patient woke in recovery, they felt groggy and in pain but was instructed how to use their PCA. The Registrar informed the patient that due to an unusual presentation in the lining of their lung, they would have to stay in for four weeks. The patient remembers feeling very shocked as they had been told prior to the operation that they would remain in hospital for three to five days. • On return to the ward, the patient reported that they had received excellent care by the nursing staff and commented on how staff make time to chat with patients as they carry out tasks. • The patient did state that an area of improvement would be their communication with the medical team. The patient described how they saw the medical team briefly each morning but says it would have been good to see the same doctor two days in a row. The patient felt that the doctors had been unable to answer their questions fully. The patient said that they had not seen their consultant since before the operation (the consultant was on leave). They felt that they were pestering the nursing staff for information that they are not able to provide. This caused the patient anxiety as they were not sure of their recovery plan going forward. • Actions from the patient story were: o Contacting the Consultant who is currently on a/l but a registrar will visit the patient. o Thank the staff involved in the patient's care both in theatre and the ward. o Feedback to surgical team regarding ward rounds and on-going communication with patients regarding their plan. • The Committee thanked ES for the story and discussed the patient's feedback as presented. • The Committee discussed the change in outcome for the patient and their increased stay in hospital after the operation. • The Committee discussed the process of current and past rounds		

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	undertaken by medical staff. Firm working is currently being used to enhance education of junior doctors; however, it was acknowledged that this does have issues for timings as the doctors need to complete rounds before 08:00 to get to theatre for briefing. There is also apparent insufficient time to scribe so there are breakdowns in communication. • The Medical Director and Deputy Medical Director thanked ES for raising the issues and stated that they would review the response given from the surgical team to the issues raised and follow up. The Committee asked for an update to be given to a future meeting on the concerns raised regarding the ward rounds and communication issues.	IS/SW	04/23
6.2.2	**Patient and Carer Experience Group Minutes (220905)** The Committee noted the pre-circulated minutes.		
6.3	**PERFORMANCE**		
6.3.1 **6.3.1.1**	**Performance Reporting** **PIPR Safe – M9** The Committee noted the pre-circulated document, with points to note as follows: • The Chair advised that the Performance Committee had requested the Committee to review VTE, SSI, which was discussed in 6.1.4, sepsis and roster approval times, to avoid duplication of discussion in separate Committee meetings. • Sepsis: Compliance in Quarter 2 was 100%, and in Quarter 3 was 81%. The areas on non-compliance in Q3 related to four patients on Critical Care. The sepsis bundle has six areas that need to be compliant for each patient to be compliant. For the four patients, one element was not achieved. However, this did not change the effect the outcome of the patient in terms of there was not a delay in treatment nor harm to the patient as a consequence of ongoing septicaemia. The Committee acknowledged that the Trust was a different type of organisation to, for example, CUH, and does not have the same type of numbers when it comes to triggers for sepsis. • Roster approval times: the national set KPI for this metric is six weeks in advance of the roster being worked. There are some key areas of improvement and good practise over the last number of months: ALERT, 3N, 4S and CCA. 5N and 5S have made more recent improvements and work is ongoing to support and sustain these. When the Trust began to look at the Theatre roster in the summer, there were fundamental problems with the roster template and how it was being managed. The template has been stripped back and rebuilt and the staff managing the role have the necessary training and skills to be able to manage it. • The Committee discussed the outpatient roster and noted that the Head of Nursing is picking up with the team. • VTE: compliance with performing VTE risk assessments was 84% in December. This continues to be an area of particular focus and actions are being monitored through QRMG and divisional performance meetings. There has been more medical engagement in recent weeks and VTE is discussed at CDC.		

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	Recent conversations have been held regarding relooking at digital hard stop solution. This has been discussed previously with the Digital Team in terms of how this can be implemented. • Staffing – roster fill rates: the roster fill rates have not improved significantly and will not do so until we get more people in post. The Trust is maintaining safety through daily mitigation, however there is a risk in terms of sustainability of that mitigation on a daily basis and the effect of that on staff. It was noted that the cardiology pipeline has improved and cardiology should be fully established in a couple of months.		
6.31.2	**PIPR Caring – M9** The Committee noted the pre-circulated document.		
7	**RISK**		
7 **7.1** **7.1.1**	**Board Assurance Framework Report** **Cover Paper – Board Assurance Framework (BAF)** **BAF** The Committee noted the pre-circulated documents, with discussion as follows: • The Chair suggested that the Committee has a future focus on how the Trust is assessing the risks around M.abscessus. Reporting suggests that the Trust is back to a reasonable baseline level, but it is still assessing the risk as being much higher than target. • AJ advised that sub-Board Committees are overseeing the Industrial Action. This was discussed at the morning's Performance Committee meeting.	AJ	03/23
7.2 **7.2.1** **7.2.2**	**Corporate Risk Register** **Appendix 1: Open/Closed Risks** **Appendix 2: Live Corporate Risk Register as at 12.01.23** The Committee noted the pre-circulated documents.		
8.	**GOVERNANCE AND COMPLIANCE**		
8.1	**First Draft Annual Governance Statement** AJ gave a verbal update, with points to note as follows: • A general standard set of terms/control mechanisms will be included. • Last year, commentary was included on, for example, M.abscessus and Surgical Site Infections. AJ would like to ensure that comments from Committees and Board are reflected this year. • AJ will create a draft and circulate to Committee members. The Committee gave initial thoughts, including: o Harm review; o Safer staffing; o Quality improvement approach taken in terms of problem solving – for example, CCA Transformation Programme and staff engagement. Learning from that programme has been particularly important.		
8.2	**Quality Accounts Priorities 22/23 Quarter 3 Update** The Committee noted the pre-circulated document.		

