Royal Papworth Hospital
NHS Foundation Trust

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

Minutes of Meeting held on Tuesday 20th August 2019 at 2.30 pm
Meeting Room 2, Third Floor

Present:		
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
MORRELL, Nick	Non-Executive Director	NM
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:		
JARVIS, Anna	Trust Secretary	AJ
RIOTTO, Cheryl	Head of Nursing	CR
TWEED, Katherine	Consultant, Radiology (Entered at 1442)	KT
Present:		
POLLARD, Kate	Quality Compliance Officer (Entered at 1450)	KP
SEAMAN, Chris	Executive Assistant to the Chief Nurse and Minute Taker	CS

1 **Apologies for Absence**

Apologies were received from Ivan Graham, Deputy Chief Nurse, Michael Blastland, Non-Executive Director and Richard Hodder, Lead Governor.

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
- Nick Morell Acting CEO Morphogenics biotech company from 1 April 2018 and as a member of the Regent House of the University of Cambridge.

There were no new declarations of interest.

3 **Ratification of Previous Minutes Part 1 (190723)**

The minutes of the meeting held on the 23rd July 2019 were agreed as a true and accurate record.

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

4 **Matters Arising**

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

5.1 Quality

5.1.1 Quality Exception Reports

5.1.1.1 QRMG Exception report

The report was presented by Carole Buckley, the Assistant Director of Quality and Risk. Discussion focused on the significant increase in incidents reported in Q1 compared to the previous quarter and the same quarter of the previous year. The Assistant Director of Quality and Risk reported that there had not, however, been an increase in the level of harm, with the majority of incidents related to booking and administration issues, and diagnosis and procedure incidents.

- There had been three new Serious Incidents (SIs) reported in the quarter with four incidents confirmed as moderate/severe harm.
- There had been one VTE event which on investigation showed no evidence of acts or omissions.
- Four inquests had been attended in Q1.
- There was one new request for disclosure of records, one letter of claim and one notification of intention to claim. Benchmarking with Liverpool Heart and Chest Hospital showed that the rate of claims was comparable. The number of open claims with the NHSLA at the end of Q1 was 17.
- 29 investigations were undertaken in Q1 (see earlier discussion).
- Patient and Advisory Liaison Service (PALS) enquiries increased by 100 in comparison to the same quarter last year. The PALS team had been working hard to resolve issues concerning communication/information/delays in appointments and treatment etc.
- There had been no new SIs since the last meeting; however, the full report of SUI-WEB30239 had since been released (see 5.1.1.2).
- There were six ongoing non-clinical claims related to manual handling incidents and trips and falls by staff.

5.1.1.2 SUI-WEB30239 – Loss of Airway.

The full report was available in the meeting papers and had been disclosed to the patient; no reply had yet been received. The prospects for the patient's recovery were good; the malignancy was treatable and the loss of airway sustained during the procedure should not have any long lasting adverse effects. The shared learning focused on pre-operative decision making, with the importance of a multi-professional discussion involving all key decision makers, consideration of all potential scenarios, eg use of guidewire and ensuring that medical notes were contemporaneous.

The report would be shared with staff for a full debrief. The Medical Director and Associate Medical Director stressed that this patient had survived only because of the extreme care taken and expertise demonstrated by the Theatre and Critical Care teams, a point that would also be reflected on in team debriefing sessions.

5.1.1.3 Quality & Risk Report Q1 19//20

The Assistant Director of Quality and Risk confirmed that this report was available on the hospital intranet and a redacted copy was available on the Trust's public internet site. The following was discussed:

- Following a request for clarification by the Chair, the Associate Medical Director explained that Near Miss incidents were indicative of a healthy reporting culture and an opportunity to celebrate good news and learning with staff.
- Oonagh Monkhouse, the Director of Workforce and Organisation Development asked whether there was an action plan for the secretarial/administrative staff issues within the booking team (as she did not have sight of this), and at which meeting(s) this had

been previously discussed. It was noted that the Patient and Public Involvement Committee (PPI) had taken an interest in this problem; however, as Richard Hodder, Chair of PPI was not present, there was no update available. There was a discussion on whether this should be presented to the Operational Executive Group (OEG) and/or escalated to the Board. The Director of Workforce and Organisation Development will liaise with Eilish Midlane, the Chief Operating Officer in the first instance.

- The Chair asked whether it should be of concern that a higher proportion of the Q1 incidents had occurred since the move. The Assistant Director of Quality and Risk explained that a large number of these were related to the laboratory/histopathology issues experienced with the new service provider since the Hospital move. She felt that the reporting of known problems demonstrated a healthy use of Datix as a monitoring system as well as a reporting system.
- The In House Urgent (IHU) targets were confirmed as part of the Quality Improvement project and would be measured and reported on quarterly.
- The high level of PALS enquiries related to unanswered phones, which had also been reflected in the weekly Friends and Family Tests, had been fed back locally to relevant teams.
- The high level of PALS enquiries concerning on-site signage to the Hospital had been escalated to Campus partners.

5.1.1.4 GIRFT Report – Litigation Pack – Trust Response and Appendix 1

This report concerned the validation of the data used in the GIRFT Litigation Pack. The data consisted of claims that had been reported during a five-year time span. GIRFT had not attempted to adjust the metric for case mix and so report did not reflect the nature of the Trust's high-risk activity. The Trust, therefore, remains an outlier in Cardiac Surgery.

5.1.1.5 Quality & Risk Management Group Minutes (QRMG) (190709)

The contents of the minutes were noted. Discussion focused on the following:

- Katherine Tweed, Consultant Radiologist, attended the meeting to present the Radiology ALERT Interim Report, referred to in QRMG minute 6.3.1a. This report (attached) related to five cases of suboptimal patient care related to lung cancer diagnosis either "missed" or detected but not acted upon with associated patient harm. The report articulated the process for referring unexpected nodules (ALERT process) separating pathways for follow-up. Katherine Tweed referred to a national report published recently (attached) in which the Executive Summary mirrored the problems experienced at Royal Papworth, ie, the monitoring acknowledgement of receipt of ALERTS was unreliable and patients were not being routinely informed of diagnosis. That the outcome of the Trust's own investigations matched the safety recommendations made by the national report was encouraging.
- The Chair noted QRMG minute 7.1 referred to incidents related to staff who had fallen while attempting to sit on wheeled chairs that move easily on hard flooring. Cheryl Riotto, Head of Nursing said that these related to chairs without arms and that formal assessments by Occupational Health were underway and the reporting pathway would be through the Health & Safety Group.
- QRMG minute 12.1 noted the findings of water samples with low counts of a non-disease producing Legionella in some areas. Whilst remedial measures were in place, the Head of Nursing reported that a silver copper filtration system had since been installed to eradicate legionella, although it would take about two weeks to become effective.

5.1.1.6 Quality Improvement Steering Group Minutes (190730)

The contents of the minutes were noted.

5.1.1.7 CCG Quality Dashboard

This was not available for presentation. The Chief Nurse took the opportunity to introduce Kate Pollard, Quality Compliance Officer, who would be involved with this in the future.

5.1.2 Fundamentals of Care Board (FOCB)

There was no Exception Report available as the August FOCB meeting had been cancelled awaiting the outcome of the recent June/July CQC inspection.

5.1.2.1 Minutes of Fundamentals of Care Board (190710)

The contents of the July minutes were noted.

5.2 Performance

5.2.1 Performance Reporting Quality/Dashboard

5.2.1.1 Papworth Integrated Performance Report Summary (PIPR) Month 04 2019/20

This report was in the shared folder for information.

5.2.1.2 PIPR Safe – Month 04 2019/20

The Chief Nurse was pleased to report that the rating for Safe had moved from Red to Amber. The Safer Staffing element remained as Red but the Care Hours Per Patient Day levels remained good in all areas. The spotlight on Safe Staffing (in the shared folder) gave more detail on the difficulties experienced on the fifth floor.

5.2.1.3 PIPR Caring – Month 04 2019/20

Overall, Caring was rated as Green. This reflected the improved Friends and Family Test response rate. Intentional Rounding had commenced in Outpatients which had been well received by patients.

5.3.1.4 PIPR People, Management & Culture – Month 04 2019/20

This was not yet available; however, the Director of Workforce and Organisation Development reported that although vacancy rates had decreased, there had been no overall improvement in mandatory training compliance. A spotlight would be available on compliance with mandatory training.

5.2.2 Monthly Scorecards - Month 04 2019/20

The Chief Nurse presented the scorecard to provide ward to board assurance. Ward 5N (Surgical and Transplant) continued to have vacancies and remained rated as Red. She reported that the recent mitigation of holding/closing beds had not been implemented lightly and had been scrutinised at every level. The recruitment pipeline did show an improvement however.

5.3 Safety

Minutes of Serious Incident Executive Review Panel (SIERP):

The information in the minutes (190723, 190806) was noted. A further SI had been reported at SIERP earlier that day, relating to a missed opportunity to accept a patient via the PPCI pathway. The patient had been declined twice, was eventually accepted, but on further transfer back to CUH had sadly died. It was recalled that a similar incident had occurred about 18 months ago: an investigation would therefore take place to see if the lessons from the earlier incident had been embedded. The recent incident had occurred in early August during the changeover period of SpRs; the investigation would also focus on the capabilities and readiness to assume the role of accepting/declining referrals. The investigation team would be led by Dr Mike Davies, Thoracic Clinical Lead, and another investigator yet to be identified.

5.3.2 Antimicrobial Stewardship Action Plan and Governance Structure

The report highlighted the use of antibiotics and included an action plan and governance structure. The Hospital's position as an outlier was explained by the complexity of its clinical cases and the prescribing for long-term outpatients.

5.3.3 Antimicrobial Stewardship Q1 Report 19/20

The NHS Standard Contract target to reduce antibiotic usage by 1% each contract year was discussed. It was felt that there were still some areas for improvement, despite the variance in volume, complexity and mix of patients in relation to peer groups. The Chief Nurse reported that Dr Yang, Consultant Microbiology was pragmatic: progress would be slow and the action plan reached into 2020 reflected this approach.

6 Risk

6.1 Board Assurance Focus (BAF):

6.1.1 BAF Risks

This was presented by Anna Jarvis, the Trust Secretary. There were no new committee risks identified this month. The Committee were asked to note the BAF Tracker.

6.1.2 BAF744 Review

The Committee noted the information in the report changing the scope related to this risk following the successful registration of the new Hospital.

6.2 Corporate Risk Register

6.2.1 Operational Corporate Risks report

The contents of this report were noted.

6.2.2 Open Risks Graded 12 and above

Risk 2273 articulated the need to shorten expiry dates of some medicines if the Pharmacy environment exceeds 25 degrees C. This had been reviewed in light of the recent very high temperatures experienced in July.

Risk 2172 The Director of Digital had reviewed the current budget situation in light of the digital senior team transformation to identify affordability. An update would be available at the next meeting.

7 Governance

7.1 Quality Impact Assessment

The contents of the report, detailing cost improvement schemes covering the period April-July, were noted.

8 Assurance

8.1 Internal Audits

There were no internal audits presented.

8.2 External Audits/Assessment

There were no external audits/assessments presented.

9 Policies & Procedures

9.1 Cover paper for DN100

The changes to this policy merely included the updating of the Hospital logo and review dates. The policy had been approved by the Hospital Transfusion Committee.

9.2 DN100 Blood Transfusion Policy

The policy was ratified by the Committee.

10 Research and Education

10.1 Research

10.1.1 Minutes of Research & Development Directorate (190614)

The minutes of the meeting were noted. The Chair noted the pleasing increase in academic publications from January – July 2019.

10.2 Education

10.2.2 Education Steering Group draft minutes

There had been no further meetings in the month.

11 Other Reporting Committees:

11.1 Minutes of Clinical Professional Advisory Committee (190718, 150819)

The contents of these minutes were noted. The Chief Nurse reported that CPAC wished the Quality and Risk Committee to be aware of the positive news concerning VTE risk assessments and the Family and Friends Test documented in the August minutes. The continued failure of the Lorenzo/Mindray link had been discussed. Andy Raynes, Director Of Digital and Chief Information Officer reported that this had been escalated to Executive level within Lorenzo, stressing the significant negative impact that the absence of a link had had on the Hospital. This issue had yet to be resolved; the Director Of Digital and Chief Information Officer had estimated the cost of this failure to the Trust and would eventually report this to Lorenzo, seeking financial compensation.
The new Chaplaincy Service was discussed. The service offered help and support to staff as well as patients and was keen to be engaged in supporting the Psychiatry service. The Associate Medical Director felt the latter would need engagement with the various clinical ethics forums.

12 Workforce

There was nothing new to report.

13 Hospital Optimisation

The Chief Nurse outlined what she saw as the urgent priorities:

- Efficient staff utilisation, with nursing capacity on the 4th floor to be reconsidered.
- Process review of patient flow through the Hospital with a view to identifying and minimising delays and exploring a rapid IHU model.
- Outpatient utilisation with optimisation of templates, booking and room utilisation.

There was a discussion on future opportunities for quality improvements concerning the more difficult decisions and conversations ahead. This focused on questioning the continuation of procedures which would probably not ultimately affect the final outcome. It was acknowledged that these difficult decisions are more easily taken, for example, in district general hospitals because they do not possess the expertise or technology to pursue further treatment, or in Oncology departments where more rational decisions are made more easily. The Medical Director cited the example of NHS IVF treatment in the Cambridgeshire and Peterborough CCG as an example of the cessation of some services.

Discussion continued on to the possibly disproportionate extent that resources were focused on achieving NHSI national standards/targets for elective surgery, detracting from the needs of IHU patients who are in more urgent need of surgery. A new body, the Joint Clinical Group, of which Josie Rudman is Deputy Chair, had been set up to bring together clinicians from across the Strategic Transformational Partnership to discuss their areas of work to help prioritise pathways that may need redesigning in order to improve patient experience, reduce duplication or maximise efficiency. It is hoped that the Joint Clinical Group would endorse an approach that would focus on IHUs and extend Referral to Treatment targets and that their discussions might eventually lead to the decommissioning of some procedures by the CCG.

Following further discussion about balancing the rights of patients, it was decided not to escalate this to the Board at present; however, the Quality & Risk Committee needed to remain sighted on this issue with a high level of scrutiny. A series of workshops across the STP were being set up to consider these ideas.

14 Committee Member Concerns

The Chair commented that at her recent interview, a member of the CQC team had noted that there was no Junior Doctor representative on this Committee. The consensus of the Committee was that this staff group did not need to be represented at this level as they were invited to other Committees, including QRMG. It was agreed that if the Chief Resident programme was currently running, this post holder should be invited to attend QRMG. The Associate Medical Director would check this with the Education team. There were no other members' concerns.

15 Any Other Business

There was no further business.

16 Issues for Escalation to:

16.1 Audit Committee

There were no issues for escalation.

16.2 Escalation to the Board of Directors

16.2.1 Patient Safety Alert

The Board is to be informed that the Trust will not adhere to a recent Patient Safety Alert regarding fans. Although the new Hospital had been designed to provide better air flow, some patients, due to their health conditions, liked to feel the flow of air. Staff would use their clinical judgement and liaise with the Infection Control Team where necessary.

16.2.2 Learning from Gosport

The Gosport report concerned the inappropriate use of opioids at the end of life. This paper highlighted how the Trust continued to monitor this.

The meeting closed at 1600 hrs.

Date of next meeting: Tuesday 17th September 2019, Third Floor Seminar Room 2.

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Signed – Susan Lintott, Chair

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Date

Quality and Risk Committee Meeting held on 20th August 2019