

Quality and Risk Committee – 26th June 2019

Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Minutes of Meeting held on Tuesday 26th June 2019 at 2.30 pm
Ground Floor Rehabilitation Room

Present:

LINTOTT, Susan	Non-Executive Director (Chair)	SL
POSEY, Stephen	Chief Executive Officer	SP
RAYNES, Andy	Director of Digital and Chief Information Officer	AR
WALLWORK, John	Trust Chairman and Non-Executive Director	JW
WEBB, Stephen	Associate Medical Director and Clinical Lead for Clinical Governance	SW

Attending:

BUSH, Liz (from 1615)	Executive Assistant to the Chief Executive Officer and Minute Taker	LB
GRAHAM, Ivan	Deputy Chief Nurse	IG
HODDER, Richard	Lead Governor	RH
HODGE-BRUCE, Sarah (from 1530)	Leadership and Staff Development Lead	SH-B
MELLOR, Greg	Consultant Cardiologist	GM

Present:

SEAMAN, Chris (left at 1620)	Executive Assistant to the Chief Nurse and Minute Taker	CS
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1. Apologies for Absence

Apologies were received from Nick Morrell, Non-Executive Director, Oonagh Monkhouse, Director of Workforce and Organisation Development, Josie Rudman, Chief Nurse, Roger Hall, Medical Director, Michael Blastland, Non-Executive Director Anna Jarvis, Trust Secretary and Carole Buckley, Assistant Director of Quality and Risk.

2. Declarations of Interest

Stephen Posey

- In holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH.
- As Chair of the NHS England (NHSE) Operational Delivery Network Board.
- Stephen Posey as Executive Reviewer for CQC Well Led reviews.

3. Ratification of Previous Minutes Part 1 (190528)

The minutes of the meeting held on the 28th May 2019 were agreed as a true and accurate record.

DECISION: The Committee ratified the minutes of the meeting held on 28th May 2019.

4. Matters Arising

Please refer to the [action checklist](#) – these were reviewed and updated. It was specifically noted that, with the Committee's authority, a number of outstanding issues had been deferred over the past few months because of the hospital move, the CQC registration visit and the Core Services inspection. It had been agreed that priorities had been identified, so the Committee was comfortable that these actions could comfortably wait until business as usual was established in the new hospital.

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5.1 Quality

5.1.1 Quality Exception Reports

5.1.1.1 SUI-WEB30296 – Mortuary incident

The completed report was available for information.

5.1.1.2 SUI-WEB30173 – Never Event of Misplaced Nasal Gastric tube

The completed report was available for information.

5.1.1.3 SUI-WEB29910 – Mindray Monitoring leading to unexpected death in Cardiology

This report had been approved and the recommended actions were in progress.

Michael Blastland (MB) raised various issues regarding this incident by e-mail via the Chair. This also led to discussions on the time line and format of the report. Attention was drawn to the timeline at Appendix 1. The Deputy Chief Nurse (IG) responded that MB's concerns were covered in the report, however he acknowledged the standard format of report used may not have immediately made this apparent. The Chair commented that the template of serious incident reports was wordy and repetitive and may be daunting when received by relatives. IG felt that the staff liaison representative attached to the family would discuss the report with them in order to prepare them for the structured format of the report. IG stated he was happy to discuss MB's concerns with him outside of the meeting if necessary and advised that it isn't a Trust template.

IG reflected on the lessons learnt and recommendations made:

- The individual staff member had been spoken to and asked to reflect on their actions.
- All staff were reminded to follow the Cardiac Monitoring policy.
- The Directorate is progressing to telemetry devices to allow patients to move away from the bedside. Wifi is being checked to ensure these devices will function.
- Intentional rounding had been in place and when the patient was found, good care had been given with CPR commenced immediately. The patient, however, had sadly died.

There was further discussion on alarm fatigue and the Chief Executive Officer asked for the results of a trial on Ward 3 South concerning alarms to be presented to this Committee. The Chief Executive Officer also asked the Committee to reflect on whether, if the family had asked if their relative had been attached to the monitor, and staff had attended him sooner, would he have survived. The Associate Medical Director responded, that on consideration, given the good success rate with CPR in the hospital, the answer may well be yes. The Committee considered this was good evidence of the Trust's openness and honesty.

5.1.1.4 Quality and Risk Management Group (QRMG) Exception report and Minutes (190514)

The minutes of the QRMG held on 190514 were noted with the following highlights discussed:

- The Critical Care Manager and Matron had been very responsive to staff concerns. Previous staff experience scores had been lower in Critical Care with staff feeling isolated in the new work environment of single patient rooms. The CQC had spent a considerable amount of time on the unit and staff reported that they felt that they had been listened to, as the sliding doors between rooms are now by default open, and only closed when necessary. Infection Control had taken a practical approach to this, in partnership with the clinical teams. The supernumerary nurse had made a difference and the staffing model was subject to regular review.
- The Operations Manager for the Administration Teams had given a presentation and assurance at the last Patient and Public Involvement group that delays in the despatch of clinic letters had been resolved by the implementation of new processes and learning from previous experiences.

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- The supplier of the new medicine storage cabinets, which had been deemed not fit for purpose, had been responsive in attending to make adjustments to all cabinets to ensure the locking mechanism was secure. However, during this period both the 5th and 3rd floor wards had moved their drugs into wall mounted purpose built cupboards with locks, in agreement with the Chief Pharmacist.

It was agreed that Hospital Optimisation should be added as an ongoing agenda item. The Chief Operating Officer and Chief Finance Officer should be invited to talk to this.

The QRMG exception report noted the following 3 new serious incidents under investigation:

SUI-WEB31119 – Retained Guidewire (Never Event)

A guide wire had been left in place after a central line insertion. A number of activities occurring simultaneously probably distracted clinical staff. The investigation to understand the new environment and human factors in place was underway.

SUI-WEB30910 – Delay in responding to Mindray alarm

This was the second Mindray incident in May. Initial assessment does not demonstrate any direct correlation between the two serious incidents, however, human factors appear to play a part in the interaction staff have with the new monitoring equipment e.g. alarm fatigue, new environment.

SUI-WEB30579 – Failure of ECMO blender dial

The failure of the blender dial was not likely to have contributed to the patient's death so this incident had been regraded to a low harm/near miss. The Perfusion service lead will investigate in-line monitoring as a result of this incident and will scope the purchase of these devices.

5.1.1.5 Quality Improvement Steering Group Minutes

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

5.1.2 Minutes of Fundamentals of Care Board (FOCB) (190312, 190508)

The minutes of the meetings were noted by the Committee.

5.1.3.1 Executive Led Environment Round Exception Report

The report was accepted by the Committee. The importance of Non-Executive Director support on these rounds was stressed.

5.2 Patient Experience

This item will feature in Month 1 of the next quarter.

5.3 Performance

5.3.1 Performance Reporting Quality/Dashboard

5.3.1.1 Papworth Integrated Performance Report Summary (PIPR) Month 02 2019/20

This is in the shared folder for information. Michael Blastland had requested a future spotlight on Hospital Optimisation and for the Effective summary to be included in future Committee papers.

There was lengthy discussion on the balance between safety and throughput/patient flow and whether the Trust should consider increasing their appetite for risk. It was decided that this should be escalated to Board.

5.3.1.2 PIPR Safe – Month 02 2019/20

Overall, Safe was green for safe staffing however some areas had reported under the 90% fill rate for registered nurses. The Deputy Chief Nurse commented that work on the e-roster templates continues to help ensure the data is accurate.

The two serious incidents mentioned on the Spotlight within PIPR had been discussed earlier in this meeting.

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5.3.1.3 PIPR Caring – Month 2 2019/20

Caring was amber as The Friends and Family test dipped under the 90% target in Out Patients. The hospital move was likely to have contributed to this drop however the last 4-5 weeks had seen an improvement in response rates, as the Out Patient team had responded well to the challenge of improving results. FFT reporting data has been reviewed to ensure Day Ward and Day case results are reported in line with NHS England requirements. In summary:

- Day case patients (who attend inpatient ward areas) are reported within the respective inpatient ward data (instead of separately)
- We are reporting Day Ward patients, with the inpatient data, with Day Ward listed as its own ward.

The number of recorded compliments had dropped during May. Staff had been reminded to send all accolades through to PALS as it was felt that this process had been disrupted during the move.

5.3.1.4 PIPR People, Management & Culture – Month 02 2019/20

The May spotlight was on Mandatory training discussed and is documented later.

5.3.2 Monthly Scorecards - Month 01 2019/20

The scorecards are displayed on the Know How Well You're Doing (KHWD) boards across the organisation with a local extract on each ward for Sisters to pick out local highlights. The Deputy Chief Nurse advised that the CQC had expressed their approval of the boards. He thanked all the teams for achieving this success and gave particular thanks to Day Ward for piloting the early part of the project.

5.4 Safety

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

The information in the minutes (190514, 190521, and 190528) was noted. Detailed discussions had taken place earlier under item 5.1.

5.4.2 Patient Safety Data

The report from the Assistant Director of Quality and Risk summarised the key issues in graph format. The patient falls graph on page 2 of the report evidenced that the falls rate had not increased significantly and the impact of single rooms had not contributed to this. Work by the ward teams and the specialist falls nurse, intentional rounding and the layout of the rooms in relation to the touchdown station in each ward quadrant, had contributed to this.

6 Risk

6.1 Board Assurance Focus (BAF):

6.1.1 BAF Risks

The Committee was asked to consider the entry onto the BAF for Hospital Optimisation and to agree the rating. The rating had been set at 15 however with the mitigation of weekly executive led meetings the Committee were asked to review. The Committee noted the impact of new ways of working and scheduling and that the hospital was only 2 months post move. Plan to move the risk target from a 3 to a 2 (= risk rating of 10) by the end of the first quarter. It was noted that when considering staff supporting other areas, that skill mix needs to be taken into consideration. Shared workforce currently working well on the 5th floor with 5N providing support for 5S and this pattern could be disseminated across other ward areas. It was noted that as a specialist hospital when demand is high across the region the Trust can often come under more pressure and that it is important we get our capacity planning and optimisation right as soon as possible. The Optimisation meeting will

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help to lead this in partnership with the clinical teams.

6.1.2 **BAF Tracker**

The Committee noted the information in the report.

7. **Governance**

7.1 **Senior Information Risk Owner (SIRO) Report Q4**

The Committee noted the information in the Q4 report, with particular reference to item 2.6 and the Freedom of Information (FOI) requests received by the Trust, totalling 93 in Q4 with no breaches within the response deadline. The Chair questioned whether FOI data could be made more accessible on the public website and how the Board could get sight of the general public's enquires and therefore understand the trends of information requests received by the Trust and possible areas requiring focus and consideration? The Trust had received an increased number of enquiries relating to commercial matters, end of life care and DNAR decisions.

8 **Assurance**

8.1 **Cardiology Directorate Presentation**

The Chair welcomed Dr Greg Mellor, Consultant Cardiologist to the meeting. Dr Mellor presented an [update](#) from the Cardiology Department including research activity within the department, ongoing clinical audits and service improvement projects.

This covered active studies within the Cardiac Rhythm Management (CRM) group of which the Committee noted were all industry funded by both pharmaceutical and medical equipment companies. Discussion focused on the study led by Royal Papworth, RECOVER-AF, a mapping system in re-do persistent AF Ablations for which internationally, outcomes are poor so this could potentially be life changing for patients who have already undergone 1 failed procedure. Patients had been recruited by Royal Papworth and other centres with a view to publishing in the next 12 months. The next stage of this trial, DISCOVER-AF, which is also industry funded was highlighted in the upcoming CRM studies.

A further upcoming study, Praetorian DFT: Need to defibrillation testing in SICKD implant discussed was considered important as potentially freeing up general anaesthetic time in the Cath Labs.

The high activity of Structural/Intervention trials relate to new drugs or new stent technologies.

Clinical Audit covered by the CRM group included an audit into the outcomes of patients with Supraventricular tachycardia (SVT) and the optimisation of the Cath Labs. The learning point from the audit was that patients presenting syncope did not need to be booked for extra interventions, therefore reducing the use of the Cath Labs.

Service Improvement initiatives include introducing telephone follow ups for SVT ablation, as most decisions were based on history, with physical examinations not required. During 2019 to date, of those who had a telephone follow up, 93% were discharged, whilst 7% were unavailable. As a result Out Patient utilisation was saved and patient travel to the hospital was also avoided with an average saving of 78 miles per patient.

A dedicated Inherited Arrhythmia clinic with a family screening clinic running alongside has been set up and links forged with the Cambridge University Hospitals Genetics department with Dr Mellor attending the Genetics MDT. This will be facilitated by the central funding of genetic testing to allow any physician to test patients following set defined criteria. The

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Associate Medical Director suggested that this initiative should be presented to NHS England with the possibility of attracting patients from wider afield. The Deputy Chief Nurse was keen for the Directorate to share this work with the CQC to demonstrate outstanding practice as a national lead.

8.2 Internal Audits

There were no other internal audits reports.

8.3 External Audits/Assessment

There were no other external audits/assessments presented.

9 Policies & Procedures

9.1 Cover paper for DN219

The summary of changes to this policy was noted by the Committee.

9.2 DN219 Policy for Procurement in the pharmacy department

The policy was ratified by the Committee.

9.3 Cover paper for HR Policies DN302 and DN81

Sara Hodge-Bruce, Leadership and Staff Development Manager, attended the meeting on behalf of the Director of Workforce and Organisation Development to present the Mandatory Training and Induction Policies. These had been reviewed to meet the requirements of the Core Skills Training Framework. Subject Matter Experts had been consulted to reconfirm and clarify who should deliver what training and in what format. The Trust has now moved from an 'all size fits all' approach to a more bespoke training delivery. This approach had been benchmarked against other peer Trusts. The biggest change was to Safeguarding Level 3 and above in recognition of the new Intercollegiate Standards. It was stressed that the Trust was compliant with the previous regime, however there were sound reasons for this review, including making the best use of both trainer and employee time. The Trust now needs to demonstrate compliance with the new policy. The new policy will be advertised through stands in the atrium and by using screen savers to reinforce the message. Doctors are now required to comply with the new training requirements to bring them into alignment with Agenda for Change staff. The lead for Safeguarding in the Trust, Penny Martin continued to attend surgical team meetings to deliver safeguarding training. Following a gap analysis the Non-Executive Directors will also need to undergo similar training.

9.4 / 9.5 DN302 Trust wide Mandatory Training Policy and DN81 Induction Policy

Both policies were ratified by the Committee. The Deputy Chief Nurse thanked Sara Hodge-Bruce and her team for their hard work.

9.6 DN270 Safeguarding Children & Young Adults

This policy had been updated to reflect the change to electronic reporting of child deaths. This was ratified by the Committee.

10 Research and Education

10.1 Research

There were no items for discussion.

10.2 Education

This item will feature in Month 1 of the next quarter.

11 Committee Member Concerns

There were no members' concerns.

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12 **Any Other Business**

None

13 **Issues for Escalation to:**

13.1 **Audit Committee**

There were no issues for escalation.

13.2 **Board of Directors**

It was decided the Board should be asked to consider the balance of safety versus throughput and discuss opportunities arising from the Hospital Optimisation Project.

Date of next meeting: Tuesday 23rd July, 3rd Floor Seminar Rooms 1 & 2.

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Signed – Susan Lintott, Chair

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Date

Quality and Risk Committee Meeting held on 26th June 2019