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8.3	**Quality Accounts Priorities for 23/24** The Committee noted the pre-circulated document, with discussion as follows: • The Committee commended the list of priorities presented and acknowledged that it would need to recommend its five top priorities to take to PPI Committee in February. • The Chair asked what specific boost is given to subjects chosen to be included in the quality priorities. • The Chair stated that Board had recently set a number of strategic priorities. • The Committee acknowledged that the topics within the report were also subjects of conversation within Committee meetings over the past year, and the importance of linking the improvement journey that the Trust is on and monitoring progress in terms of setting targets for each year and monitoring same. Additionally, the Committee noted the importance of not creating a number of additional work streams going forward. • The Chair gave suggestions for potential inclusion, including OD capacity, grow-your-own proposals, frailty service code collaboration. • The Committee discussed the optics of dropping a current priority. Would the subject still have the internal attention that it would get if it were still a priority? • The Committee discussed potential priorities including: VTE, barcode medication. MS advised that she would expect to see barcode medication within the medicine administration programme. • The Committee recognised the regulatory framework around the Quality Accounts and the link between quality and safety and workforce. • The Committee noted the importance of linking the priorities to the Quality Strategy and the importance of understanding why a previous Quality Accounts priority may not have succeeded. Is it because we have had too many priorities? Should we just concentrate on one overarching priority and sit others underneath that? For example, training. • MS has taken the list to EDs and is awaiting comments. • Committee members to send suggestions and comments to MS for consideration and inclusion.	Committee	31/01/23
8.4 **8.4.1** **8.4.2** **8.4.3** **8.4.4** **8.4.5**	**CQC Fundamentals of Care Board Update** **Regulation 20: Duty of Candour Report** **Regulation 20: Duty of Candour Highlights** **Regulation 16: Receiving and Acting on Complaints Report** **Regulation Receiving and Acting on Complaints Highlights** **Regulation 14: Nutrition/Hydration Needs Highlights Update** The Committee noted the pre-circulated documents. • The Committee acknowledged that the new review programme was going well and had good commitment from staff.		

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8.4.6	**CQC Fundamentals of Care Board Minutes (221207)** The Committee noted the pre-circulated document.		
8.5	**SIRO Report** AR led the Committee through the pre-circulated document, with points to note as follows: • Work has commenced on the 2023 submission for the Data Security and Protection Toolkit 22/23. • Three recommendations were made from the last audit, all have been completed, so no issues are anticipated. • Information governance training compliance is currently sitting at 90% for the Trust, which is 5% lower than the required rate for the toolkit submission. • 44 information governance related issues recorded on Datix for Quarter 3. 7 were actual incidents, with the remainder being near misses. Incorrect communications, whereby patient data is sent to the wrong recipient via letter/email or handed to them by ward/outpatient staff continues to account for the majority of actual incidents. • There have been no externally reportable incidents in Quarter 3. • The Committee discussed the hybrid mail project that the Trust is currently undertaking to reduce errors of letters/emails being put in the wrong envelope, etc. This project is ready to go live and is also part of the Trust's sustainability agenda. • AR highlighted ongoing training and education regarding data breaches. • The Committee discussed externally reportable incidents and required assurance that the Trust was reporting these when appropriate. AR advised that the Trust takes the standard for external reporting from the Information Commissioner's Office (ICO) and internal reporting is robust via the SIRO report and the Information Governance Steering Group.		
8.6 **8.6.1**	**Cover: Document Control** **Document Control – Out of Date Documents** The Committee noted the pre-circulated report and the improving position, and noted the importance of staff members informing document control once their documents had been approved by relevant committees.		
8.7 **8.7.1** **8.8**	**Internal Audits:** **Infection Control – Compliance with Hygiene Code December 2022** The Committee noted the pre-circulated document. **External Audits/Assessment:** There were none to report.		
9	**POLICIES**		
9.1	**DN006: Ionising Radiation Safety Policy v9 2023** • The Committee noted that the pre-circulated document had been ratified via Chair's Action to ensure that it met the deadline for CQC IR(ME)R Improvement Notices. The Policy was noted by the		

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	Committee which had no comments.		
9.2	**DN100 Blood Transfusion** • The Committee ratified the pre-circulated document.		
9.3	**QRMG Terms of Reference** • The Committee ratified the pre-circulated document.		
10	**RESEARCH AND DEVELOPMENT**		
10.1	**Minutes of Research & Development Directorate Meeting (221111)** The Committee noted the pre-circulated document.		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** • No escalations noted from the January CPAC meeting.		
11.2	**Minutes from Clinical Professional Advisory Committee** • No CPAC meeting held in December 2022, due to Industrial Action.		
11.3	**Clinical Ethics Committee Minutes (221209)** The Committee noted the pre-circulated document.		
12	**ISSUES FOR ESCALATION**		
12.1	**Audit Committee** • There were no issues for escalation from Part 1.		
12.2	**Board of Directors** • There were no issues for escalation from Part 1.		
12.3	**Emerging Risks** • There were no emerging risks.		
13 **13.1**	**ANY OTHER BUSINESS** **Forward Planner for 2022** • The Committee noted the pre-circulated document. • No further business reported.		
	Date & Time of Next Meeting: **Thursday 24th February 2023 at 2.00-4.00 pm, via Microsoft Teams**		

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Signed

23rd February 2023

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee