Royal Papworth Hospital
NHS Foundation Trust

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

Held on 23rd February 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	(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 (left 14:29, returned to meeting 15:05)	(IS)	Medical Director
	Wilkinson, Ian	(IW)	Non-Executive Director
In attendance	Shillito, Elizabeth (Observer)	(ES)	Theatre Matron
	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
Apologies	Hodder, Richard	(RHo)	Governor
	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 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		

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	Change by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration, as a 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 commented that following the February Board meeting, he had considered whether Trustees might be unsighted about very short-term pressures on patient safety. At January's Quality & Risk Committee meeting, LP had made a presentation that that given the Committee assurance on the outputs of patient safety, but does the Trust have metrics that could give the earliest possible indication that levels of patient harm were beginning to show signs of strain and stress? The Committee discussed the above, with points to note as follows: • The Committee noted that the Trust is already monitoring metrics such as hospital acquired infections, falls, pressure ulcers, red		

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	flags, and patient experience, all of which are robust measures that can be accurately documented and give an understanding of when patient safety and care might be slipping. • The Committee noted the robust work undertaken on SSIs. • It was acknowledged that the Committee receives monthly reports but asked whether there was possibility of accelerating information of emerging trends/risks. • The Committee was informed that the Trust follows all national governance guidelines. • The Committee was given assurance that triangulation was undertaken through clinical audits. • Additionally, SIERP meetings are held each week. • JA reiterated a point raised in a previous meeting by the Chief Nurse whereby the importance of going 'back to basics' has some early indicators but are not summative. • Does the Trust need to gather more soft intelligence and discuss with staff at the end of their shifts, for example, what they felt they did not quite get around to doing, and whether they had to make a discretionary choice between what got done, and what got sacrificed? • The Committee discussed the types of subjective conversations that could be held with staff members, for example: 'how good a job did you feel you did?' 'what did you wish you had done that you did not have time for?' 'would you have managed to get everything done if you had more resources?'. The Committee agreed on the importance of staff commentary and wondered how this kind of soft intelligence could be collected. • MS highlighted that the Trust was aware of the current difficulties with vacancies and fill rates and reiterated the extraordinary efforts that people were making every day to mitigate these to ensure patient safety and good patient experience. MS reiterated that no detrimental effect from this is being seen on patient outcomes as demonstrated in LP's presentation to the Committee in January. • The Committee acknowledged that the Trust was a smaller organisation than most and that the Executive is alerted to issues more readily and sighted on them through the incident reporting system. • The Committee acknowledged that staff shortages do have an impact on staff wellbeing, job satisfaction and retention of staff. • MS reiterated the early warning signs that the Trust monitors and acknowledged the key piece of work that has been undertaken over the past few months concerning ensuring that – following the pandemic - Matrons are back in their areas and fulfilling their Matron role. In addition, the Committee noted that a piece of work is currently in development regarding the Ward Sisters, which is key in terms of supporting staff and providing clinical leadership and oversight of wards and generally developing the Ward Sister role. • The Chief Executive stated that she noted the level of detail provided in dashboards developed for individual ward areas, teams and PIPR but acknowledged that there had been a few occasions during her tenure at RPH where information had been tracked through a lower level dashboard but the spirit of curiosity		

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	and inquiry around spotting the trend early had not necessarily been there. • EM: I wonder whether the focus is not actually to go and look for new metrics, but to encourage and train people to be curious about the metrics they are seeing and to escalate? • IS: We are having more conversations about the metrics and the risks posed. And if we were to ask staff whether they did a good job, most would say 'yes', but there is only so long they can do that through extra effort, through mitigation, through missing their breaks, and it is becoming a top priority. • OM: I have been thinking about assessment and discussion of patient harm, and we are right to focus on this, but are we balancing the harm to staff? • The Committee acknowledged that the indicators of harm to staff were clear in the staff survey, which will be discussed in Part 2 of Board as it is still embargoed. • Is the Trust balancing harm to patients and harm to staff appropriately in its discussions and decision making? • The Committee agreed on the importance of this discussion and suggested that the Workforce Committee continue to consider this important topic. • The Committee agreed that Executives should consider and give a proposal on how the Trust can gather soft intelligence to help earlier detection around staffing pressures and how this may close the gap for any potential patient harm indicators or occurring trends.	MS	03/23
4	**MINUTES OF THE PREVIOUS MEETING – 26th January 2023** The minutes from the Quality and Risk Committee meeting dated 26th January 2023 were agreed to be a true and accurate record of the meeting and signed.		
5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 - from 26th January 2023** The Committee noted the pre-circulated document All 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 the escalation from QRMG that was raised as part of the Trust wide Q3 Quality and Risk report update for harm free care section, in relation to Venous Thromboembolism (VTE) monitoring. • The Trust is regularly not achieving the 95% VTE national target and the VTE Oversight Group is recommending that the Trust should not apply for revalidation as an exemplary site. • Instead, the Committee was asked to consider that a focus is given on informatics and engagement at clinical and patient level in preparation for re-applying next year. The Committee agreed to		

