Royal Papworth Hospital
NHS Foundation Trust

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

Held on 27 August 2020 at 2 pm
Via Microsoft Teams

M I N U T E S

Present	**Ahluwalia, Jag**	**(JA)**	**Non-executive Director**
	Blastland, Michael (Chair)	**(MB)**	**Non-executive Director (Chair)**
	Dr Stephen Webb	**(SW)**	**Associate Medical Director and Clinical Lead for Clinical Governance**
	Graham, Ivan	**(IG)**	**Deputy Chief Nurse**
	Hall, Roger	**(RH)**	**Medical Director**
	Hodder, Richard	**(RH)**	**Lead Governor**
	Monkhouse, Oonagh	**(OM)**	**Director of Workforce and Organisation Development**
	Raynes, Andy	**(AR)**	**Director of Digital & Chief Information Officer**
	Rudman, Josie	**(JR)**	**Chief Nurse**
In Attendance	**Jarvis, Anna**	**(AJ)**	**Trust Secretary**
	Chris Seaman	**(CS)**	**Executive Assistant (Minute taker)**

	Buckley, Carole	**(CB)**	**Assistant Director of Quality & Risk**
	Makings, Ellie	**(EM)**	**Medical Examiner**
	Riotto, Cheryl	**(CR)**	**Head of Nursing**
Apologies	**Wilkinson, Ian**	**(IW)**	**Non-Executive Director**

Agenda Item		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 Panel for the Cholesterol Treatment Trialists' Collaboration, as a		

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	freelance journalist reporting on health issues and as an advisor to Bristol University's Centre for Research Quality and Improvement. • Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd. • 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 • 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. • 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. • There were no new declarations of interest declared.		
3	**MINUTES OF THE PREVIOUS MEETING – 30 July 2020**		
	Approved: The Quality & Risk Committee approved the minutes of the previous meeting held on the 30 July 2020 and authorised these for signature by the Chair as a true record.	Chair	
4	**MATTERS ARISING AND ACTION CHECKLIST PART 1 (200730)** These were reviewed and updated.		
5.1	**QUALITY**		
5.1.1	**Quality & Risk Management Group (QRMG) Exception Report** This was presented by the Associate Medical Director and Clinical Lead for Clinical Governance • The rise in the cardiac surgery mortality rate in Q1 was discussed at length; it was considered highly likely that this was attributable to the increase of emergencies of the sickest patients during the pandemic (therefore a higher risk of mortality). The Deputy Chief Nurse observed that the higher emergency activity against lower number of cases shown in Table 2 on the Exception Report fitted with the theory of higher acuity in a shorter period of time. The Chair requested that further assurance could be provided by comparing against other similar acuity cases and with Euroscore. The Medical Director expressed caution as the risk stratification score was less accurate the higher the risk. It was noted that RPH mortality data is reported into the national database for cardiac surgery and a comparison report was produced regularly. • The Chair requested further clarity on the mortality numbers	SW	

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	reported in PIPR, to understand whether the data was Euroscore-adjusted or unadjusted. It was agreed that if a variable life adjusted display (VLAD) was used, trends would be more easily apparent and more meaningful. The Associate Medical Director agreed to investigate and confirm the difference between the raw data and the statistical analysis, and what was reported nationally. • JA queried whether there were any common themes with the deceased patients, eg, delays in theatre etc. The Associate Medical Director commented there were no such trends however the extreme risks of performing cardiac surgery on COVID positive patients had been marked and consequently there had been an increased reluctance to undertake surgery on positive patients. He remarked that there had been no other obvious lessons to learn.	SW	
5.1.1.1	**Q1 20/21 Quality and Risk Report – Trust Wide** This report and the divisional reports at 5.1.1.2 were accepted by the Committee. JA expressed caution on the description relating to the number of complaints and suggested that a pro-rata view would be preferable, to avoid the Trust unintentionally seeming complacent.		
5.1.1.2	**Q1 20/21 Quality and Risk Report – Divisions and Business Units** There was a discussion on the WHO Surgical Checklist compliance rate and concern expressed that this was not an embedded routine. The Associate Medical Director agreed that this had been challenging and various different approaches to achieve better compliance had been attempted. He advised that a Theatres/Cath Lab optimisation group had been looking at this with post COVID intelligence with the expectation of increasing the compliance rate. Reasons for non-compliance were often due to just one item of the checklist being incomplete. This was considered to be a documentation error rather than omission of action and the Deputy Chief Nurse was confident that the Theatre Matron was addressing this by designing the problem out by considering a more appropriate check list. He commented that it was healthy to have a culture with this amount of debate.		
5.1.1.3	**Generic Terms of Reference (ToR) for Mortality and Morbidity Meetings** The ToR had been developed following a potential gap in governance was noted as a result of a recent serious incident. A generic template had been developed to ensure standardisation of approach and to articulate a clear expectation for escalating new concerns raised at M&Ms through the governance process for serious incidents.		
5.1.1.4	**QRMG Minutes (200811)** These were accepted by the Committee.		
5.1.1.5	**New BAU Risks 12+** It was noted that these were mostly COVID and capital expenditure related.		
5.1.2	**Fundamentals of Care Board (FOCB)**		
5.1.2.1	**Minutes of FOCB** There had been no further meetings in the last month.		
5.1.3	**Executive Led Environment Rounds** The Chief Nurse advised that these had recommenced at the end of July. Four had taken place to date with one cancellation caused by the prioritisation of an urgent regional consideration. The Medical Director		

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	considered these to be an important way to maintain a Board visible presence and an opportunity to talk to staff. The main themes to all rounds had proved to be the accumulation of clutter on ward areas, limited storage space, issues with temperature and ventilation and the delay in response by partners with regard to Estates issues. Staff were reluctant to report issues as regularly no evidence of resolutions could be seen. The Director of Workforce and Organisation Development reported that a Staff Experience Committee was being set up with representatives from each area and would be chaired by Andrew Selby, Associate Director for Estates and Facilities, in recognition that 90% of the issues staff reported were environmental.		
5.1.4	**Quality Accounts update** The Trust Secretary advised that an update would be available shortly and that the final draft report would be complete for sign off at the next meeting prior to circulation to stakeholders for comments.		
5.2	**PERFORMANCE**		
5.2.1	**Performance Reporting/Quality Dashboard**		
5.2.1.1	**PIPR Safe – M04** **Update to period of increased incidence of Surgical Site Infection (SSI):** Action plans remained in place, led by the Tissue Viability and Surgical Site Surveillance Nurse, which had reviewed a number of areas including • ventilation in theatre • theatre traffic • theatre discipline • ANTT trust wide • reflection on closure technique in theatres The Chief Nurse reported that further investigations were ongoing that had suggested the following explanations for the increase of SSIs. • COVID19 had caused patients to miss appointments prior to surgery at which antibacterial soap for the pre-operative washing would have been distributed • Prophylactic antibiotics had been administered outside the optimum window Continued liaison with PHE, SSI Surveillance about progress and actions taken remained in place.		
5.2.1.2	**PIPR Caring – M04** This was noted by the Committee.		
5.2.1.3	**PIPR People, Management & Culture (PMC) – M04** This was noted by the Committee.		
5.2.1.4	**Monthly Ward Scorecards: M04** This was noted by the Committee.		
5.3	**SAFETY**		
5.3.1	**Serious Incident Executive Review Panel (SIERP) minutes** (200728, 200804, 200811 200818) The SIERP minutes as outlined above were received by the Committee.		
5.3.2	**Paper on elevated Surgical Site Infection rate Oct to Dec 2019 + Appendix 1** This was discussed earlier at 5.2.1.1.		
6	**RISK**		
6.1	**Board Assurance Framework Report**		
6.1.1	**BAF Report**		

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	The BAF report was accepted by the Committee.		
7	**WORKFORCE**		
7.1	The Director of Workforce and Organisation Development reported minor adjustments to the Covid staff Risk Assessment process. JA noted the positive metrics demonstrated on the PIPR PMC report however queried the impact of long term COVID related sickness figures. The Director of Workforce reported that the Trust was trying to do the right thing by everyone but that all were different and it was a balance of weighing up absence versus the risk factor. Redeployment could be a consideration for some however national discussions were ongoing on this issue.		
8	**GOVERNANCE**		
8.1	**Paper on Digital Strategy** This was presented by the Director of Digital. The Committee noted that he had been asked to present the key choices and priorities to the Board.		
8.1.1	**Appendix 1 – Digital Strategy** This was received by the Committee.		
8.1.2	**20/21 CQUIN update and Appendix 1**		
9	**ASSURANCE**		
9.1	**Emergency Planning** The Emergency Preparedness Committee had met on 26 August 2020 and the Committee received the update paper.		
9.1.1.1	**EPRR Core Standards Check List** The self-assessment of compliance with core standards was included for information.		
9.1.1.2	**CCG Acknowledgement of EPRR Core Standards** The Trust had received notification that it was now substantially compliant with the core standards.		
9.1.1.3	**RPH ICNARC Report on Covid in Critical Care** This report was received by the Committee and encouraged a discussion on the deprivation profile of patients at RPH, with the most deprived being least likely to be treated here. It was not clear whether this simply reflected the population from which the Trust received its referrals or whether it was a reflection of the perceived wider health inequalities and equity of access to our services. Finance had begun some work in this area to further understand the spread of referrals across the region to ascertain whether there was a biased selection process at the referral stage that did not meet the needs of the population. The Chair requested that the Associate Medical Director should liaise with Finance to bring their findings to a future meeting and that the equity of access should be a standing agenda item. JA was in full support of this. It was suggested that a study of the deprivation profile of all ICNARC reports should be undertaken to ensure that RPH had its referral criteria right. It was agreed that this should be an issue more for the local STP however, that RPH should do all it could to highlight the issue if areas of concern were identified as a result of further investigation. It was agreed that this issue should be escalated to the Board for information.	SW	
9.1.1.4	**CPLHRP Covid-19 Shared Learning & Good Practice** This had been presented at the Cambridgeshire & Peterborough Local Health & Resilience Partnership by the Trust operational lead for emergency planning.		
9.1.1.5	**Fire Alarm Activation papers** Following the recent internal incident on 18 July 2020 an incident debrief		

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	had been held and with key learning shared and actions agreed. An update on this would be presented to the next Emergency Preparedness meeting.		
9.1.2	**Staff Pandemic Debrief Cover Paper 200820** The debrief project undertaken by the Quality Compliance Officer and an HR consultant had resulted in the set-up of Task and Finish Groups to address the key themes in the report. Work would be completed by the end of September and the pandemic plan would be updated as a result of the outcomes. The Staff Debrief paper would be circulated to the Committee in full when the final additions from the Freedom to Speak Up Guardian and key Critical Care staff had been included. RH, the Lead Governor reported that the draft document had been shared at the Emergency Preparedness and had been an information and worthy document.		
9.2	**QIA Assurance Report** The QIA initiative, providing CIP governance, was being re-energised to ensure that all projects were passed through the QIA process.		
9.3	**Internal Audits: None**		
9.4	**External Audits**		
9.4.1	**National Cancer Experience Survey 2019 presentation** **9.4.1.1 National Cancer Experience Survey Results** JA congratulated the Trust on an excellent report however had had some difficulty reconciling the numbers quoted in all documents. **Post meeting note**: add in IG comments.		
10	**POLICIES**		
10.1	**DN762 Organ Donation for Transplantation Policy** It was noted that the document still carried the old Trust logo but was ratified by the Committee.		
10.2	**DN810 Learning Disability & Autism Policy** This was the culmination of a year's work by the Deputy Chief Nurse and the Lead for Safeguarding. The number of RPH patients in this group were small but due focus had still been given. The policy included a number of different national initiatives related to learning disabilities and autism including booking priorities in line with NICE guidance. The Chair congratulated the Trust on achieving this encompassing policy. This was ratified by the Committee.		
10.3	**DN799 COVID-19 Infection Control Living with Covid Policy** This had been given Chair's action earlier in the month however was presented for completeness. New guidance for 3 pathways had since been received which was being considered.		
11	**RESEARCH AND EDUCATION**		
11.1	**Research**		
11.1.1	**Minutes of Research & Development Directorate meeting (none)** There were no minutes to present.		
11.2	**Education**		
11.2.1	**Education Steering Group minutes (200814)** These were received by the Committee.		
11.2.2	**Clinical Education Report** This report was due in Q1 only.		
12	**OTHER REPORTING COMMITTEES**		
12.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** The Chief Nurse reported that the committee had approved the application for the Trust Chronic Pain Service to be a nurse led clinic		

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	support by an on-site anaesthetist and nurse consultant (remote access). This was following the departure of the clinic Consultant Anaesthetist lead and the clinic would be handed over to CUH when they were in a position to provide the service.		
12.1.2	**Minutes of Clinical Professional Advisory Committee – (200716)** These were noted by the Committee.		
12.2	**Minutes of Safeguarding Committee (200807)** These were presented by the Deputy Chief Nurse who informed the Committed that the local CCG representative had attend the meeting and advised that the CCG would be implementing thresholds on the mandatory training requirements. He was confident that these would align with the Trust's trajectory for safeguarding training. He informed the Committee that whilst this was an active committee there were no major issues to report.		
13	**LIVING WITH COVID-19**		
13.1	**Minutes of Living with Covid Steering Group (200720 - 200727)** These were noted by the Committee.		
13.2	**Update to Performance Committee on CCA Optimisation Project** This had been presented to the Performance Committee however as the Quality and Risk Committee had been keen to learn of progress in CCA it had been included in meeting papers for information.		
14	**ANY OTHER BUSINESS** The Trust Secretary recommended that the committee undertake a reflective view of whether it was meeting the purpose for which it was convened. The Chair asked the committee to consider on balance whether it was discussing the correct issues. JA commented that the separation of the documents into separate packs had helped with the assimilation of information. He asked whether there were other matters that the Executive Directors (EDs) might be concerned about that this committee should be discussing. It was suggested that the meeting could start with an ED 'worry list' but that the committee should not get unnecessarily side-tracked by this discussion. Current ED concerns were focussed around: • SSI rates • Health inequalities that might affect patient outcomes • Threats to quality in the way system organisation was moving, concerning financial and commissioning decisions • CCA regional variation and EoE developments that may impact on quality, eg transfer services The Chair asked members to consider giving time at the next meeting to system relevant information and related decisions on this committee.		
15	**COMMITTEE MEMBER CONCERNS** None were raised.		
16	**ISSUES FOR ESCALATION**		
16.1	**Audit Committee** There were no issues for escalation.		
16.2	**Board of Directors** • Inequality of access to treatment		
	Date & Time of Next Meeting: **Thursday 24 September 2.00-4.00 pm**		

The meeting closed at 1545 hrs

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee
Meeting held on 27 August 2020