Royal Papworth Hospital
NHS Foundation Trust

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

Held on 28th October 2021 at 2 pm
Via Microsoft Teams

M I N U T E S

Present	Ahluwalia, Jag (left the meeting at 16:00)	(JA)	Non-executive Director
	Blastland, Michael (Chair)	(MB)	Non-executive Director (Chair)
	Fadero, Amanda	(AF)	Non-executive Director
	Hodder, Richard	(RHo)	Governor
	Jarvis, Anna	(AJ)	Trust Secretary
	McCorquodale, Chris	(CMc)	Staff Governor
	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development
	Palmer, Louise	(LP)	Assistant Director for Quality & Risk
	Screaton, Maura	(MS)	Chief Nurse
	Seaman, Chris	(CS)	Quality Compliance Officer
	Smith, Ian	(IS)	Acting Medical Director
In attendance	Fowles, Jo-Anne	(JAF)	Nurse Consultant Critical Care & ECMO
	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
Apologies	Hall, Roger	(RH)	Medical Director
	Posey, Stephen	(SP)	Chief Executive
	Raynes, Andy	(AR)	Director of Digital & Chief Information Officer
	Webb, Stephen	(SW)	Deputy Medical Director and Clinical Lead for Clinical Governance
	Wilkinson, Ian	(IW)	Non-executive Director

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.

Agenda Item		Action by Whom	Date
1	**APOLOGIES FOR ABSENCE**		
	The Chair opened the meeting and the apologies above were noted.		
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		

Agenda Item		Action by Whom	Date
	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. • Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd. • 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. • 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. • Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH; Chair of the NHS England (NHSE) Operational Delivery Network Board; Trustee of the Intensive Care Society; Chair of the East of England Cardiac Network and an Executive Reviewer for CQC Well Led reviews. • Amanda Fadero as a Trustee of Nelson Trust, a charity predominantly supporting recovery from drug and alcohol addiction with expertise in trauma informed care for women; Associate Non-Executive Director at East Sussex NHS Healthcare Trust. • Maura Screaton as a director of Cambridge Clinical Imaging and with shares in some biotech companies.		
3	**COMMITTEE MEMBER PRIORITIES** • The Committee noted that initial conversations were taking place to draw up the Quality Account Priorities for next year. • The Committee requested to review a longer list of priorities than in previous years so that it could be more involved in the process. • A list of priorities and provenance to be presented to November meeting.	MS	Nov
4	**MINUTES OF THE PREVIOUS MEETING – 30th September 2021**		
	The minutes from the Quality and Risk Committee meeting dated 30th September 2021 were agreed to be a true and accurate record of the meeting and signed.		
5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 30th September 2021** • The Committee noted the action checklist part 1. • *N2: FOCB Exception Report – MS to inform the Committee how the fundamental standards are prioritised.* MS informed the Committee that the fundamental standards are reviewed rotationally and elevated if necessary. The action is now closed. • All other actions either on agenda or for future Committee meetings.		

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6.1	**WORKFORCE**		
6.1 **6.2**	**Workforce and OD Director Report – Quarterly Update on Employee Relations Activity:** **Employee Relations Report Q1 and 2: April to September 2021** The Committee discussed the pre-circulated reports that summarise all formal and informal employee relations activity during the period April to September 2021. Points to note are as follows: • The team worked on 96 individual cases in total, of which 63 were formal and 33 were informal. Of the 96 cases, 39 pre-dated the Q1/Q2 2021/22 reference period. 18 of the 39 cases that were carried forward were brought to a conclusion during this period. • The Committee noted the data breakdown in the document and the case type distribution in Q1. The Committee noted that the volume of sickness absence case management (56%) is higher than any other case type, with the next highest type performance management (12%) followed by grievance cases (11%). • The Committee questioned whether both informal and formal routes for the disciplinary process are on record and was informed that the outcome for the informal process will be training or development needs which will be on record with a letter. • The Committee asked whether there was a greater risk of reoccurrence with an informal resolution and was advised that this wasn't the case and that, although the informal route was less intensive, it was a good route. • The Committee noted that one issue currently being found is that, when trying to resolve cases more informally from a training perspective, some people that have raised the complaint do not feel that they have had justice. This is particularly an issue with dignity at work and allegations of discrimination and racism. • The Committee questioned that Cardiology is not well represented in the directorate breakdown and wondered whether that was due to fewer problems in that department, or whether issues are not being escalated. • OM advised that she had reviewed and checked this data and that no conclusions can be drawn at present as it is from a snapshot in time, but that trends will be reviewed. The Committee noted that Cardiology is a stable environment. • IS informed the Committee that grievances had been reported by junior doctors against working practices in Cardiology through different lines. This was reported in an exception report to Board. • The Committee further discussed its agreement to revise the Committee agenda and terms of reference to incorporate further scrutiny of workforce matters at the beginning of future meetings. • The Committee was advised that a meeting had taken place to review what items would be categorised under Workforce and noted and agreed to the proposal for the following items to be reported to Q&R: o EDI o Health and wellbeing o Compassionate and Collective Leadership Programme o Freedom to Speak Up – quarterly report to Q&R o Safer staffing		

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	○ Employer relations ○ Workforce development, in terms of career pathways/new roles. • The Committee also agreed that the following would also be beneficial to review quarterly: ○ Medical revalidation ○ Safe working reports ○ Unresolved recruitment challenges ○ HEE – staffing allocations, training numbers, etc. • The Committee agreed that this would be a comprehensive framework and that it would welcome quarterly reports to enable easier review of trends on some agenda items. • OM asked whether education should also be placed under Workforce. • The Committee asked where discussions around changing roles and collaborating with other organisations should be held. • The Committee noted that Performance Committee looks at recruitment, retention, temporary staffing spend and sickness absence. • The Committee agreed to the above lists being presented to Q&R. • OM to present Committee with a forward planning schedule for future meetings.	OM	
7.1	**QUALITY**		
7.1.1	**QRMG and SIERP Key Highlights and Exception Report** The Committee discussed the pre-circulated report, with points to note as follows: • No formal escalations from the QRMG held in September 2021. • One escalation from SIERP meeting held on 19th October: new reported Serious Incident reference SUI-WEB41024. The Committee noted that duty of candour and investigation process is underway. • The Committee noted that there were three open SUIs at the time of reporting to QRMG. Two have since been submitted and the last one is currently being completed. All are within the agreed timeframe. • The Committee noted that four Trust wide audits are currently in progress. Learning from closed audits will be reported to future meeting through QRMG report. The Chair advised the Committee that he had spoken to LP about constructing a grid to show all audit and quality improvement works. LP stated that the team are currently working on a clinical audit plan for Quarter 1. • The Committee noted that, at the time of reporting to QRMG, there were a total of 601 open risks, compared to 580 in the previous month which demonstrates active recording of risks across the Trust and at all levels. • The Committee acknowledged the inclusion of the line concerning updates and monitoring of Serious Incident reports. • MS alerted the Committee to page 4 of the report regarding update of Surgical Site Infections. The Committee was informed that the National benchmark is 2.8% and the Trust is currently at 5%. The team is monitoring this along with surgical teams and a recent discussion has taken place around a change to sutures. The Committee noted that there were no organ or deep wound infections.		

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	• The Committee discussed the low level emerging risk to supplies not being delivered on time due to the current national fuel/driver crisis that is affecting pharmacy deliveries, The Committee was given assurance that no major issues have been reported. • The Committee queried the timeline for SUI-WEB41024 and sought assurance that whilst the investigation is being undertaken, steps are being taken to ensure that this is not repeated. • JA: how do we check the integrity of our systems where there is a material dependency upon human compliance? • LP assured the Committee that work was ongoing and work and discussions had already taken place with the Digital team. Part of the terms of reference is to look at whether there is an issue on clinical aspect of this and how it is used, and also harm to patient. • IS advised that a review of the design of Lorenzo in this regard, i.e. to move the buttons further apart, would be useful as this could lead to human error. • IS informed the Committee that approximately a year ago there was anxiety about patients not appearing back in clinics when they were expected. A thorough investigation of patients was undertaken and mitigations put in place. • The Committee agreed on the importance of closing loops.		
7.1.2	**Minutes of Fundamentals of Care Board (210908)** The Committee noted the pre-circulated document.		
7.1.3	**Regional Health Inequalities** The Committee discussed the pre-circulated document, with points to note as follows: • The Committee commended IS on the paper presented to the Committee and on pulling together a coherent position for the Trust. • The Committee noted that previous work has been undertaken by the Trust to address health inequalities in relation to sex distribution and the current project work in relation to social deprivation for people referred for investigation of obstructive sleep apnoea from across the East of England. • The Committee recognised the importance of maternal health, childhood and environment to health inequalities and of looking at radical solutions, and talking to practitioners about how to communicate with communities that need to be reached. • The Committee asked whether the Trust had an internal structure and money to enable the research that it would need to do and was advised that Tim Glenn has said that he will identify resource. Additionally, IS informed the Committee that the majority of patients with sleep apnoea already have a diagnosis made by GPs, but IS suggested that it would be worth looking at how many people convert to being referred to RPH. • JA: Have you had an opportunity and resource to do the health, economic analysis of your intervention – to see how much money we might have saved the system, let alone the patient benefits? If we can demonstrate some traction in that direction then funding becomes more sustainable. • IS advised that, although not yet, he was keen to get one circuit of		

Agenda Item		Action by Whom	Date
	data and research complete to see whether it made a difference. • The Committee agreed the importance of the ICS to look at this as a health population management issue as they may have resources and analytics to gain an insight into communities where health inequalities may be more paramount. • The Committee noted that a meeting had been arranged for IS, MS, and members of finance and digital to scope next steps. • The Committee agreed that an annual plan of work identifying next steps was necessary in order to proceed. • The Committee agreed that Health Inequalities should be reported to the Quality & Risk Committee quarterly. • The Committee agreed to take the paper to the next Board meeting for discussion.		
7.2	**PERFORMANCE**		
7.2.1	**Patient Story** J-AF led the Committee through the verbal patient story, with points to note as follows: • The patient story concerns a patient who was supported on ECMO for 113 days, and who stayed with CCA for 10 days post ECMO before being repatriated. • The patient was awake since day 50. • The patient said that unsurprisingly the environment was noisy, but that they found the alarms, etc, reassuring. However, the patient did state that they became anxious when clinical teams just turned the alarm off without acknowledging that they had done so and giving reassurance. This has been discussed and acted upon. • The patient was able to sleep at night. • The patient said that they felt very safe and that the nurses were 'always there and knew exactly what they were doing'. • The patient thought the environment was very clean and that people would introduce themselves every day and stated how important that was to them. • The patient felt that they had clear treatment plans and they were able to ask questions. • The patient was taken outside and stated how important it was for them to be allowed outside, in the fresh air. The patient said that the act of being able to go outside could take them through the next two or three days of treatment. • The Committee noted that taking a patient on ECMO outside is not without risks, but has now become part of practice in Critical Care. • The patient stated that the ventilator caused him discomfort as it is more aggressive than ECMO and this has been discussed by the team. • The patient had said that they would have liked more discussion about when they needed to get up and work plans for the morning, as they were not a morning person. Also, they mentioned that they sometimes felt that clinicians had betrayed the patient's trust as, if the patient was doing well, clinicians would say 'just 10 minutes more' and then '10 minutes more' after that. J-AF had conversations with the patient concerning boundaries and explained why they were being pushed. However, this discussion has led to conversations		

