Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 2, Month 3
Chair: Michael Blastland
Held on Thursday 26 September 2024 2.00 pm – 3.30 pm
Rooms 88 and 89 HLRI and via Microsoft Teams

Present	**Role**	**Initials**
Blastland, Michael (Chair)	Non-Executive Director	MB
Fadero, Amanda	Non-Executive Director	AF
Midlane, Eilish	Chief Executive	EM
Palmer, Louise	Assistant Director for Quality & Risk	LP
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
In attendance		
Hurst, Rhys	Staff Governor	RH
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
Monkhouse, Oonagh	Director of Workforce & Organisational Development	OM
Harris, Annemarie	Head of EPRR (For 9.5 – EPRR Policy)	AH
Apologies		
Professor Ian Wilkinson	Non-Executive Director	IW

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.

P A R T O N E

Item		**Action by whom**	**Date**
1.	**Welcome & Apologies** The Chair opened the meeting, and apologies were noted as above.		
2.	**Declarations of Interest** There is a requirement that those attending Board Committees raise any specific declarations, if these arise during discussions; none were raised.		
3.	**Committee Member Priorities**		

	• The Chair noted that previously, when the agenda was lighter than usual, invitations to the meeting had been extended to those in the tier below clinical leads and divisional heads; this had been helpful in gaining a further understanding as to how systems and processes work operationally in maintaining quality and safety. It was suggested that those in positions directly facing the demands would make a valuable contribution and that, going forward, invitations should be considered at meetings where time was available. • AF concurred and EM highlighting that a member of theatres could provide an informed view around, for example, SSIs programmes. Any further thoughts were invited to be directed to MS.		
4.	**Ratification of Previous Minutes Part 1 (240829)** The minutes of the 29 August 2024 Quality & Risk Committee (Part 1) meeting were agreed to be a true and accurate record of the meeting and signed.		
5.	**Matters Arising – Part 1 Action Checklist (240829)** ***069 – EDS/Health Equalities****: IS to consider how a future Board Workshop could be framed to support a discussion on health inequalities, noting the resources already available from ICS. IS to provide an update to June Committee meeting.* IS noted that the Workshop was scheduled for June 2025 and had met with Pippa Hales to discuss further. To be **CLOSED**. ***074 – QRMG & SIERP Highlight and Exception Paper:*** *Organogram of QRMG and sub-groups to be brought to QR for information.* Organogram included in today's meeting under item 6.3. To be **CLOSED.**		
6.	**Quality & Safety** • LP conveyed highlights of Quality & Risk Management Group (QRMG) and Safety Incident Executive Review Panels (SIERP), further to meetings held on 10 September and in August 2024, respectively. • Risk management had improved with 12% overdue; clinical risk management was much improved, and all were taking 12+ risks back to committee meetings. Other areas would be focused on, and the importance of continuing training was emphasised. • MS queried the maximum number of days overdue on the paper. This concerned one risk that had not been updated and required removing. • LP noted that there was more assurance and there had been positive progress in the area of risk management. • MB queried whether when risks were moving; was this for good reason? LP stated that there was more proactivity with updating and spending focused time to identify that risks may have changed.		

	Audit • MB queried the CCU module and what it comprised. LP stated that this was a template in the coronary care module in Tomcat. • MB noted previous discussion of the improvement programme for self-administration of medications. This appeared to be a one-off project, and something programmatic would be of interest to develop the methodology for incremental quality improvement. • EM stated that the NHS Impact Team, who were rolling out continuous improvement, would be providing a Board session. • LP highlighted that the NICE clinical audit had been completed for the year; of the 186 NICE guidance, 20 were relevant. • AF requested to understand the process in determining those that applied to the Trust. LP summarised the process via clinical audit including involvement from Clinical Governance Lead David Meek and Deputy Medical Director Stephen Webb. • MB queried compliance, noting implementation at 5. This comprised those that were not relevant, but which were circulated for wider learning. LP noted that the NICE guidance existed and often implemented a practice change; a safety issue would be imparted via the safety alert system which would have a timeline. • Regarding complaints, there appeared to be a theme around discharge assurance and discharge letters. This was being fed to the Discharge Assurance Group to feedback on/address. • EM noted that there had been a conversation around standard discharge summaries and the fact that the GPs did not favour them. • AR stated that this had been followed up with the Professional Records Standards body who had set the standard and content of the discharge summaries. Nothing had been changed and dialogue was to be maintained, although it was suggested that this area would require lobbying for any changes to be implemented; AR to follow up. • Quality of information and accuracy of information were the issues. • **ACTION**: Standard Discharge Summaries: dialogue to continue with the Professional Records Standards body regarding the content of the summaries, which were not favoured by GPs, and any amendments that could be identified by way of improvement to the documents. • MB noted questioned whether there was confidence in processes working for patients. EM queried whether the focus on earlier discharge was linked to a haste with compiling the discharge summaries. LP suggested that it appeared to be concerned with knowledge base and clinical practice. • AF stated that an understanding of how this linked to the EPR programme was important. Must-dos, quality of reporting and speed of discharge and the data were required for inclusion in the EPR system.	**LP**	**11/24**

	• MB stated that assurance was required, and whilst it was not intended to escalate a couple of cases into a significant theme, there appeared to be several linked issues. • EM highlighted the positivity around problem sensing and queried the incidents not being investigated at 770 and 600 overdue. These numbers were increasing and were a theme. The strategy to overcome this was questioned, along with the need for further understanding. LP stated that every incident had been subject of review and screened, prior to being considered. The incidents remained as "not investigated" whilst open; there was, therefore, movement with the cases. • At the Leadership Day, there had been feedback as to how Datix was used as a tool to passively aggressively raise issues. In indicating that Datix was, on occasions, being used in an inappropriate way, this detracted from actual proper use to identify serious quality and risk issues. • An anonymous reporting tool was being considered, although this was subject to advantages and disadvantages. A SOP had been requested. MB queried if this comprised a quality and risk issue or a workforce one; the latter was confirmed. • LP stated that volunteers were growing in number and were due to commence wearing a new jade uniform, which would replace the present purple, to distinguish from other staff. • MS highlighted the prevention for future deaths reporting, which concerned a case in a local private hospital, where a patient died of a pulmonary embolism, although thought to be related to the use of significant quantity of local anaesthesia. There was a Trust responsibility to assess and return with a risk assessment. LP stated that this item had been to QRMG and cardiology this week, STA division and CDC for further discussion, prior to action being put in place. The outcome was requested to be brought back to this meeting with action confirmed. • **ACTION:** Prevention for Future Deaths Reporting: Assessment and compilation of risk assessment in progress via QRMG, Cardiology, STA division and CDC. The outcome and proposed action to be brought to the next Q&R Committee meeting. • AF queried the burden that inquests put on some members of staff. An ATR had been progressed to assist with the administration and details around inquests and tied in with legal team for dedicated sessions for staff to attend, by way of preparation for an inquest. Coroners were also recognising the impact on staff and coroners' officers had been allocated to each staff member, with meetings arranged with the governance team.	**MS**	**11/24**

6.1	QRMG and SIERP Highlight and Exception Paper There had been no formal escalation from QRMG in September or from the SIERP meeting held in August. The Committee **REVIEWED** the paper.		
6.1.1	Serious Incident Executive Review Panel (SIERP) minutes (06.08.24, 13.08.24, 20.08.24 and 27.08.24) There was one Staff RIDDOR, where a member tripped over a foot stool; this was the subject of a review as a workplace injury. The Committee **NOTED** the SIERP minutes.		
6.1.2	Organogram of Sub-committees to QRMG • MB queried how the working groups' governance operated. LP stated that minutes were received, and that agendas were discussed at QRMG. Plans and escalations were considered. • EM stated that some of the sub-groups could have a valuable offering at the Quality and Risk Committee meetings, at the appropriate time. • MB suggested that quality improvement, clinical audit and other functions whose accountability came through Quality and Risk could be added to the organogram to assist further. LP highlighted that ToR for these subcommittees were available, and queried if these would suffice to demonstrate that quality improvement programmes in place. • AF queried if work programmes existed for the committees to enable tracking and management of QRMG agendas; this was identified as a significant quantity of information to manage. LP explained that a record of committee meetings was logged and that there were monthly reporting processes in place. The Committee **REVIEWED** the organogram of sub-committees to QRMG.		
6.2	SSI Quality Monitoring Dashboard Quality Monitoring September 2024 (August 2024 data) • This was a much-improved position in that there had not been an organ-based infection since January or a deep wound infection since May. All infections received had been superficial, via the wound clinic rather than admission. • This had been discussed in detail at the SSI Clinical Group to ascertain the effect of results. Much had been implemented, including changes in dressing, ERU opening, and increased speed to mobilise patients. The contract had changed for sterilisation of instruments. The next piece of work involved a timeline to map interventions with rate of infections over time to		

	draw inference. There remains further work to continue improvement. • MS noted that in June/July there had been a reduction in theatre foot fall, although this had gone up again in the last month, along with a slight increase in infections; this was a potential cause for concern. • MS noted that a cross infection had been identified in critical care and there was still work to undertake around screening, compliance and practice. As part of the outputs on the action tracker, the timeline piece would be required to identify the areas to be focused on, in addition to diabetes. • MS highlighted that care was required around the change in sterilisation contract and clarity sought, if evidence suggested this was an issue, due to the implications. • MB queried who was responsible for the numbers in a theatre. It was suggested that this was everyone's responsibility, as a team. A theatre briefing was held each morning, with checklists for every procedure, and there was opportunity to pick up the issue of numbers. The committee **REVIEWED** the SSI Quality Monitoring Dashboard.		
6.3	M.abscessus Dashboard September 2024 (August 2024 data) • MS noted that this report was for information. Clarity had been sought from NHSE around the relaxation of the oversight structure currently in place and moving to a more BAU structure for management of M.abscessus. The Committee **REVIEWED** the M.abscessus Dashboard.		
6.4	Highlight Report for Health and Safety (H&S) Committee held on 28 August 2024 • MS noted that this was a result of the last H&S Committee meeting, the minutes of which would go through the next Committee to be ratified, prior to being included in the appendices for this meeting. The H&S 2023/24 annual report would be available in October. • MB enquired as to how the Committee was developing. MS stated that this was well attended, with correct reports and that colleagues were building capability for presentation. All were keen to ensure correctness. The Committee **REVIEWED** the Report for Health and Safety Committee.		
6.8	**Performance**		
6.8.1	Performance Reporting: PIPR M5 • The report was taken as read. MS raised the Ward supervisory sister/charge nurse time issue; a deep dive had been undertaken with scrutiny around recording and prioritisation – there was a clearer position. Whilst fill-rates were very good, banking agency spend was increasing.		

	• MB queried if the issue was associated with staff having adopted a different pattern of work; MS confirmed this and noted that re-education was necessary to return to good governance. MS was assured of plans in place and that these would provide improvement, noting that cardiology was making particularly positive progress. • MS noted that the use of overtime and agency required addressing as the present volume should not be necessary. • AF queried if a conversation had taken place at the earlier Performance Committee around overall RTT, diagnostics and elective activity, and the relationship to quality and harm, raising concerns about the direction in which the Trust was moving. MS responded that missed opportunities in month, in terms of optimising performance around activity, was due to several factors – lack of oversight for annual leave and cancer breaches. AF sought assurance at Board. • LP noted that there were no complaints being received with respect to these areas, although for a time, there were some relating to CT backlog. Surgery dates were generally the most enquired about. MS noted recognition that emergency activity was quiet in August – i.e. transplants etc. The Committee **NOTED** the PIPR M5.		
7.	**Risk:**		
7.1	Cover: Board Assurance Framework (BAF). The report was taken as read. The Committee **NOTED** the BAF.		
7.1.1	Appendix 1: BAF Report The report was taken as read. The Committee **REVIEWED** the BAF report.		
7.1.2	Appendix 2: BAF Tracker The report was taken as read. The Committee **REVIEWED** the BAF tracker.		
8.0	**Governance and Compliance**		
8.1	Quality Accounts Priorities 24/25 Update • LP noted that overall, the priorities set by the working groups were progressing well. The Dementia and Delirium groups had experienced some lag. • Safety partners comprised part time volunteers and this venture was developing positively, with more news forthcoming next month. Three people had so far been placed with two further on the reserved lists. They would be linked to quality accounts to be patient advocates, to undertake patient focus work. • LP suggested that these people would be linked to quality accounts and sit on floor-to-board committees, as patient representatives. NHS mail accounts would be provided. There		

	would be paid sessional work when, for example, they attended Quality and Risk meetings, in addition to their voluntary work. • MB noted that there was no printed report on Safety Partners in the pack; LP to circulate. The Committee **REVIEWED** the Quality Accounts Priorities 24/25 Update.		
8.2	Internal Audits: None		
8.3	External Audits/Assessment: None		
9.	**Policies and Procedures** AR commended those presenting the policies for ratification for their efforts in good governance around documentation.		
9.1	DN562 Protected and high-profile individuals (VIP) Procedure (ratified at Emergency Preparedness Committee 11.09.24) After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.2	DN633 Adverse weather (Heatwave) Plan (ratified at Emergency Preparedness Committee 11.09.24) • At the Joint Staff Council meeting, the DN032 was referred to and related to the procedure which led to staff absence in adverse weather; this was in lieu of the special leave policy mentioned in DN633. Clarification was sought as to which should be referred to. After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.3	DN643 Critical Incident Plan (ratified at Emergency Preparedness Committee 11.09.24) After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.4	DN830 Evacuation and shelter (ratified at Emergency Preparedness Committee) After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.5	DN897 EPRR Policy (ratified at 11.09.24) After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.6	DN323 Medical Gas System Operational Policy (ratified at Health and Safety Committee 28.08.24)		

	After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.7	TOR014 Health and Safety Committee Terms of Reference After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
9.8	DN297 Management of Medical Device and Equipment Policy After summary of the paper, the Committee **RATIFIED** the pre-circulated document.		
10.	**Research and Development**		
10.1	Minutes of Research and Development Directorate meeting (R&DD) (120724) The Committee **NOTED** the minutes from R&DD meeting.		
11.	**Other Reporting Committees**		
11.1	Escalation from Clinical Professional Advisory Committee MS noted that there was nothing to escalate.		
11.1.1	Minutes from Clinical Professional Advisory Committee (CPAC) (24.08.22) The Committee **NOTED** the minutes from CPAC.		
12.	**Areas of Escalation and Emerging Risk:**		
12.1	Audit Committee No escalations noted.		
12.2	Board of Directors No escalations noted.		
12.3	Emerging Risks None to report.		
13.	**Any Other Business** With no further business to discuss, MB concluded Part 1 and, with the departure of RH, continued with Part 2 of the meeting.		
	Date and time of next meeting Thursday 31 October 2024, 2-4 pm via Microsoft Teams		

Chair ……