

Quality and Risk Committee – 28th May 2019

Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Minutes of Meeting held on Tuesday 28th May 2019 at 2.30 pm
3rd Floor Seminar Room 2

Present:

BLASTLAND, Michael	Non-Executive Director	MB
BUCKLEY, Carole	Assistant Director of Quality and Risk (left at 1542 hrs)	CB
HALL, Roger	Medical Director (left at 1542 hrs)	RH
LINTOTT, Susan	Non-Executive Director (Chair)	SL
RUDMAN, Josie	Chief Nurse	JR

Attending:

JARVIS, Anna	Trust Secretary	AJ
RIOTTO, Cheryl	Head of Nursing and Staff Governor	CR
WEBB, Stephen	Associate Medical Director and Clinical Lead for Clinical Governance	SW

Present:

SEAMAN, Chris	Minute Taker	CS
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1. Apologies for Absence

Apologies were received from Nick Morrell, Non-Executive Director, Ivan Graham, Deputy Chief Nurse, Richard Hodder, Lead Governor and Oonagh Monkhouse, Director of Workforce and Organisation Development.

2. Declarations of Interest

- Josie Rudman as Vice Chair of the Cambridgeshire and Peterborough Joint Clinical Group.
- 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 and as a freelance journalist reporting on health issues.

3. Ratification of Minutes

The minutes of the meeting held on the 23rd April 2019 were agreed as a true and accurate record. Cheryl Riotto, Head of Nursing was added to the list of attendees.

DECISION: The Committee ratified the minutes of the meeting held on 23rd April 2019.

4. Matters Arising

Please refer to the [Action checklist](#) for outstanding actions – these were reviewed and updated.

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5. Quality

5.1 **Patient Safety/Effectiveness of Care**

The Assistant Director for Quality and Risk presented the Quality Exception Report and associated papers. It was noted that the Q4 and the Annual Quality and Risk report were combined in one document which also includes a summary of complaints.

5.1.1 **The Quality Exception Report**

- The last year has seen a slight reduction in patient safety reporting. This reduction is not seen as a concern, as in comparison to peers, Royal Papworth still maintains a higher reporting rate.
- 15 Serious Incidents (SIs) in total have been reported through the year, compared with 11 in the previous year; however, the standard for reporting has been raised. Discussion followed concerning whether an audit of SIs was needed, looking at whether an incident was as a result of act or omission and whether the increase in SIs is as a result of increased reporting or increased harm. A Just Culture Review, (initiated by the National Patient Safety Agency in 2007 and recently reinvigorated) was considered. This review would tease out human influences when a bad outcome occurs. The performance of people, sabotage, adequate systems and checks and controls are all involved. Stephen Webb agreed to circulate the Just Culture Guide. Michael Blastland asked how, when standards were raised, which led to increased reporting, incidents that are actually indicative of an increase in harm were identified. Stephen Webb assured the Committee that all incidents were looked at in detail in conjunction with mortality rates. Independent reviews of deaths were now undertaken as a new initiative at the weekly Serious Incident Executive Review Panel meetings, which involved constructive discussion about escalation to SI level. The category 'Known Complications' was no longer in use in the Trust; this category of incident would previously have been classed initially as a moderate harm, and following a peer review would possibly be escalated to an SI.
- The Trust had fulfilled the Duty of Candour requirements both verbally and in writing for all SIs.
- The Trust had given evidence at 19 inquests, with 32 pending. A pre-inquest review hearing was now expected, creating an increased workload; however, the process was now more helpful to the family. A negative response from the coroner in terms of outcome was rare.
- Patient Advisory Liaison Service enquiries had increased during the year, with many concerns being resolved at a local level with both the clinical and non-clinical teams.
- The Trust was compliant in its response to Safety Alerts.
- The full report was in the shared drive for reference.

5.1.1a SUI-WEB29720 – Flu Outbreak – there had been an exemplary staff response; no patients had been harmed although organisational difficulties had been created with the closure of some wards. The report was noted by the Committee.

There were four SIs still under investigation:

SUI-WEB30173 – Never Event of Misplaced Nasal Gastric tube – a new incident and still under review.

SUI-WEB29910 – Unexpected death in Cardiology – there were concerns in regard to staff ensuring that the patient had been attached to Ventricular Fibrillation monitor. The final report was expected.

SUI-WEB30239 – Loss of airway during bronchoscopy – under investigation.

SUI-WEB30579 – Failure of ECMO blender dial – this was a new incident; the 72 hour report had been prepared for the commissioners. All ECMO machines had since been checked and no fault had been found. The incident was still under investigation as all ECMO machines had been inspected after the move before release to areas, prior to this incident. There have been no other reports of equipment malfunction. The Trust was about to undergo a full Duty of Candour process with the family.

This equipment failure prompted discussion on the increased risks that the Trust may need

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to consider following the Hospital move.

- Michael Blastland asked whether there was a process in place to gather experiences/incidents as a result of unfamiliarity with the environment. Assurance was given that briefings, which included a check on whether the correct equipment was in the correct location, occur before every intervention. Directorate meetings had discussed this topic with each speciality thinking and reflecting on their individual areas with a visualisation tested out in Cath Labs. A debriefing after intervention had also been introduced.
- It was recognised that the experiences of the bedside nurses were not being captured
- There was discussion on the occurrence of the potential for an incident caused by becoming alarm and noise blind. It was suggested that the Education team should test to see whether machines were emitting alarms or whether there was alarm fatigue. Safety briefings should address new learning in a new environment. This subject would be picked up in the Hospital Optimisation Project.
- Richard Hodder gave assurance that safety events had been discussed with other Trusts prior to the move to ensure greater awareness. It was suggested that Royal Papworth could compile experiences/incidents in order to provide support to the next big Trust that moves location.
- VTE monitoring had declined slightly over the month; however, a mandatory field on Lorenzo had been authorised and a timeline for implementation was expected.
- The recent concerns about the performance of the Booking Team at the House remained on the Patient and Public Involvement agenda, with a presentation from the Booking Team manager given at the most recent PPI. The implementation of the new switchboard had caused additional problems, and it had been acknowledged that the scale of work required had not been fully appreciated at the time, and therefore sufficient resource had not been available.

5.1.1.1 Q4 Quality and Risk Report

The report was noted by the Committee.

5.1.1.2 Q4 Directorate & Business Unit reports

The report was noted by the Committee.

5.1.1.3 Quality and Risk Management Group Minutes (190409)

The information in the minutes was noted.

5.1.1.4 Quality Improvement Steering Group Minutes

There had been no meetings since the last Quality and Risk Committee.

5.1.2 Fundamentals of Care Board (FOCB) Exception Report

The FOCB had met on 8th May. Key highlights included successful registration of the new site with the first mock inspection taking place on 22nd May. External reviewers attending the mock inspection had been very impressed and pleased that the Royal Papworth team spirit had been transferred with the move.

CQC listening events had picked up on some negative vibes from the Junior Doctor workforce mainly focused around office and rest facilities. Resolutions for both areas of concern were being sought.

5.1.2.1 Minutes of Fundamentals of Care Board

These were not available at the time of the meeting.

5.1.2.2 Notification of CQ Inspections (June/July)

The dates given in the letter were noted by the Committee.

5.2 Patient Experience

5.2.1 Patient & Public Involvement Committee (190225)

The information in the minutes was noted.

5.2.2 Patient and Carer Experience Group (PCEG)

There were no minutes available.

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5.3 Performance

5.3.1 Performance Reporting Quality/Dashboard

5.3.1.1 Papworth Integrated Performance Report (PIPR) Month 1

The Committee noted the contents of the report.

PIPR Safe Section M01 was rated Green and PIPR Caring section M01 rated Amber. It was acknowledged that Safe was Green probably as an outcome of the annual leave ban over the move period. It was expected that this rating would return to Amber until the recruitment pipeline had improved. It was suggested by Michael Blastland that WTE should be included to enable a clearer interpretation of staffing data.

Caring had scored Amber, which was due only to an increased response time to complaints, probably caused by clinicians and executives being more engaged on this occasion with move priorities. The Friends and Family satisfaction scores had achieved 100% in the first week of May for the whole Hospital. The mock CQC inspectors had seen evidenced of this high level of satisfaction in their conversations with patients.

The rolling average for measuring written complaints had been replaced by the NHS Model Hospital to enable national benchmarking.

5.3.2 Monthly Scorecards - Month 01 2019/20

The data in the monthly ward scorecard was accepted. Scorecards would be displayed on the Know How Well You're Doing boards as soon as these were in situ.

Various different initiatives were being considered to support increased recruitment:

- Discussions with new universities (Hertford) were ongoing and links with the University of East Anglia had improved
- There were currently 84 WTE Health Care Support Worker vacancies across the Trust. Twenty-four of these vacancies could be turned into apprenticeships, which would reduce WTE vacancies by five as cover needed to be provided while the apprentices were absent due to training. Although the apprenticeship levy could be rolled over for two years, there number of available programmes was insufficient.

The Cardiac Network would be approached for support to apprenticeship program.

It was acknowledged that staff were currently feeling the impact of a longer working day due to generally increased working hours, following the move.

5.4 Safety

5.4.1 DIPC Report 2018/19

The annual Infection Prevention and Control Report was presented to the meeting. It was noted that there was a discrepancy in the figures on Page 18 which may affect the aggregated numbers. The Chief Nurse would follow up with the author of the Report. There was discussion on how the Trust would achieve the 15% reduction in the use of antibiotics, a target set as part of the five-year national action plan. It was acknowledged that the Commissioning for Quality and Innovation target (CQUIN) was mainly aimed at A&E departments, the community care and secondary care providers and did not take into account of complex, and therefore expensive medication prescribed at Royal Papworth. The Trust will look to negotiate the CQUIN with Commissioners.

5.4.2 Learning from Deaths 18/19 Annual Report

The report was a national requirement following the Harold Shipman enquiry, mandating a greater scrutiny on deaths in hospitals. The Learning from Deaths framework, published in 2017, required an extra level of scrutiny in addition to the existing four methods of scrutiny:

- Death certification system and the new Medical Examiner process
- Case record review process.
- Mortality and morbidity meetings (where most deaths are discussed).
- SI investigation.

Each death can go down either one or several channels for complete scrutiny. From 1 April 2018 to 31 March 2019, 163 patients died in Royal Papworth Hospital, which is lower than in previous years.

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5.4.2 Minutes of Serious Incident Executive Review Panel (SIERP):

The information in the minutes (190507, 190514) was noted.

6 Risk

6.1 Board Assurance Focus (BAF):

- A new risk relating to site optimisation had been created and would appear on the next Committee report. There had been a few teething issues related to different ways of working on wards and Critical Care in particular with single rooms
- The risk for ageing (old) estate had been closed.
- The key movement had been in BAF 744 (CQC Fundamentals of Care), moving from a rating of 15 to 10 with a successful registration visit and mock inspection rating the hospital as 'Good to Outstanding'.

6.1.2 BAF Tracker

The Committee noted the information in the report.

7. Governance

7.1 Senior Information Responsible Officer Report Q4

This report was not available.

7.2 Summary of Commissioning for Quality and Innovation Schemes (CQUINS) for 20/19

CQUINS are both national and local targets. There are fewer this year.

7.3 Structure of Future meetings

- The proposed structure for future monthly meeting was presented and agreed.
- The importance of exception reporting was stressed.
- A regular agenda item for Workforce would be added to the Performance section.
- It was agreed that there should be an increased focus on Research with a requirement of greater awareness by the Board eg, highlighting early research that may result in changes to clinical practice. It was decided to invite an R&D representative to attend quarterly in Month 3 to present a current research project, with quarterly reports to inform the Annual Report more directly.

8 Assurance

8.1 Internal Audits

There were no internal audits reports.

8.2 External Audits/Assessment

There were none presented.

9 Policies & Procedures

There were no policies or procedures for review.

10 Research and Education

10.1 Research

There were no items for discussion.

10.2 Education

10.2.1 The report on Learning Beyond Registration Funding with the award of £48,000 was noted by the Committee.

11 Committee Member Concerns

There were no members' concerns.

12 Any Other Business

There was no Any Other Business.

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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.

Date of next meeting: Tuesday 25th June, Ground Floor Rehabilitation Room

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Signed – Susan Lintott, Chair

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Date

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