Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Quality & Risk Committee (Parts 1)
(Sub Committee of the Board of Directors)
Quarter 4, Month 1
Chair: Michael Blastland
Held on Thursday 30 January 2025, 2–4 pm
Via Microsoft Teams

Present	**Role**	**Initials**
Blastland, Michael (Chair)	Non-Executive Director	MB
Palmer, Louise	Assistant Director for Quality & Risk	LP
Midlane, Eilish (from 15:00 hrs)	Chief Executive	EM
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
Wilkinson, Ian	Non-Executive Director	IW
Fadero, Amanda	Non-Executive Director	AF
In attendance		
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
Hurst, Rhys	Staff Governor	RH
Meek, David	Consultant Respiratory Physician in Thoracic Oncology/ Associate Medical Director – Clinical Governance	DM
Monkhouse, Oonagh	Director of Workforce & Organisational Development	OM
Watson, Alice	Executive Assistant	AW
Apologies		
Glenn, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG

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

P A R T O N E

Item		**Action by whom**	**Date**
1.	**Welcome & Apologies** 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; none were raised.		
3.	**Committee Member Priorities**		

	The Chair noted internal audit canvassing for potential targets; he explained this had been taken to Executives with subsequent a selection of targets which included capacity for quality improvement. It was noted this item was included on the list for the coming year.		
4.	**Ratification of Previous Minutes Part 1 (19.12.24)** The minutes of the 19 December 2024 Quality & Risk Committee (Q&R) (Part 1) meeting were agreed to be a true and accurate record of the meeting and signed.		
5.	**Matters Arising – Part 1 Action Checklist (19.12.24)** ***076 – National cardiac audit programme data:*** Narain Moorjani to be invited to the February Q&R meeting to provide an example of the National Cardiac Audit Programme and its use. Alternatively, a member of the audit team would be invited. To remain **OPEN**. ***077 – AMS 2024/25 Report:*** This item was due to be heard in December but had been deferred to January 2025. The Q3 report had been received, and MS would amend as necessary. IS highlighted conversations around prioritisation of patients and sequencing of discussions i.e. at Q&R and/or Board. MS stated that it was for Q&R to hear about this item and take views and recommendations to the Board. AF queried the sensitivities and whether this was for inclusion in Part 1 or 2 of Q&R; it was concluded that it was appropriate for Part 1. To be **CLOSED.** ***079 – Provide progress report on discharge summaries, digital position and pilot update in RSSC:*** A paper had been presented to QRMG and information added to the Q&R highlights report. To be **CLOSED**. ***081 – Produce a report on the QUACS study findings:*** IS advised that a response was awaited from SN. Action to be raised again at Q&R in February 2025. To remain **OPEN.** **ACTION:** Sam Nashef to be invited to the February Q&R meeting. **Post Meeting Note** = Decision by board to invite Sam Nashef to a board workshop to discuss this (date TBC). To be **CLOSED** for Q&R. ***082 – Intensive Care National Audit & Research Centre (ICNARC) -*** *Internal Review April 2022 to March 2024: LP and MS to consider the most appropriate Q&R meeting for Dr Cagova to attend and extend the necessary invitation.*		

	It was agreed that the appropriate way forward was to bring the NICOR to February Q&R and incorporate ICNARC within the Annual Learning from Deaths Report, inviting Dr Lenka Cagova to the corresponding meeting to provide further details. To be **CLOSED** The discussion moved to assurance, emphasizing the importance of bench marking RPH mortality compared to other trusts. This was decided that it would be discussed offline as to what could be addressed at the March Q&R meeting. **ACTION:** Clarity and assurance to be provided at March Q&R using the available data to understand how well RPH is performing compared to other centres. ***083 – Gemma Bibby to be invited to attend an upcoming Q&R meeting for a focused session on mouth care, work undertaken and areas of progress.*** MS suggested that Dietitian Assistant, Gemma Bibby, should be invited to attend a future focused session on the work undertaken and progress made in relation to mouth care. To remain **OPEN.** ***084 – MS/KMB to meet, to map out next year's reports.*** It was noted this item would be presented at the Q&R Committee in February 2025. To Be **CLOSED** The Committee **reviewed** and **noted** the Matters Arising – Part 1 Action Checklist.	**DM/LP/ MS/IS**	**03/25**
6.	**Quality & Safety**		
6.1	LP introduced the QRMG and SIERP Highlight and Exception Paper, which was taken as read. It was requested that the Committee noted the following points: • Quarterly Report for Medical Examiners Q2 had been received and there was assurance with reference to the MEO scrutinised deaths. These MEO reports were to be received at QRMG bi-annually going forward, with Q3&4 combined in the next report. • The Digital Safety Officer's report had been received for Q3, and it was noted that the issues highlighted had been previously raised at QRMG. The Mighty alerting system was the most significant item; the task and finish group was considering digital and the capability of another alerting system. The Deteriorating Patient Group was		

	also considering the skill mix of obs being taken through to oversight. These items were ongoing and would return to QRMG.
	
	• E-discharge summaries: there were two parts brought to QRMG:
	
	  • E-discharge summary: digital aspect.
	
	  • Discharge assurance group.
	
	• SI Action Plan: there were to be no further SIs or Action Plans with the introduction and embedding of the Patient Safety Incident Response Framework (PSIRF).
	
	• Three RIDDORs for staff were highlighted.
	
	• Complaints: the information recorded was as perceived by those making the complaint. LP had commenced to undertake an initial review, to assist with assurance, prior to an investigation being undertaken.
	
	• Sub-groups: The Hospital Transfusion Committee had provided an update of the concerns.
	
	The Chair noted that discharge assurance would be considered as part of quality priorities.
	
	DM highlighted that the three RIDDORS reported in the month comprised one which dated back to July 2024, and one which involved a needle stick - this would not normally be reported, but in this instance concerned an HIV positive patient. For purposes of assurance, the level of RIDDOR incidents had not tangibly risen.
	
	IW requested that abbreviations were defined to provide clarity for all. There was surprise at the Chief Pharmacist's comment that "this was not a concern", with medicine related incidents being elevated. LP stated that this was a monthly update, and detail was provided in the quarterly report, which contained figures and provided further assurance.
	
	AF queried the effects of the tunnel closure. LP outlined that from a Health and Safety perspective all was moving positively, with good collaboration and teamwork, and day-to-day issues being managed.
	
	The Chair had drafted a Chair's handover for the Q&R group and stated that governance was in a good place, with new initiatives embedded well, and no causes for concern; overall, there was reasonable assurance. AF concurred and noted that the light agenda reflected the high level of assurance. The new committee would be required to		

	consider how the meeting time was utilised and that quality improvement should be considered for focus. The Committee **reviewed** the QRMG and SIERP Highlight and Exception paper.		
6.1.1	Serious Incident Executive Review Panel (SIERP) minutes (03.12.24; 10.12.24; 17.12.24; 24.12.24; 31.12.24) The Committee **noted** the SIERP minutes.		
6.1.2	Scan4safety Progress and National Learning QRMG had received a report from the Lead Cardiac Physiologies outlining the government Scan4safety initiative and RPH's learning and actions for barcode scanning. AR stated that the initiative had been evolving for several years, and it had been recognised that the Trust would experience increased benefits, in terms of efficiency for hospital flow and financial management, in addition to the long-term advantage of being able to share information across networks and regions. The Committee was requested to consider pathway opportunities for scanning to improve patient safety. It was noted that the vision was for end-to-end scanning of all processes within the hospital, resulting in the live monitoring of patients, products and services. AR highlighted the importance of a traceability trail in addition to the safety aspect. MS noted the oversight of outputs and stated that it would be helpful to gain further understanding around the embedding of this system. In employing the methodology, associated costs would be required to be considered and addressed. IS stated that a closed loop medication project was underway in Pharmacy and highlighted this as a positive case study, coordinated by Chris McCorquodale. This was proving invaluable in avoiding harm incidents which were being documented. A visit was taking place with NHSE on Friday 31 January 2025 to look at how the system was being utilised. The Chair queried around the compatibility of the system with the EPR. AR referred to a table in the paper detailing front runners in terms of compliance with the standard. It was noted that US based systems were less compliant and that the Lorenzo system was very compliant and recognised wrist bands (GSRN). The Chair requested the Committee consider evaluation of the seriousness of the compatibility issue and did not feel that the outline business case fully addressed this. Clarity was requested as to how to		

	seek more assurance around the compatibility and the prospects for the system. IW concurred that this was an important issue. AF stated that this had been discussed at Board but had not penetrated the issue adequately to assess the real risk. It was suggested that the Executive team, along with the SRO, be given the opportunity to consider this further. The Chair suggested referral to SPC for additional assurance. OM agreed with this path of escalation. **ACTION:** Scan4safety initiative: Compatibility issues and prospects for the system were required to be thoroughly scrutinised to provide assurance. The Executive and SRO were requested to be made aware and the matter escalated to SPC. The Committee **noted** the Scan4safety Progress and National Learning Report.	**MS/OM**	**02/25**
6.1.3	PSII-WEB52388 – Organisational – Cardiology TAVI pathway report DM thanked the authors for their report, which was taken as read and which was PSII had commissioned through the SERP meeting, following three reports of patients who had died at local hospitals whilst waiting to arrive at Papworth for urgent TAVI procedures. As a cluster, the PSII was issued. There was a further case resulting in four cases in total. DM noted there were four key lines of enquiry which were outlined in the report. DM explained that each case had been explored individually to allow feedback to each family and areas flagged for learning had been highlighted i.e. referral process, clear review around capacity of the treat and return process, and that a capacity review was underway for the whole TAVI pathway. He noted that the PSII report had been published, and a round table review convened. There were key developments to the long and short term action plans, which were included in the report. The Chair thanked DM and emphasised positivity around the report. General capacity of TAVI was then raised as a point requiring further consideration. AR noted the Patient Referral Information System (PRIS) and was chairing the latest group to deliver a PRIS version 3, which was a better technology, which once tested would go live. IW noted the comprehensive report and queried how much of the problem concerned the inability of consultants in another hospital to either access PRIS or complete the information as this could cause inherent delays. IS queried how this was controlled as the access requirement was part of the system design and it was essential that access was available.		

	DM acknowledged that there appeared to be a disconnect which needed to be resolved. AF stated that whilst the report, process and recommendations were positive, there were many interdependencies and there was much to complete; it was queried how this was to be managed as an improvement and how this Committee would have oversight as to progress. It was questioned whether there was a programme of work being led by an SRO. MS stated that the referral aspect was being overseen, with the TAVI clinical side being led by the TAVI Team. IS stated that the coordination sat with Harvey McEnroe (HMc) and IS, noting the complexity. Creating capacity was the most pertinent aspect which involved displacing other departments. It was identified that a timeline for completion of work highlighted in the TAVI pathway report was essential. AR emphasised that for IT, requirements needed to be identified and developed into a specification, which then had to be baselined and delivered. Once the product had gone live, further versions/upgrades would be developed; noting there was a systematic method of releasing technology. LP noted further incremental changes were in progress and there were mitigations to the risk as the process was developing. **ACTION**: PSII-WEB52388 – Organisational – Cardiology TAVI pathway: Progress with action as identified from the PSII-WEB52388 in relation to TAVI pathway to be brought back to Q&R in July 2025 for update.	**MS**	**06/25**
6.2	Learning from deaths 6-month report The report was taken as read. IS noted that many of the individual incidents had previously been considered by the Q&R Committee. The Chair noted that the report provided assurance and that lessons were being learned. The Committee **reviewed** the Learning from Deaths 6-month Report.		
6.3	SSI Quality Monitoring Dashboard Quality Monitoring MS highlighted that the Q1/Q2 figures were confirmed, with Q3 subject to change, with presentations from patients. There was cautious optimism that all was gradually moving in a positive direction, although there remained some way to go. MS then provided comment on the following areas:		

	• The monitoring dashboard: a single non-conformance of instruments in terms of sterilisation and decontamination issue had been identified and investigated. This concerned one instrument which did not reach the patient. • Compliance with other metrics: focus concerned cleaning and decontamination of equipment used for and between patients in critical care and on level 5. • Theatres: it had been reported that an infection prevention and control inspection had been carried out by the lead for prevention of infection and control, and all had been found to be much improved compared to previously. Efforts would continue to achieve further improvement. The Chair acknowledged progress was being made and monitoring would continue. The Committee **reviewed** the SSI Quality Monitoring Dashboard Quality Monitoring.		
6.4	M.abscessus Dashboard (Dec 2024 data) MS noted a case, presently being investigated, which was related to the outbreak strain. Issues from clinical colleagues had been received in relation to M.abscessus, but did not require escalation at this Committee; there had been no change. Assurance with the water testing from the commercial company used was inadequate as, before the filtering of water, M.abscessus was evident. It was not proposed to remove filters. **ACTION**: M.abscessus Dashboard: A briefing to be provided at the end of March 2025 to review progress. The Committee **reviewed** the M.abscessus Dashboard (Dec 2024 data).	**MS**	**03/25**
6.5	Safeguarding Committee Minutes This document was taken as read. The Committee **noted** the Report for Health and Safety Committee.		
7.	**Patient Experience**		
7.1	Patient Story: Ambulatory Care. MS conveyed to those present that the presenter of the patient story was unwell and not present at the meeting.		

7.2	Patient & Carer Experience Group Minutes This document was taken as read. The Committee **noted** the Patient & Carer Experience Group Minutes.		
7.3	End of Life Steering Group Minutes This document was taken as read. The Committee **noted** the End-of-Life Steering Group Minutes.		
8.0	**Performance**		
8.1	Performance reporting: PIPR M9 Safety: MS highlighted the key performance challenge concerning the management of pressure ulcers and numbers reported. It was recognised that pressure ulcers were generally caused by either device related issues or moisture related pressure ulcers. Improvements were being considered to prevent common causes. AF queried the uptake of supervisory shifts; whilst progress had been made, a dip had been experienced in December, which was related to increased sickness levels and meant ward sisters had been required to take up more clinical duties. It was hoped that progress with improvement could resume. The Committee **noted** the Performance reporting: PIPR M9.		
9.	**Risk**		
9.1	Cover: Board Assurance Framework (BAF) The Chair questioned the point at which the risk rating for infections might be considered, and whether this would only occur when on target. MS responded that whilst in an escalation phase and categorised as an outlier, caution was being taken to retain the risk at the present rating. The Committee **noted** the Board Assurance Framework (BAF).		
9.1.1	Appendix 1: BAF Report This document was taken as read. The Committee **reviewed** the BAF Report.		
9.1.2	Appendix 2: BAF Tracker		

	This document was taken as read. The Committee **reviewed** the BAF Tracker.		
9.2	Corporate Risk Register (CRR) – 12> Open Risks LP presented the CRR, which was taken as read, and highlighted the three extreme risks included. AF queried 'Risk 3635 – Cabinet Office (Treasury) impose contract checkpoints. IS noted that this concerned the NEXUS programme. LP to update the risk description for clarity. EM stated that a number of the risks were minimalist in their titles; LP to amend register to provide provision for more description. The Committee **noted** the Corporate Risk Register – 12> Open Risks.		
9.2.1	Appendix 1: Corporate Risk Register The Committee **reviewed** the Corporate Risk Register – 12> Open Risks.		
10.	**Governance & Compliance**		
10.1	Annual Quality and Risk Committee Self-Assessment The Chair thanked those who completed this; the majority of participants had been positive in their responses regarding the Committee's performance. Several "do not agree/disagree" responses were commented upon. These were detailed further and open feedback requested: • The Board was active in its consideration of the Committee composition – 12.5% did not agree or disagree. • This result had been observed in the self-assessment at other committees, and it was acknowledged that a Board discussion was required. A further category was suggested to account for those people who attended committee meetings but not Board and/or a comment added noting that Board was not attended. • The Chair suggested that this be escalated to the Board for consideration. **ACTION:** Annual Quality and Risk Committee Self-Assessment - "The Board was active in its consideration of the Committee composition" - a uniform and not entirely supportive response had been received through self-assessment across a number of committees. As participants	**KMB**	**02/25**

	undertaking self-assessment did not attend Board, consideration to be given as to how this should be addressed in the assessment to ensure accuracy of response. Escalation to Board for consideration. • Committee members have a good understanding of what is expected of them in their role and have the skills and expertise to scrutinise the business of the Committee – 12.5% did not agree or disagree. • A comment had been made around clarity of the role of staff governors. It was acknowledged that the Chair was required to discuss with staff governors on appointment, with MS or LP in attendance, regarding the contribution to be made. MS noted that AH had implemented procedures for an induction around orientation. It was noted that the number of respondents to the self-assessment was low. • Changes to the Committee's current and future workload discussed and approved at Board level – 37.5 % did not agree or disagree. The Committee have a forward plan for its meetings so it can consider issues at the right time and in the right level of detail – 12.5% did not agree or disagree. Forward planning was noted as in place. • The Committee is appropriately sighted on significant projects and programmes throughout their lifecycle – 12.5% did not agree or disagree. • The Committee has the skills and expertise to provide effective critical challenge on the financial management, delivery risks and overall progress of projects or programmes – 25% did not agree or disagree. It was acknowledged that this was not a subject that the Committee spent time considering, as not often deemed appropriate. EM highlighted that the same questions appeared for all committees in the self-assessment; it was agreed that there were some questions where individual committees may lack familiarity or specialism, as a result. It may be appropriate for the questions to be tailored to the relative committee to ensure accuracy of responses, although regarding finance and costs, all committees were deemed to have a responsibility to scrutinise costs for a given service. OM explained that time factors had impacted the ability to tailor questions. AF conveyed positivity around the Chairmanship of the Q&R Committee, which was evident from the responses.		

	The Committee **reviewed** the Annual Quality and Risk Committee Self-Assessment.		
10.1.1	Appendix 1: Q&R Committee Self-Assessment for 2024-25. This document was taken as read. The Committee **reviewed** the Q&R Committee Self-Assessment for 2024-25		
11.	**Audits**		
11.1	Internal Audits Nothing to report.		
11.2	External Audits/Assessment Nothing to report.		
12.	**Quality Accounts**		
12.1	Quality Accounts Schedule for 2025/26 The Chair highlighted the extensive list of priorities. MS continued from the themes conveyed at last month's meeting and explained that the current level of assurance influenced the focuses going forward. The highest priorities included in the schedule were conveyed to those present and included the impact of resourcing, outcome of patient survey, duplication of any items being already addressed through other agendas/programmes. EM queried the health and equalities piece and whether adequate efforts had been made to establish if patients seen within the service were proportionately represented from groups that would be expected to have illness. Further work was required; a programme was suggested as appropriate and LP stated that this would form part of the three-year plan. In agreeing that this was a longer piece of work, EM challenged that the insights piece could be brought forward. The Chair stated that from an assurance point of view, this subject was a particular gap in RPH activity. IS referred to pulmonary hypertension which was particularly high in Cambridge and noted that outreach services were needed in Peterborough. AR noted that data quality should be considered along with the collection of information. Additionally, information required collecting via the EPR. With a secure data environment established,		

	decisions could be taken as to connection of this to the EPR or shared care record to provide better insights into population health. The Chair suggested that the EDs had a discussion to decide the appropriate place to give this sufficient focus and whether a one-year quality priority would be adequate to enhance the item. There was a lack of assurance in this area. Patients not attending the hospital formed a significant gap and information was not always forthcoming to hospital staff. DM stated that lung cancer screening was arriving at Cambridge and Peterborough which was deemed positive. RPH was engaging with this ICB programme to drive this forward, including additional resourcing. LP requested that the impact to staff of the quality account priorities, when agreed, required to be considered along with the importance of the work plan and the conveying of the difference that staff were making. It was paramount that priorities were achievable in the timescales allocated. IW acknowledged that all were aware of inequalities in the system and stated that, further to conversations in the ICB, the plan to solve the problem was required in lieu of constant measuring of demographics. Patients not presenting themselves and professionals not referring were two identifiable issues. The Committee **reviewed** the Quality Accounts Schedule for 2025/26		
12.1	Quantity Accounts Priorities Long List for 2025/26 The Committee **reviewed** the Quantity Accounts Priorities Long List for 2025/26.		
13.	**Policies & Procedures**		
13.1	TOR030 Clinical Ethics Terms of Reference LP noted two changes by way of update, and it was noted that the Clinical Ethics Team did report into Q&R. The Committee **ratified** TOR030 Clinical Ethics Terms of Reference.		
13.2	DN849 – Building Ventilation Policy and Cover Paper This was a new policy that had been brought forward. The Committee **ratified** DN849 – Building Ventilation Policy and Cover Paper.		

13.3	DN153 – Being Open and Duty of Candour Policy and Cover Paper This was an historic Trust policy which had been updated. The Committee **ratified** DN153 – Being Open and Duty of Candour Policy and Cover Paper.		
14.	**Research and Development**		
14.1	Minutes of Research & Development Directorate Meeting (24.11.24) The Committee **noted** the Minutes of Research & Development Directorate Meeting (24.11.24)		
15.	**Other Reporting Committees**		
15.1	Escalation from Clinical Professional Advisory Committee There were no escalations from the Clinical Professional Advisory Committee.		
15.2	Minutes from Clinical Professional Advisory Committee (CPAC) (16.1.24) The Committee **noted** the minutes from CPAC.		
16.	**Areas of Escalation and Emerging Risk**		
16.1	Audit Committee There was nothing to report.		
16.2	Board of Directors There was nothing to report.		
16.3	Emerging Risks There was nothing to report.		
17. 17.1	**Any Other Business** MS addressed lightness of agendas and invited thoughts on a quality improvement focus for the meeting and whether this should be a standard agenda item, with an update from a quality improvement aspect provided. This would be included in those meetings where a Patient Story was not being reported. This item would be concerned with areas being invested in, the assurance that this was value for money and providing assurance and improving quality and safety in care e.g. 2024 investment in psychological medicine workforce; an update from this team was suggested as valuable. MS had been liaising with the consultant regarding improvements and an annual review was proposed which could be presented at this meeting.		

17.2	**ACTION:** Committee priorities: to be placed on agenda for formal discussion, with a view to including a Quality Improvement item on the agenda going forward. LP concurred with undertaking this review of agenda composition; AF noted that the new Chair of Q&R would also have a view. Assurance Ratings: TAVI – The Chair felt that the process had been positive, with assurance around governance. Outcomes regarding capacity and specific improvements dictated moderate assurance overall. SSIs – some improvement noted, but further work was essential, therefore not the required assurance and outcomes to date. Committee's self-assessment – all were reasonably content with outcome. Quality count priorities – not assured at present. Learning from Deaths – all content and assured.	**MS**	**03/25**
	Date & Time of Next Meeting: Thursday 27 February 2025 14:00-16:00 hrs via Teams		

Chair ……

Date ……