Royal Papworth Hospital
NHS Foundation Trust

Part 1: Quality and Risk Committee (Q&R)
Thursday 27th March 2025 – 14:00-16:00
Chair: Michael Blastland
(Quarter 4, Month 3)
In Person - HRLI 088/089 - with Teams link

Present	**Role**	**Initials**
Blastland, Michael (Chair)	Non-Executive Director	MB
Fadero, Amanda	Non-Executive Director	AF
Glenn, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG
Midlane, Eilish	Chief Executive	EM
Powell, Sarah	Clinical Governance Manager	SP
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
In attendance		
Cooper, Deborah	Trust Governor	DC
Edwards, Steven	Head of Communications	SE
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
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
Renwick, Jacqui	Head of Quality Improvement and Transformation	JR
Vaithamanithi, Raj	Deputy Director of Digital	RV
Wilkinson, Ian	Non-Executive Director	IW
Apologies		
Palmer, Louise	Assistant Director for Quality & Risk	LP

PART ONE

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.

Item		**Action by whom**	**Date**
1.	**Welcome & Apologies** The Chair opened the meeting, and apologies were noted as above.		
2.	**Declarations of Interest** No declarations of conflict of interest were raised.		
3.	**Committee Member Priorities** This was noted to be MB's last meeting as Chair of the Q&R committee prior to stepping down.		

4.	**Ratification of Previous Minutes Part 1 (27.02.25)** The minutes of the 27 February 2025 Quality & Risk Committee (Q&R) (Part 1) meeting were **AGREED** to be a true and accurate record of the meeting and would be signed as such.		
5.	**Matters Arising – Part 1 Action Checklist (27.02.25)** ***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.*** A date in May was being secured with Dietitian Assistant, Gemma Bibby, to attend for a focused session on the work undertaken and progress made in relation to mouth care. To remain **OPEN. Post meeting note: We closed this as date has been confirmed**. **085 –** ***Clarity and assurance to be provided at the March Q&R meeting to understand how well RPH was performing compared to other centres.*** IS updated the committee that there had been a meeting at which data sources had been considered. Further to a deep dive in raw scores, improvements in cardiac surgery performance were noted. In respect of other services, Transplant, which came through the National Institute for Cardiovascular Outcomes Research (NICOR), had identified issues which had subsequently been flagged by NHSBT, for which necessary mitigations had already been put in place; figures had improved as a result. Thoracic surgery also came through NICOR and the numbers were reassuring, although cases were acknowledged to be small. Primary Percutaneous Coronary Intervention (PCI) was recorded in NICOR, which had enabled scrutinization of the data, with positive results. In respect of Transcatheter Aortic Valve Implantation (TAVI), where there were areas of concern, data was examined and acted upon. The Chair acknowledged the positive assurance regarding consistency of the Trust's own standards and questioned performance relative to other centres, which had initiated the debate. IS confirmed that with the exception of TAVI, all of the data had national comparators and an associated report would be produced. IS added that a more rigorous metric had been given to RPH, due to the Trust performing above its peers and as a result, an alert had been generated by NHSBT advising of a 'dip' in performance. This alert would not have been received by another centre with a more moderate metric.		

	The Chair questioned whether IS had been aware that the department was looking at an issue, prior to receipt of the alert, and IS confirmed that he had been made aware, although not immediately prior to the alert arriving; it was highlighted that this was a concern and not a formal breach of targets and had resulted from the use of donor hearts which were not in optimum condition for transplantation but still within outlined parameters for transplantation. The level of alert was felt to be appropriate and had related to three deaths. The Chair was of the view that the action could be closed, pending a date for receipt by the committee of a comprehensive report on the subject, with a date to be arranged. To be **CLOSED.** ***086 – M.abscessus Dashboard: A briefing to be provided at the end of March 2025 to review progress.*** This item was on today's agenda as part of PIPR report. To be **CLOSED**. **088 – PSII-WEB52388 – Organisational – Cardiology TAVI pathway.** Progress with this action as identified from the PSII WEB52388 in relation to the TAVI pathway to be brought back to Q&R in July 2025 for update. To remain **OPEN**. **090 – Annual Quality and Risk Committee Self-Assessment.** This item had been referred to the Board. To be **CLOSED**. **091 - Zivver Review: The Chair had requested that a trend be included in the report, in respect of the percentages, as for other areas, to demonstrate practice being spread across the organisation.** It was concluded that this item was not required as an action and therefore could be **CLOSED**. **092 – AMS Quality Improvement Presentation: Quality improvement work in respect to reducing hospital acquired pneumonia be brought back to Q&R in six months' time, to assess progress. The national concern of antimicrobial resistance was highlighted as extensive and required addressing for RPH patients but also for the wider health economy.** This item was noted to be due in August 2025. To remain **OPEN**. **093 – Eolas App: To confirm it has been through a privacy impact assessment.** MS advised this had been completed**.** To be **CLOSED.** **094 - Review of Terms of Reference (ToR): LP would liaise further with KMB to make the necessary amendments, and the ToR would come back to Q&R.** This item was on today's agenda. To be **CLOSED**.		

	The Committee **reviewed** and **noted** the Matters Arising – Part 1 Action Checklist.		
6.	**Quality & Safety**		
6.1	QRMG and SIERP Highlight and Exception Paper SP presented the QRMG and SIERP Highlight and Exception Paper. There were no formal escalations from the QRMG held in March 2025. The Committee's attention was drawn to the following: • For SIERP meetings held in February 2025, there had been one Patient Safety Incident Investigation (PSII) commissioned in February - WEB55370 - Cardiology Complication of PCI surgery - Cardiology/Cath Lab, for which DM noted the complexities of the case and provided the committee with a summary of the issues. IW commented that what had occurred were recognised complications, but it was unusual for these to have occurred simultaneously. • SP noted a significant increase in formal complaints in February (totalling 11) however, consideration of trends over time had identified these figures to be similar to the previous year. Many of the complaints in question had escalated from enquiries, with dissatisfaction with the initial response resulting in a formal complaint being pursued. Scrutiny of cases relating to thoracic surgery had failed to reveal any specific themes. **Discussion:** IW referred to concluded inquest number one, expressing surprise at the decision to have returned the patient to Respiratory, when an aortic lesion had been evident. SP explained that the coroner had pursued this issue and it had been concluded that the patient would have been unlikely to survive had they been transferred sooner, due to what had occurred at the time of induction of the anaesthetic; transfers between private and NHS treatment had also been considered a factor. IW contended that should RPH wish their standards to be as high as possible, there were learnings to take from this case, as diagnosis had been evident. DM provided additional background and highlighted the issues which had led to the decision to refer back to Respiratory, who remained unsure as to specifics of the lesion, in what was noted to be a particularly complex case. AF raised the Evaluation of Rotablation PCI at RPH and the summary of key findings which read "the safety outcomes for patients undergoing Rotablation at RPH are acceptable." AF sought further clarity around the term "acceptable" and its implications, and DM explained that the type of audit meant that it was not possible to excel, and represented more of a pass/fail result. The Chair wished to know whether EM was concerned by the increase in formal complaints, to which she responded that the nature of the complaints were relatively standard, with a slight discharge theme being evident. EM		

	had investigated with HMc whether this could relate to the acceleration of patients being discharged, and this was receiving further consideration. DM added that the proportion of formal/informal complaints had been reviewed and only five informal complaints had been noted in this period. It was acknowledged that there required to be early communication and resolution of questions for patients and families in order to avoid progression to the formal process. SP flagged that for the month of March, figures had returned to normal, with only four formal complaints received. The Committee **noted** the QRMG and SIERP Highlight and Exception Paper.		
6.1.1	Patient Safety Incident Response Framework (PSIRF) 2025/26 Plan SP presented the Patient Safety Incident Response Framework (PSIRF) 2025/26 Plan and it was noted that evaluation of previous work conducted would follow in a future report. Three priorities had been identified for the next year and had been separated from business as usual work, such as falls and pressure ulcers. The three workstreams selected for progression were Medication (including administration), implementation of care and unavailability of appointments. **Discussion:** The Chair observed the usefulness of the examples displayed within the report and suggested it would be helpful for future reports to contain detail of the types of delay which could occur to give rise, for example, to a deteriorating patient. AF concurred and considered evaluation of the five themes identified, plus an evaluation of new ways of working would be useful to note, questioning if this was underway. SP confirmed this was the case and acknowledged that it was not just about changing the language, but also the learning responses. The Chair referred to the six-month review and the summary data regarding different approaches to incidents, and queried whether this would continue to be a separate exercise or whether it would take the form of an annual report. An annual report was confirmed to be the planned way forward. EM sought to link the quality account priorities to the areas of focus, suggesting it would be helpful for the triangulation to establish alignment between the two and then overlap on the waiting list and the harm element. SP noted the different drivers and the wish to keep a broader view of the quality priorities rather than a focus on specifics. The Committee **ratified** the Patient Safety Incident Response Framework (PSIRF) 2025/26 Plan.		
6.2	SSI Quality Monitoring Dashboard		

	MS presented the SSI Quality Monitoring Dashboard noting its positive elements. Q1-Q3 had observed reductions in terms of overall rates, however, in January of Q4, there had been three infections comprising one deep sternal wound (1.2%) and four superficial leg wounds (4.7%); all had been inpatients. This had resulted in an infection rate of 5.9% (5/86). In February 2025 there had been one superficial sternal wound infection identified (1.4%). The need to remain focused on SSIs was emphasised. Leaders in specific areas were required to self-manage in respect of compliance, in order to reduce the significant input provided to date. The Chair questioned whether the committee should receive an update on progress in this regard and MS suggested there was a need to consider a transition programme and for relevant staff to be invited to report back on progress in three months' time. In the interim, 'arms-length' support would continue to be provided. The Chair suggested that relevant staff should be invited to Q&R in three months' time to provide a report on progress in respect of SSI compliance (**action).** MS added that dashboards would continue to be produced and brought to this meeting, and those meetings with infection control colleagues, to ensure sufficient oversight. The Committee **noted** the SSI Quality Monitoring Dashboard.	**MS/ KMB**	
6.3	M.abscessus Dashboard (Feb 2025 data) MS presented the M.abscessus Dashboard (February 2025 data), noting that relatedness studies on one patient WEB55250(7) had shown a link to the outbreak cluster. The patient was under the care of the Lung Transplant Service. Water samples had also shown M. abscessus linked to the Outbreak cluster. The IPC Team were undertaking review of cleaning and flushing practices within patient rooms and working with the Water Safety group on any further recommendations. The patient's clinical condition was being closely monitored by his medical team. **Discussion:** IS noted numbers to be disappointing; it remained to be seen whether this patient was infected or whether this was carriage or a false-positive. MS noted the reference to M.abscessus within the PIPR but advised that this document had not been included in the pack for today's meeting; KMB duly circulated this by email to the committee. The Chair sought to understand whether three cases was a number which may become the norm periodically, or whether it should be cause for concern. IS was of the view that the fact that a transplant patient had been affected		

	was worrying due to the levels of caution exercised by the team; and that understanding how the situation occurred was key. The Chair queried next steps, and MS advised that action would comprise continuation of the Water Safety plan and a review of what had occurred. MS noted that there was no national guidance as to how frequently drains should be examined, which was an area where M.abscessus arose; a regime for cleaning the grills and the initial part of the drains was a way forward, as was attention to toilet seats. IW highlighted that the total number of cases was in fact seven, due to there also being four non-related cases in addition to the three related incidents. IS responded that the four would have originated in the community, which IW found to be of interest, observing that both related and non-related cases had risen in number and yet were not genetically related. IS advised that during the meeting, he had reconsidered the graph within the performance pack relating to M.abscessus and that, in fact, the trend in the data was less evident than first thought. EM queried whether cases might have related to a change in testing provider or regime. The Chair suggested that M.abscessus was another area That needs to continue to have periodic attention. The Committee **noted** the M.abscessus Dashboard (Feb 2025 data).		
7.	**Patient Experience** Nothing to note.		
8.	**Performance: Performance Reporting: PIPR M10** MS presented the PIPR, M10. Highlights were as follows: • Three red areas obvious within the performance summary table were noted to comprise the PSII previously mentioned, plus metrics relating to Support Worker fill-rates and Supervisory Ward Sister/Charge nurse time, which had dropped due to unexpected sickness in one particular division. • VTE had been reported as amber but performance was still described positively. • All metrics had been scrutinised to ensure they did not flag red unnecessarily going into next year. • The PIPR was shared with the committee and a key performance challenge slide focusing on safe medicines management was highlighted.		

	• The result of an audit by the IPC team which had looked at compliance with the various measures the Trust had in place to protect patients from M.abscessus, had been positive. • The Caring performance summary was reported as green, with late response of one complaint raised as an issue previously now resolved. **Discussion:** The graph referred to earlier in the meeting, relating to M.abscessus, was shared with the committee and the gap between related and unrelated cases was noted to be pertinent. The Committee **noted** the PIPR M10.		
9	**Risk**		
9.1	Board Assurance Framework (BAF)		
9.1.1	Appendix 1: BAF Report The BAF Report was taken as read. The Committee **reviewed** the Board Assurance Framework (BAF).		
9.1.2	Appendix 2: BAF Tracker The BAF Tracker was taken as read. The Committee **reviewed** the BAF Tracker.		
10.	**Governance & Compliance**		
10.1	Internal Audits/Assessment:		
10.1.1	Quality Accreditation Pilot - Cardiology JR presented the Quality Accreditation Pilot – Cardiology. The approach replaced the previous Peer Reviews which reviewed and assessed how the Trust was meeting CQCregulations across the Trust. The approach would support assurance within the Safe and Caring domains and Regulations 8-20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). These regulations were displayed for the benefit of the committee and were noted to be the fundamental standards below which care must never fall. The aims of the assessment, with methods of evaluation and tools used, were also displayed and explained. The unannounced Cardiology assessment had taken place on 03 March 2025 and details of the format of the day and names of the staff who undertook the assessment were noted. A summary of findings detailing the high quality of care observed on the day was relayed, and the enthusiasm with which the department had participated in the pilot approach was commended. The cohesiveness of the whole ward		

	team and the leadership behaviours observed had been considered excellent examples of Trust values in practice and were to be celebrated. Survey feedback received, post-assessment, had been extremely positive. Next steps would see the assessment/report compilation passed to Cardiology to enable a locally led improvement plan to be developed. The opportunity to develop the assessment tool and expansion of the data pack were to be explored, along with an accreditation scoring matrix, to allow for stretch targets. **Discussion:** AF noted the intensity of the process and questioned whether there was an associated roll-out plan. JR advised that comparable Trusts would begin in inpatient areas prior to developing a tool for specialist areas, and the pilot would now be reviewed and developed, prior to further assessments being undertaken. AF questioned whether any unexpected findings had arisen via the process with Cardiology, and JR explained that one factor of note was that the assessment team had felt they wished to spend a more extended period of time in the clinical area. AF questioned how the information had been shared with other ward areas, and JR responded that the details had been shared at the Fundamentals of Care Board yesterday, which was the first time the information had been imparted. MS explained that alongside this work, ward and department self-assessment were being undertaken and the CQC standards and regulations were being mapped across, to ensure all evidence was in place in preparation for CQC preparedness, which would provide additional assurance and necessary triangulation. The Chair wished to define the terminology involved in the process and suggested that quality accreditation related to checking that standards were met in those areas of work and that these were “ticked off”. MS agreed but added that there were different levels to the accreditation, such as bronze, silver and gold, which resulted in an improvement programme as departments addressed any deficiencies. The Chair questioned whether the Trust had capacity to support the necessary level of continuous improvement through this process. JR felt positive in this regard, with Cardiology being of the view that the feedback shared had not passed on anything new and they had an existing plan around how they would reach the necessary goals; the process merely formalised that. MS added that the work would form part of business as usual, rather than being viewed as a separate task of making improvement.		

	OM referred to CQC standards and that some of these standards applied to non-clinical as well as clinical elements and questioned any associated plan. JR advised that other organisations would create a peer review-type evaluation for non-clinical areas but as these areas did not have the same number of standards as clinical departments, they would not be graded in the same way; this was confirmed to encompass 'Well Led'. The Committee **reviewed** the Quality Accreditation Pilot – Cardiology.		
10.2	External Audits/Assessment: There were none to review.		
10.3	External Audits/Assessment: There were none to review.		
11.	**Quality Accounts**		
11.1	Q3/Q4 Quality Accounts Priorities 2024/25 Update MS introduced the Q3/Q4 Quality Accounts Priorities 2024/25 Update, which was taken as read. A detailed workup of quality priorities for next year would be presented to the next Q&R meeting. A timeline for the priorities was displayed. JR provided the committee with a breakdown of the three priorities, which comprised: • Safe care and improvement in the management of patients with Diabetes. • To improve patient experience with their nutrition and hydration needs while staying or visiting the hospital. • To Improve outcomes for patients who experienced delirium under RPH care or had dementia and care needs requirements. **Discussion:** The Chair questioned the levels of success achieved by the setting of quality account priorities as a system, and JR was able to advise that the method worked due to it becoming a Trust focus and demonstrative of what had been achieved over time. Should a group not exist to drive those improvements, one would be formed, or if there was an existing group, a 'check and challenge' would ensure correct resource with the right people in that space to help support them with those improvements. Monitoring and measuring would ensure the ability to measure success. The Chair referred to previous discussion on healthcare inequalities, which EM advised had received extensive discussion with executive directors, when bespoke pieces of work had been identified which would form part of the proposals, once these were presented.		

	The Committee **reviewed** the Q3/Q4 Quality Accounts Priorities 2024/25 Update.		
11.2	Quality Account Timetable Update The Committee **noted** the Quality Account Timetable Update.		
12.	**Policies & Procedures**		
12.1	DN270 Learning from Deaths Policy The policy was taken as read. MS advised that the document had received significant refresh and set out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of RPH. The Committee **ratified** the DN270 Learning from Deaths Policy.		
12.2	DN195 Complaints Policy The policy was taken as read. Main changes were noted to be related to clarity around timeframes. IS referred to appendix four of the Complaints Procedure relating to vexatious complaints, noting the possibility that these could be borne out of a mental health issue. IS questioned whether it should be the Trust's responsibility to consider these irrational behaviours. EM suggested this fell under the ambit of safeguarding. MS did not feel this would necessarily meet the safeguarding threshold and process would be referral back to the community. Swift communication with the GP was considered key and formed part of clinical practice. It was queried whether the issue should be made more explicit within the policy and following further discussion, the committee concluded that the wording should be reviewed to reflect cases where mental health was implicated in vexatious complaints. MS agreed to review the wording with IS as necessary (**action**). Completed – To be Closed Subject to the above amendment, the Committee **ratified** the DN195 Complaints Policy.	**MS**	
12.3	TOR002 Quality and Risk Committee Terms of Reference (ToR) The ToR were taken as read and had been updated in line with additional reporting coming into QRMG or Q&R. In addition, changes in terminology, and to the minor change to the cycle of business, particularly in relation to the quality and safety report, which was now biannual rather than quarterly, had been reflected. CQC preparedness work had also been included. The Chair sought clarity in respect of quorum and MS confirmed this to be two Non-Executive Directors, including the Chair. The Committee **ratified** the TOR002 Quality and Risk Committee Terms of Reference.		

13.	**Research and Development**		
13.1	Minutes of Research & Development Directorate meeting The minutes were taken as read. The Committee **noted** the Minutes of the Research & Development Directorate meeting.		
14.	**Other Reporting Committees**		
14.1	Serious Incident Executive Review Panel (SIERP) minutes (04.02.25, 11.02.25, 18.02.25, 25.02.25). The minutes were taken as read. The Committee **noted** the Serious Incident Executive Review Panel (SIERP) minutes (04.02.25, 11.02.25, 18.02.25, 25.02.25).		
14.2	Escalation from Clinical Professional Advisory Committee There was nothing to escalate.		
14.2.1	Minutes from Clinical Professional Advisory Committee (Jan 2025) The minutes were taken as read. The Committee **noted** the Minutes from Clinical Professional Advisory Committee (Jan 2025).		
15.	**Areas of Escalation and Emerging Risk**		
15.1	Audit Committee There was nothing to report.		
15.2	Board of Directors There was nothing to report.		
15.3	Emerging Risks There was nothing to report.		
16. 16.1	**Any Other Business** MS extended profuse thanks to the Chair for his input both to Q&R and to the hospital over the past six years, noting the time, dedication and leadership demonstrated had enabled open dialogue, encouraged challenge and unified the team, whilst always considering the wider issues and bringing an independent perspective; these sentiments were echoed by the committee.		
17.	Date and time of next meeting Thursday 24 April 2025, 14:00-16:00 - Microsoft Teams		