Royal Papworth Hospital
NHS Foundation Trust

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

Held on 26th May 2022, at 2 pm
Via Microsoft Teams

M I N U T E S

Present	Ahluwalia, Jag (Chair)	(JA)	Non-Executive Director
	Fadero, Amanda	(AF)	Non-Executive Director
	Jarvis, Anna	(AJ)	Trust Secretary
	McCorquodale, Christopher	(CMc)	Staff Governor
	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Acting Medical Director
	Wilkinson, Ian	(IW)	Non-Executive Director
In attendance	Gorman, Eamonn	(EG)	Deputy Director of Digital
	Graham, Ivan (arrived 15:00, left 15:28)	(IG)	Deputy Chief Nurse
	Powell, Sarah	(SJP)	Clinical Governance Manager
	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
Apologies	Blastland, Michael	(MB)	Non-Executive Director
	Hodder, Richard	(RHo)	Governor
	Palmer, Louise	(LP)	Assistant Director for Quality & Risk
	Posey, Stephen	(SP)	Chief Executive
	Raynes, Andy	(AR)	Director of Digital & Chief Information Officer
	Seaman, Chris	(CS)	Quality Compliance Officer
	Webb, Stephen	(SW)	Deputy Medical Director and Clinical Lead for Clinical Governance

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 apologies were noted as above.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions. The following standing Declarations of Interest were noted:		

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	• Michael Blastland as Board member of the Winton Centre for Risk and Evidence Communication; as advisor to the Behavioural Change by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration, as a freelance journalist reporting on health issues. The Chair advised that he was Co-Chair on a review of impartiality of BBC coverage of taxation and public spending. • Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd; CIS UCQ is a trademark for health and car IT courses established under consultancy ADR Health Care Consultancy Solutions 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; Consilium Partners is a specialist health consultancy working wit health and care organisations to help them plan, improve and deliver successful and sustainable futures. Interim CEO role St Barnabas and Chestnut Tree House Hospices for 6/12. • Maura Screaton as a director of Cambridge Clinical Imaging and has shares in some biotech companies. • Richard Hodder as Deputy Chair of the Clinical Policies Forum – Cambridgeshire and Peterborough CCG. • Roger Hall as: Director of a medical services company Cluroe & hall Ltd.		
3	**COMMITTEE MEMBER PRIORITIES** • No priorities reported.		
4	**MINUTES OF THE PREVIOUS MEETING – 28th April 2022** The minutes from the Quality and Risk Committee meeting dated 28th April 2022 were agreed to be a true and accurate record of the meeting and signed.		

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5	**MATTERS ARISING AND ACTION CHECKLIST PART 1 - from 28th April 2022** The Chair led the Committee through the action checklist and matters arising, with all actions on the agenda, for discussion at a future meeting, or closed.		
6.	**WORKFORCE**		
6.1 **6.1.1**	**Cover for Employee Relations Annual Summary Report Q3 Q4** **Employee Relations Annual Summary Report Q3 Q4** OM led the Committee through the pre-circulated documents, with points to note as follows: • The Committee noted that with data available for quarters 3 and 4, the distribution of case type can be shown across the whole year. • Sickness absence accounts for the majority of casework each quarter and there is a significant rise in sickness cases from Q2 to Q3. Sickness absence cases account for approximately 60% of all cases. Cases requiring an intervention of any kind tend to be those where the problems have reached a chronic stage and will be difficult to manage effective to a positive outcome in a short period of time. Ambition is to focus on reducing the number of cases that escalate to a formal management stage and work on improving the time taken to resolve cases. • The Committee noted that there has been an increase in employee relations activity over the last two quarters. • The Committee was advised of the vacancies within the Workforce division to which the Trust has not been able to recruit as yet. This has led to capacity issues within the workforce team. It was noted that STA has identified funding for an additional joint post due to the number of issues within that division and the size of the team. The post will sit within STA but be tied in with the central workforce team. • The Committee noted that a number of cases that had been put on hold due to the pandemic were coming once again to the fore and that there were a number of difficult employee relation cases ongoing which were absorbing a lot of time as they require significant experience. It was noted that some of these cases will end up in appeals and some may go to tribunal as they work their way through the processes. • The Committee noted the ethnicity demographics and that the majority of cases involve someone from a white background (77% of all cases in Q3 and again in Q4). This equates to 4% of the Trust's white population engaged in an active case in this period. • 15% and 11% of all cases in Q3 and Q4 respectively concerned staff with an Asian background, equating to 4% and 3% of the number of staff from an Asian background. • The Director of Workforce advised the Committee that Cultural Ambassadors had completed their training last week. The Trust now has 11 Cultural Ambassadors. Work is ongoing regarding integrating them into the processes and the workforce team will work with them to look at any underlying bias or issues and improve informal resolutions. • IW requested that future breakdown data include percentages in brackets for ease of reference.		

Agenda Item		Action by Whom	Date
	• The Committee acknowledged that sickness absence in the Trust and workforce team had impacted on the cases and challenged the duration of some cases and asked whether all cases were dealt with. OM acknowledged that this was a reflection on capacity within the team and the impact of the pandemic and advised that the Trust was within its timelines for informing people of allegations, but that the investigation process can be elongated especially if the more difficult cases are behavioural and/or relationship issues. It was acknowledged that staff members involved were kept informed. • The Committee discussed the difference between the informal and formal processes and the benefit of earlier intervention at an informal stage to correct behaviour or performance – OM acknowledged that the workforce team has the equivalent of two funded WTE posts dedicated to employee relations case work and that this was not sufficient capacity to respond quickly to the volume of casework seen in this reporting period. • The Committee discussed whether an aggregated number of how many days of work are lost each quarter or each year due to sickness absence would be helpful. OM to consider whether the 'cost of sickness' would encourage line managers to understand the financial benefits of good absence management. • The Committee expressed its thanks to Larraine Howard-Jones and the team for their continued hard work.	OM	07/22
6.2	**PIPR People, Management and Culture M1** The Committee noted the pre-circulated document, with discussion as follows: • The Committee noted that turnover was over the Trust target of 14%, with a six-month turnover average of 16.62%. This, together with a challenging job market and rising vacancy rates will mean that some vacancies will remain unfilled for extended periods, with administration and non-professional grades in bands 2 to 5 the most difficult to recruit to. • It was noted that this was a similar picture nationally and regionally within the NHS due, in part, to national pay bargaining arrangements. • The Committee noted that IPR rates remain below the KPI with areas still struggling to release staff for appraisals due to continuing high absence rates. Additionally, it was noted that compliance with roster approval KPI reduced in April. The key reason for areas not publishing rotas six weeks in advance is lack of line manager and/or administration time. A monthly rostering review meeting led by Heads of Nursing has been established. • AF commented that progress seems to be hampered by recuring themes of sickness, absence, vacancies, etc. and that, despite all that the Trust is doing in terms of staff wellbeing and leadership support, it is difficult to improve. The Committee discussed and acknowledged that this was thematic within the NHS as a whole at the moment and that we need to think not just what we are doing as a Trust, but what the NHS is doing. Fatigue, deprivation and the gap in terms of people's needs and pay, are issues being experienced nationally. • The Committee discussed the team's focus on developing the		

Agenda Item		Action by Whom	Date
	Compassionate and Collective Leadership and EDI programmes, plus good line management programmes and education and training, as they will strengthen staff engagement and reduce turnover. • The Medical Director enquired about linking diversity and inclusion with retention of staff and noted that in staff surveys there had been concern among BAME colleagues regarding bullying and promotion prospects – does that reflect in turnover? • The Director of Workforce advised that this had been reviewed in a recent PIPR Spotlight focus that did indicate that there was a higher turnover among staff with a BAME background with less than two years' service. It was acknowledged that reasons for leaving given during the exit interview may not reflect the true underlying reason as exit interviews may be carried out by a line manager, for example. An improved exit process was being actioned. • The Committee enquired whether there was enough resource in the team's budget to support capacity and the work that is required. OM advised that there were some gaps that are taking a while to recruit to but commented that post pandemic a lot of work that had been put on 'hold' was now needing to be dealt with and it was a matter of prioritisation. • The Committee questioned again whether additional funds and capacity is required to help in this post-pandemic period.		
7.1	**QUALITY**		
7.1.1	**QRMG and SIERP Key Highlights and Exception Report** SJP led the Committee through the pre-circulated document, with points to note as follows: • The Committee noted that there were no formal escalations from May's QRMG nor from the SIERP meetings held in April. • The Committee noted the reestablishment of the Discharge Assurance Group that is not only looking at the process and paperwork of discharge but also looking at patient feedback, serious incidents, action plans and learning. • The Committee discussed apparent emerging themes in reports presented to the meeting that there had been a deterioration in relation to some basic and essential aspects of process including correct documentation of the administration of drugs, recording of VTE risk assessments, anti platelet prescribing and general incident reporting. This was discussed further in agenda item 7.1.2 and it was decided that the Chief Nurse and Medical Director would review these matters as a whole and bring recommendations back to the Committee. • The Committee noted and discussed that there had been a number of scrub team resignations. • The Committee noted the increase in incidents between June and November 2021 regarding deteriorating patients following transfer from the Cath Labs to CCU, with all incidents occurring at the weekend on a daytime shift. The recommendations from QRMG were noted.		06/22
7.1.1.1	**Quarter 4 Report** The Committee noted the pre-circulated document, with discussion as		

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	follows: • The Committee noted the work undertaken by the new VTE lead in increasing the Trust's compliance. • The Committee noted the frustration regarding digital systems in this regard, and discussed and agreed that this related to the theme of a failure in relation to basic and essential aspects of process. The Committee discussed the balance of understanding and being sympathetic to people's fatigue and workload and ensuring that these basic and essential aspects are adhered to. The Committee discussed and agreed the importance of development and recognition of accountability at all levels of the organisation. As discussed in agenda item 7.1.1, the Chief Nurse and Medical Director will review all matters as a whole and bring recommendations back to a future Committee meeting. • The Committee asked why one ward was more compliant than others and was advised that Advanced Nurse Practitioners and Alert Team were available on those wards as non-medical prescribers.		
7.1.1.2.	**Serious Incident Executive Review Panel (SIERP) minutes (220405, 220412, 220419, 220426)** The Committee noted the pre-circulated documents.		
7.1.2	**Surgical Site Infections Report** The Committee noted the pre-circulated documents, with discussion as follows: • The Committee noted that since moving to the Cambridge Biomedical Campus in May 2019, the Trust had seen a higher than previous SSI rate. In addition, Quarter 4 data indicates a spike in SSI in particular in respect to deep and organ space infections. • The SSI stakeholder group was set up in 2019 and met quarterly until December 2021 when frequency of meetings increased as a result of continued high incidence in SSIs. The group has multi-professional membership. These meetings have stepped up to bi-monthly meetings. • The DIPC meets weekly with key leads to review, challenge and support the SSI action plan. • The Committee noted that the UKHSA surveillance team had written to the Trust about the SSI Q3 incidence, stating that the Trust was an outlier. • The Committee noted the extensive workstreams and actions that had been put in place to improve practice governance and assurance, including undertaking harm reviews on patients that have had a deeper and organ space infection. • The Committee requested that a monthly update be presented to future Quality & Risk Committee meetings. • As discussed in 8.1.1, the Committee advised that it expected to see improvement in two quarters.	MS/IS	06/22
7.1.3	**Establishment Report – Six Month Review** The Committee noted the six-month Establishment Report.		
7.1.4	**Antimicrobial Stewardship Report Q4**		

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	The Committee noted the pre-circulated document.		
7.1.5	**Learning from Deaths Report** The Committee discussed the pre-circulated document, with points to note as follows: • The Committee noted that 182 patients had died in RPH from 1st April 2021 to 31st March 2022. The increase was due to the prevalence of COVID. • 86% have been discussed at M&M meetings, with 19 (66%) of those reviewed by the Retrospective Case Record Review. • No deaths were investigated by a Serious Incident investigation and no deaths were considered more than 50% likely to have been potentially avoidable. • The Committee noted the scrutiny of cases and the comprehensive review of all deaths to identify issues and improve quality and safety for patients, including: Medical Examiner Scrutiny Review, Retrospective Case Record Review, Morbidity and Mortality meeting case discussion, and Serious Incident Investigation. • The Committee challenged whether an occasional external peer review would be beneficial in supporting the scrutiny process. • The Committee noted that the Trust is continuing to work with other organisations in the region to improve its ability to learn lessons from patients who died after transfer from RPH to another hospital.		
7.2	**PATIENT EXPERIENCE**		
7.2.1	**Support and Palliative Care Annual Report 2021/22:** The Committee noted the pre-circulated report.		
7.3	**PERFORMANCE**		
7.3.1 **7.3.1.1**	**Performance Reporting/Quality Dashboard** **PIPR Safe – M1** The Committee noted the pre-circulated document, with discussion as follows: • The Committee gained assurance that staffing had returned to green. • The Committee noted that, as part of the ongoing VTE work, the key monthly metric for monitoring VTE assessment on admission has been updated to be easier to interpret. • The Committee noted that there were two E coli bacteraemia and one Klebsiella bacteraemia during April 2022.		
7.3.1.2	**PIPR Caring – M12** • The Committee noted the contents of the pre-circulated document.		
8	**RISK**		
8 **8.1** **8.1.1**	**Board Assurance Framework Report** **Cover Paper – Board Assurance Framework (BAF)** **BAF** The Committee noted the pre-circulated documents, with discussion as follows: • The Committee noted that the paper sought to resolve the discussion at a previous meeting regarding whether the Committee		

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	expected to see improvements and changes in ratings where risks were significantly above target levels. Have we got realistic plans to mitigate our BAF risks? • The Committee discussed the importance of having a timescale for improvement, so it is tracked as part of a KPI measure. • The Committee noted that BAF 675 HCAI had been running at a raised level since April 2021, with several rating changes reported relating to national guidance for COVID and management of nosocomial infections and latterly two escalations in response to elevated SSI rates. • The Committee discussed SSIs to consider a recovery trajectory and agreed that it would expect to see improvement in two quarters. • The Committee noted and agreed that it could receive only partial assurance in relation to the HCAI risk at present.		
8.3	**Emerging risks** There were none to report.		
9.	**GOVERNANCE AND COMPLIANCE**		
9.1 **9.1.1**	**Cover Paper: Quality Accounts 2021/22** **Quality Accounts 2021/22** • The Committee noted the pre-circulated document and the Chair requested that any comments should be sent directly to AJ prior to papers being circulated for Board w/c 30th May. • The Chair commented that evidence for progress against the Trust's original objectives seemed to contain narrative description of what the Trust has achieved rather than evidence. It was suggested that when setting objectives, consideration should be given as to whether they were measurable.	Q&R Members	06/22
9.2 **9.3**	**Internal Audits:** There were none to report. **External Audits/Assessment:** There were none to report.		
10	**POLICIES**		
10.1 **10.1.1**	**Cover Paper: DN708 IT Acceptable Use Policy** • The Committee noted the pre-circulated document. **DN708 IT Acceptable Use Policy** • The Committee ratified the policy.		
10.2 **10.2.1**	**Cover Paper: DN219 Policy for Procurement in Pharmacy Dept** • The Committee noted the pre-circulated document. **DN219 Policy for Procurement in Pharmacy Dept** • The Committee ratified the policy.		
  10.3	**Post Meeting Note:** **DN257 Dress Code and Uniform Policy** The policy had been ratified at the March Quality & Risk Committee		

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	meeting but, following actions implemented in light of the increase of SSI rates, revisions had been made with key points as follows: • Staff should only be wearing scrubs if it is necessary for the clinical environment they are working in. At RPH this is mainly the hot floor. • Staff who do not need to be in scrubs should change out of them and where issued, staff should wear their uniform. • Theatre hats must not be worn outside of theatres and the Cath Labs unless they are clinically required for example, during an intervention in CC or attending an emergency in the hospital. • Staff must not wear their own cloth theatre hats or self-purchased scrubs in theatres and the Cath Labs. • Scrubs and theatre footwear must not be worn outside of the hospital, including HLRI. • The recommendations have been approved by CPAC and also discussed and supported at CDC. The Chair ratified the policy by Chair's Action.		
11	**RESEARCH AND EDUCATION**		
11.1 **11.1.1**	**Research** **Minutes of Research & Development Directorate Meeting (220211, 220311)** The Committee noted the pre-circulated documents. The Committee extended an invitation to Paddy Calvert to present at a future Quality & Risk Committee meeting.	IS	07/22
11.2 **11.2.1** **11.2.1.1** **11.2.1.2** **11.2.1.3**	**Education** **RPH School Update** **Appendix 1 Staff Briefing Paper** **Appendix 2 Hopes and Concerns** **Appendix 3 Process Plan for Phase 2** IG led the Committee through the pre-circulated documents, with points to note as follows: • The Committee noted the updates to the project and that the school project team has explored the VLE options in more detail. • For RPH staff, there will appear to be no changes to education provision, particularly during the 2022/23 reporting year. • The Committee was advised to send any comments to IG directly. • The Committee supported the direction of travel of the project.		
11.2.2	**Education Report** The Committee noted the pre-circulated document and noted the Trust's compliance with Level 3 Safeguarding training. IG assured the Committee that, although the intercollegiate evidential requirements mean that it is difficult to get the evidence required, this was being reviewed by the Safeguarding Committee and would be discussed at its next meeting in June.		
11.2 **11.2.3**	**Education:** **Education Steering Group minutes** • None available.		

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12	**OTHER REPORTING COMMITTEES**		
12.1	**Escalation from Clinical Professional Advisory Committee (CPAC)** • There were no issues for escalation from the May 2022 CPAC meeting.		
12.2	**Minutes of Clinical Professional Advisory Committee (220421)** • The Committee noted the pre-circulated document.		
13	**ISSUES FOR ESCALATION**		
13.1	**Audit Committee** • There were no issues for escalation from Part 1.		
13.2	**Board of Directors** • There were no issues for escalation from Part 1.		
14	**ANY OTHER BUSINESS** • None.		
	Date & Time of Next Meeting: **Thursday 30th June 2022 at 2.00-4.00 pm, via Microsoft Teams**		

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Signed

……30th June 2022….
Date

Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee