NHS
Royal Papworth Hospital
NHS Foundation Trust

Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 2, Month 1

Minutes of Meeting held on Tuesday 23rd July 2019 at 2.30 pm
Meeting Rooms 1 & 2, Third Floor

Present:

BLASTLAND, Michael	Non-Executive Director	MB
BUCKLEY, Carole	Assistant Director of Quality and Risk	CB
HALL, Roger	Medical Director	RH
LINTOTT, Susan	Non-Executive Director (Chair)	SL
MONKHOUSE, Oonagh	Director of Workforce and Organisation Development	OM
RAYNES, Andy	Director of Digital and Chief Information Officer	AR
RUDMAN, Josie	Chief Nurse	JR
WEBB, Stephen	Associate Medical Director and Clinical Lead for Clinical Governance	SW

Attending:

HODDER, Richard	Lead Governor	RH
JARVIS, Anna	Trust Secretary	
SHILLITOE, Lizzie	Matron	LS
YANG, Huina	Consultant Microbiologist	HY

Present:

SEAMAN, Chris	Executive Assistant to the Chief Nurse and Minute Taker	CS

1   Apologies for Absence

Apologies were received from Nick Morrell, Non-Executive Director and Ivan Graham, Deputy Chief Nurse

2   Declarations of Interest

- Susan Lintott, positions held within the University of Cambridge, particularly in relation to fundraising, and membership of the Regent House of the University of Cambridge.
- Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities.
- Josie Rudman, Partner Organisation Governor at CUH, Executive Reviewer for CQC Well Led reviews and Vice Chair of the Cambridgeshire and Peterborough Joint Clinical Group.
- Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd
- 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.

There were no new declarations of interest.

3   Ratification of Previous Minutes Part 1 (190626)

The minutes of the meeting held on the 26th June 2019 were agreed as a true and accurate record with the following amendments:

1. The Chair requested further clarification to be added to the existing minute at **Agenda item 5.1.1.3** concerning the case of a patient who had not received optimal monitoring overnight, who suffered a MI and subsequently sadly died.

'It seemed there were actually three separate lapses. One, when the patient was first observed disconnected, but was not reconnected; two, when he was observed getting up but not reconnected and 3, when the alarm sounded, was acknowledged, but no action taken. Michael Blastland was concerned to understand how we should regard three separate incidents for one patient in one night.   He asked

- Whether monitoring lapses this common but not usually harmful, are not usually noted?
- Was this therefore indicative of a general problem with monitoring?
- If there was a general problem, how does this arise?

He stated that whilst training and policy reminders were welcome, if there were other underlying issues like alarm fatigue then he was concerned that the behaviour would soon reassert itself.   He asked what further steps, if any, we could take to understand and address this'.

2. Michael Blastland asked for the minute **at Agenda item 5.3.1.1** to be amended to read 'Michael Blastland had requested a future spotlight on Hospital Optimisation to be included in future Committee papers'.

DECISION: The Committee ratified the minutes of the meeting held on 26th June 2019 subject to the above changes being made.

4   Matters Arising

Please refer to the action checklist – these were reviewed and updated.

5   Patient Story

Lizzie Shillitoe, Matron (Cardiology) attended the meeting to present a patient story. She emphasised that this story had been taken at the old site but that the lessons learnt could be transferred to the New Hospital environment. The patient was admitted via the PPCI route on Good Friday with chest pains. She was referred to the Cath Lab where it was decided that she was not suitable for a stent insertion. She was then referred for a Cardiac MRI and ECHO tests. Her discharge was delayed because of the lack of availability of Diagnostic staff to undertake these tests over the Bank Holiday weekend; she commented that there were other patients in the same bay who were experiencing similar delays. Otherwise, she commented, that her stay in the Hospital was overall a positive experience. She had felt safe and had been treated with dignity and respect. Her only frustrations were her delayed discharge and not being able to go outside for some fresh air. Matron Shillitoe commented to the Committee that as telemetry devices were now on order, the inability to move around would in future be resolved.

There followed a discussion on the continued national shortage of Diagnostic Radiographers and whether, if more staff could be recruited, the Trust should consider a 24 hour service for routine tests including weekends. The Medical Director felt strongly that we should challenge ourselves as to whether the diagnostic tests (recommended as best practice) were actually necessary. If they were felt to be necessary, the patient should be seen as an outpatient rather than being held in hospital, as a precaution, until the diagnostic service was available. He said that data suggested that approximately only 5% of patients are identified as having an issue as a result of these tests. Michael Blastland suggested that a review of quality thresholds in this area might be beneficial. The Medical Director suggested that consideration should be given to whether these tests were appropriate and /or necessary.

Consideration was given to proposing that the issue be included in the Hospital Optimisation project. It was decided to escalate the matter to the Board for discussion.

6   Quality
6.1.1   Quality Exception Reports
6.1.1.1 QRMG Exception report
SUI-WEB30579 – Failure of ECMO blender. Investigation had concluded that the harm sustained by the patient was not connected to the failure of the ECMO dial incident. This incident had led to further discussion on whether aging kit transferred from the old Hospital was still fit for purpose, despite this not being a contributory factor in this case. A review of the equipment was now being undertaken by the Medical Devices Group.

6.1.1.3 GIRFT Litigation Pack – Covering Letter
This item was discussed together with the next agenda item.

6.1.1.4 GIRFT RPH Litigation Data Pack 2019
Carole Buckley, Assistant Director for Quality & Risk, presented the data pack, which included five years of data on open and closed claims and benchmarked performance against other acute and specialists Trusts providing the same service. Trusts could therefore review their claims to facilitate learning and improvement of patient care. The Trust was shown to be an outlier in Cardiothoracic Surgery for adults. The data had not, however, taken into account the high-risk specialist surgery that Royal Papworth undertook. There were five recommendations outlined in the data pack to be shared with clinicians. She said that she had yet to validate the data to understand the cases that had been included. Once the data, she would report back her findings to the Committee. Michael Blastland asked whether a high-litigation risk was part of the decision making process in whether to proceed with a high-risk procedure. The Medical Director replied that Cardiac Surgery was undertaken and assessed using a validated risk-scoring system, that is, the risk of death; the Trust does not make decisions regarding clinical treatment on the basis of the risk of litigation. The Associate Medical Director commented that nearly all our claims have resulted from the highly-complex procedures against relatively low numbers.

6.1.1.5 Quality & Risk Management Group Minutes
There were no minutes available.

6.1.1.6 Quality Improvement Steering Group Minutes
There were no minutes available.

6.1.1.7 Attendance at Health & Safety Committee
The Assistant Director of Quality and Risk reported that the first meeting of this Committee at the new site had refreshed interest in health and safety and that attendance had improved.

6.1.2   Fundamentals of Care Board (FOCB)
6.1.2.1 Minutes of Fundamentals of Care Board (FOCB)
There were no minutes available.

6.2   Patient Experience
6.2.1   End of Life Steering Group Draft Minutes (190602)
These were presented to the Committee by the Chief Nurse as good governance. The End of Life Care Dashboard is to be expanded to include more data, for example, covering number and location of deaths, length of inpatient stay and bereavement services. It is expected that standardised Care Plans on Lorenzo can be introduced which would be personalised to the needs of the individuals. The Chief Nurse confirmed that Royal Papworth does not use the Liverpool Pathway tool.

It was noted by the Committee that, although there had been no issues attributed to the use

of the blue Advanced Directive wrist bands which were used to communicate blood and blood product decisions, the End of Life minutes noted some concern on the misleading nature of their message. Some staff still associated Advanced Directives with resuscitation decisions and not the refusal of blood products. The Associate Medical Director commented that the potential for confusion had been discussed at length in the Quality & Risk Management Group (QRMG) and it had been decided that a review of the wristbands was necessary. The conclusions would be presented to QRMG in August and subsequently reported to Quality and Risk.

The Director of Workforce and Organisation Development noted that the introduction of Schwarz Rounds was under consideration as these were a useful tool for aiding the review of the emotional impact of difficult cases on both patients and staff, which she had seen successfully implemented in other Trusts. The Associate Medical Director said that he was keen to discuss the clinical ethics of this round with the lead Consultant in Palliative Medicine. The Director of Workforce and Organisation Development said that she was interested in being involved.

Further discussion followed on end-of-life care in general, prompted by Michael Blastland. He asked if the Trust had a means of measuring whether Consultants took the quality of end-of-life care into consideration, as well as saving life, when considering the patient's next intervention. The Medical Director acknowledged that staff were measured on outcome and mortality and that metrics for ethically-complicated decisions were very difficult. He reported that Mr Nashef, Consultant Surgeon, was conducting a trial looking into the quality of life after cardiac surgery and hopefully his observations would inform practice.

The Chief Nurse highlighted that for some while the Palliative Care Team had been actively part of the Critical Care Team, which together with the Service Level Agreement with the Arthur Rank Hospice, had provided a more supportive environment. The Palliative Care Team were routinely involved in decision making on the patient's next intervention. It was suggested, that as the Palliative Care team are involved in all deaths in CCA (unless sudden and catastrophic), their involvement could be used as a metric. This was agreed. The Medical Director considered that having a metric which records the element of 'good death' planning was difficult to introduce and that for most patients was not possible. Consideration of the patient's end-of-life pathway was uppermost in all Multi-Disciplinary Team discussions at all levels and ward rounds. The Associate Medical Director acknowledged that improvements could always be made and that efforts were ongoing. Conscious of an awareness to balance the needs and wants of the family with what was good for the patient, he said that Psychiatry and the Safeguarding team had input into discussions and decisions. He suggested that Dr Sarah Grove, Consultant in Palliative Medicine and Dr Thirza Pieters, Consultant Psychiatrist, could be asked to speak to the Committee about these discussions at the bedside.

The Chief Nurse suggested that data could be captured by collecting patient/relatives stories. Some patients nearing the end of life chose the Hospital as a place to die and evidence of conversations with these patients could be used as a metric.

6.2.2   Patient & Carer Experience Group Draft Minutes (190415)
Richard Hodder presented these to the meeting and informed the Committee that the Patient & Carer Experience Group had also met the day before (22nd July). Highlights from yesterday's meeting were:
- Norfolk Zipper Club had reached a total of £1.2 million through fundraising. The money had been put towards hospital equipment.
- To date, 56 volunteers had signed up since the move.
- Concern was raised by a group member about the process for establishing a patient's

UK residency and their right to receive free NHS care. There is a process in place, but it was not always followed. The matter would be investigated further.

6.2.3   Patient & Public Involvement Committee Draft Minutes (190513)
Richard Hodder presented these to the meeting and highlighted that this meeting of this Committee had been the first in the New Hospital. Highlights were:
- Agreement of Quality Account priorities.
- Progress on Lorenzo optimisation and the connection to Epic at CUH.
- The achievement of a safe hospital move.
- The Leadership & Culture project, which was fully underway.
- Presentation given by Jane Speed, Operations Manager for the Booking Team, on the progress made so far.

Michael Blastland had also attended this meeting and wished to encourage more of his Non-Executive Director colleagues to attend.

6.3   Performance
6.3.1   Performance Reporting Quality/Dashboard
6.1.1.1 Papworth Integrated Performance Report Summary (PIPR) Month 03 2019/20
This report was in the shared folder for information.

6.3.1.2 PIPR Safe – Month 03 2019/20
Overall, Safe was rated red for month 03 but the metrics for Never Event and Safer were rated red, due to one Never Event (retained guidewire) reported in June and Safe Staffing levels for both days and nights falling short of the desired 90% fill rate. Not all beds were used (due to staffing shortages); however, eRoster templates were set up for all beds, and therefore the fill rate was short of what was required for a full template. Care Hours Per Patient Day (CHPPD) was therefore a more accurate indicator as it describes the actual care hours delivered per patient: all areas remained Green. The spotlight on Safe Staffing (in the shared folder) gave more detail.

6.3.1.3 PIPR Caring – Month 3 2019/20
Caring was rated amber overall, with the Friends and Family Test for Outpatients rated as red.   Some Hospital Optimisation projects were reflected in this score; however, some areas, such as hospital signage, was outside the gift of the Hospital and relied on campus partners. The Project Team had liaised with the Biomedical Campus authorities to request improved signage. Length of waiting time in clinics was commented on negatively, and it was acknowledged that the health and well-being checks of waiting patients had not been reinstated since the move to the new Hospital but that Staff were working to reinstate these checks. It was also noted that there was a low response rate; there was a spotlight for information in the shared folder giving more details.

Richard Hodder related his recent experience of arriving for his outpatient appointment only to learn at the desk that it had been cancelled. The Chief Nurse reported that a number of issues with incorrect clinic templates had resulted in some clinics being over filled with others under filled. Mr Hodder said that although Out Patient reception staff had behaved in an exemplary manner, the booking and administration of Out Patient clinics was clearly still a problem.

The Assistant Director for Quality & Risk commented that the recent challenges experienced in the Booking Team had been reflected in the number of complaints. It was likely that this reflected a skill set and training issue rather than a vacancy issue.

It was discussed whether to invite Jane Speed, Operations Manager of the Booking Team, to return to Performance and Patient and Public Involvement Committees to provide an update.

It was agreed that would only be necessary if there were significant changes to report.

6.3.1.4 PIPR People, Management & Culture – Month 03 2019/20
This report was in the shared folder for information.

6.3.2 Monthly Scorecards - Month 03 2019/20
The Chief Nurse presented the results in order to provide ward to board assurance.

6.3.3 Length of Stay (LOS) Productivity
The Chief Nurse reported that she had met Keith Donovan, Service & Cost Improvement Programme Manager, to discuss the launch of a Quality Innovation Productivity and Prevention Programme (QUIPP) on LOS to keep track of projects that would impact on LOS.

6.3.3.1 LOS Programme report April 2019
The Committee were asked to note the contents of this report.

6.3.3.2 LOS Programme Benefits Realisation
The Committee were asked to note the contents of this report.

6.3.3.3 LOS Programme Terms of Reference
The Committee were asked to note the Terms of Reference for this programme.

6.3.3.4 LOS Report by Service Line
The Committee were asked to note the contents of this report.

6.4 Safety
6.4.1 Minutes of Serious Incident Executive Review Panel (SIERP):
The information in the minutes (190604, 190611, 190618, 190625, 190702, 190711 and 190716) was noted.

6.4.2 Patient Safety Data
6.4.2.1 NHS Patient Safety Strategy Paper
The Assistant Director for Quality & Risk presented the Patient Safety Strategy, which reflected the Trust's Quality Improvement Strategy and would align reporting in order to improve patient safety. It required the involvement of all stakeholders in a proactive way to assist the design of better patient safety and would include learning from things that go well, in addition to continued reflection on things that go wrong. Michael Blastland said that he found it difficult to align the general guidelines outlined in the strategy to real clinical experience and requested examples of involving patients in their own safety. The Assistant Director for Quality & Risk said that families were a major stakeholder in investigations. Medicines Safety sought to include patients in actively managing and recording their own data and reporting incidents and things that do not go right. When asked if the Trust needed to develop a patient/public reporting system, she reported that an anonymous national system was being set up. Other examples given were increased reflection on patient stories, consideration of former patients joining patient safety walk rounds, and gathering feedback from groups of patients with chronic disease. Changes had already been implemented to the process of handling serious incidents, following reflection on patient and family feedback. Communications with families had improved. The Duty of Candour letter often included the Terms of Reference for the incident and enquired whether there was anything else the family or patient wished the investigation team to consider.

6.4.2.2 NHS Patient Safety Strategy
This was discussed under the item above.

7   Risk
7.1   Board Assurance Focus (BAF):
7.1.1   BAF Risks
Anna Jarvis, Trust Secretary presented the open BAF risks as at month 03.

- BAF 73: Research Good Clinical Practice and Research Governance had been closed following discussions at Executive Directors.
- BAF 1929: Low levels of Staff Engagement had been reviewed and had been maintained at the same residual risk rating reflecting the level of mitigation that is in place. This rating will be reviewed again to see if the recruitment pipeline had improved. The Medical Director was of the opinion that as the risk remained the same, but the consequences had increased, this became an issue and not a risk.

Committee members found the Governance Structure charts particularly useful, which demonstrated clear accountability lines ensuring that all BAF risks were mapped to 2019/20 Strategic Objectives. It was noted that the presentation of the Clinical and Professional Advisory Committee minutes needed to be reinstated on the Quality & Risk agenda. Following discussion, it was agreed that the Papworth Medical Advisory Committee (PMAC) was a professional forum managed by Consultants as a staff engagement Committee. The minutes, therefore, were not required to be presented. It was also noted that the Education Steering Group did not appear on these charts. The Trust Secretary would make this amendment to the chart.

7.1.2   BAF Tracker
The Committee noted the information in the report.

7.1.3   Corporate Risk Register 190716
As it was not readable in its current format, the document was not considered. The Assistant Director for Quality & Risk noted this comment.

8   Governance
8.1   General Data Protection Regulation (GDPR) Audit
8.1.1   Cover Paper for DGPR audit
The Director of Digital and Chief Information Officer presented the paper to the meeting.

8.1.2   GDPR Audit and proposed actions
The Committee were asked to consider the findings of the internal audit, which had been undertaken with the support of the Trust's auditors and reviewed one year on. A second independent audit had been commissioned to ensure that the audit was fair and impartial. The Committee noted that the Terms of Reference of the Information Governance Steering Group had been reviewed. Michael Blastland asked whether the Trust would be liable for potential fines when there is non-compliance of the recommended retention period. The Director of Digital and Chief Information Officer believed that this would be unlikely, as evidence of the adequate protection of stored images could be provided.

8.1.3   Senior Information Risk Owner (SIRO) Report Q1
The Director of Digital and Chief Information Officer presented the report. The Committee's attention was drawn to point 2.8, which detailed the top five websites accessed by staff. There was some concern that this evidence might represent a breach of protocol of the Acceptable Use Policy.   Before undertaking an audit of the risk, The Director of Digital and Chief Information Officer would investigate further to ensure that this use was only representative of the opening of the current default web browse: the opening of the top hit websites and Hotmail sites could increase the risk of cyber-attacks.

It was agreed that the Director of Digital and Chief Information Officer and the Director of

Workforce and Organisation Development would consider the following outside of the meeting:
- Turning off the current default web browser.
- Pinpointing the users of the websites, although this would be harder to achieve with the increased use of roaming profiles.
- Re-education of staff, that unless accessed for work purposes, access of these sites and other social media sites constituted a breach of the Acceptable Use Policy.

9 Assurance
9.1 Internal Audits
9.1.1 Antibiotic Usage 18-19 Report
Dr Huina Yang, Consultant Microbiologist presented the report.

For 2019/20, Trusts were expected to reduce total antibiotic consumption by 1%. In 2018/19 there had been an 8% increase in usage from the preceding year. Asked what lay behind this increase, Dr Yang noted that the decrease in admissions but acknowledged that usage was higher than desired. She explained that because of the nature of the disease, patients with Cystic Fibrosis generally had a higher use of antibiotics to reduce exacerbations; outpatient Cystic Fibrosis patients were prescribed antibiotics at Royal Papworth which they held until required in order to prevent hospital admission. Nebulisers were also included in this figure.   Twenty percent of the data collected represented inpatient use and these were likely to be patients undergoing elective surgery.

Dr Yang confirmed that an action plan with time lines as well as governance of the antimicrobial stewardship reporting would be developed and presented to the August Quality & Risk Committee for approval.

9.1.2 DNACPR Audit
9.1.3 Last Days of Life Audit
These were not considered as the Chief Nurse acknowledged that the audits included were out of date.

9.2 External Audits/Assessment
There were no external audits/assessments presented.

10 Policies & Procedures
10.1 Cover paper for DN139
The changes to this policy were noted.

10.2 DN139 Risk Management Strategy
The policy was ratified by the Committee. The Chair asked for track changes versions to be presented in the future. The Assistant Director of Quality and Risk noted this request.

10.3 Cover paper for DN341 and DN260
The contents were noted by the Committee.

10.4/5 DN341 Data Protection Policy V3 and DN260 Records Management Policy
Both policies were ratified by the Committee.

10.6/7 Cover Paper for Health Care Science Strategy 2019
This paper was not approved as it did not articulate the actions taken since the last presentation, nor did it reflect which other groups or committees had considered the strategy. The Director of Workforce and Organisation Development agreed that she would liaise with Karl Sylvester, the Lead Healthcare Scientist – Head of Joint Respiratory Physiology Services to make the necessary amendments.

11   Research and Education
11.1   Research
11.1.1 Minutes of Research & Development Directorate (190419)
The minutes of the meeting were noted.

11.2   Education
11.2.1 Education Update
The report was not available. The Chief Nurse would liaise with the Assistant Director of Education to provide a regular quarterly education report in line with the new structure of the Quality & Risk Committee.

11.2.2 Education Steering Group draft minutes (190619)
The minutes of the meeting were noted.

12   Worforce
Culture & Leadership Progress Review July 19
The Director of Workforce and Organisation Development said that she was pleased with the progress made so far. Forty five staff had been nominated and had committed to engage with the project. These included a wide range of staff groups, which had been organised into teams for different functions. A lead for each group was self-identified, modelling collective leadership. NHSI had been supportive and would provide training to each team. They would also identify those Trusts ahead of us in the review cycle to act as buddies.

13   Committee Member Concerns
There were no members' concerns.

14   Any Other Business
14.1   Hospital Optimisation
The Chief Nurse gave an update on the progress of the Hospital Optimisation project. She reported that it had been decided at Executive Directors earlier that day to pull all the project strands together to create a QUIPP rather than concentrate on one area at a time. A global view of the Hospital would be taken, so that when a decision was made in one area of the Hospital it would not have a negative impact elsewhere. Small gains could be distributed more easily and evenly. All areas were working hard to optimise activity, with each area tasked to initiate their own individual action plans. Two weekly progress update meetings had been established. Progress so far was outlined:
- Critical Care had worked through a new model of staffing. The Health Care Support Worker (HCSW) recruitment pipeline was looking healthier. The increased number of HCSWs would release registered nurses from some tasks. The staffing model would not go beyond what was agreed in Gateway 2.
- The Trust had reached out to CUH and was now using CUH bank staff to help open more beds on the fifth floor. Three out of the five closed beds on 5 North had now been opened.
- CUH were also being approached with regard to supporting the Critical Care unit with bank staff.
- There would be 18 registered nurses for the fifth floor between now and October.
- The Director of Workforce and Organisation Development had explored further overseas recruitment, but not European nurses on this occasion.
- Work had been ongoing in Out Patients to reduce the number of unfilled clinic appointments.

Michael Blastland questioned whether the Trust had the expertise to bring a complicated project together. The Medical Director was confident in the Trust's ability, given the recent success of the Hospital move. The Strategic Project Team would now support the clinical

teams to manage the Optimisation Programme. He was confident that the vibe around the Hospital was positive, with a demonstrable 'can do' attitude to fixing problems. He was keen that the enthusiasm of all the clinicians should continue to be harnessed.

When asked by Michael Blastland if there were any surprises as a result of the new environment , the Medical Director cited two examples:

- The unexpected discovery that Cardiologists were spending more time walking between clinic and ward environments as a result of the location of Out Patients in relation to the wards.
- Theatres now required two porters to move patients around due to the double doors on the route

15   Issues for Escalation to:

15.1   Audit Committee
There were no issues for escalation.

15.2   Escalation to the Board of Directors
It was decided the Board should be asked to consider the patient experience of being kept in hospital, versus discharging them to return as an outpatient to undergo diagnostic tests when the services were unavailable over a weekend. The Board should also be asked to consider whether these tests continued to be appropriate or necessary given that fewer than 5% of patients were found to have issues following diagnostic testing.

Date of next meeting: Tuesday 20th August, 3rd Floor Seminar Room 2.

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Signed – Susan Lintott, Chair

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Date

Quality and Risk Committee Meeting held on 23rd July 2019