Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 3, Month 3

Held on 17th December 2019
2.30 – 4.30 pm
3rd floor offices, rooms 3 & 4

M I N U T E S

Present				
	Michael Blastland	**(MB)**	**Non-executive Director (Chair)**	
	Dr Roger Hall	**(RH)**	**Medical Director**	
	Dr Nick Morrell	**(NM)**	**Non-executive Director**	
	Andy Raynes	**(AR)**	**Director of Digital**	
	Josie Rudman	**(JR)**	**Chief Nurse**	
	Dr Stephen Webb	**(SW)**	**Associate Medical Director and Clinical Lead for Clinical Governance**	
In Attendance	**Ivan Graham**	**(IG)**	**Deputy Chief Nurse**	
	Anna Jarvis	**(AJ)**	**Trust Secretary**	
	Richard Hodder	**(RH)**	**Lead Governor**	
	Kate Pollard	**(KP)**	**Quality Compliance Officer**	
	Chris Seaman	**(CS)**	**Executive Assistant (Minute taker)**	
	Ellen Making	**(EM)**	**Medical Examiner**	
	Dr Mike Davies	**(MD)**	**Clinical Lead for Thoracics and Ambulabatory**	
Apologies	**Dr Jag Ahluwalia**	**(JA)**	**Non-executive Director**	
	Professor Ian Wilkinson	**(IW)**	**Non-executive Director**	
	Cheryl Riotto	**(CR)**	**Head of Nursing**	
	Jane Speed	**(JS)**		
	Carole Buckley	**(CB)**	**Assistant Director of Quality & Risk**	

Agenda Item	*For*	Action by Whom	Date
1	**APOLOGIES FOR ABSENCE**		
	The Chair opened the meeting and apologies were noted as above.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions. The following standing Declarations of Interest were noted: • 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		

Agenda Item	*For*	Action by Whom	Date
	Panel for the Cholesterol Treatment Trialists' Collaboration and as a freelance journalist reporting on health issues. • 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 • Nick Morell Acting CEO Morphogenics biotech company from 1 April 2018 and as a member of the Regent House of the University of Cambridge. • 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; as Executive Reviewer for CQC Well Led reviews and Chair of the East of England Clinical Cardiac Network Group. • Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. There was one new declaration of interested declared as follows: • Michael Blastland as advisor to Bristol University's Centre for Research Quality and Improvement.		
3	**MINUTES OF THE PREVIOUS MEETING – 26 November 2019**		
	Approved: The Quality & Risk Committee approved the Minutes of the meeting held on 15 October 2019 and authorised these for signature by the Chair as a true record.		
4	**MATTERS ARISING AND ACTION CHECKLIST PART 1 (191217)** The action checklist was reviewed and updated.		
5.1	**QUALITY**		
5.1.1	**QUALITY EXCEPTION REPORTS**		
5.1.1.1	**QRMG Exception report** The Associate Medical Director and Clinical Lead for Clinical Governance presented the Exception Report. • A plan is in place to identify and resolve recent problems with delays in clerking, reviewing and admitting patients in a timely way at weekends. There was some discussion as to whether this had led to SUI-WEB32357 (see below). • Both SI updates (below) were final reports with summaries included. There was some discussion on the fact that investigations usually resulted in a recommendation to adhere to a Trust policy and whether there was a limited capacity for absorbing this. It was acknowledged that adherence to policies contributed to only part of the overall recommendations.		
5.1.1.2	**SUI-WEB32356 – delay in PPCI referral acceptance** This report was received by the Committee. For all PPCI admissions the on the call SpR team should be discuss the case with the on-call consultant if there is any doubt regarding the diagnosis. In all cases where there is a second referral is made after an initial discussion there should be a discussion with the on-call consultant cardiologist.		
5.1.1.2	**SUI-WEB32357 – Omission of VTE Risk Assessment post admission** This report was received by the Committee. The VTE risk assessment was essentially missed through multiple small problems and the failure to		

Agenda Item	*For*	Action by Whom	Date
	follow VTE policy DN500. Digital support is now in place to support the completion of a risk assessment and a Just Culture Review will be undertaken.		
5.1.1.4	**QRMG minutes (191112)** These were received by the Committee.		
5.1.1.5	**Clinical Audit Annual Plan Progress Report** This paper was received by the Committee. This report outlined the aim to re-align the clinical audit team to support the delivery of the quality improvement culture. The Chief Nurse acknowledged that the Clinical Audit team needed to be better sighted of activities across the Trust and reported that in the past this strategy had proved successful at driving improvements. The Chair suggested that the Clinical Audit & Improvement Manager, and author of this report (Mike Bates), should be invited to attend a future meeting to provide a progress update.	**CS**	
5.1.1.6	**QISG Minutes (1901029)** These were received by the Committee.		
5.1.1	**Fundamentals of Care Board (FOCB)** This Board monitors the CQC activity within the Trust.		
5.1.2.1	**Minutes of FOCB (191113)** These were received by the Committee**.**		
5.1.3	**Executive Led Patient Environment Round** These had been reduced to one per month however due to ED unavailability only one had been carried out in the last quarter. This paper sought to provide assurance that other similar activity had taken place and that these monthly rounds would recommence again in January 2020. The check list for providing consistency to these rounds was noted.		
5.1.4	**Quality Accounts – Half Year update** The Quality Compliance Officer, Kate Pollard, presented this paper. She highlighted that some key aims had already been achieved and that some (In House Urgent pathway, Falls Reduction and the Deteriorating Patient) would be moving to business as usual (BAU). Following challenge from the Chair concerning the falls reduction the Committee provided assurance that the Specialist Nurse for Falls Prevention was confident that all precautions were already in place to minimise the risk of falls. It was acknowledged that, whilst the rate remained low, it has not decreased. The Chief Nurse advised that Royal Papworth had learned from other hospitals that had moved to single room occupancy and that the Trust had not seen an increase in falls since the move to the new hospital; given this she was confident that this quality improvement indicator would become BAU. It was noted that the number of falls was also monitored by PIPR Safe section. Aim 5 within Priority 1 - Building QI Capability - Build and develop QI capability within the QI team and across the organisation – this linked in with the Clinical Audit Annual Plan Progress Report discussed earlier.		

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	Priority 3 – Optimisation of Lorenzo - the Director of Digital outlined the significant plans for the year ahead. This would be regularly reported through the Strategic Projects Committee. He highlighted the forthcoming exciting trial of the voice recognition software to be used in patient consultations to support the production of clinic letters ready for review by the consulting clinician.		
5.2	**PERFORMANCE**		
5.2.1	**Performance Reporting/Quality Dashboard**		
5.2.1.1	**PIPR summary M07** This was circulated to the Committee for information.		
5.2.1.2	**PIPR Safe M07** • Safe was rated green overall. • The safe staffing fill rate for registered nurses had moved from red to amber on days (86%) and amber to green for nights (92.4%); placing safe staffing amber overall. • Review of roster templates in partnership with Ward Sisters continued to support more accurate data for the fill rate. • Falls are monitored per 1000 bed days and the fall rate remained low. • Spotlight on Safe Staffing showcased the new data range table which used the patients acuity and dependency levels entered into the SafeCare system, benchmarked against staffing levels on HealthRoster. Data was placed in order of the highest utilisation and showed required against actual care hours per patient day. The Chief Nurse advised that Royal Papworth would shortly be joining a national pilot to look at staffing.		
5.2.1.3	**PIPR Caring M07** • Caring remained green in month 8. • The number of formal complaints in month was 6 in comparison to 5 the previous month. There were no trends noted across the services and specialities. • Outpatient Friends and Family Test remained at 95% recommendation rate despite increased activity.		
5.2.1.4	**PIPR People, Management & Culture (PMC) M07** • PMC remained red in month. • Voluntary turnover remained below the KPI of 15% at 12.87%, however had increased during the winter period as staff struggled with the increased commute time. Correspondingly the numbers of staff leaving for work/life balance had increased. • Main reason for sickness absence was stress/anxiety which linked back to the work life balance discussed previously. The Chief Nurse said that change fatigue was currently high within the Trust however staff should be encouraged to access the opportunities in place to support them. The Deputy Chief Nurse stressed that staff continued to join the Trust due to the new location and that it was a transitional stage before a status quo was reached. It had been very sad to see long term employees decide to		

Agenda Item	*For*	Action by Whom	Date
	leave, however he noted it was pleasing to see previous employees returning to the Trust. The Chair noted that the numbers for long term sickness absence did not add up – the Director of Workforce would be informed.	**CS**	
5.2.2	**Monthly Ward Scorecard: M08** This was not available at the time of the meeting.		
5.3	**Safety**		
5.3.1	**Serious Incident Executive Review Panel (SIERP) minutes (191126)** The SIERP minutes were received by the Committee.		
5.3.2	**Patient Safety Data** The Chair was pleased to see that data was tracked over a longer period and requested that pre-move data should be retained on this report for future benchmarking. He questioned whether there should be concern over the increased number of medication incidents reported. Some of these would be near misses or no harm caused, which evidenced good reporting culture however it was acknowledged that further support for the junior medical team was required; Dr Zilley Khan from the Clinical Education Team had already been included in discussions to provide this. Digital work was already ongoing to design out the capacity for error in the safe administration of medicines. The Medical Director commented that an expected average error rate would normally be 30-40 incidents per month and that medication incidents associated with harm are either very low or zero. The Chair requested that incidents rated as 'harm' should be included in the data for the next report.	**AP** **AP**	
5.3.3	**Mortality Board**		
5.3.3.1	**Learning from Deaths Q2 report 19-20** The Associate Medical Director and Clinical Lead for Clinical Governance presented the Q2 report which set out the standard metrics the Trust reported on and assured that deaths continued to be monitored using the multifaceted approach. He highlighted that the spreadsheet system currently used for recording Mortality Case Record Reviews was being updated and the current process for saving and accessing M&M meeting minutes was being revised to ensure that data could be more easily obtained. The new Clinical Audit & Quality Improvement Manager (Mike Bates) and the Medical Examiner (Ellen Making) would support the ongoing Mortality Case Record Review process by the review of current processes and initial rapid assessment of all deaths respectively. The Medical Examiner's role as the regional Medical Examiner Service had much to benefit the Trust by encouraging shared learning and rapid case reviews. The Chair enquired about mortality reviews of patients on the waiting list and he was assured that the Surgical Operations Manager had been asked to engage with this. The Associate Medical Director informed the Committee that by April 2021 all community deaths would be incorporated into the system which would help in the assessment. He also added that through the SI process the Trust is alerted to unexpected patient deaths in other organisations who were on our waiting lists.		
5.3.3.2	**DN792 Medical Examiner Scrutiny Review Procedure** This was presented for information however is under review to eliminate current delays for some bereaved families.		

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6	**RISK**		
6.1	**Board Assurance Framework: Committee Open Risks November 2019** The Trust Secretary presented the report to the meeting. • BAF 1787: EPR Optimisation. The risk rating had been reduced in month from a rating of 12 to 8. When reviewed against the original optimisation plan, much had improved. As the risk was being monitored through the LDE program the Digital Director was of the opinion that this would be better managed through the Corporate Risk Register.		
7	**GOVERNANCE**		
7.1	**Terms of Reference – Clinical Professional Advisory Committee** These were received and ratified by the committee.		
7.2	**Terms of Reference – Safeguarding Committee** These were received and ratified by the committee. The addition of both carer representation and patient representation on the committee were highlighted by the Deputy Chief Nurse.		
7.3	**Terms of Reference – Education Steering Group** These were received and ratified by the committee. The major change was the multi-professional make-up of the group.		
8	**ASSURANCE** **Thoracic Directorate** Dr Mike Davies, Clinical Director, attended the meeting to provide an update on the activity, research and audit within the Thoracic and Ambulatory Directorate. The presentation is circulated with the minutes for information. Royal Papworth was a tertiary referral centre providing a service across six specialities (some combined with CUH). Activity trends were noted and research and innovation topics highlighted. Audit had been streamlined (mostly national audits) and reduced to activities that could be re-audited and would link to quality improvements. Nursing staff recruitment in this directorate had been the last to see a positive improvement however a Head of Nursing had recently been appointed for the directorate. With six specialities, patients had very different needs; this, combined with the geography of the fourth floor wards, had proved challenging and the team had recently worked on nurse activity and productivity. The two ward sisters had recently undertaken a useful visit to Brompton to look at their unit and the visit would be reciprocated. A table top exercise, chaired by the Deputy Chief Nurse had recently been held to improve staffing allocation. There was a further discussion on the activity dip in the Respiratory Support and Sleep Centre (RSSC). There were increased numbers on the waiting list with 5071 patients due for an appointment, and the RTT position was challenging at 92%. Dr Davies felt the delay in the hospital move was a contributory factor in this figure as the admission timetable		

Agenda Item	*For*	Action by Whom	Date
	for patients had been severely disrupted. He also attributed the fall in outpatient activity and consequent backlog specifically to problems with booking processes, with clinics often booked at well below their full capacity. Recent Meridian work had highlighted various process issues including empty clinics and incorrect clinic templates. Whilst patient throughput had improved over the last two month Dr Davies was not fully confident that all processes would be in place by the end of Meridian's contract and that it would take some time to become fully operational again.		
8.1	**Internal Audits**		
	There were none.		
8.2	**External Audits/Assessments**		
	There were none.		
9	**POLICIES AND PROCEDURES**		
9.1	**Cover paper for DN194** DN194 had been amended to reflect current NICE guidelines and the geography and layout of the new hospital.		
9.1.1	**DN194 Falls Prevention & Management Policy** This was ratified by the Committee.		
10	**RESEARCH AND EDUCATION**		
10.1	**Research**		
10.1.1	**Minutes of Research & Development Directorate meeting (none)**		
10.2	**EDUCATION**		
10.2.1	**Education Steering Group (ESG) minutes**		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Clinical Professional Advisory Committee (Minutes from 191119)** The minutes were received by the Committee.		
12 **12.1** **12.2** **12.3**	**WORKFORCE** Update on Booking & Secretarial work SOP for Activity Cancellations Draft Outpatients Dashboard All items were deferred to the January 2020 meeting.		
13	**COMMITTEE MEMBER CONCERNS** There were none.		
14 **14.1**	**HOSPITAL OPTIMISATION UPDATE** **CCA Update and Action Plan** The Chief Nurse gave an update on the position within Critical Care. Initial analysis had shown that CCA had been struggling with capacity related to staff availability resulting in a high procedure cancellation rate in theatres. • Project was being led by Alain Vuylsteke, Clinical Director and Cheryl Riotto, Head of Nursing supported by Maggie Maxwell,		

Agenda Item	*For*	Action by Whom	Date

	Deputy Chief Operating Officer and Operational Director.
	• With a workforce of 300+ staff the agreed flat rate head room of 20% was significant.
	• Staffing would be split into 3 more manageable teams; it was hoped that this might address some of the low level bullying and harassment anecdotally reported. Team areas had been agreed and the new way of working commenced on Monday 16.12.19.
	  o 48 hour post op area
	  o HDU (in the central area of the unit)
	  o Two higher level care areas (outer areas)
	• Ultimately the unit was working with the equivalent of 3 wte down on a daily basis. This should equate to 2-3 beds and not the higher number of closed beds recently experienced.
	• Work on rostering had been ongoing; essential leave and study leave only was allowed whilst fundamental building blocks of the 3 teams were put in place.
	• 80 staff had been identified with fixed working patterns still in place from historical and un-reviewed flexible working agreements. 60 of these have been reviewed with 20 still to go.
	• A temporary external Project Manager had been engaged to review the diagnosis and remedial actions already put in place.
	• Back fill for the e-Roster Manager whilst she supported the CCA project was proving challenging due to lack of available staff with the correct training and experience.
	
	The Chair queried whether, in asking for significant changes to rotas, the work life balance of staff would be made considerably harder. The Chief Nurse responded that although one member of staff had since chosen to leave, acknowledgement of the potential hardships caused to other staff by having to work around these historical flexible working agreements had to be considered. The Chair suggested that a staff story from a member of the CCA workforce be requested for a future meeting.
	
	The Deputy Chief Nurse reported that agreement from the national group had been gained, to look at utilising Nursing Associates within CCA. He informed that the current cohort of seven Nursing Associates had all been approached and offered positions within the Trust with five of the group earmarked for the fourth floor and two for Day Ward. Benchmarking had already been done so that the Trust could manage this staff group against the expectations of those caring 1-1 and he was keen to advertise and recruit another cohort who would graduate at the same time and provide peer support for each other.
	
	The Associate Medical Director agreed that it was appropriate to investigate other staffing models, eg Nursing Associates, whilst reviewing the current levels of CCA care and staffing levels.
	
	The Chief Nurse reported progress had been made already within 2 days of the implementation of new working areas, with improved bed rate opening witnessed, however it was too early for a recovery trajectory to be mapped yet.
		CS	

15	**ANY OTHER BUSINESS**		

Agenda Item	*For*	Action by Whom	Date
	The Chair noted that this was Nick Morrell's last meeting with the Trust in his position as Non-Executive Director. He thanked Nick for his support and guidance.		
16	**ISSUES FOR ESCALATION TO:**		
16.1	**Audit Committee** There were no issues for escalation.		
16.2	**Board of Directors** There were no issues for escalation.		
	Date & Time of Next Meeting: **Thursday 30th January 2020 – Fourth floor meeting rooms 3 & 4**		

The meeting finished at 4.30 pm

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality and Risk Committee
Meeting held on 18 December 2019