Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Minutes of Meeting held on Tuesday 20th November at 2pm
Upper Lecture Theatre

Present:		
HALL, Roger	Medical Director	RH
POSEY, Stephen (until 1507)	Chief Executive Officer	SP
RUDMAN, Josie	Director of Nursing	JR
ZIMMERN, Ron (Chair)	Non-Executive Director	RZ
Attending:		
BUCKLEY, Carole	Assistant Director of Quality & Risk	CB
GRAHAM, Ivan	Deputy Director of Nursing	IG
HODDER, Richard	Lead Governor	RHod
JARVIS, Anna	Trust Secretary	AJ
JENKINS, David	Consultant Surgeon	DJ
RIOTTO, Cheryl	Head of Nursing	CR
WEBB, Stephen	Consultant Anaesthetist	SW
RAYNES, Andrew	Director of IM&T	AR
Present:		
SEAMAN, Chris	Minute Taker	CS

1. Welcome and Apologies for Absence

- The Chair welcomed the Committee members to the meeting.
- Apologies were received from Nick Morrell.
- It was noted that Karen Caddick had left the committee; a further NED to be identified before the next meeting.
- It was also noted that the meeting was not quorate.

2. Declarations of Interest

There were no declarations of interest.

3. Ratification of Minutes

The minutes of the meeting held on the 11th September 2018 were agreed as a true and accurate record.

DECISION: The Committee ratified the minutes of the meeting held on 18th September 2018.

4. Matters Arising:

Please refer to the Action checklist for outstanding actions – these were reviewed and updated. \\Resource\papworth\shared\Board of Directors Reports\Quality & Risk Committee\2019 Meetings\Item 4 - Q&R Action Checklist following 181120.docx

5. Quality:

5.1 Patient Safety/Effectiveness of Care: Quality and Risk reports were circulated and the following items were highlighted and/or discussed:

5.1.1 The Quality Exception Report: The information in the report was noted by the Committee highlighting the following:

- There were six 52 week breaches escalated from QRMG relating to patient episodes being closed on Lorenzo through user error. JR reported that a further patient, outside of the initial scope of this exercise, had been identified. This has initiated a further wider audit of patients who may have breached.

SI Update

There are 4 new SIs all now under investigation:

- SUI-WEB28071 – Delay in accepting PPCI Referral
- SUI-WEB28194 – Grade 4 pressure ulcer in CCA – initial investigations indicate all appropriate care was in place
- SUI-WEB28193 – Missed lung cancer nodule on CT – delay in diagnosis
- SUI-WEB28342 – Patient sustained hypoxic brain injury (1-way ventilation T valve in place; cardiac arrest as no exhalation possible)

There are 3 further completed SI reports included in the papers for information:

- SUI-WEB27357 – Thoracic surgery incident
- SUI-WEB7476 – Delayed diagnosis of lung cancer
- SUI-WEB27608 – Patient fall (fractured femur)

The Chair congratulated the Quality & Risk team for the excellent investigation reports, commenting he felt confident that all the correct actions had been taken.

JR asked that the Committee be aware of a recent radiation exposure in the Cath Labs where 3 consultants had been exposed to higher radiation than the recommended levels. She reported that remedial actions have been taken, resulting in 1 consultant currently no longer on duties in the Cath Labs.

5.1.1.1 Q2 Quality and Risk Report

Report evidences a continued good reporting culture with low harm/no harm incidents**.**

Highlights:

- VTE monitoring - the graph on page 8 of report shows an upward trend.
- Medication incidents show a downward trend.
- Patient falls – Quality Improvement project to reduce falls is developing a mini RCA to improve the capture of the contributory and human factors that may help to put actions in place to prevent a fall.
- Risk management monitoring – the Committee were informed that SP has asked for a regular corporate risk register review to be maintained.
- The Chair expressed satisfaction with the patient safety data commenting that this was a remarkable achievement in view of recent staffing problems. He asked for staff to be congratulated.

5.1.1.2 Directorate & Business Unit reports Q2: The information in the report was noted.

5.1.1.3 QRMG Minutes (02.10.18): The information in the minutes was noted.

5.1.1.4 QISG Minutes (30.10.18): The information in the minutes was noted.

5.1.2 Patient Safety Incident Report: The information in the report was noted.

5.1.3 Mortality Case Record Reviews

SW updated the Committee on progress to date, highlighting the challenges (detailed in the report – Item 5.1.3.1) acknowledging that the full value of the rapid retrospective case review process is yet to be realised. The Trust has had a good reporting culture for a long time but this additional process alongside existing reviews has taken a while to bed in. In response to the Chair's concern that this was an extra process required of staff, SW was of the opinion that the rapid case reviews are an integral part of the 4 part process of reviewing deaths. It was noted by RH that after April 2019 all deaths will be reviewed by a Medical Examiner.

The Chair suggested that the figures included in the report should include all mortality reviews, not just those undertaken by a rapid case review. This will add greater context to the figures reported.

5.1.4 Quality Improvement Assessment Reports (QIA)

The QIA reports for August and September 2018 were noted.

5.1.5 QI program update: Quality Strategy

The Chair expressed approval of the document and the Committee confirmed that this should be presented to the Board. CB informed the Committee of the NHSI Just Culture initiative which supports the fair treatment of staff in a culture of openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. This initiative would be added and referenced in the strategy. The Chair formally recommended that the Board should focus on the process of the Fundamentals of Care and the positive aspects of embedding quality and safety into the Trust structure at least twice a year.

DECISION: The Quality Strategy was approved and should be presented to the Board.

5.2 <u>Patient Experience</u>:

5.2.1 Patient and Public Involvement (PPI) Minutes (15.10.18): The information in the minutes was noted. RHod reported that the PPI committee had been asked to nominate 2 individuals to act as judges for the staff awards.

5.2.2 End of Life Steering Group Minutes (06.07.18 and draft 20.09.18): The information in the minutes were noted.

5.2.3 2017 National Cancer Patient Experience Survey Results: Lavinia Magee (LM), Nurse Consultant Thoracic Oncology, attended the meeting, to present the recent National Cancer Patient Experience Survey. She explained that this has been an annual national survey since 2010, comparing Papworth patients' experiences with other Trusts. The survey has remained unaltered since 2016/17 and can be completed by patients aged 16 and over who are admitted with a primary cancer diagnosis. There was a good response rate at 63%.

Headlines:

- Papworth scored 9.1 on a scale of zero (very poor) to 10 (very good) when asked to rate their care (national average 8.8).
- 81% definitely involved in decisions on care/treatment (national average 79%).
- 4 other markers were also above the national average.
- Positive comments included praise for all staff groups in the oncology team.
- The few negative comments show there is always room for improvement.

The survey results are due to be tabled at the Council of Governors meeting on 21.11.18. SP asked if patients were worried about longer waits; LM reported that she was not aware

of any complaints, with most patients surprised at the speed with which they are referred. RH congratulated the whole team on the service provided.

5.3 Performance:

5.3.1 Performance Reporting Quality/Dashboard:

5.3.1.1 PIPR: The Committee noted the information in the report and acknowledged it was the same PIPR that was presented to Board.

5.3.2 Monthly Scorecards - Month 5 2018/19: The data in the monthly ward scorecards was accepted. Liaison is ongoing with the business team to improve the timeliness of these reports as they are often a couple of months behind.

5.4 Safety:

5.4.1 PIPR Safe KPI Review

The Committee were asked to review the PIPR Safe KPIs. JR presented the paper and recommended 3 dashboard KPIs in PIPR. These have been made after benchmarking against neighbouring Trusts' safe KPIs.

- **Falls**: A nurse sensitive indicator so recommend this KPI is an outcome KPI It is recommended to put this above the line with 4 per 1000 bed days.
- **Pressure Ulcers**: If outcome is be included in the dashboard KPIs then a rolling average should be applied. Consider changing this KPI for 19/20. No change at present.
- **CHPPD**: it is recommended that this be considered as a dashboard KPI with a target of 7.8 for ward areas and 32.9 for CCA.
- **Medication errors**: it is not recommended that a target KPI is set for the reduction of incidents as this may encourage a reduction in reporting, possibly undoing all the work already undertaken to achieve a reduction in medication errors.
- **Infection Control**: 3 organisms in addition to MRSA have been reported in PIPR since 04/2018. National ambition is to reduce infections by 50% in 6 years. It is recommended that a target KPI is set in the future for the reduction with existing monitoring is to remain in place.
- **HII**: This is currently measured by audits in ward areas and presented as a %. A high level of compliance has been achieved over the last year. It is recommended that this should be moved to a dashboard KPI with a target of 97% compliance.
- **CVC related infections**: this information is already captured in DIPC and CCA quality report. No change recommended.
- **Learning from deaths**: it is recommended that this KPI is considered in the New Year reporting 04/2019 onwards.
- **Sepsis**: it is recommended that this continues to be reported quarterly in DIPC and the Combined Quality reports.

There was some discussion on a review of PIPR domains, however it was agreed that 3 KPIs (Falls, CHPPD and HII should be recommended for inclusion as dashboard KPIs with a continuance of monitoring of organisms under Infection Control and Learning from Deaths in the monitoring KPIs. This was agreed as an interim measure with a comprehensive review at the January Q&R meeting.

5.4.2 Cardiology Staffing Update

JR presented the paper and recommended that the cardiology beds on Hugh Fleming should be reduced to 29, without adjusting the staffing levels at this stage, providing a CHPPD of 7.7 (above recommended level of 7.4). Further work would be undertaken to manipulate the rosters when the necessary skills are recruited. The Committee agreed that this option should be presented to the Board.

5.4.3 Safeguarding Annual Report year ending May 2018

The Committee noted the contents of this report. JR reported progress on the Learning Disability strategy, a review of the Safeguarding Adults policy and the Chaperone Policy. It should be noted in the Chair's report to the Board that the Committee had acknowledged the report.

DECISIONS:

1. **Falls, CHPPD and HII should be recommended for inclusion as dashboard KPIs as interim measure. A comprehensive review to be undertaken at January 2019 Q&R.**
2. **Recommended option for Cardiology beds was agreed. To be presented to the Board.**

6 Risk:

6.1 BAF Focus:

6.1.1 BAF Risks for Q&R

The Committee noted the information in the report. BAF risk 744 - CQC Fundamentals of Care has been escalated to reflect the risks around registration of the new hospital site with the CQC.

6.1.2 BAF Tracker 181101

The Committee noted the information in the BAF tracker.

6.2.1 Corporate Risk Register Summary Report

The Committee noted and accepted the information in the report.

6.2.2 Corporate Risk Tracker

The Committee noted and accepted the information in the report acknowledging further work was needed to map corporate risks to individual ED's area of responsibility.

6.3 Assessing Urgencies in Cardiac Surgery

DJ attended the meeting to update the Committee on the agreement of the new prioritisation criteria for the elective urgent waiting list, to help the RTT position and capacity. The aim is to equalise the waiting lists between different consultants and review the criteria for adjusting patient priority. He confirmed that a new set of criteria for priority 1 patients on the waiting list, for closing waiting lists, and for redistribution of patients between surgeons, had all been agreed.

A base line audit has been done to enable future comparison, hopefully providing evidence of successful implementation of criteria. The Chair recommended that key KPIs should be identified and DJ should provide the Committee with an update in 6 months' time.

ACTION: DJ to provide an update on IHU project in 6 months' time.

7. Governance:

7.1 SIRO Report Q2

AR attended the meeting to highlight the key items in his report. This was noted by the Committee.

7.2 CQC Mock Inspection report

JR gave a brief update on the outcome of the inspection with 9 'must do' actions

highlighted. These will be monitored through the Fundamentals of Care Board. The report will be shared with Clinical Directors and Deputy Director of Operations and the Board in December. A CQC registration visit is scheduled for early February 2019.

7.3 Minutes of Serious Incident Executive Review Panel (SIERP): 02.10.18, 09.10.18, 16.10.18, 23.10.18, 30.10.18, 06.11.18

These were accepted by the Committee.

7.4.1 Update on preparation for EU Exit

This report highlights issues if the UK leaves the EU without agreement; worthy of note are the possible implications on workforce and staffing, pharmacy and procurement issues. OM reported that HR is in the process of drafting a letter to all EU staff and the Trust will act as a pilot for the Settled Persons status. The Chair sought confirmation that the relevant EDs were aware of the possible implications on their areas of a 'No Deal'.

7.4.2 EU Exit NHS Contract Review Self

This paper was noted by the Committee.

8 <u>Assurance:</u>

8.1 Internal Audits:

8.1.1 Risk Management (draft) report

The risk management review was undertaken by internal auditors; this gives a favourable opinion with 2 Low Priority actions. The report was noted by the Committee and will be presented at the Audit Committee.

8.2 External Audits:

8.2.1 GIRFT – Letter from Chair of GIRFT - Deep Surgical Site Infection (SSI) Audit

This was noted by the Committee.

8.2.2 GIRFT - Deep Surgical Site Infection (SSI) Audit – data pack

The results of this audit demonstrate that the Trust is performing wel,l with the SSI infection rate at 0.6%; this is below the lower quartile infection rate of responders.

9 <u>Policies & Procedures:</u>

9.1.1 DN708 Digital Acceptable Use Policy

Richard Bowes and James Johnston from Digital attended the meeting to present this policy. The new policy aims to ensure that all staff are aware of their responsibilities for using the Trust's IT equipment and services. Concern was expressed by the Chair on the means of communication to staff to ensure all are fully aware of their responsibilities and the details in the policy. The document was ratified with the following provisos:

- A summary of key points should compiled and added to the document at the first revision stage in three months' time.
- The summary of the policy's key points should be referenced in the Trust's Contract of Employment.
- The summary of key points should be included at Trust induction and in the Staff Handbook.
- The Section on Bring Your Own Devices (page 10) is to be reinforced by a stronger definitive explanation of 'inappropriate use' of personal devices in the work place and linked to staff Codes of Conduct. This should include reference to the NMC and GMC regulations that health care professionals should not breach IG rules (at the first revision stage in three months' time).
- The approving board should be amended to read QISG in place of QRMG.
- Q&R should be added to the pathway of approving boards.

IG acknowledged the work already undertaken by the Digital team in getting the policy to this stage.

9.1.2 DN331 Purchasing for Safety Policy
This was presented for ratification by the Committee with small changes to text in the light of new legislation. It was confirmed that this policy was approved by D&TC via Chairman's action on 06.09.18. The policy was ratified by the Committee.

9.1.3 9.1.3.1 DN045 CCTV Procedure
9.1.3.2 DN047 Wheelchair Users Safety Procedure
9.1.3.3 DN480 Legionellosis Management & Control
DN480 was ratified by the Committee, however it was noted for future reference, that procedures do not need to be presented at Q&R for ratification.

DECISION:
1. **DN708 was ratified with the proviso of the inclusion of the agreed changes**
2. **DN331 was ratified by the Committee**

10 Research and Education:
10.1 Research

10.1.1 R&D Directorate Minutes (18.09.18): The Committee noted the information in the minutes.

10.2 Education
10.2.1 Update on Education Strategy
This was presented for information by IG and ratification by the Committee with the addition of the proposed amendments discussed at the last meeting. It was agreed that the Trust's main academic providers should be included in the strategy for clarity. The Committee agreed that the strategy could be presented to the Board with this amendment.

IG confirmed that he and JR had met with OM to discuss the TOR for the Education Steering Group to ensure engagement with HR was optimised.

DECISION: The Committee agreed that the strategy could be presented to the Board with the agreed amendment.

11 Committee Member Concerns:
There were no concerns.

12 Any Other Business:
12.1 Change of name for NAC to Clinical Professional Advisory Committee (CPAC)
This was noted and accepted by the Committee.

13 Issues for Escalation to:

13.1 Audit Committee: There were no issues for escalation.

13.2 Board of Directors: There were no issues for escalation.
The meeting closed at 4.05pm

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Signed – Ron Zimmern, Chair

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Date

Quality & Risk Committee Meeting held on 20th November 2018

Date	Time	Comments	Venue
22nd January 2018	**2.00pm – 4.00pm**		**Board Room, CTBI**