Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 4, Month 1

Held on 30 January 2020
2.00 – 4.00 pm
Fifth floor, rooms 5 & 6

M I N U T E S

Present	**Michael Blastland**	**(MB)**	**Non-executive Director (Chair)**
	Dr Roger Hall	**(RH)**	**Medical Director**
	Oonagh Monkhouse (until 3pm)	**(OM)**	**Director of Workforce & Organisational Development**
	Andy Raynes (from 3.10pm)	**(AR)**	**Director of Digital**
	Josie Rudman	**(JR)**	**Chief Nurse**
	Carole Buckley	**(CB)**	**Assistant Director of Quality & Risk**
	Dr Jag Ahluwalia	**(JA)**	**Non-executive Director**
	Professor Ian Wilkinson	**(IW)**	**Non-executive Director**
In Attendance	**Ivan Graham**	**(IG)**	**Deputy Chief Nurse**
	Anna Jarvis	**(AJ)**	**Trust Secretary**
	Lizzie Shillitoe	**(LS)**	**Matron**
	Kate Pollard	**(KP)**	**Quality Compliance Officer**
	Cheryl Riotto	**(CR)**	**Head of Nursing**
	Chris Seaman	**(CS)**	**Executive Assistant (Minute taker)**
Apologies	**Dr Stephen Webb**	**(SW)**	**Associate Medical Director and Clinical Lead for Clinical Governance**
	Jane Speed	**(JS)**	
	Richard Hodder	**(RH)**	**Lead Governor**
	Ellen Making	**(EM)**	**Medical Examiner**

Discussions did not necessarily follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.

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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		

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	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, as a freelance journalist reporting on health issues and as an advisor to Bristol University's Centre for Research Quality and Improvement • 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 • Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. • Ian Wilkinson as: Hon Consultant CUHFT; Employee of the University of Cambridge; Director of Cambridge Clinical Trials Unit; Member of Addenbrooke's Charitable Trust Scientific Advisory Board; Senior academic for University of Cambridge Sunway Collaboration and Private health care at the University of Cambridge. Although not declared at the meeting the following is noted for the record: • Jag Ahluwalia as: CUH Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer;. Programme Director for East of England Chief Resident Training programme, run through CUH; Trustee at Macmillan Cancer Support;. Fellow at the Judge Business School - Honorary appointment and am not on the faculty; Co-director and shareholder in Ahluwalia Education and Consulting Limited; Associate at Deloitte; and Associate at the Moller Centre.		
3	**MINUTES OF THE PREVIOUS MEETING – 17 December 2019**		
	Approved: The Quality & Risk Committee approved the Minutes of the meeting held on 17 December 2019 and authorised these for signature by the Chair as a true record.		
4	**MATTERS ARISING AND ACTION CHECKLIST PART 1 (191217)** There were no outstanding actions for review.		
5.1	**QUALITY**		
5.1.1	**QUALITY EXCEPTION REPORTS**		
5.1.1.1	**QRMG Exception report** The Assistant Director of Quality & Risk presented the Exception Report. The main item for escalation and discussion was the management of diabetes care. Diabetes training is no longer part of the Trust's mandatory training program which was of concern as there appeared to be a lack of general knowledge amongst nursing and medical staff regarding diabetes management. A gap analysis carried out against the Diabetes UK Standards, which set out 25 standards, highlighted that the Trust is not compliant with any standard. There was limited availability to a Diabetes Consultant (eight sessions per annum, through the SLA with CUH), therefore the Diabetes Specialist Nurses felt unsupported by more senior clinical colleagues. E-learning tools were being considered and classroom training had been targeted at Junior Medics; a Diabetes Specialist Nurse had attended M&M meetings to update more senior colleagues. The nature of harm was considered to be low as all incidents were classified as near misses or no harm, however the volume of reported incidents had increased. Dr Ahluwalia asked to what extent prescribing		

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	insulin protocols were digitised and suggested that liaison with CUH would prove helpful to ascertain if there was a simplified protocol the Trust could adopt for patients; it was recognised that with the variable doses of prescription this would be a large piece of work. The Committee agreed to explore this further by discussing the digital options to reduce prescription error, with the digital team. This would focus only on the inpatient stay part of the patient pathway.	**JR**	
5.1.1.2	**SUI-WEB32980 – Patient fall** This was related to a fall caused by tripping on trailing ECG wires; the patient sustained a fracture and was sadly bed bound on discharge. This report was received by the Committee. Dr Ahluwalia asked whether there was now a wireless solution for this. The Chief Nurse reported that unfortunately this had proved challenging due to issues with Wi-Fi coverage. The solution had been to provide clips to hold cables more out of the way to avoid a trip hazard. The Medical Director expressed concern that this referral was accepted when the likely outcome was poor; a discussion followed on the judgement between pros and cons of medical intervention, which was equally as important on deciding what intervention maybe necessary. He advised that this aspect was being considered by the frailty work on-going in the Trust at present.		
5.1.1.3	**QRMG minutes (191210)** These were received by the Committee. Dr Ahluwalia enquired how the separate database for capturing telephone and/or e-mail advice would link to the patient record. The Committee was advised that there would be an automated link between the database which would be triggered on admission of a patient (if a record existed) by a unique identifier, and an archive of the conversation would be pulled forward. This solution was in the early days of development however had good clinical engagement.		
5.1.1.4	**QISG minutes** There were none available.		
5.1.2	**Fundamentals of Care Board (FOCB)** This Board monitors the CQC activity within the Trust. The Chief Nurse advised the Committee that the Trust's CQC Relationship Advisor had changed; Rachael Scott had replace Alison Smith, who had been transferred to King's Lynn. She reminded those present that a Mock CQC Inspection was scheduled for 3 February 2020 and would be focussing on the End of Life Service, and those areas that did not achieve Outstanding last year. In addition, she advised that Royal Papworth could be expected to receive another Well Led inspection in 2020.		
5.1.2.1	**Minutes of FOCB (200108)** These were received by the Committee**.**		
5.2	**PATIENT EXPERIENCE**		
5.2.1	**Family Story** A story was presented by Lizzie Shillitoe, Matron concerning the parents of a young Down Syndrome patient who was on Ward 3S for a few weeks prior to surgery. Their story presented a mixture of experiences, both		

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	positive and negative. On the positive side, he was in a room with an anteroom so that parents could stay overnight. His lines failed regularly and he was also needle phobic but the rebooking of his pic line was quickly escalated at CUH. The junior anaesthetic who undertook his pre-operative anaesthetic assessment assured him that one parent could go into theatre with him and the family was also reassured by promises that their son could be kept sedated for 24 hours after the operation. Unfortunately there followed a lack of communication between hospital departments which led to the following negative experiences. The patient was second on the list and experienced anxiety during the wait; his father was not allowed into the theatre environment with him for the administration of the anaesthetic and he was also woken up during the night post op. Whilst the bedside nurse had gone for a break the young patient vomited leading to a bleed from his neck line. His mother called for assistance however as there was also a patient in the next room who required immediate support there was a delay in attending and he sadly died. This story had been shared by Matrons at the Critical Care MDT and Matron Shillitoe had met with both Theatre and Critical Care representatives. She would also be looking to introduce a policy for vulnerable patients on the theatre pathway via the Safeguarding Committee. During the investigation it was also noted that the Junior Anaesthetist had not fully documented his discussions with the patient in his pre-op anaesthetic notes. **Discussion**: This story prompted a discussion by the Committee on not allowing the rule of the red line to impede the needs of the vulnerable patient as there was a facility in theatres' holding bay where the rule of the red line was not required. Vulnerable patients were discussed at safety briefings and an alert could be attached to the patient record. The Committee discussed the introduction of a further measure to highlight the vulnerable patient similar to the discreet sticker used by the End of Life team. It was agreed that the Trust would engage with patients and families on what they would be prepared to accept as a flag for a vulnerable patient. The Medical Director also considered that the Trust had made an unreasonable promise in guaranteeing that the patient could be kept asleep overnight.	**IG / JR**	
5.2.2	**End of Life Steering Group Draft Minutes (200116)** These were received by the Committee**.** Cheryl Riotto highlighted the memorial services co-ordinated by the Supportive and Palliative Care team in conjunction with the Critical Care Matron. These were held in the Faith Centre, for families of deceased loved ones and had proved popular and successful in supporting both bereaved families and staff alike.		
5.2.3	**Patient & Carer Experience Group Draft Minutes (200120)** These were received by the Committee**.** The Chair remarked on the intention of the Library Service to extend its services to patients. The Deputy Chief Nurse reported that the patient questionnaire on what this service might offer was being reviewed by this group. He felt this was an excellent extension of the work being undertaken to engage with patients to prevent possible isolation caused by single rooms (for example, lunch time clubs). He also reported on a moving patient story which gave a powerful insight into the effects of delirium. The ex-patient was part of the growing		

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	volunteer team and regularly met with patients undergoing a similar procedure to that which he underwent himself. The Deputy Chief Nurse also highlighted a good example of responding to patient feedback on the mandatory overseas letter that was distributed to all outpatients. This had subsequently been reworded and was now in circulation. The other highlight of note was the uplifting report from the Transplant Support and Sports Group; it was hoped that medals won from the Transplant Games would be displayed in the Outpatients waiting area.		
5.2.4	**Patient & Public Involvement Committee Draft Minutes (191125)** These were received by the Committee**.**		
5.3	**PERFORMANCE**		
5.3.1	**Performance Reporting/Quality Dashboard**		
5.3.1.1	**PIPR summary M09** This was circulated to the Committee for information. Although Responsive and Effective were not Quality and Risk domains there were lengthy discussions on the reduced activity levels in Critical Care and whether this could be linked to the worsening RTT position, (aggregate RTT position in December was 91.09%). The Chair was keen for assurance that the balance of risk in Critical Care was right; he was uncomfortable with not knowing whether the unit should accept more risks to reduce the RTT. **Discussion:** • The Director of Workforce and Operational Development considered that frustrations this may be taking longer than expected to resolve, should not be allowed to damage the longer term outcome. She was assured that the practical steps identified were manageable but would take time. There were limited number of resources to hand; staff engagement of the already pressurised CCA team was crucial to maintain delivery. • Emergencies, such as dissections, would never be turned down and were always managed safely, however the trade off with the health and well-being of staff was not quantifiable. • Patient harm or deterioration on the waiting list was difficult to assess, with potential harm caused possibly not apparent until some years post procedure. • Consideration of a buddy system with another Trust to test decision making was suggested. The Chief Nurse advised that she was facilitating a session at the National Cardiac Benchmarking Collaborative (NCBC) and would include this as a discussion point.	**JR**	
5.3.1.2	**PIPR Safe M09** The Deputy Chief Nurse outlined that he was proposing to put the fill rate measure for 90% under the line and CHPPD over the line with a detailed breakdown into ward areas.		
5.3.1.3	**PIPR Caring M09** This was received by the Committee.		

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5.3.1.4	**PIPR People, Management & Culture (PMC) M09** This was received by the Committee.		
5.3.2	**Monthly Ward Scorecard: M09** This was received by the Committee.		
5.4	**Safety**		
5.4.1	**Serious Incident Executive Review Panel (SIERP) minutes (191210, 191217, 191224, 191231, 200107)** The SIERP minutes were received by the Committee.		
5.4.2	**Wuhan Coronavirus outbreak** The Chief Nurse advised that there were no further details on this other than what was being stated publically. The Trust had been asked to provide a return on spare capacity for potential patients if necessary. This was likely to have more impact on the ECMO service than other areas of the Trust.		
6	**RISK**		
6.1	**Board Assurance Framework:**		
6.1.1	**Committee Open Risks January 2020 and Appendix** The Chair sought assurance that what he perceived as isolated risks were intricately linked. The Associate Director of Quality and Risk provided assurance that the detail was in layers below this register. Quarterly corporate risk register were now going out to all Committees.		
6.1.2	**BAF Policy and Trust Governance Structure** The Trust Secretary confirmed that DN433 had been presented to Executive Directors, Audit and QRMG committees and would be presented to all other Board Committees, along with the governance structure.		
6.1.3	**Appendix A DN433 BAF Policy** DN433 had been updated to reflect changes in the frequency of reporting to the Board and subcommittees, and changes in reporting to reflect the ownership of BAF risks which sits across Board sub committees.		
6.1.4	**Appendix B Governance Structure** Both the BAF and the risk management strategy were reliant upon escalation through the Trust management and committee structures. Appendix B summarises the Trust Governance Structure.		
6.2	**Quality Report and Accounts Timetable 19/20** This paper provided the Committee with an overview of the process and timetable for producing the Annual Report and Quality Report for 2019/20. The Quality & Risk Committee oversaw the production of the Quality Report ahead of submission to the Audit Committee and the Trust Board for approval.		
6.2.1	**Appendix 1 Draft Annual Governance Statement** The Quality & Risk Committee was also required to review the Annual Governance Statement (AGS) within the Annual Report with particular		

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	reference to the risk and control framework. The first draft forms Appendix 1.		
7	**GOVERNANCE**		
7.1	**SIRO report Q3** The Director of Digital presented this to the Committee. The key highlights were: • Timely submission of the Data Protection and Security Toolkit 2019/2020 which encompasses more of the cyber agenda. Auditors were expected in mid-February and the Trust was on track to complete submission. • Datix incidents had levelled out with a heightened awareness of cyber risks since recent communications via the Weekly Brief and a Board Learning session. The recently reported three global cyber incidents reported over the Christmas 2019 period had proved this is not a case of 'if' but 'when' the Trust was compromised. Each incident had been the result of a click on a link so it was more important than ever that staff remained aware and vigilant. He confirmed that a further phishing exercise would be undertaken; the Chair was keen to continue with these until the return was zero. Both Kate Pollard, the Quality Compliance Officer and Carole Buckley, the Assistant Director for Quality & Risk stated that they had recently received phishing e-mails; it was suggested that 'high risk' addresses could be displayed on the Intranet sliding banner to increase staff awareness. • The overall % rate for mandatory IG training was below the expected compliance so the Director of Digital had asked for this to become a focus for line managers • IGSG attendance had dwindled again over recent months which was concerning and he requested support in maintaining attendance. This message had also gone out through the Operational Executive Group recently. It was suggested both the scheduling of meetings and the attendance list could be reviewed to support increased attendance. A review of the attendance list should also focus attention on why individuals were not attending. • VIP hits on medical records are monitored and no inappropriate access was noted during the quarter.		
7.2	**Reduction of Health Records opening hours** This paper was accepted by the Committee.		
7.3	**Fundamentals of Care Board Terms of Reference** These were noted by the Committee. Changes had been made to attendees and titles in line with the new divisional structure.		
7.4	**Quality & Risk Management Group Terms of Reference** These were noted by the Committee. Changes had been made to attendees and titles in line with the new divisional structure.		
8	**ASSURANCE**		

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8.1	**Internal Audits**		
	There were none.		
8.2	**External Audits/Assessments**		
8.2.1	**Report on the External Peer Review of the Adult Congenital Heart Disease (ACHD)** The Chair was pleased to note that a sensible solution to this problem had been achieved that encouraged increased partnership with other centres across the East of England region. The proposal was to channel existing resource at Royal Papworth into specialised imaging and intervention for the whole region, whilst merging existing ACHD clinical resource with the Norfolk and Norwich (NNUH) ACHD service. This would allow NNUH clinical ACHD staff to lead the level 2 service whilst sharing staffing expertise and data management.		
8.2.2	**NHSE Notification of Annual Assessment Outcomes 2019/20 – Specialised Services and Appendix** These were received by the Committee.		
9	**POLICIES AND PROCEDURES**		
9.1	**Remediation policy for medical staff** This policy was noted by the Committee for information only.		
10	**RESEARCH AND EDUCATION**		
10.1	**Research**		
10.1.1	**Minutes of Research & Development Directorate meeting (191108)** The minutes were received by the Committee.		
10.2	**EDUCATION**		
10.2.1	**Education Report Q3**		
10.2.2	**Education Steering Group (ESG) minutes (191206)** The minutes were received by the Committee.		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Clinical Professional Advisory Committee (Minutes from 191219)** The minutes were received by the Committee.		
11.2	**Safeguarding Committee (minutes from 191031)** The minutes were received by the Committee.		
12 **12.1**	**WORKFORCE** **Report on the Compassionate and Collective Leadership Programme** The Director for Workforce and Organisation Development presented this report to the Committee. She outlined that phase 1 of this project had been completed in December 2019 culminating with a presentation to Board on areas for focus of the strategy moving forward. The second phase would take the form of a gap analysis between what exists now and what is set out in the program and would identify strategies for implementing phase 1 findings. Phase 3 will implement the findings and review the outcomes. A charity bid was being prepared to support the move into the next phase to ensure correct skills were available to support the project. Communication to staff on the project process was		

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	via the weekly briefing and through the engagement champions from phase 1. The project was still on timetable. This project also aligned with a National People Plan so a new project for this would not need to be implemented. Cheryl Riotto queried how action plans from the recently published Trust Survey would fit with this project. The Director for Workforce acknowledged that there had been deterioration from last year's survey results in a number of areas and the focus would be on engaging with local teams on behaviours and valuing line managers.		
13 **13.1** **13.1.2** **13.1.3**	**HOSPITAL OPTIMISATION UPDATE** Update on Booking & Secretarial work SOP for Activity Cancellations Draft Outpatients Dashboard All items were deferred to the February meeting as Jane Speed was unable to attend.		
13.2	**CCA Update and Presentation** The Chief Nurse gave a presentation to the meeting to provide assurance and reassurance with regard to maximising activity on the unit. The diagnosis of the issues in CCA had been validated by an external project manager: • Gateway 2 document was not reflected in the e-rostering template. • Diluted skill mix was reliant too heavily on less experienced grades. • Registered Nurse gap related to approximately 7.7 beds - recruitment pipeline did not match the gap in workforce. • Complex rota processes and inflexibility caused by long standing flexible working arrangements. • Higher than average levels of sickness absence and maternity leave. The Chief Nurse was confident that the following agreed actions matched the diagnosis and would solve activity problems: • New recruits to be pulled forward with recruitment to expedite pre-employment checks. • CCA team to be split into 3 more manageable teams. • Support provided to Sisters to manage teams (currently have zero non-clinical time). • Ambition to turn Assistant Practitioners into Nursing Associates (NA). The latter were registered and could administer medicines and work independently (The NA role was similar to the old SEN role with the first graduates due this year). **Discussion**: • The term 'supernumerary' was considered misleading as supernumeraries were essential; they were staff who walk the floor but were not assigned to a particular patient. • The basal establishment had a headroom element and study leave built in. Clinical areas were staffed for the average with a small number of staff that could provide a contingency, eg Matrons, Education Team. • Roster changes were not yet on the beds forward plan. • All indicators showed that the unit remained safe although fragile		

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	staffing wise. Matrons, Heads of Nursing, Clinical Director and the Clinical Business Unit lead had remained clinically present every day. • Feedback from patients remained unchanged but the health and wellbeing of staff had suffered. • The Chair asked the Committee to consider the balance within the system of risks if the unit were to open more beds, against the trade-off of cancellations and the potential harm caused to patients who were waiting for treatment. The Deputy Chief Nurse commented that the Trust was mandated against establishment levels and to stretch this further would push the balance of risk too far when dealing with emergencies. Overall, despite recognising the efforts of all staff concerned, the Chair remained uncertain that the balance between risks was correct given that assurance was difficult to gather from patients who may potentially be a risk from delays. • The balance of risk was considered to be a triangulation of a number of metrics and there was not a 'one size fits all' key performance indicator. Cheryl Riotto, Head of Nursing, invited Committee members to visit the unit to view the positive aspects; she would facilitate a visit if members cared to e-mail her.		
14	**COMMITTEE MEMBER CONCERNS** There were none.		
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	**Board of Directors** The Committee wished to acknowledge their recognition and support for the work being undertaken by all staff to resolve the issues on Critical Care.		
	Date & Time of Next Meeting: **Thursday 27th February 2.00-4.00 pm, 5th floor Room 6**		

The meeting finished at 4.17 pm

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality and Risk Committee
Meeting held on 30 January 2020