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	this request. • It was noted that VTE is shortlisted as a quality priority for 2023/24. • The Committee noted the work that has been undertaken regarding delirium. CCA has completed some work on assessment and management of patients with delirium and the Delirium Working Group (DWG) would like to share this and adapt to wider Trust practice. Identification of improvements has been made and an action plan is in place to support the improvement. This to be supported and monitored by QRMG. • The Committee noted the Divisional report highlights and acknowledged staff's contribution to safe staffing by being flexible, and by redeployment, etc. • It was noted that Level 5 can safely open to 63 beds and the Committee was assured that the Trust has undertaken modelling around the number of beds needed with reduced theatre activity. The Committee noted that whilst recruitment is ongoing the Trust would face pressure should activity return to full capacity. • Two moderate harm incidents were reported in the month of January 2023. • The Committee discussed the grading of WEB46362, regarding possible missed doses of anticoagulation and was advised of the grading process. IBW requested to see the full report when available. • The Committee noted the WHO Surgical Checklist Compliance and challenged that it was below the expected standard of 100%. Is this a recording issue? The Committee noted the work that was being undertaken regarding this and the improvement that is being made. A focus on this to be brought back to a future Committee meeting. • No Serious Incidents were reported to QRMG in January 2023.	MS/LP	04/23
6.1.1	**SUI WEB 45103 Organisation O2 review – Final Report and Action Plan** The Committee noted the pre-circulated document and discussed the grade of harm and lessons learned. • The Committee discussed that it had noted two different ventilation issues with low harm and noted the thorough review that had taken place and the triangulation that had taken place at SIERP. • It was noted that the incident team undertakes a review of what other incidents have occurred, and this is included in SIERP. • It was noted that the incident review team went above and beyond in this investigation.		
6.1.2	**SUI WEB 44277 Category 3 PU Final Report and Action Plan** The Committee noted the pre-circulated document and discussed the contributory factors and lessons learned.		
6.1.3	**Serious Incident Executive Review Panel (SIERP) minutes (2301.03, 230110, 230124, 230131)** The Committee noted the pre-circulated documents.		
6.1.4	**Trust Wide Quality & Risk Q3 Report**		

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	The Committee noted the pre-circulated document, with discussion as follows: • The Chair noted that the severity of patient safety incidents data. In Q3, incidents graded as near miss and no harm have decreased, but low harm incidents have increased. • The Committee queried the definition of non-clinical accidents and incidents and was informed that these were incidents involving staff, contractors, the organisation or visitors, and that future reports on staff incidents would be presented to the Workforce Committee. The Committee noted the increase in non-clinical incidents compared to Q2. The Committee suggested that LP review the classification of incidents to ensure clarity. • The Committee noted that incidents are reportable to the Health and Safety Executive if they meet the criteria. • The Committee noted that the Trust was undertaking a health and safety tabletop exercise and that an update will be given to both Workforce Committee and Quality & Risk Committee. • The Committee reiterated its acknowledgement of the Trust's staff in working flexibly and mitigating issues to ensure patient safety through safe staffing.		
6.1.5	**Surgical Site Infection (SSI) Dashboard** The Committee noted the pre-circulated document, with discussion as follows: • The Trust will report to UKHSA that the overall percentage of inpatient admissions with SSIs post CABG surgery has increased to 7.1% from 4.8%. This is the equivalent of 14 out of 196 patients. It was noted that the data does include one patient with three infected wounds which are counted as separate episodes, so there are 12 patients affected. • The Trust's internal monitoring for all patients and outpatients who have developed an SSI for Q3 was 8.6% which is a decrease from Q2. • The Committee noted the processes and actions in place and acknowledged the increased assurance regarding surgical instruments. • It was noted that a review of January data shows that there had been no non-conformances in relation to the cleanliness of instruments. More intelligence has recently been received that some of instruments were old and had an element of rust. These are being replaced. • The Committee acknowledged the ongoing work around ANTT training and compliance with IPC measures. • The Committee noted the data concerning compliance with surgical prophylaxis antibiotic administration and challenged the compliance of 80% in November 2022. • Additionally, the Committee asked whether there was a suggestion that the organisms are clonally related for any of these infections. • The Committee was advised that the microbiologists have undertaken a review and found no specific commonality. • AF commented that the discussion highlighted a common theme that basics are not always being met for, for example, VTE, WHO		

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	checklist, SSIs, etc. This links back to how the Trust's staff are feeling and the stresses and strains placed upon them. • The Committee noted that initial data for January shows that overall infection rates had risen, but deep infection rates had decreased. • The Committee agreed that it should support the Trust's current approach but acknowledged that the Trust may have to explore other causes and mitigations should the current efforts fail to reduce infection rates. • The Committee noted the issues presented by the number of digital databases that are used. Root cause analysis undertaken from forty SSIs highlighted up to six digital systems were in use that were not as intuitive as they could be. AR advised that the Trust does need to try to reduce the number of systems in place and that it is on the Digital Team's radar. • The Committee also noted the current queries concerning the ventilation system in Theatres. Monitoring of these systems confirms that they are compliant and the Ventilation System Group meet regularly to discuss current issues and concerns.		
6.1.6 **6.1.6.1** **6.1.6.2**	**CQC IR(ME)R Inspection Update** **Appendix 1: CQC IR(ME)R Trust Response from CEO 230215** **Appendix 2: DN006 Ionising Radiation Safety Policy v9** The Committee noted the pre-circulated documents and thanked MS and LP and their teams for their work.		
6.2	**PERFORMANCE**		
6.2.1 **6.2.1.1**	**Performance Reporting** **PIPR Safe – M10** The Committee noted the pre-circulated document, with points to note as follows: • The Performance Committee had requested Quality & Risk Committee to consider the Klebsiella bacteraemia cases identified in January and also the fill rates in respect of night registered nurses. • Klebsiella bacteraemia: the three cases were very complex patients. • One patient who was diagnosed with E.coli bacteraemia was a long term complex Covid patient. • The Committee was assured that the Trust's microbiologists review all bacteraemia cases to identify commonalities and learning and found no care or service delivery concerns or issues. • With regard to safe staffing at night fill rates, the Committee noted that this was due to a combination of issues: the Trust had made a conscious effort to increase daytime staffing as, generally, it was found that agency and temporary staffing preferred to fill the night shifts due to work/home life balance and better pay. However, some night shifts were not filled by agency/temporary staff and so staff were moved to night shifts to mitigate. • The Committee noted that patient to staff ratios have not exceeded minimum expectations. • The Committee noted that the red on the staffing fill rate is pre-mitigation.		

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	• Response to Performance Committee to be included in the Chair's Committee report to Board.		
6.31.2	**PIPR Caring – M10** 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. • The Committee agreed that it would be beneficial to see an indicator for changes to BAF risk targets. • AJ advised that this can be flagged in the narrative.		
8.	**GOVERNANCE AND COMPLIANCE**		
8.1	**Annual Report (Performance Report) and Quality Accounts Timetable** The Committee noted the pre-circulated document with points to note as follows: • AJ advised that the national guidance had not been published as at the date of this meeting, but the team is making the assumption that it will not change this year. • The Quality Accounts are published electronically on the NHS Choices website by 30th June. The Committee noted the draft timetable and that it would receive a first draft in the March Quality and Risk Committee meeting.		
8.2 **8.2.1** **8.2.1**	**Quality & Risk Committee Annual Self Assessment and Review of Terms of Reference** **Appendix 1: QR Self-Assessment 2022-23** **Appendix 2: TOR002 Quality & Risk Committee** The Committee noted the pre-circulated documents. • AJ advised that discussions had taken place at other Committee meetings regarding the self-assessment, and it had been agreed that a summary assessment would be required. Therefore, a SurveyMonkey will be sent individually to Board members for completion and contribution. • It was noted that Committee attendance is expected to be 50%. The Committee discussed whether the new Chair of QRMG from 1st April should attend Quality & Risk Committee. AJ to review ToR to see whether Chair and Deputy Chair of QRMG should be listed as required to attend. • AJ suggested that she and the Chair review the ToR to remove items relating to the Workforce Committee and to retain the health and safety oversight requirement. • Further amendments to be made to the Committee attendance list for 2021/22 – post meeting note: this has been completed. • For the self-assessment section, the Committee was advised that the meeting should consider what reflections it wants to capture and review the checklist questions. The Committee noted the drafted narrative and discussed the scoring of ratings and actions for improvement required as a result of the self-assessment. This	AJ	03/23

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	to include training. • The Committee discussed training and asked whether members receive training specific to the functions of the Committee. The Committee also acknowledged the importance of familiarisation – for example, the Chair expressed that he would have found shadowing the previous Assistant Director for Quality and Risk beneficial before he became Chair of the Committee to see how quality data is assembled and serious incidents are investigated. • The Committee agreed on the importance of understanding the details regarding the way the Trust operates. • The Committee agreed on the benefit of training in relation to health and safety and executive expectations. • AF stated that she was the NED link for safeguarding and would welcome relevant legislation training. • The Committee discussed the Checklist and agreed that for number 32, internal audit would look at safe staffing; and for number 34, Chris McCorquodale was a representative as Staff Governor and that links to representative groups and other stakeholders. • JA recommended a possible annual 15-minute structured focus on how data is collected and cleansed would be beneficial to get further assurance on data methodology. • The Committee discussed how it could gain greater assurance on data quality and discussed how members had previously talked to people at the middle level of the organisation to get an understanding of processes which otherwise would appear as a line of text on a page. Would it be of benefit to restart this? It was agreed that understanding the processes of data and the quality of the data/numbers would be beneficial. • LP advised that PIPR does give the data source and should give the Committee assurance. The Committee also noted that the RTT patient pathway and Lorenzo data quality report goes to the Performance Committee. • The Chair recommended that this discussion be considered as to how it would link into the Committee's self-assessment.		
8.3	**Cover: Document Control Compliance** **Document Control Spreadsheet – Out of Date Documents** The Committee noted the pre-circulated document, with discussion as follows: • The Committee noted that the out-of-date document report is produced every fortnight and that the number of out of date documents at the time of this meeting is 161, reduced from 187. • The team is continuing to monitor out of date documents and working with document owners to review and revise where appropriate. Additionally, there is a group reviewing ways to improve the process of document control, including digitally.		
8.4 **8.5**	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		

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9	**POLICIES**		
9.1	**Remediation Policy** • The Committee raised some queries regarding the policy concerning reporting timeframe. It was agreed that the policy should be presented and ratified at the Workforce Committee and that the reporting to Committee timeframe be reduced to annually with exception reporting as required.		
9.2	**Cover: DN322 Fire Policy v7** • The Committee noted the pre-circulated document.		
9.2.1	**DN322 Fire Policy v7** • The Committee ratified the pre-circulated document.		
9.3	**DN057 Security Policy** • The Committee ratified the pre-circulated document.		
9.4	**DNxxx Volunteers Policy** • The Committee ratified the pre-circulated document.		
9.5	**DN694 Policy for Implantable Loop Recorders v3** • The Committee ratified the pre-circulated document.		
10	**RESEARCH AND DEVELOPMENT**		
10.1	**Minutes of Research & Development Directorate Meeting** • None available.		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** • No escalations noted from the February CPAC meeting.		
11.2	**Minutes from Clinical Professional Advisory Committee (230119)** • 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	**ANY OTHER BUSINESS** • The Committee discussed the issue of escalations from other Committees and the importance of ensuring that their questions raised are framed correctly and loop closed. It was noted that a		

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	response to escalations and requests for further information by other Committees are noted in the Committee Chair's Report to Board and in the minutes of the meeting. • No further business reported.		
	Date & Time of Next Meeting: **Thursday 30th March 2023 at 2.00-4.00 pm, via Microsoft Teams**		

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Signed

30th March 2023
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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee