Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 1, Month 3

Held on 30th March 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
	Hodder, Richard	(RH)	Lead Governor
	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
	Wilkinson, Ian (left 15:35)	(IW)	Non-Executive Director
In attendance	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
Apologies	Smith, Ian	(IS)	Medical Director
	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 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		

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	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 highlighted the query at the recent Governors Meeting made by one of the Governors as to whether the Board and Governors were getting complete reports and whether the data regarding safety is reliable. The Governor reported that they had experienced a slight deterioration in care they received as a long term patient. This was more fully discussed in Agenda Item 4, below. • MS advised that the Performance Committee had requested the Quality & Risk Committee to review the five reported moderate harm incidents for February, and the reported Alert Organisms. To be discussed later in Agenda Item 6.1.1., and 6.2.1.1 below.		
4	**MINUTES OF THE PREVIOUS MEETING – 23rd February 2023** The minutes from the Quality and Risk Committee meeting dated 23rd February 2023 were agreed to be a true and accurate record of the meeting and signed, subject to an amendment in the Committee		

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	Member Priorities section, to read as follows: *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.*		
5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 - from 26th January 2023** The Committee noted the pre-circulated document and discussed as follows: • 032: To be brought to April's meeting. • 038: MS advised that she had been reflecting on what the soft intelligence could look like and highlighted the importance of visibility and environment rounds, matron quality rounds, speaking to patients and staff and being more curious, plus the voice of the patient coming through in patient stories. This interface is already in place, but we will look at further ways of reporting. Additionally, with the work that is being done with matrons and ward supervisory sisters going forward to get them back to doing their roles, we will be able to collect that information more robustly. The Committee agreed that this can be captured and brought to future meeting intermittently. It was noted that Matron Reports were highlighted in the QRMG/SIERP Highlight and Exception Paper. The Chair stated that in the metrics available around the hard stops, there is no definitive evidence of harm. However, the soft intelligence will enable the Committee to review and be problem sensing rather than comfort seeking should an issue become apparent. LP advised that on PIPR month 11, to be discussed later in the meeting, the Trust has been using information from the Friends and Family Tests and that the lack of robust soft intelligence had been recognised. MS/LP to review how the soft intelligence can be captured and reported to the Committee more robustly and bring to future meeting. • 040: Has now been discussed and approved at Board. Action to be closed. Further actions are on the agenda, for discussion at a future meeting, or closed.	MS/LP	05/23
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 due to the Junior Doctor Industrial Action and planned annual leave, the meeting was not held in its normal format but that a high level QRMG meeting was held instead. Additionally Chairs/Deputy Medical Director actions were given to documents following review at the meeting. • There was one escalation from QRMG: storage of medical gases.		

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	Level 1 storage area did not meet current regulations on storage of medical gases. A decision from Medical Gas Committee on how to proceed is outstanding. This review is underway. This has been brought to QR for awareness at present and the Committee requested that LP advise on resolution timeline at next meeting. • No escalations from the recent SIERP meetings held since last QR Committee meeting. • The Committee noted the Medical Examiner's Officer Report for Q3. • The Committee noted the five new moderate harms reported in February, all of which are currently under investigation. LP advised that two of the five only just made threshold as moderate harm but have been included to ensure robust investigation with a formal level one report for review. For example, WEB46548, failure of chest drain – this was on the cusp of moderate harm but involved a national procurement issue, so the team wanted to commission a level 1 report to understand the procurement process, etc. • MS: do we need to tease out any further human factors element that might be a commonality across these five harms? Are they in the high-pressure areas? • LP advised that human factors are a part of harm reviews such as these, but that she will highlight for the reviews to have an increased consideration of human factors due to increased pressures and include in report. • The meeting noted the risk update. • Two RIDDOR reportable incidents were reported to the Health & Safety Executive and are under internal investigation. • The Committee noted the incident where a member of staff was assaulted by a patient with delirium on Critical Care. This was a traumatic experience for the member of staff who is being supported by the Trust. It was noted that the Trust is reviewing its Violence and Aggression Policy to ensure that it is fit for purpose. • The Committee acknowledged that the number of overdue risks continues to fluctuate with 23% being overdue risks. The Committee requested that the dates on the table be reported the other way round – with the most recent month in the right-hand column. • Three formal complaints were received in February. • The Committee noted that five Inquests were heard in February. IW requested further information regarding INQ2223-07. LP to share offline. The Committee suggested inclusion of further explanation in narrative to give assurance that there was no action for the Trust. Care to patient was being supplied by West Suffolk Hospital, but RPH had supplied ventilation support machine for patient use.	LP	05/23
6.1.1	**Adult Critical Care Services Peer Review Report** The Committee noted the pre-circulated document. • The Committee acknowledged that it was a positive peer review and noted that the CC Transformation Programme (CCTP) update/review was reported to the March Workforce Committee.		

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	• MS advised that work is continuing in the CCTP to ensure integration. • AF highlighted the importance of integration of AHPs and Pharmacy into the work of divisions – this should be a key focus of both the Workforce and Quality & Risk Committees. • The Committee acknowledged the high turnover in Critical Care and the challenge this presents. • CMc advised that at the time of the review, there were two Critical Care Pharmacists as the third was on a career break. Therefore, the Trust is in a better position that what is indicated in the review. • The Committee agreed that although it is important to challenge peer reviews, this should be celebrated.		
6.1.2	**Serious Incident Executive Review Panel (SIERP) minutes (230207, 230214, 230221, 230228)** The Committee noted the pre-circulated documents.		
6.1.3	**Trust wide Clinical Audit Forward Plan April 23 – March 24** The Committee noted the pre-circulated document, with discussion as follows: • The forward plan provides a comprehensive list of all the national and local audit activity at Royal Papworth Hospital, that has been agreed by all divisional leads at the beginning of the financial year 2023-24. • The Committee noted that the audit culture is growing again in the Trust. This is year 2 of recovery since the pandemic. • The Trust has seventeen national audits that it is mandated to be part of. Ninety-two local audits planned for the year, with some trust wide audits included in the Quality Accounts so they will go forward again next year. • The Committee acknowledged that this was a large piece of work and was assured that resource is available in the relevant divisions. LP advised that the Clinical Audit Team was looking at how clinical audits can be shared on the intranet to ensure cross learning internally. The Clinical Audit Team is also looking at how the Trust can use software to support the audits, at present it involves quite a lot of manual work and is labour intensive. • EM offered a slot to promote the clinical audits and share learning at a future Monday Weekly Briefing session. • The Committee asked how many of the smaller local audits qualify as an audit cycle and whether they are followed through in serial years? The Committee noted that audit frequency was stated in the document and was assured that Trust wide audits under nursing, for example the IPC audits, etc, will always be held annually as they are part of annual assurance. Some divisions choose other audits to be annual as they have, for example, a professional interest in that area. These are supported and audit outcome reviewed to determine frequency. • JA: the self-actuated audits, particularly for people to learn about audit can be of modest value and do not get repeated. The return on investment for audit is often quite modest unless they are properly followed up. • The Committee asked whether some audits were of more value to		

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	the Trust and was advised that divisions had committed to the audits. • The Committee noted that the Trust is currently developing work regarding quality improvement projects alongside clinical audits, and it is intended that this work can be reviewed by the Committee at the end of the next financial year. • The Committee thanked the Clinical Audit Team for their work.		
6.1.4	**Surgical Site Infection (SSI) Dashboard** The Committee noted the pre-circulated document, with discussion as follows: • Data submitted to UKHSA for Quarter 3 is 8.1% (16/196) of inpatients/readmissions who had developed an SSI post CABG surgery. • Review of patients from January shows one additional patient with an organ space sternal SSI post CABG surgery, which increased the reportable percentage for January to 11.10% from 9.5%. Initial data for February shows one patient with deep SSI sternal wound and three with superficial SSIs. The Committee noted that these figures may increase. • MS advised that the figures were not where the Trust wants to be and are concerning. The Trust is continuing with quality monitoring, as outlined on the second slide, and the SSI Stakeholder Group is very engaged with more surgical consultant engagement. SSIs are also a standing agenda item at the Surgical M&M meetings. • The Committee noted that in the last week or so, the SSI Stakeholder Group and relevant teams have really questioned themselves in terms of what else can be done and have reviewed the NICE guidance around surgical site infections. The Trust is ensuring that it is as robust as it could be with regard to antibiotic coated sutures and gentamicin impregnated dressings for high-risk patients. Additionally, focus is being given to footfall in theatres and the opening/closing of doors. • MS advised that she had attended a Decontamination and Sterilization Conference in London with other RPH colleagues and made contacts in terms of what more the Trust can do. Although the Trust has had an outside surgical review, MS is considering a review from a Director of Infection Prevention Control to invite further scrutiny. • The Committee agreed that further scrutiny would be welcome as would the focus on NICE guidelines and footfall in theatres. • The Committee discussed ongoing concerns regarding ventilation in theatres and noted that the Trust had received assurance reports from Skanska regarding the ventilation. The Committee agreed that an external review from an NHSE expert would be beneficial. • The Committee noted that audits had taken place in the theatres and wondered whether the surgical teams were embracing the ongoing work. MS advised that this was the case and that a lot of work had been undertaken in the operative phase of the patient journey and theatres in the last six to eight months. Following the audits that were done in that time, there have been huge		

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	improvements. • The Committee noted the complex comorbidities of the high-risk patients, the importance of marginal gains everywhere and the Trust's continued strive for improvement. • The Committee asked whether the Trust should consider duty of candour and was assured that this was already in place and timings were confirmed.		
6.2	**PERFORMANCE**		
6.2.1 **6.2.1.1**	**Performance Reporting** **PIPR Safe – M11** The Committee noted the pre-circulated document, with points to note as follows: • Compliance with performing VTE risk assessments was 91.70% in February. This continues to be an area of particular focus and is monitored through QRMG and divisional performance meetings. • The Committee noted the Spotlight On Supervisory Sister/Charge Nurse Role section. • The Performance Committee had requested further discussion of Alert Organisms at the Quality & Risk Committee meeting. Two identified cases of Klebsiella bacteraemia had been reported on PIPR for month 11, and two cases had been reported of E Coli. The Committee was assured that this was the normal rates of Klebsiella and E coli. The patients affected are long term immunocompromised patients or patients with ventricular assist devices who have long stays in critical care with a lot of interventions. The Committee was assured that the Consultant Microbiologist was not concerned about transmission of these bugs between patients. • The Committee noted that Performance Committee had asked QR to review the data as part of its remit as Performance did not have time to review this data in detail.		
6.31.2	**PIPR Caring – M11** 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 Chair reiterated his concerns regarding targets and the gap between target and rating. At present, the BAF gives mitigations to the risk but does not state whether the risk will reduce if these mitigations are completed. The Chair recommended that clear actions are attributed to the relevant risks and targets. • AJ advised that conversations had taken place at EDs to look at the BAF risks in context of, actually, what the target was for resolving the risk and what the target level is set at. • The Committee noted that recent discussions had agreed that the Covid risk would move to HCAI. • The Committee discussed BAF3040 M.abscessus risk. The Trust's stakeholders have suggested that the Trust can step down		

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	governance around M.abscessus in terms of external stakeholder meetings due to the knowledge that the Trust has regarding M.abscessus and the controls that are in place. Discussion to be held at next M.abscessus Executive meeting. • AJ advised that discussion at the March Performance Committee highlighted that the Industrial Action BAF risk was managed by a single rather than multiple committees. Because it relates to productivity and performance in terms of the impact of industrial action on the Trust, Performance Committee has suggested that this would sit with them. The QR Committee agreed.		
8.	**GOVERNANCE AND COMPLIANCE**		
8.1 **8.1.1**	**Cover: Draft Quality Accounts** **Appendix 1: Quality Accounts – first draft** The Committee noted the pre-circulated documents. • The Committee noted that a second version of the document would be brought to the April meeting, following which it will be sent for external stakeholder review, with sign off in June. • The Committee acknowledged that work on the report was still ongoing and that details are still being pulled together. • The Chair commended being able to view the VTE data over two years and the progress made over that time.		

8.2	**Quality Account Priorities 23/24**
	The Committee noted the pre-circulated documents, with discussion as follows:
	• The Committee noted the proposed five quality priorities as:
	  ○ Patient Safety Response Framework
	  ○ Inequalities
	  ○ Resourcing and retention
	  ○ Harm free care
	  ○ Reducing surgical site infections
	• The Committee discussed the importance of a focus on Inequalities and discussed a recent report regarding potential inequalities in maternity outcomes with an increased risk of maternal death in, for example, black women in 2022. Could the Trust look at equities of outcomes for people from different backgrounds and genders as part of a quality improvement exercise?
	• The Committee advised that the Trust needs to be committed to ensuring that resources are available to ensure proper review of Inequalities and gave an example of the database that had been built for the sleep clinic inequalities work.
	• EM highlighted the large amount of work that would be involved in Inequalities and that the diagnosis might take one year. Is inequalities the right project to put on the shortlist? Can the Trust identify specifics within the first year? It may be that the one-year work is a diagnostic and informative year.
	• IW highlighted that he thought that medicine administration/bar coding would be a more pertinent piece of work as it has been discussed in the Committee from a quality and safety perspective.
	• The meeting discussed the top five priorities and whether there was an opportunity to scale the five priorities to four and place the		