Agenda Item		Action by Whom	Date
	within the team and led to a change of practice. • The Committee thanked J-AF for the story and commented on how worthwhile it had been to hear from a patient on Critical Care and also how important it was for a long term patient to have exposure to fresh air. • AF: What impacted on me was that the patient felt that you had broken their trust when you were just trying to encourage them to do a little more, and this is so important to hear as it is something that we all do. • The Committee asked J-AF whether she felt that she was cared for as a member of RPH staff and was assured that staff on Critical Care do feel valued and cared for and stated that COVID had opened Critical Care to more staff. The Committee also acknowledged the work that the RPH Charity had done for staff wellbeing during and post COVID.		
7.2.2	**NHS Adult Inpatient Survey 2020** • The Committee congratulated the Trust on its very positive survey results. • The Committee noted that Pippa Hales is looking at more proactive preparation for patients who are being discharged.		
7.2.3	**End of Life Steering Group Minutes.** None available.		
7.2.4	**Patient & Carer Experience Group Minutes (210712)** The Committee noted the minutes.		
7.2.5	**Patient & Public Involvement Committee Draft Minutes (210816)** The Committee noted the minutes.		
7.3 **7.3.1**	**PERFORMANCE** Performance Reporting/Quality Dashboard		
7.3.1.1	**PIPR Safe – M6** The Committee noted the pre-circulated document, with points to note as follows: • The Committee discussed the recording of CHPPD and how it provides a single consistent way of recording and reporting on the deployment of staff working on inpatient wards/units. • MS advised that CHPPD has limitations as the only measure of assessing safer staffing. Nurse to patient rations, skill mix, roster fill rates, monitoring of patient outcomes, etc, should also be reviewed. • CHPPD is a useful benchmarking tool against similar wards or organisations and is a 'point in time'. • The Committee noted that underpinning good safer staffing was good establishment setting and work on this is currently being undertaken and would be bolstered by additional resource at the end of the year. • The Committee agreed on the importance of being able to review a robust indicator of safe staffing and that it took assurance that MS and her team are reviewing it carefully. • The Committee was given an example of how red flags had been used successfully in Critical Care in alerting the Executive team to an over capacity issue that allowed for a pause/break to be utilised		

Agenda Item		Action by Whom	Date
	successfully.		
7.3.1.2	**PIPR Caring – M6** The Committee note the pre-circulated document.		
7.3.1.3	**PIPR People, Management & Culture – M6** The Committee note the pre-circulated document.		
7.3.2 **7.3.2.1**	**Monthly Ward Scorecard Cover Paper** **Monthly Ward Scorecard: M06** The Committee noted the pre-circulated documents.		Autumn
7.4	**SAFETY**		
7.4.1	**Serious Incident Executive Review Panel (SIERP)** (210928, 211005, 211012, 211019) minutes • The pre-circulated minutes noted above were received by the Committee. • The Committee agreed that the minutes should be included in the QRMG and SIERP Key Highlights and Exception Report section of future meetings.		
7.4.2	**Digital Clinical Safety Presentation** CMc led the Committee through the presentation.		
8	**RISK**		
8.1	**Board Assurance Framework Report** • The Board Assurance Framework was accepted by the Committee. • The Committee noted that M.abscessus risk is included.		
8.2	**Corporate Risk Register Report and Corporate Risk Register** The Committee noted the pre-circulated documents and noted that a risk action plan has been drafted and will be reviewed at the December Quality & Risk Committee meeting.		
8.3	**Emerging risks** There were none to report.		
9.	**GOVERNANCE**		
9.1	**SIRO Report Q2** The Committee noted the pre-circulated document.		
10.	**ASSURANCE**		
10.1 **10.2**	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		
11	**POLICIES**		
	No policies were presented to Committee for ratification.		
12	**RESEARCH AND EDUCATION**		

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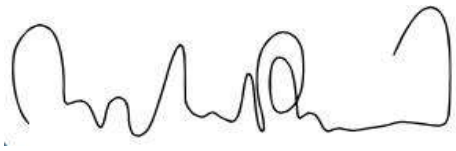
12.1	**Research**		
12.1.1	**Minutes of Research & Development Directorate Meeting** None available.		
12.2	**Education**		
12.2.1	**Education Steering Group minutes** None available.		
12.2.2	**Clinical Education Report – October 2021** The Committee noted the pre-circulated document. MS advised the Committee that education compliance is being reviewed and that trends and further information will be available to present to a future meeting.		
13	**OTHER REPORTING COMMITTEES**		
13.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** There was no escalation from CPAC.		
13.1.1	**Minutes of Clinical Professional Advisory Committee (210923)** These were noted by the Committee.		
14	**ISSUES FOR ESCALATION**		
14.1	**Audit Committee** There were no issues for escalation from Part 1.		
14.2	**Board of Directors** Health Inequalities.		
15	**ANY OTHER BUSINESS** There was no further business and the meeting closed at 16.06hrs.		
	Date & Time of Next Meeting: **Thursday 25th November 2021 at 2.00-4.00 pm, via Microsoft Teams**		



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Signed

25.11.21

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee
Meeting held on 25th November 2021