Royal Papworth Hospital
NHS Foundation Trust

Part 1: Quality and Risk Committee
Thursday 24th April 2025 – 14:00-16:00
Chair: Ian Wilkinson
(Quarter 1, Month 1)
Microsoft Teams

Present	**Role**	**Initials**
Wilkinson, Ian (Chair)	Non-Executive Director	IW
Fadero, Amanda	Non-Executive Director	AF
Midlane, Eilish	Chief Executive	EM
Paddison, Charlotte	Non-Executive Director	CP
Palmer, Louise	Deputy Director for Quality & Risk	LP
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
In attendance		
Cooper, Deborah	Trust Governor	DC
Meek, David	Consultant Respiratory Physician in Thoracic Oncology/ Associate Medical Director – Clinical Governance	DM
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
Monkhouse, Oonagh	Director of Workforce & Organisational Development	OM
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Renwick, Jacqui (item 6.1.1)	Head of Quality Improvement & Transformation	JR
Watson, Alice	Executive Assistant	AW
Weldon, Caroline (item 7.1)	Matron	CW
Apologies		
Glen, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG
Raynes, Andrew	Chief Information Officer	AR

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; apologies noted from Tim Glenn and Andrew Raynes		
2.	**Declarations of Interest** No declarations of conflict of interest were raised.		
3.	**Committee Member Priorities**		

	MS advised that Afua Tobigah had been due to deliver a patient story at today's meeting, but could no longer do so. Caroline Weldon had attended in her stead and would present an alternative patient story. In respect of item 6.1.1, QI Project on Medicines Management, Jacqui Renwick, Head of Quality Improvement and Transformation, would be joining the meeting to present this item. The Committee **noted** the Committee Member Priorities.		
4.	**Ratification of Previous Minutes Part 1 (27.03.2025)** LP requested a change to her title from 'Assistant' to **'Deputy'** Director for Quality and Risk **(action)**. Subject to the above amendment, the minutes of the 27 March 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.	**AW**	**04/25**
5.	**Matters Arising – Part 1 Action Checklist (27.03.2025)** **088 – PSII-WEB52388 – Organisational – Cardiology TAVI pathway.** Improvement plan to be brought back to Q&R in July 2025 for update. To remain **OPEN**. **092 – AMS Quality Improvement Presentation: Quality improvement work in respect to prevention of hospital acquired pneumonia (HAP)** This item was noted to be due in August 2025. To remain **OPEN**. **095 – SSI Compliance Progress Report: Relevant staff should be invited to Q&R to provide a report on progress in respect of SSI incidence and compliance with standards.** Action due in July. To remain **OPEN**. MS raised two escalations from Performance Committee as follows: • **Waiting Lists** (particularly the Oncology pathway) – CP had raised the impact of delays where it was understood from national data that there was a three-month delay, equating to a 10% increase in mortality. What data was available to monitor the Trust's position, to whom and on what pathways was the most harm happening, and what data would inform who was prioritised? MS suggested that the above should be added to the actions log for monitoring purposes and an update would be provided at the next meeting. The Performance Committee had also requested feedback by way of assurance. AF queried how this differed from previous conversations relating to harm reviews. MS advised that many of the questions raised by CP would feed into the actions around the harm reviews, but cross-referencing was required to ensure all was captured. MS would distil down previous Q&R discussions and the issues raised at the Performance Committee and create an action for the log **(action)**.	**AW**	**04/25**

	DM confirmed he had emailed CP in respect of the above issue and the detail for the relevant cancer patients was available, hence there should be a swift resolution to the query. • **CT Reporting Backlog** – Concerns regarding lack of insourcing and outsourcing and the potential for the backlog to increase. Was the Q&R assured in respect of any risk of associated harm? MS advised that incidents had been apparent from the Safety Incident Executive Review Panels (SIERP) process in respect of delays, and consideration was always given to whether the CT reporting backlog influenced any harm to patients as a consequence. The Chair suggested that the appropriate metric related to how many operable cancers had been missed and had become inoperable as a result. DM advised of a governance monitoring CT backlog meeting which had been set up but had now been stood down and formed part of Performance. Throughout the six months that that meeting ran, all complaints and incidents had been monitored and no serious harm had been evident and nothing had been missed that would have meant different actions being taken earlier; psychological impacts of the delays were acknowledged. MS suggested it be reported back to the Performance Committee that the current systems and processes in place would identify any relevant issues and this was being monitored constantly. The information would be added to the actions log as having arisen at the Performance Committee, with the response noted; the action could then be closed **(action)**. EM considered it would be helpful for the above information to feature within the Q&R Chair's report to the Board, for completeness, which the Chair confirmed to be his intention **(action)**. The Committee **reviewed** and **noted** the Matters Arising – Part 1 Action Checklist.	**MS/AW**	**05/25**
6.	**Quality & Safety**		
6.1	QRMG and SIERP Highlight and Exception Paper DM presented the QRMG and SIERP Highlight and Exception Paper. No escalations had been noted from Q&R. There had been two main areas of discussion at QRMG, being the aforementioned Medication Management QI Project and the Patient Safety Incident Response Framework (PSIRF) Plan Evaluation. There had been two patient safety incidents in the month, which were being reviewed at divisional level; one was being fed back to the originating Trust whilst the other was under review with the local team at RPH and would be fed through QRMG. A number of audits had been published, including a large national cardiac audit from which it was evident that RPH had not been an outlier in any area. Local audits were also flagged.		

	Five formal complaints had been received in month and all were under review. The figure of five was noted to reflect a normal baseline for receipt of complaints further to last month's discussion around a rise in numbers. **Discussion:** The Chair referred to the two Coroner's inquests detailed within the report. AF wished to question the detail behind SSI WEB55798, relating to a patient who had developed a deep sternal wound infection with Aspergillus Fumigatus two weeks after heart transplantation. MS advised that this had been an unusual case as the infection had been significant and had developed early post-operatively; the patient had passed away. The matter was being investigated and this would consider air quality and ventilation in theatres. A question had been raised around the local building works, which would be pursued further and the investigation would involve the theatre being closed for half a day in May. AF referred to the divisional and local clinical audits and queried the drop in completion of Standard 7: TOE Care Pathway World Health Organisation (WHO) checklist (80%) since the last audit. MS advised that this should be 100% and the matter had been discussed with the ECHO team. A re-audit in six months' time was noted, but DM was of the view that this should be brought forward given that the performance had slipped. MS confirmed that the WHO checklist was monitored as part of the ward and department scorecard on a monthly basis and this would also provide the necessary further monitoring **(action)**. The Committee **noted** the QRMG and SIERP Highlight and Exception Paper.	**MS**	**05/25**
6.1.1	QI Project on Medication Management JR presented the QI Project on Medication Management, which had been undertaken to review four thematic areas identified by the Chief Pharmacist, namely reporting culture, controlled drugs (CDs), intravenous (IV) medications and Dopamine infusions. A review of all medicines incidents reported from April 2021 to August 2024 had been undertaken to understand reporting over time and emerging themes. The data findings guided areas to undertake exploratory discussions with wards/departments through meetings, observations of practice and discussions with the nursing teams. This enabled further understanding through a system lens, the challenges posed in practice and potential opportunities to support safe medicines management. In respect of findings, following review of the incident data, it was demonstrated that the number of incidents reported and themes remained largely the same over the data period (April 2021 – August 2024). Management and storage of medications outside the drug storage room differed from ward to ward, and at times by nurses within the same ward. Reasons cited were patient cohort, experience of staff and practice norms, 'work-arounds' to inefficient processes, equipment, and sufficient ward stock of medications.		

	At times, medications were observed being left unattended on top of Workstations on Wheels (WOW). Drug keys including CD keys were also observed unattended alongside medications on two separate occasions. Nurses experienced high levels of interruptions and distractions by others (MDT team, patients, visitors, porters etc) during medication administration. This was cited as a common cause of potential and actual errors and increased the likelihood of medications being left unattended. Experience, hierarchy norms, and cultural differences influenced nurses' confidence to challenge or query medication prescriptions and instructions relating to patient care. The principles of PSIRF and using a system-based approach to learning was not well embedded in practice. Staff reported that responsibility and focus remained on the individual responsible for administration when reviewing medication incidents. A number of recommendations had been made, as follows: • A ward-based review be undertaken of medication rounds and the transport and management of medicines whilst outside the drug storage room, to ensure safe practice and adherence with regulatory requirements. This would consider whether suitable equipment and supply/stock of medication was available to facilitate safe practice. • A review of systems and workflow process for medicines administration, utilising simulation and digital systems to inform improvements and enable efficient and safe practice. • A review of the management of drug keys to ensure safe keeping and appropriate access. • A review of ward working practices. Excellent examples of safe and effective medicines management practices had been observed, and examples where wards had made significant improvements. Wider sharing of their improvement journey and approach to learning was recommended. The embedding of PSIRF and applying a system-based approach to learning from medicines incidents was recommended. The improvement recommendations would be taken forward and monitored via the Medicines Safety Group. **Discussion:** The Chair referred to breakdown of the Dopamine and IV drug incidents, noting examples where significant harm could have been caused. MS added clarity that the Dopamine issue had related to peripheral rather than central administration.		

	AR observed the technology failings identified within the report and expressed the wish for digital teams to be involved in the relevant investigations, by way of support. AF praised the quality and detail of the report and its themes as well as the cultural aspects of the findings and considered the human factors and the link to PSIRF would be important in the implementation of the recommendations and next steps. MS echoed the above and noted the value of the investigation. MS also stated that a review of models of care for caring for patients in single rooms was to be established with focus on working practices and organisation of care. It was felt that this would link in with many of the improvement projects being undertaken and there would be enablers to assist with the improvements going forward. CP noted the that the PSIRF had commenced in January 2024 and questioned the timing of the medication review, which JR confirmed to have been undertaken in the Autumn of 2024. This being the case, CP queried, if human factors were noted to be an issue in January, and remained evident, how the learning could be taken forward effectively from this point. JR clarified that the data period had been for a significantly longer period (April 2021 to August 2024) which DM added had been compounded by Covid-19, restructuring and other factors. MS advised PSIRF had been a protracted process but that there was now the opportunity for focus with the benefit of a learning improvement lens. LP confirmed that the PSIRF plan for next year had been signed off and there had been recognition from the ICB that the plan had been safe, proportionate and appropriate. LP would attend the national patient safety meeting next week (w/c 28 April) to showcase the plan more widely. The Committee **noted** the QI Project on Medication Management**.**		
6.2	Evaluation of the year 1 PSIRF plan-v1 - 15 months (Jan24-March 25) DM noted that it had been observed in earlier conversation that PSIRF had been a “slow burn” and whilst each organisation had put in a 12-month plan, this had evolved to be 15-18 months. Five objectives had been set from retrospective consideration of incidents followed by the targeting and highlighting of those as points for improvement. Successes and areas of focus were evident from the report, with programme, plan and targets for the next year established. Three areas had been identified for further scrutiny, namely: • Recognised but unintended outcome of treatment or procedure. • Implementation of care or treatment issues within patient pathway. • Medication safety. Positive progress had been made and work was ongoing, with LP attending many meetings from which it had been evident that RPH held exemplar status in respect of its PSIRF implementation. **Discussion:**		

	MS queried whether, via duty of candour, RPH patients had expressed higher levels of satisfaction as a result of the implementation of the framework, and DM expressed this was not simple to establish; RPH had historically had a good reputation in respect of duty of candour and its open reporting culture. Monitoring of an already high baseline would be necessary to assess any changes. The importance of not losing the individual within the system reviews was highlighted. Staff feedback had been positive and outcomes and learnings were being derived by the team, for the team, and were actionable and accountable to them. CP referred to the year-ahead plan and the section entitled 'Planned Responses' noting that the first three entries appeared generic and high-level and the same across all three in terms of planned response. It was suggested that further detail, actionable objectives and clear plans be included. CP used Priority 2 by way of example in relation to deteriorating patients, where there were known issues, for which actionable objectives were required. DM advised of a task-and-finish group looking at the acute deteriorating patient which had reviewed the full ward process from healthcare support workers and nursing team; divisional directors would respond from a medical perspective. Work was therefore ongoing but DM agreed to note CP's specific concerns so that these could be addressed **(action)**. AF extended thanks to LP and MS for the successful rollout of the PSIRF framework but suggested that what had been learnt had failed to do justice to the significant programme of work in place and the alternative approach being adopted. DM highlighted the extent of feedback now being received by staff which had not always been the case with SIs and how this was empowering people to make changes for their particular departments. The Committee **noted** the Evaluation of the year 1 PSIRF plan-v1 - 15 months (Jan24-March 25).	**LP/DM**	**05/25**
6.3	SSI Quality Monitoring Dashboard MS presented the SSI Quality Monitoring Dashboard, noting that lower rates of SSIs had been maintained. In respect of heart transplant patients, the previously mentioned unusual incidence of Aspergillus was noted. The monitoring dashboard reflected a significant improvement across many of the audit standards that were measured and monitored. Good work had been highlighted at this week's SSI meeting in respect of cleaning and decontamination in Critical Care, and the ownership that the team held around the issue. Compliance with skin decontamination prior to surgery was being observed. The Committee **noted** the SSI Quality Monitoring Dashboard Quality Monitoring.		
6.4	M.abscessus Dashboard (March 2025 data) MS presented the M.abscessus Dashboard (March 2025 data) with no significant updates to impart. Relatedness studies on one patient WEB55250(7) from a sample in January 2025, had shown a link to the outbreak cluster.		

	The Committee **noted** the M.abscessus Dashboard (March 2025 data).		
7.	**Patient Experience**		
7.1	Patient Story CW presented the Patient Story. The Committee were advised that this related to a Bronchiectasis patient who had become progressively unwell and after some issues as to the most appropriate route for her treatment, had been admitted to 4 South Ward at RPH at the end of November 2024; a number of channels of treatment were commenced on her admission. The patient's status was noted to be challenging. She lived alone, with no family or next of kin and no friends; her poor standard of living had been flagged by the company who had provided her oxygen but had refused to do so latterly, due to the risk of fire in her home as a result of clutter. The patient had been pleased to stay in hospital and in a bid to remain, had used a variety of tactics for delay when her discharge had been initiated. In addition, she had been rude to staff and had received a warning about her behaviour. The patient lived in a private rental property and did not wish the landlord to view the accommodation due to its condition. She had no wish to go into a care home and had asked to return home. In order to assist, the discharge and social work teams had identified a company called "We Can Declutter" who had been willing to declutter the patient's property. Once the challenge of consent had been overcome, the keys were released to enable the charity to perform their function, and the patient received photos of the rooms that had been decluttered. An additional challenge was explained to be heating to the property, which had been identified to be unsuitable. In an effort to rectify the situation, the social work team had liaised with the RPH charity to source a suitable heater, which had subsequently been approved and purchased; staff had also worked together to facilitate the purchase of a microwave for the patient. In order to install long-term oxygen into her home, "We Can Declutter" agreed to attend the patient's residence and meet the oxygen company, when agreement was reached to resupply the long-term oxygen required. The patient was discharged the following day with appropriate heating, a microwave and sufficient food from Housekeeping to sustain her in the short-term. Attention was drawn to the length of time it had taken to address the patient's needs in order to facilitate her discharge (November 2024 to end of January 2025) although the specific challenges were noted to be unusual. It was considered that staff had gone "above and beyond" to ensure the patient was able to return home.		

	The question of repatriation to the patient's original hospital where she had refused to be treated had been raised, but due to winter pressures at the time, it had been considered preferable to discharge directly. **Discussion:** The Chair thanked CW for the quality of her presentation and congratulated the team for the hard work undertaken to resolve the situation. The Chair questioned the duration for which the patient had remained in hospital beyond that which she would have done, had her situation been more favourable. CW inferred the normal admission period for such issues would have been two weeks, so this had been a protracted stay, but the patient was never medically fit for discharge due to requiring oxygen in order to be sent home. LP reiterated the complexities of this patient's particular discharge and highlighted the methodical leadership and teamwork which had resulted in the patient's optimum safety being achieved. EM echoed the above sentiments and questioned whether any other patients had been cancelled as a result of the patient's extended stay. CW had not been aware of any direct cancellations but noted that should other patients require lung defence treatment and RPH did not have capacity, they would have to be referred elsewhere. EM further questioned the patient's current living conditions but CW advised that due to a number of factors, this would be difficult to establish. AF praised the achievements of the team and queried the hours that staff would have given to this particular patient over and above the norm, in order to facilitate her safe discharge. CW advised this to have been many hours, including hours of personal concern experienced by the staff involved. DM referred to the "greater good for the NHS" having been achieved by addressing the issues with the patient and questioned whether 'We Can Declutter' had been recognised for their helpful contribution. CW advised that the specialist discharge nurses had made contact and thanked them for their role in assisting the patient. It was suggested that, in addition, EM wrote to them, by way of appreciation, and CW would pass on their details to EM for this purpose **(action)**. The Committee **noted** the Patient Story.	**CW/EM**	**05/25**
7.2	Patient & Carer Experience Group Minutes The minutes were taken as read. The Committee **noted** the Patient & Carer Experience Group Minutes.		
8.	**Performance: Performance Reporting: PIPR M12** MS presented the PIPR, M12, which noted an overall amber position in respect of 'Safe'. This was reflective of compliance with VTE risk assessments which was slightly down, fill rates for healthcare support workers on days, and not attaining the 90% in terms of Ward Sisters' supervisory time; none of these factors were indicative of safety issues.		

	A key performance challenge slide within PIPR related to acute kidney injury (AKI) and an audit undertaken in accordance with NICE guidelines. The AKI bundle compliance for 2024/25 was 46.8% which it was explained was not a cause for concern in respect of patient safety, but rather the documentation of a bundle of practices which should be undertaken when a patient flagged as having AKI; a plan was in place to improve compliance in this regard. A focus on treating tobacco dependency noted the positive work being undertaken to benefit health outcomes of patients. AF alluded to the balance scorecard, contending that amber was a harsh reflection of the levels of safety of the Trust, which were more positive than this suggested. MS concurred and confirmed that going forward, the new PIPR would offer improved balance in this respect. IS referred to the 335 AKI cases noted within a year, expressing that this reflected circa. 3% of admissions, but observed that the headline figure detailed an expectation of 25% of admissions. Clarity was requested and it was confirmed that the latter figure reflected national statistics pulled from acute Trusts. Work was underway to address the Lorenzo template to reduce the extent of the 'triggers' being generated. The Committee **noted** the PIPR M12.		
9	**Risk**		
9.1	Board Assurance Framework (BAF)		
9.1.1	Appendix 1: BAF Report The BAF Report was taken as read. One risk was highlighted as related to infection prevention and control rates, with SSI rates noted to be at 3.9% in March 2025. The risk rating remained as for the previous period. 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.		
9.2	Corporate Risk Register (CRR) Report: For All Risk 12+ Risks LP presented the Corporate Risk Register Report: For All Risk 12+ Risks, which was taken as read. CP drew attention to '3694 Risk of deteriorating patient not being escalated for review' and referred to the NEWS2 and requested that the narrative be updated to reflect earlier discussions on this issue (point 6.2) **(action)**. LP relayed that going forward, as part of the PSIRF plan, in lieu of the high level plan and objectives, achievements per quarter would be demonstrated, as for the Quality Accounts. MS conveyed that the NEWS2 and alerting system was in ward areas and advised of the acquisition of the software to be able to put a fully-functioning dashboard back in place. MS further confirmed that there was a workstream on the deteriorating patient that covered all the actions and the levels of assurance CP had been seeking.	**LP**	**05/25**

	AF highlighted a selection of the extreme ratings and queried their accuracy and whether they truly reflected risks for the CRR. MS concurred and advised that as part of the BAF review and review of governance structure around the CRR, there was a proposal for a Risk Oversight Committee to be established. This would ensure any entry on the register with a rate of 12 or above was considered by the committee by way of 'check and challenge', support and to establish whether it was truly a risk. EM had also scrutinised Datix to clarify the data and noted that the EPR procurement process had generated many of the risks related to the abolition of NHSE and uncertainty around whether the process would stand. EM suggested to LP that within Datix, there should be a form of directorate location (the Nexus Programme) which would aid context and link the different elements together **(action)**. The Committee **reviewed** The Corporate Risk Register Report: for all Risk 12+ Risks.	**LP**	**05/25**
9.2.1	Appendix 1: Corporate Risk List +12 The Corporate Risk List +12 was taken as read. The Committee **noted** the Corporate Risk List +12.		
10.	**Governance & Compliance**		
10.1	Internal Audits/Assessment: There were none to review.		
10.2	External Audits/Assessment: There were none to review.		
11.	**Quality Accounts**		
11.1	Quality Accounts for 2024/25 MS extended apologies for the absence of April's Quality Accounts which had been incomplete and therefore not included, but would be circulated before the end of w/c 28 April. Explanation of the process for ratification, with a timeframe, was provided to the Committee. The Committee **noted** the plan for the Quality Accounts for 2024/25.		
12.	**Policies & Procedures**		
12.1	Cover Paper for All Policies/ToR section The Committee **noted** the Cover Paper for All Policies/ToR Section.		
12.2	DN306 Consent to Examination or Treatment Policy LP presented DN306 Consent to Examination or Treatment Policy which was taken as read. CP referred to informed consent processes and whether these accurately reflected to patients, the information required to make balanced decisions around benefits and harms of a procedure. LP advised of her participation in the Trust's Consent Working Group and noted that for all consent covered by the policy, there were patient information leaflets with embedded consent forms providing latest information and what was being consented to for risk; these were completed per patient and audited as part of the process with this recognised as a safe process. The data was also shared with the legal team (Kennedys) who would conduct regular reviews. The forms had been tested in court for clinical negligence and inquest, and had been deemed to contain sufficient information to inform patients around consent. The Chair recalled that for particular issues such as M.abscessus, specific discussion would be		

	had with patients to explain the increased risk; the process required to be adaptive to the situation. MS added that all patients were consented, having been made aware of the current higher SSI rate at the hospital and that would be adjusted every month based on the rate of infection at the time, and also the patient's risk factors for developing an infection. IS echoed these comments and highlighted the individual patient statistics fed into the 'EuroScore' system to generate the risk, alongside individual conversation on the issue. There were further calculators for the 'time to benefit' element, which were not used routinely, and the aim was to introduce these going forward. DM noted the frequency of MDTs and the clear collective consensus reached in respect of risk of surgery for individual patients, which aided assurance. The Committee **ratified** DN306 Consent to Examination or Treatment Policy.		
12.3	ToR020 - Safety Incident Executive Review Panel LP presented ToR020 - Safety Incident Executive Review Panel which was taken as read. The Committee **noted** the ToR020 - Safety Incident Executive Review Panel.		
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 (04/03/25; 11/03/25; 18/03/25; 25/03/25). The Committee **noted** the Serious Incident Executive Review Panel (SIERP) minutes (04/03/25; 11/03/25; 18/03/25; 25/03/25).		
14.2	Escalation from Clinical Professional Advisory Committee There were no escalations.		
14.2.1	Minutes from Clinical Professional Advisory Committee (February 2025) The minutes were taken as read. The Committee **noted** the Minutes from the Clinical Professional Advisory Committee (February 2025).		
14.3	Clinical Ethics Minutes The minutes were taken as read. The Committee **noted** the Clinical Ethics Minutes.		
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.	**Any Other Business**		

	MS referred to a number of harm incidents which had arisen, particularly in relation to the 5th Floor, as well as complaints and patient experience issues emanating from the surgical wards. A deep dive was being undertaken and outcomes would be scrutinised through divisional performance committees. Further detail would be provided, once clarity had been established. OM highlighted a deterioration in the staff survey scores for this area, as well as a shift in workforce metrics. MS confirmed that this data had been linked into the investigation, which was confirmed to be internal. The Chair referred to previous conversations regarding annual consideration of non-surgical mortality across the organisation. LP referenced the 'Learning from Deaths' annual report where this area would be focussed upon, acknowledging that the information was collected from different systems. The Chair sought the committee's levels of assurance on the matters discussed at the meeting and this will be added to chairs report to BoD. CP remained "moderately assured" in respect of delays and recognising deteriorating patients, and the NEWS2 scores coming through in a timely way. Assurance was sought with regard to a timeframe for reducing any technical issues around delays in those scores coming through for clarity, and to ensure that the right controls were in place. The Committee **noted** the Other Business.		
17.	Date and time of next meeting Thursday 29 May 2025, 14:00-16:00 - Microsoft Teams		