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	inequalities focus as a longer ambition in the Trust's Quality Strategy. It was noted that the Inequalities focus in the Quality Accounts could be a scoping exercise. The Committee agreed to the suggestion and also that Inequalities could be included as a longer piece of work in the Quality Strategy. • OM advised that consideration was being done as to how to frame resourcing and retention with aspects of culture whilst still retaining the work undertaken on the Compassionate and Collective Leadership project. • The Committee challenged the inclusion of reducing SSIs as this was a piece of work that is ongoing at present. Are these priorities signalling? And, if so, is signalling a good enough reason to include as priorities? • It was agreed that the Committee will be presented with SMART actions against the recommended priorities at the April meeting.		
8.3 **8.3.1** **8.3.1.1**	**Cover: CQC Fundamental of Care Peer Reviews** **Regulation 19 Fit and Proper Persons Employed Peer Review Presentation** **Appendix 1: regulation 19: Fit and Proper Persons Employed Report** The Committee noted the pre-circulated documents and noted that the review was RAG rated as Green.		

8.3.2	**Regulation 13: Safeguarding Service Users Peer Review Presentation**
	Appendix 1: Regulation 13: Safeguarding Service Users Report
	Appendix 2: Regulation 13: Safeguarding Services Users Action Plan
	The Committee noted the pre-circulated documents, with discussion as follows:
	• The Committee noted that the overall RAG rating was Amber-Red.
	• The review noted that there was good safeguarding practice observed with no concerns noted on the day of inspection. Also, there was significant evidence of staff considering patient safety on wards, good general EDI awareness and all patients were treated with respect and dignity.
	• However, the review highlighted the following areas for improvement:
	  ○ Low levels of compliance with mandatory safeguarding training, notably Level 3.
	  ○ Delivery of safeguarding training did not meet staff needs.
	  ○ Lack of knowledge and confidence among staff regarding Power of Attorney, MCA and Best Interests assessments.
	  ○ Lack of a published and consistent safeguarding referral process.
	  ○ Lack of staff awareness of process for admitting patients under the age of 18 and patients with a learning disability or autism.
	• MS advised that following this review actions have now been drawn up and acted upon.
	• The Safeguarding Committee and Trust had already recognised that the process for gaining Level 3 Safeguarding training was		

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	convoluted and difficult to access. The training is consistent with the intercollegiate guidelines for safeguarding in terms of process, but the Trust has now recognised that the training needs to be responsive and make attending the training easier for staff. A review of how this can be done has been undertaken and solutions are already in place with some face-to-face sessions as well as online learning available. • The Committee noted that the Safeguarding Team had had a gap due to long term sick leave. An Interim Safeguarding Lead started in December and has identified some improvements that can be made with the referral process as well as to help with some of the gaps of knowledge that were found. • The action plan for this review will be overseen by the Safeguarding Committee and will come to Quality & Risk Committee through usual governance. • The Committee discussed that the NED Safeguarding Lead position had been recently assigned to AF. • It was agreed that an update on the action plan would be brought to the Committee in six months' time.		
8.3	**Cover: Document Control Compliance** **Document Control Spreadsheet – Out of Date Documents** The Committee noted the pre-circulated document, with discussion as follows: • It was noted that Workforce documents had been discussed at the Workforce Committee. Some Workforce documents are being rewritten in line with best practice. • AR advised that there was traction on out-of-date documents and numbers are improving.		
8.4 **8.5**	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		
9	**POLICIES**		
9.1	**AHP Strategy** • The Committee ratified the pre-circulated document.		
9.2	**Cover: DN270 Safeguarding Children and Young Adults Policy** • The Committee noted the pre-circulated document.		
9.2.1	**DN270 Safeguarding Children and Young Adults Policy** • The Committee noted the Policy had been reviewed against the new guidance and terminology in the intercollegiate document and updated. • The Committee ratified the pre-circulated document. • The Committee noted that the adult safeguarding policy would also be reviewed in light of the new guidance and terminology.		
9.3	**Paper for DN799 Covid Policy – to be archived** • The Committee approved that DN799 should be archived.		

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10	**RESEARCH AND DEVELOPMENT**		
10.1	**Minutes of Research & Development Directorate Meeting (230113)** • 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 March CPAC meeting.		
11.1.1	**Minutes from Clinical Professional Advisory Committee (230216)** • The Committee noted the pre-circulated document.		
11.2	**Minutes from PPI Committee (230213)** • 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** • No further business reported.		
	Date & Time of Next Meeting: **Thursday 27th April 2023 at 2.00-4.00 pm, via Microsoft Teams**		

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Signed
27th April 2023
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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee