Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 2, Month 2
Chair: Michael Blastland
Held on 29th August 2024, at 2 pm
via Microsoft Teams

M I N U T E S

Present	Blastland, Michael (Chair)	(MB)	Non-Executive Director
	Fadero, Amanda	(AF)	Non-Executive Director
	Midlane, Eilish	(EM)	Chief Executive
	Palmer, Louise	(LP)	Assistant Director for Quality and Risk
	Raynes, Andrew	(AR)	Director of Digital and Chief Information Officer
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
	Wilkinson, Ian	(IW)	Non-Executive Director
In attendance	Halstead, Abi	(AH)	Public Governor
	Howard-Jones, Larraine	(LHJ)	Deputy Director of Workforce and Organisational Development
	Mora, Ana (Observing)	(AM)	HLRI CRF Operations Manager
	Mensa-Bonsu, Kwame	(KMB)	Associate Director of Corporate Governance
	Steadman, Lisa	(LS)	Head of Nursing
	Stephens, Teresa (Minutes) (Note: Minutes written by Rosary Hall, Bank EA, due to illness of TS).	(TS)	Executive Assistant
Apologies	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development

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 raise any specific declarations if these arise during discussions. • None raised.		

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3	**COMMITTEE MEMBER PRIORITIES** • MS updated that the CPE outbreak is under control, with no new cases since 22 July. In total, 31 patients were affected, with none coming to harm. The control measures and IMT meetings are continuing for now. • The Chair commented on the speed that the Trust managed to bring this under control. MS replied that the Trust being a single room hospital was beneficial to preventing the spread and commended the quick implementation of IPC factors. The outbreak did not have a significant impact on activity or capacity. • EM stated that the Declarations of Interest were not included in the pack, they should be going forward.		
4	**MINUTES OF THE PREVIOUS MEETING – 25th July 2024** The minutes from the Quality and Risk Committee meeting dated 25th July 2024 were agreed to be a true and accurate record of the meeting and signed.		
5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 – from 25th July 2024:** The Committee noted the pre-circulated document and discussed as follows: • LP noted item 074 will come back to the Committee in September, not August. • All other actions are on the agenda, for discussion at a future meeting, or closed.		
6.	**QUALITY AND SAFETY**		
6.1	**QRMG and SIERP Highlight and Exception Paper** LP led the Committee through the pre-circulated document, with points to note as follows: • No escalations from the QRMG and SIERP this month. • The Quality Improvement Project is an area of development, undergoing three months of planning time. The results will be fed back to Medicine Management, QRMG, and Q+R. • The divisional report came to QRMG as usual. It queried whether Datix is being used correctly. Masterclasses will be run for Matrons and Leads as a refresh. • The first instalment of the Trust wide, twice yearly, Quality and Risk report is due in October. • There were three incidents of moderate, and one incident of serious harm reported over the month. They are going through the investigation process currently. • The month has been busy for inquests, as reflected in the report. • The Paediatric 3D TOE Probe was approved by the Clinical Practices Committee last month. • IW asked how long the wait is for aortic stenosis patients to receive treatment, and what happens when a case becomes urgent. IS replied that there are communication channels for when a patient needs urgent treatment, and it is discussed regularly at MDT meetings. • MS raised that the Trust is unable to provide a predicted 'reasonable wait time' to patients waiting on the TAVI service. If they are alerted to a deteriorating patient, they are transferred quickly. The team are working		

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	on providing a time in which they expect to see critical patients. This is being picked up under PSII. • IW recommended they share what these expectations are, and how the Trust will meet them. • LP said that, following the death of the patient IW is referring to, her team has taken action on safeguarding the individual referral process, and they have gained assurance that it is now being done correctly. Further investigation into the TAVI and internal pathways would be beneficial to the safeguarding of the service. • MS advised that the Committee could have further discussions once the reports from the investigations are available. • AF asked if there has been reflection on the new processes. LP said she could give assurance that the new processes were being suitably worked through. A 7-month review of the PSIRF indicated that the vast majority of incidents fell within their original expectations. They are analysing the correct learning outcomes and conducting round table reviews which has led to enhanced end results. LP was pleased with their progress, however there is still work to do as change takes time to embed and allow users to develop confidence. • LP reflected on the benefits she gains from attending the Community of Practice meetings, where they conduct informal check and challenge. She felt that RPH was doing well compared to other organisations. • AF asked when this Committee will see a review. LP said the action plan will be presented to the Committee in October. • The Chair reflected on the increase in information this Committee now receives. It would be beneficial to see what is coming in, how it is dealt with, and what the responses are to give assurance that the right processes are in place. • The Chair asked how the change has impacted the volume of work for the team. LP said that the work has shifted, with more required at the beginning of the process and less at the end. There is potentially more work for the clinical teams in the set-up stage. • Staff are in the process of this change, however; the feeling is that it is positive and permits more immediate change at a local level. LP said that it is hard to quantify the change. • 30 people have been trained to complete after-action reviews and a further 10 are completing the training now.	LP	10/24
6.1.1	**Safety Incident Executive Review Panel (SIERP) minutes (240702, 240709, 240716, 240723, 240730)** The Committee noted the pre-circulated documents.		
6.1.2	**PSII – Trust wide thematic review of patients treated in CCA requiring lower limb amputation** The Committee noted the pre-circulated document, with discussion as follows: • This is the first PSII. Following the report, a round table review was held, with stakeholders of change. The recommendations were discussed to determine which would make a difference to the patients involved, and which were more aspirational, long-term plans. As a result of this discussion, they determined that monitoring and oversight should be increased, as well as other small-scale improvements. IS added they		

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	need assurance that the basics are being done correctly. • The Chair praised the report, indicating the importance of seeing where the Trust is and where they need go. • AF asked for more clarity on the conclusions drawn on the treatment of Patient 4. LP replied, although the documentation was challenging for investigation purposes and should have been more thoroughly executed, there was clear rationale for their decision making. The findings took into consideration the challenges with the EPR system, however, she stressed this did not remove the requirement to make notes on decisions.		
6.1.3	**Harm Free Care Quarter 1** The Committee noted the pre-circulated document, with discussion as follows: • The first panel meeting's minutes have been circulated in the reference pack. • This is a new internal process to facilitate check and challenge across four areas; VT, falls, diabetes, and pressure ulcers. • The reports will not regularly come to this Committee. The Chair confirmed this was suitable. • The data triangulates with information from the Heads of Nursing and AHP Leads. • The ward scorecards have been revamped, running alongside PIPR. It is used by departments at a granular detail, assessing what it behind harm incidents and complaints. • LP proposed that an example of a scorecard be presented to this Committee by someone who uses it. • Having the data in one place shows trends that have previously not been identified. There is a culture change towards recognising the significance of the data and using it for quality improvement. • The Chair asked how this report adds value as it duplicates the data they receive in quarterly reports. LP replied that the six-monthly report will not contain the VTE because the data is now in this report. The aim is to provide more detail behind the data. • MS highlighted that the aim of the panel is to encourage data sharing between teams. She has already seen evidence of this happening between Ward Sisters. • LP advised that harm free care helps specialised roles cross-share information, giving them an influence with the small resources they have.		
6.2	**SSI Summit Report** MS and IS led the Committee through the pre-circulated documents, with key highlights as follows: • The SSI summit was held on the 8 August to take stock, review the current measures, and gain a consensus on future areas of focus. • Two presentations were delivered on air monitoring and ventilation. Alain Vuylsteke (AV) fed back on an air flow study he had been involved in. A ventilation authorised engineer shared the findings of an audit he carried out on the ventilation system. The output listed remedial works to do, however he listed nothing that would suggest a serious defect contributing to SSIs. • Microbial plate testing in Theatres returned low count rates, which is reassuring.		

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	• The assumption that there are drastic differences between RPH theatres and orthopaedic theatres which is leading to SSIs was discussed. The microbiologists and ventilation experts countered this belief, RPH ventilation system is fit for purpose. • It was discussed that an increased footfall in theatres leads to an increased bioburden on the ventilation system. This is why they have seen fewer SSIs on days where fewer people are in the theatres, such as on the weekends. The output of this conversation was a commitment to reduce the number of people in theatres from fourteen to twelve. • Regarding diabetes, the issue is the control of the condition, rather than the condition itself. An audit concluded that the Trust often runs patients high in terms of hyperglycaemic control. New guidance launching next week intends to offer guidance on lowering the limits. MS stressed the importance of embedding change and ensuring it is done sustainably. It will take time and resource to build confidence in staff to make these changes. • IS reflected that circa 140 people attended the summit. They heard positive stories of challenge and had the opportunity to tackle some of the myths circulating the teams. • They discussed the proportionality of performing endoscopic vein harvesting as a SSI prevention strategy, with it costing a significant amount. The benefits of offering this need to be discussed going forward. • AF asked for a reflection of the mood of the room. IS replied that the messages were well received, and he enjoyed the challenges made. There was opportunity for real conversation. • IW asked about access to a consultant diabetologist resource. MS replied that the Trust does not consultant expertise currently, however they have been given funding for two PAs of a diabetologist. IW agreed that a plan should be developed. • The Chair asked if there was sufficient traction from the teams to make the improvements. MS said that she was positive, but it is too early to say conclusively. • The Chair highlighted there are degrees of buy in. MS said they reflected on the CPE story and how the Trust put control measures in place that were regularly audited and this ensured the Trust was on top of it. The outbreak highlighted the importance of these fundamentals. • The scorecard shows one infection in July. Is there a correlation between the reduction in SSI rates and the measures put in place for the CPE outbreak? The numbers for July are not verified because of late presentation of infection, however, this does give more evidence to the importance of fundamentals. • The Chair said there is inconsistency in the variation of numbers of cases. • The Chair said there are agreed behaviours, how will they be assured that these are coming online, and people are following them? Does there need to be targets and dates? MS agreed and said that this is not an assurance report, and a detailed work plan was required with timelines and targets so they can monitor what is happening and what is having an impact. This work is being done through the Clinical Practice Group and the SSI Stakeholder Group. • The Chair asked when the Committee will see reporting on this and was advised that the Committee will continue to received the SSI dashboard. One of the things they could look at is the reporting to see if there is the		

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	opportunity to put in a few more things that can be monitored monthly. It is more about the culture and getting a feel of how we do things. It would be good to hear about this. MS advised this could come through as qualitative data, via a staff or patient story for example, that could be brought forward in a few months to triangulate this. • The Chair agreed, he would be happy to see it in that form. There are a lot of expectations around this summit, and they need to track the progress and find a way to 'take the temperature', and having a look at behaviours so they can be assured that the right things are happening. If they aren't, they will need to act again. • The Chair said this should be an action- bring back to this committee how they propose to do bring assurance that change is happening, such as updating the dashboard. • AF is mindful this is an improvement plan; it has discrete actions and cultural change and noted that the task and finish groups will take forward the work. It would be helpful to understand who has governance over the work. There are tangible pieces here and they need to be able to measure the success of the cultural change. • The Chair congratulated the team for holding this event.	MS/IS	11/24
6.3	**SSI Quality Monitoring Dashboard August 2024 (July data) v1** The pre-circulated report was noted by the Committee.		
6.4	**M.abscessus Dashboard 2023-24 August 2024 (July 2024 data)** The Committee noted the pre-circulated document.		
6.5 **6.5.1**	**Cover: Infection Prevention and Control Annual Report 2023/24** **Infection Prevention and Control Annual Report 2023/24** This is a significant annual report and is here for ratification. MS led the Committee through the pre-circulated documents, with key highlights and discussion as follows: • The Trust continues to report and take part in mandatory surveillance of the key alert organisms, such as C.diff, MRSA, MSSA, etc. • There is a spike in C.diff with our numbers at seventeen for in-year. This is consistent with national figures and has been discussed at this meeting previously. A lot of scrutiny is done on this, and the nursing team are involved with the ICB and other organisations to make improvements. • SSIs continue to be an area of focus for the Trust. • For M.abscesses, it was noted that there have been two unconfirmed cases in-year. This has been discussed at a previous Q+R meeting. There was some investigation in terms of any lab contamination or error. • The Committee agreed on the benefit of inviting external agencies to review practices and of Trust employees visiting other Trusts to learn from them. It was noted that there were two internal visits, and one external visit in-year. • It was noted that antimicrobial stewardship was a national focus. In • terms of antimicrobial usage, we have a good stewardship team who engage in work around sequence, the watch and reserve campaigns, etc. and they have achieved the targets in relation to these in year. It is an area that is only going to grow due to the increase in resistant strains. One mentioned that they are seeing better prescribing practice of		

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	antibiotics on the surgical pathway as a response to the work done on CPE. The Committee acknowledged the importance of continuing these improvements. • The Trust and OCS worked together to implement the updated NHS cleaning standards. There was a delay in this, and still work to do on the embedding practices, such as some aspects of the rating scales. • Compliance with infection prevention and control training for Level 1 is 94%, and for Level 2 it is at 83%. The Trust continues to monitor itself against hygiene codes. • Focus in the latter half of the year has also been given to ventilation safety, Occupational Health reporting in terms of assurance around vaccination status of patient facing staff and embedding the cleaning standards. • The Chair confirmed that the Committee notes a lot of this data on a regular basis and should not be trying hard to interrogate the trends, this is business as usual. The Committee has been asked to ratify and report and recommend it to Board in November. • The Chair commended the report but asked if it ought to address the inconsistency between the Trust's response to things like CPE and Covid, and our response to SSIs, to further understand the issues. It is possible the SSI rates were low in July because the Trust was being hypervigilant about infection and asked if the Trust needed to tighten up procedures. The Chair questioned whether this should be included in the report for 24/25. • AF echoed MB's reflections. • AF was struck by the detail about what the team does, its structure, etc. there was a section that says what the team does externally and the meetings they attend. There was no reflection on what benefit this had and what learning they took from attending external meetings. She wondered what the added value was and whether it contributed to the turning of the dial. MS replied that this also applies to the content of the Safeguarding Report. She was happy to include this going forward. The meetings the team attend are positive and include shared learning. The leads, in particular, do peer reviews for each other. It was agreed that this proves beneficial and that it would be good to see this reflected in the report. • AF asked for future reports to allude more to the role of the IPC team in the SSI long-term improvement plan. • The Committee were happy to ratify the document and recommend it to the Board.		
6.6 **6.6.1**	**Cover: Safeguarding Annual Report 2023/24** **Safeguarding Annual Report 2023/24** This report is at the Committee for ratification. MS led the Committee through the pre-circulated document, with key highlights and discussion as follows: • JW was key to pulling this report together. She is on annual leave and so unable to present it today. • MS reflected that, whilst the incidents relating to safeguarding are low, there is a huge amount of work and activity in respect to engaging with the system, and new statutory duties, the consequences of this, the training and education. It can appear disproportionate to the safeguarding activity;		

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	it is important to comply with statutory regulation to keep patients and relatives and staff safe.
	• Key take aways:
	  ○ There were two child deaths in-year. As part of this, the Trust is involved in the Child Death Oversight Panel. As they do not occur very often at this Trust, there was some confusion at the time as to what should happen. However, it was noted that the Trust gained substantial learning from the events and a lot of improvement work has been done since, including around reporting.
	  ○ The Safeguarding Team receive a large number of safeguarding referrals – some of which are not safeguarding concerns. This means that the Team needs to filter the issues they receive.
	  ○ Referrals are received through a number of different routes, for example via email, and Lorenzo. This should be considered when reviewing the new EPR system. Work is being undertaken in Trust regarding referrals as the quality of some can be quite poor.
	  ○ There has been an increase in the number of reports for domestic abuse. This is not unusual and has been known since COVID.
	• In terms of legislation, the team have been working on the Oliver McGowan training, which is the LD and Autism training. Level 1 training is going well, Level 2 has not commenced because of the work that needs to be done around the set up of the training using people with experience in the area.
	• Some of the wording in this report on the serious violence legislation needs to be amended.
	• The duty, in terms of serious violence is working more closely with multi agencies to make sure that we are able to recognise and prevent any serious violence from happening.
	• Education and training: there is good compliance with Levels 1 and 2, but challenges remain with Level 3. The Team has appointed a 0.5 wte education lead who will be able to pick this up.
	• Transitional care, this is a reasonable area for us in terms of activity and transitioning from paediatric to adult services. A lot of patients seen by Safeguarding Team in this transitioning stage are waiting for assessments in terms of needs – this is something that is beyond the Trust's control but that does have an impact on some patients' experience.
	• The Trust has undertaken a thorough review of CQC Fundamentals of Care Review Regulation 13 concerning safeguarding. A number of actions arose that have since been signed off. Regulation 13 gives assurance that safeguarding is suitable to protect vulnerable adults from abuse and improper treatment.
	• The commented that it must be challenging to have such a high state of training and preparedness when there are such low numbers of cases. He asked if it were proportionate but acknowledged that this is clearly something that they cannot let lapse.
	• MS advised on the importance of collaboration with CUH with regard to learning disabilities and autism. It is challenging for the Trust to have a named nurse for this as it has very few LD and autism patients. However, the Committee acknowledged the importance of ensuring that protection is in place.
	• The numbers of training compliance for Board members has increased hugely. It was at 83% at the time of writing the report, and they are now		

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	up to nearly 100%. They will be able to report at Board that everyone is compliant. • EM asked about the percentage of people with LD or autism amongst patients and whether this felt right compared to the levels more generally in the population. She asked for assurance that the Trust does not have any inequality of access concerns as the numbers feel on the lighter side. MS replied that she does not believe there is an inequality in access issue, but stated that there were potential issues with safeguarding alerts on the EPR system as some people put on an inappropriate alert, using their own interpretation of the situation rather than a diagnosis. This is something the ICB is working to improve. There has been extra scrutiny on equality of access following a concern that was raised in the ICB. A presentation to the System Quality Board was given by the Trust as assurance on this. • EM confirmed that she got a great deal of assurance from the team that there are reasonable adjustments being made for people. She was asking if there is awareness to identify people, are the right questions being asked? EM was advised that information is flowing through the shared care record, there is a wider question on where alerts are being captured, maybe in primary care, how is it pulled through, so the Trust is pre-warned and able to prepare suitably for these patients. • AH asked if the number of CF referrals was normal as it appeared to be higher than the number of patients. MS confirmed this is normal, one patient may have more than one referral. • MS said that Penny Martin, who has been the Safeguarding Operational Lead at RPH for over twenty years is retiring at the beginning of September. She has been a credit to the organisation and should be recognised for her work. The role will be taken on by Afua Tobigah. • AR explained that this is a good example on how shared care can help on this space. He offered to bring a paper to this committee to emphasis the benefit. It is perfect for raising alerts, concerns, and consent issues to protect this information. MB said this would be helpful as such small numbers of patients were involved. • This Committee ratified and recommended the document to Board.		
6.7	**CQC Adult Inpatient Survey – 2023 Results** The Committee noted the pre-circulated document, with discussion as follows: • Noted by the Committee.		
	PERFORMANCE		
6.8.1 **6.8.1.1**	**Performance Reporting** **PIPR M4** The Committee noted the document, with key points as follows: • MS reflected on Safe being Amber this month. This is because the supervisory sister and charge nurse time is in the Red. There has been a decrease in the last month, it is an area of focus, particularly in Cardiology and Cath Labs. They have not done so well because of sickness in the teams. It is a work in progress and key to good ward management. • The Chair asked if the numbers include the Band 6s who may be covering for this role when the ward sisters are unavailable. MS said it does. The		

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	challenge at the moment is that the fill rates are very good so the time should be given to meet this target. • The Chair advised that it was interesting that the PIPR is not more regularly reported to Board as Part 1 Board meetings now occur every other month. The longer reflections on PIPR are not necessarily doing any harm and anything urgent would come through. The balance of reporting on PIPR is now more proportionate. • EM said that they had discussed at EDs the amount of effort and energy which goes into populating the full PIRP on a monthly basis. EM is planning to propose to Board having a stripped-down version on the in-between month which will highlight trends but which will release the time for staff to do, rather than to report what is going on. The Chair said he would support this. There needs to be confidence that any sudden change will come through as soon as possible, however, there are other channels to do this, and it does not need to come through PIPR every month. • EM said the teams would escalate as they will still be tracking the data.		
7	**RISK**		
7 **7.1** **7.2**	**Cover: Board Assurance Framework (BAF)** **Appendix 1: BAF Report** **Appendix 2: BAF Tracker** The Committee noted the pre-circulated documents and progress update. • The Chair noted that there were no significant changes. • Change to risk 742 to reflect the progress on pharmacy recruitment. MS has already referred to the CPE infection.		
8.	**GOVERNANCE AND COMPLIANCE**		
8.1	**SIRO Report Q4 (deferred from July's meeting)** AR led the Committee through the pre-circulated document, with discussion as follows: • The report highlights the return on the data security protection toolkit, with all the standards being met. He thanked Cath Willcox and the team for their hard work. • Cybersecurity will be an important focus going forward. • The report brings into focus incident reporting- there is an issue here with a reportable incident followed up to NHSE involving a patient receiving a significant data set. Thankfully the patient was cooperative, however this is the second time it has happened. The learning they have taken from this includes speaking at length with teams involved, the ability to use Zivver and the comprehensive use of this tool to allow emails to be retracted. • There has been an increase in the number of FOIs across the hospital. The table included in the paper refers to the use of exceptions to reduce, where possible, FOIs that do not need to be responded to based on certain criteria. The team have these, and AR is alerted to any requests which are sensitive to data security. • Document control is at 76% compliance. There is a 24% gap. As colleagues know, they have put in place an escalation process from next week so that they get some traction. Policies and procedures need to be up to date, and effort needs to go in to bring this back on track. • The Chair asked if emails are flagged that are above a certain size. AR		

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	replied that NHS Net will not let you send above a certain size. Zivver uses AI to detect use of names in the emails to flag the sender's attention to any confidential information. • The Chair asked if it is being deployed and was informed that it was. Sensitive information must be sent via Zivver. • AF commented that Zivver is a challenging tool, she asked if they knew why it was not being successfully deployed, what is the expectation for the rollout and the compliance with usage. AR replied that it is part of standard desktop deployment, it is easily installable on devices. It is deployed on admin PCs. • AF asked why it was not being used. AR replied that it is now being used. There was one incidence, they have followed up with the individual, who was a new member of staff. AR asked if consultants were using it well. AR said that he could bring back evidence in a future report. They had a meeting with Zivver of the numbers of potential incidents that have been avoided thanks to the service.		
8.2	**Out of Date Documents** The Committee noted the pre-circulated document.		
8.3 **8.4**	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		
9	**POLICIES**		
	The Committee has sought and gained assurance that policies presented for ratification at the Committee are reviewed and approved at appropriate level meetings before being presented to Quality & Risk. The Committee also noted that there had been occasions when policies had not been ratified at the Committee that had requested further work and at Committee's before it at, for example, CPAC and QRMG.		
9.1	**ToR 036 Emergency Preparedness Committee (ratified by Emergency Preparedness Committee in June 2024)** • The Committee ratified the pre-circulated document.		
10	**RESEARCH AND DEVELOPMENT**		
10.1	**Minutes from Research & Development Directorate Meeting (240614)** • The Committee noted the pre-circulated document.		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** • MS did not have anything to escalate. • She updated that progress had been made around the documentation of Anaesthetic Associates and the standard operating procedures and policies. These went through CPAC last week for final confirmation.		
11.1.1	**Minutes from Clinical Professional Advisory Committee (240718)** • The Committee noted the pre-circulated document.		
11.2	**Minutes from End-of-Life Steering Group meeting (240716)**		

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	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** • Two papers for recommendation.		
12.3	**Emerging Risks** • There were no emerging risks.		
13	**ANY OTHER BUSINESS** • No business was raised for Part 2. The minutes were approved from July. • MB thanked TS for her time at the Trust and wished her well on her future endeavours.		
	Date & Time of Next Meeting: **Thursday 26th September 2024 2.00-4.00 pm, via Microsoft Teams**		

Meeting closed 15:52

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee