Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 2, Month 3

Held on 24th September 2020 at 2 pm
Via Microsoft Teams

MINUTES

Present	**Ahluwalia, Jag**	**(JA)**	**Non-executive Director**
	Blastland, Michael (Chair)	**(MB)**	**Non-executive Director (Chair)**
	Buckley, Carole	**(CB)**	**Assistant Director of Quality & Risk**
	Chris Seaman	**(CS)**	**Executive Assistant (Minute taker)**
	Hall, Roger	**(RH)**	**Medical Director**
	Hodder, Richard	**(RH)**	**Lead Governor**
	Monkhouse, Oonagh (from 1503 hrs)	**(OM)**	**Director of Workforce and Organisation Development**
	Raynes, Andy	**(AR)**	**Director of Digital & Chief Information Officer**
	Rudman, Josie	**(JR)**	**Chief Nurse**
Apologies	**Graham, Ivan**	**(IG)**	**Deputy Chief Nurse**
	Jarvis, Anna	**(AJ)**	**Trust Secretary**
	Makings, Ellie	**(EM)**	**Medical Examiner**
	Riotto, Cheryl	**(CR)**	**Head of Nursing**
	Webb, Stephen	**(SW)**	**Associate Medical Director and Clinical Lead for Clinical Governance**
	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 freelance journalist reporting on health issues and as an advisor to Bristol University's Centre for Research Quality and Improvement.		

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	• 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 – 27 August 2020**		
	Approved: The Quality & Risk Committee approved the minutes of the previous meeting held on the 27 August 2020 and authorised these for signature by the Chair as a true record.	Chair	
4	**MATTERS ARISING AND ACTION CHECKLIST PART 1 (200827)** These were reviewed and updated.		
5.1	**QUALITY**		
5.1.1	**Quality & Risk Management Group (QRMG) Exception Report** This was presented by the Associate Director of Quality & Risk. The availability of TOE machines and the management endoscopic washers were discussed, and the risk involved with the lack of a nominated lead. The committee was advised that the action was with Maggie Maxwell as Deputy Chief Operating Officer to appoint an operational lead.	MM	
5.1.1.1	**QRMG Minutes (200908)** These were accepted by the Committee		
5.1.1.2	**New Risks as of 200907** These were noted by the Committee.		
5.1.1.3	**Overdue Extreme Risks as of 200907** The Chair asked for assurance that progress was being made in reviewing overdue risks. The Associate Director of Quality and Risk reported that this had been raised at Management Executive this month with all risk owners prompted to review their risks. The Director of Digital confirmed that all the digital risks were reviewed monthly however would always appear overdue given the timing of reviews.		
5.1.1.4	**Clinical Audit & Q1 update** This was deferred to next month.		
5.1.2	**Fundamentals of Care Board (FoCB)**		
5.1.2.1	**FoCB Exception Report** The Chief Nurse advised that the Board had met on 23 September and		

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	decided to postpone the annual Provider Information Request (PIR) update exercise as the CQC were currently reviewing requirements for this exercise. She also advised that the Trust's internal auditors would be undertaking an audit later this month to consider how the Trust Board assured itself of on-going compliance against CQC requirements.		
5.1.2.2	**Minutes of FOCB (200923)** These were not available due to the time of the meeting and would be presented next month.		
5.1.3	**Regional Health Inequalities** This discussion was deferred to next month.		
5.2	**PERFORMANCE**		
5.2.1	**Performance Reporting/Quality Dashboard**		
5.2.1.1	**PIPR Safe – M05** This month's spotlight was on Safe Staffing (fill rate). With this in mind the Chair commented that on a recent Patient Safety Round he had participated in on 5 South, a number of staff were convinced that the ward was frequently understaffed. He was curious to know what contributed to this opinion in the light of the healthy staffing figures demonstrated in the spotlight, and the fact that RPH was the third best staffed organisation in the country. Discussion followed: • The Chief Nurse had explored this phenomenon with the Matrons. • Ratio on 5 South was usually no more than 3-5. • CHPPD was always fulfilled and actually creeping higher in some areas. • There was a perception by some staff that others may be basing their opinion on past conceptions. • Was there a misconception by some on what an adequately staffed ward looked like? • Low staff morale was reflected in the Surge Response Staff Debrief. The Chief Nurse had suggested that these opinions should always be responded to by the following approach? • Ask staff if their perception of understaffing was based on 'today' or was a retrospective view point. • Help staff to put things into perspective despite the acuity of the patients. • Encourage Matrons to support the staff by presenting the staffing data. • Ask 'What are we not able to do for our patients today if you feel this way?' Dr Ahluwalia was in agreement with this supportive approach as the CQC would definitely reflect this approach in their questioning of staff. It was important to help staff understand the staffing data without misrepresenting it to seem more favourable. It was also agreed that the ED led patient environment rounds were a good platform from which to ask this question of staff.		
5.2.1.2	**PIPR Caring – M05** This was noted by the Committee. The spotlight was on the Bereavement Care Administration Service which resumed as a Royal Papworth Hospital Service from 7 September 2020, managed by the PALS team.		

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5.2.1.3	**PIPR People, Management & Culture (PMC) – M05** The Chair noted that the long and short term % sickness absence totals did not tally and that as a result was flagging amber. The sharp increase in agency was as a result of staff leaving the Trust following lockdown/initial surge. Dr Ahluwalia asked what intelligence was there to reflect on how junior doctors were coping. The Medical Director responded to say that the Junior Doctor forum was supported by Drs Goddard and Khan who reported the specialist training grades uniformly had exposure to a good experience. There were worries for some foundation year 2 and core medical training students who it was perceived did not undergo such a good experience at RPH. The Medical Director reported that the Guardian of Safe Working (Dr Goddard) was sighted on rotas to ensure a broad spectrum of experience was acquired.		
5.2.	**Monthly Ward Scorecards: M05** This was not available at time of circulation of the papers.		
5.3	**SAFETY**		
5.3.1	**Serious Incident Executive Review Panel (SIERP) minutes (200825, 200901, 200908, 200815)** The SIERP minutes as outlined above were received by the Committee.		
5.3.2	**Patient Safety Data** This was postponed to a future meeting as the report had been delayed due to work pressures within the governance team.		
5.3.3	**Learning from Deaths Q1 report 20-21** There were 61 adult deaths in Q1 which would all, under normal circumstances, have been reviewed by the Medical Examiner however due to COVID this had not been achievable due to her deployment elsewhere. The Medical Director did assure the Chair that all deaths were reviewed at SIERP where the Medical Examiner had the opportunity to ask for more information. The Associate Director for Quality and Risk advised that SIERP decided collectively whether an investigation as a learning exercise or as part of the incident investigation / SI process was warranted. Dr Ahluwalia asked for further assurance in future reports by including a statement in the report to confirm that all deaths had been reviewed at SIERP.	CB	For Q2 report
5.3.4	**Report on Mycobacterium Abscessus outbreak** The Committee received an update from the Chief Nurse on the M.Abscessus outbreak. There had been recent media interest following the approach to lawyers by two patients, one of whom had decided to pursue a claim against the Trust. M.abscessus was an environmental bacteria and had been found following extensive investigation to be present in the water at certain locations in the hospital. Genetic comparison of the mycobacterium in the water and patients found that in some patients this was similar enough to conclude a link, although further interrogation of the data was ongoing. The Trust had implemented stringent measures to reduce the concentration of all myco bacterium counts in its water which had proved successful and continued to refer to PHE for support with genomic relatedness; further environmental testing had also been commissioned. The Chair remarked that he was conscious of the efforts undertaken by the Trust to understand this outbreak and further investigation had the support of the Non-Executive Directors.		

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6	**RISK**		
6.1	**Board Assurance Framework Report**		
6.1.1	**BAF Report** The Chair queried the halving of the risk estimation for Risk 1929 Low levels of Staff Engagement. He also noted changes to Risk 1853 (turnover) and Risk 1854 (recruitment). The Director of Workforce and Organisation Development agreed to investigate the changes to the risk rating.	OM	Oct 20
7	**WORKFORCE**		
7.1	**Staff Risk Assessment update** The Director of Workforce and Organisation Development updated the Committee that the staff risk assessment process was almost complete; it was noted that some staff had chosen not to take part. She reported that the Trust continued to work with those staff rated as high risk in supporting a return to the work place with a further review of the approach to mitigating risk. The Trust had previously avoided the placement of 'red' risk staff in purple (Covid) areas, however some staff had found this challenging given the constrictions to role fulfilment and overall enjoyment that this had presented. Following panel review of nosocomial transmissions and consultation with staff side the Trust had decided to enable those red risk staff that wanted to, to work in purple areas. She advised that Occupational Health had not recommended this, however, the risk team would continue to work with red risk staff and swift review would follow any increase in nosocomial transmission within the hospital. Dr Ahluwalia asked whether the Trust had considered the consequences of the legal position, notwithstanding that red risk staff were asking to work in purple areas. The Chief Nurse advised that other organisations had taken a similar approach and she was in support of this approach with the use of appropriate PPE in place, given that it was a fine balance between limiting, or possibly ending a career, with providing a safe working environment. At the potential onset of a further surge the Trust would consider withdrawing the red risk staff from purple areas particularly if there was a shortage of PPE.		
8	**GOVERNANCE**		
8.1	**Quality Report** The draft quality report was behind process. Narrative on the actions against last year's Priority 1 targets was given by the Associate Director for Quality & Risk (see next item). Dr Ahluwalia commented that some targets/priorities required quantitate improvements but the evidence provided was descriptive without data to support outcomes. **Priorities for 20/21** • These were considered and it was broadly agreed to roll over priorities from last year, and to ensure these were firmly embedded in the culture. • Objective 1 of Priority 2 – Improving Same Day Admission may prove challenging in a COVID environment however this had been identified as a priority last year. • Dr Ahluwalia requested that reference to mental health within the priorities should be included. • The Chair asked for system priorities to feature in alignment with Trust priorities in future years.		

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8.1.1	**Appendix 1 - Quality Report 2020/2021** **Review of last year's priorities:** **Embed an improved safety culture through implementation of the SCORE culture tool across the organisation** Pre Covid, 3 areas had been surveyed however the funding for this tool and therefore the use of the external provider for data analysis, had been withdrawn. Focus would continue on the actions identified. **Deterioration and Complications** • NEWS2 scoring embedded within the organisation. • Study days for both Mindray and The Deteriorating Patient established. • Competence assessments for HCSW established. • ALERT team response to NEWS scores of 5 or more – work ongoing. • Improving the use of SBAR – work continued. • Out of Hours – actions now embedded with huddles at night working well and post of Night Matron introduced. **Falls Risk Reduction** Project completed. It was noted that whilst falls continue to occur, reporting of incidents has improved with more strategies in place. Audits continue. **In House Urgent (IHU) Pathway** • Development and engagement with external referrers. • Pathway was business as usual within cardiology and surgical work streams. **Building QI Capability** It was still a work in progress to use business software to improve data more effectively. A QI roadmap would be developed, notwithstanding a second surge.		
8.1.2	**Security and Protection Toolkit submission** The Director of Digital advised that the 95% target for compliance of mandatory Information Governance training had been met and the toolkit would be submitted. He thanked everyone for their efforts in achieving this. Whilst the Committee was pleased with this outcome there was some consideration given to amending the compliance year from Sept-Sept rather than the financial year to deflect the obvious competing pressures at this time of year. The Chair was happy to support this.		
9	**ASSURANCE**		
9.1	**Internal Audits** There were none.		
9.2	**External Audits** There were none.		
10	**POLICIES**		
10.1	**DN644 Policy for Assessing Continuing Compliance with the CQC Fundamental Standards** This was ratified by the Committee.		
10.2	**DN108 Information Governance Cover Paper and policy** This was ratified by the Committee.		
10.3	**DN101 Moving and Handling Cover Paper and Policy** This was ratified by the Committee.		
10.4	**DN271 Moving & Handling Cover Paper and Procedure** This was ratified by the Committee.		

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11	**RESEARCH AND EDUCATION**		
11.1	**Research**		
11.1.1	**Minutes of Research & Development Directorate meeting** (200710) The minutes as detailed above were accepted by the Committee.		
11.2	**Education**		
11.2.1	**Clinical Education Report** This report was due in Q1 of the Committee cycle only.		
11.2.2	**Education Steering Group minutes (none)** As there had not been an ESG since the last Committee meeting there were no minutes to review.		
12	**OTHER REPORTING COMMITTEES**		
12.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** There were no escalation issues from CPAC this month.		
12.1.2	**Minutes of Clinical Professional Advisory Committee – (**200820**)** These were noted by the Committee.		
12.2	**Minutes of Safeguarding Committee (200807)** These were not available at the time of the meeting and would be presented next month.		
13	**LIVING WITH COVID-19**		
13.1	**Minutes of Living with Covid Steering Group** (200810-200824) These were noted by the Committee.		
13.2	**Staff Debrief report and Nursing report** The Chair and other members of the Committee commended this detailed debrief report which the Chief Nurse said would inform how the Trust proceeded in a potential second surge. The Task and Finish groups set up as a result of this report would help to improve the response as there was a strong obligation to show that staff had been listened to. It was apparent that the redeployment process had had the greatest impact on the health and wellbeing of staff. This Task and Finish group, led by the Director of Workforce and Organisation Development, had looked at the timing of redeployment communications, training, rotas and line management along with psychological support measures in place to support staff. Complexity of skill mixes required, regular rotation of redeployed staff and length of deployment had all been considered. The Director of Workforce and Organisation Development considered that the timely messaging to staff of redeployment expectations and ensuring a clearer line management structure were most important. The Chief Nurse assured there was now a clear requirement of what was needed in terms of staffing/equipment and infrastructure for surging into all zones. It was acknowledged that the system and region would have a significant part to play if more than 54 critical care beds were required at RPH. There had been a staff perception that the pandemic response had not been fair and equal across the system and that RPH had been asked to compromise some standards in relation to other partners to provide care. It was therefore important for staff to witness support of regional partners. The fantastic quality outcomes and patient survival rates had been shared with staff, demonstrating that the sacrifices made had been justified. The Medical Director considered that the pandemic had shown a spotlight on the inequalities of critical care units across the region which would have to be addressed by the local partnerships.		

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14 **14.1**	**ANY OTHER BUSINESS** **Digital Aspirant Programme** This was noted by the Committee.		
14.2	**EPR Options Appraisal September 2020** This was noted by the 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** There were no issues for escalation		
	Date & Time of Next Meeting: **Thursday 29 October 2020 2.00-4.00 pm**		

The meeting closed at 1602 hrs

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Signed

29 October 2020
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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee
Meeting held on 24 September 2020