

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

Held on 27th October 2022, at 2 pm
Via Microsoft Teams

MINUTES

Present	Ahluwalia, Jag	(JA)	Non-Executive Director
	Blastland, Michael (Chair)	(MB)	Non-Executive Director
	Fadero, Amanda	(AF)	Non-Executive Director
	Hodder, Richard	(RHo)	Governor
	Jarvis, Anna	(AJ)	Trust Secretary
	McCorquodale, Christopher	(CMc)	Staff Governor
	Midlane, Eilish	(EM)	Chief Executive
	Monkhouse, Oonagh	(OM)	Director of Workforce and Organisational Development
	Palmer, Louise	(LP)	Assistant Director for Quality & Risk
	Raynes, Andy	(AR)	Director of Digital & Chief Information Officer
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
	Wilkinson, Ian	(IW)	Non-Executive Director
In attendance	Hales, Pippa	(PH)	Chief AHP
	Pieters, Thirza	(TP)	Consultant Liaison Psychiatrist
	Stephens, Teresa	(TS)	Executive Assistant (Minutes)
	Weldon, Caroline	(CW)	Matron
Apologies	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: <ul style="list-style-type: none"> Michael Blastland as Board member of the Winton Centre for Risk and Evidence Communication; as advisor to the Behavioural 		

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	<p>Change by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration, as a freelance writer and broadcaster. The Chair advised that he was Co-Chair on a review of impartiality of BBC coverage of taxation and public spending.</p> <ul style="list-style-type: none"> • 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. • Eilish Midlane as: Chair of C&P Diagnostic Steering Group; Holds an unpaid Executive Reviewer Role with CQC; as Director of CUHP; Voting Member of ICB. • Jag Ahluwalia as: Employee of 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. • 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 with 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 Screatton as a director of Cambridge Clinical Imaging and has shares in some biotech companies. • Richard Hodder as Deputy Chair, Clinical Policies Forum, NHS Cambridgeshire and Peterborough ICB. 		
3	<p>COMMITTEE MEMBER PRIORITIES</p> <ul style="list-style-type: none"> • None reported. 		
4	<p>MINUTES OF THE PREVIOUS MEETING – 29th September 2022 The minutes from the Quality and Risk Committee meeting dated 29th September 2022 were agreed to be a true and accurate record of the meeting and signed.</p>		
5	<p>MATTERS ARISING AND ACTION CHECKLIST PART 1 - from 29th September 2022 The Committee noted the pre-circulated document. Actions are on the agenda, for discussion at a future meeting, or closed.</p>		
6.	<p>WORKFORCE</p>		
6.1	<p>Workforce and OD Director Report – Quarterly Update on</p>		

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	<p>Compassionate and Collective Leadership Programme, including EDI and Health and Wellbeing</p> <p>OM led the Committee through the pre-circulated document, with points to note as follows:</p> <ul style="list-style-type: none"> • The Committee noted that attendance to Values and Behaviours Workshops is over 50% compliance, with HCS attendance rising to 71%, A&C to 61% and AHPs to 56%. Nursing staff attendance has also risen from the last reported position of 15% to over 44%. • Workshops planned until March 2023 and focus over Quarters 3 and 4 will be to continue to promote attendance. • The Committee noted the additional resource that has been put in place to progress work on the Fair Recruitment Report and recommendations. A focus in Q3 and 4 will be on relaunching the revised Appraisal Policy, with training and promotion in Q4. • The Transformational Reciprocal Mentoring for Inclusion Programme continues to receive excellent feedback from participants and the team is assessing the feasibility of running a second cohort. • The Committee noted that staff uptake for flu and Covid boosters was slower this year, which is mirrored in the community in general. • AF commended the work progressed so far and commented that she recognised the difficulties on delivering the programmes due to capacity and resilience. • The Chair advised that whilst attending a Black History Month event, he had a sense of increasing impatience that more should be done generally and nationally on recruitment and promotion. • MB: In that respect, are you beginning to think about more significant interventions on workforce? • OM advised on the importance of the appraisal process in providing a base. Additionally, the EDI team are looking at the detail in the recommendations set out in the Fair Recruitment Report. At present, it is felt that the Trust does not have enough evidence to support deciding which interventions would have the most impact. The team now has resource and capacity to undertake a diagnostic piece of work on understanding the recruitment processes being used and outcomes of selection processes for Bank 6 and above posts. The Committee also noted that the Trust is looking at other recruitment providers. 		
6.2	<p>PIPR People, Management and Culture M6</p> <p>The Committee noted the pre-circulated document, with discussion as follows:</p> <ul style="list-style-type: none"> • The Committee noted that turnover had increased significantly in September with 48 (44.4 WTE) leavers. • This month's report had a Spotlight On: long term sickness absence. The rate of long-term sickness has been consistently over the KPI for the last two years. The biggest proportion of absence in the last 12 months was due to mental health conditions and this continues on an upward trend. The other reason that is on an upward trend is 'other known causes – not elsewhere classified'. All other reasons are either on a downward trend or are static. • The Committee noted that Surgery, Transplant and Anaesthetics (STA) is the largest division and therefore the greatest proportion of 		

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	<p>long-term absence is in this division. The trend in this division is strongly upwards whilst for all other divisions/directorates the trend has been downwards or static. This could be multifaceted and the ongoing impact of the Covid-19 pandemic on staff in this area could be contributing to absence. Additionally, the Division as a whole has had staff survey results below the average for the Trust for the last two years, indicating lower levels of staff engagement.</p> <ul style="list-style-type: none"> • OM: Staff feel significantly under pressure, and when you're feeling under pressure your resistance is lower. • The Committee noted that Level 5 has a significant number of vacancies at present which is impacting on its pressures. • The Committee discussed staff stresses related to redeployment and noted that work, including advanced planning, secondments, mentoring and peer support is ongoing. • The Committee noted the current national pressures, including the possibility of industrial action. • The Committee acknowledged the national picture of staffing vacancies and absence within the NHS but asked whether the Trust could mobilise a different approach and ask staff in clear focus groups what would make them feel differently. • MS advised the practice of having a Duty Matron was being changed – this would allow matrons to be in their clinical areas more and therefore provide more support to their ward sisters and teams and ensure that improvement work is implemented. • JA: Have the majority of staff members who are on long term sickness been with the Trust for a longer time, eg over 10 years, or are they newer joiners? There may be different approaches needed for those who have been in the Trust for many years, rather than recently joined. OM advised that the data was not cut to be reviewed this way. • LP wondered whether facilitating coaches or mentors for some nurses would support resilience. • IS: I think it goes back to earlier conversations about recruitment and fairness and transparency and everyone feeling involved and included. Giving staff members the tools to do their job successfully would be a very valuable gift. • The Chair suggested that experience could be shared from areas that are doing extraordinarily well under difficult circumstances. • The Committee asked whether the Trust was confident in its current constraints and staffing situations and challenges and knew the optimum bed number for each area. • The Committee discussed and acknowledged the need for continued, ongoing forward planning and the national and regional ask in terms of additional surge capacity and requests from other Trusts to support. 		
7.1	QUALITY		
7.1.1	<p>QRMG and SIERP Key Highlights and Exception Report</p> <p>LP led the Committee through the pre-circulated document, with points to note as follows:</p> <ul style="list-style-type: none"> • There was one escalation from the recent SIERP meetings held since last reported to Quality & Risk Committee. A Serious Incident (SI) was declared SUI-WEB45103. A full investigation is underway. 		

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	<ul style="list-style-type: none"> • One escalation was also received from QRMG held in September as the above SI was reported to that meeting and is recorded in the pre-circulated report. • The Committee noted the Digital Clinical Safety Officers' Report for Q2 that develops the conversation between digital, quality and wards. • The Committee noted the lessons learnt regarding SUI-WEB 43470 regarding Cath Lab to CCA transfer on an empty O2 Cylinder and challenged the line under the Lessons Learnt section that due to the urgency of the procedure required, there was not trained anaesthetic assistant to support the anaesthetist. The procedure was not an emergency, so was there not time to get one in? • IW requested that abbreviations are not used in the executive summary and challenged whether the severity should have been higher. LP advised that the full report gave more detail. • LP advised that the full pre-circulated report in the reference pack outlines the incident more fully and that there had been full conversations regarding the lessons learnt. • The Committee noted and discussed SUI-WEB 43718 regarding surgical site infection. • JA: do we have an opportunity for external review of the SIs? • LP advised that the reports go to the Trust's commissioners who have individual panels to review and give scrutiny. The Committee also noted that the ICB has visited the Trust with a focus on particular SIs, • The Committee discussed the SSI rate and noted that there were no overall root causes to the Trust's increase and severity of SSIs that would have contributed to the overall SSI rate in year of 10%. • It was acknowledged that pre-operative risk factors such as diabetes and raised BMI were identified as a significant reason why patients were more like to have an increased risk of acquiring SSIs post-surgery. • The Committee noted that a comprehensive action plan was produced with actions monitored and escalated to Stakeholder and Response groups. • The Committee commended the depth and rigour of the review process that included examination of the patient pathway. • The Committee noted that the Trust also engages with Barts regarding collaborative work around SSIs. 		
7.1.2	<p>SUI WEB 43470 and SUI-WEB 43718 Final Reports and Action Plans</p> <p>The Committee noted the pre-circulated documents, with discussion above in agenda item 7.1.1.</p>		
7.1.3	<p>Serious Incident Executive Review Panel (SIERP) minutes (220913, 220920, 220927, 221004)</p> <p>The Committee noted the pre-circulated documents.</p>		
7.1.4	<p>Review of Psychological Medicine at RPH</p> <p>The Chair welcomed TP to the meeting, who led the Committee through the pre-circulated report with discussion as follows:</p> <ul style="list-style-type: none"> • The Committee noted that the Psychological Medicine team 		

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	<p>provides a valuable service to patients and services at the Trust and that provision of psychological support is part of service design and the Trust has commissioned psychological services from CPFT since 2014.</p> <ul style="list-style-type: none"> • The Committee recognised that there had been a significant increase in service growth across transplant, CF and critical care both nationally and at the Trust, and also acknowledged that the current service provision for nationally commissioned services falls short of the recommendations. • The Committee noted that resources in the Trust are less compared to other specialist services and was asked to offer guidance about the specification of the service that the Trust wants to deliver. • The Chair asked for information on outcomes where interventions had been possible and where they hadn't in order to understand what productive benefit can be delivered, but acknowledged the difficulties in sourcing this. TP advised that it would be challenging to extract specifically what the outcome of mental health input is within a patient's journey. • The Committee acknowledged the importance of the service and asked to be kept updated. 		
<p>7.1.5 7.1.5.1</p>	<p>Cover – AHP Strategy Update 2022 AHP Strategy Update 2022 The Chair welcomed PH to the meeting and noted the pre-circulated documents.</p>		
<p>7.1.6</p>	<p>Health Inequalities Presentation The presentation was deferred to a future meeting due to time constraints.</p>		
<p>7.2</p>	<p>PATIENT EXPERIENCE</p>		
<p>7.2.1</p>	<p>Patient Story The Chair welcomed Matron Caroline Weldon (CW) who gave a verbal patient story, with points to note as follows:</p> <ul style="list-style-type: none"> • The story concerns a patient who was in 3N, and CW was contacted to assist the patient in getting to the car park. • Whilst with the patient, they described the ward as like being in a Bupa hospital and was very complimentary of all of the staff who, they said, had been fantastic. The patient also complemented the environment and food. • The patient highlighted difficulties they had experienced with parking. They had arrived at the hospital in their own car but had been told by security that they could not park in the car park directly outside the hospital despite having a blue badge as parking was only permitted there for four hours. The patient was advised to park in car park 2. • However, once parked, the patient was unable to get to the hospital without assistance and due to being so breathless they were unable to walk far. A passer-by found the patient in distress and helped the patient by finding a wheelchair and pushing them to the hospital. • The patient told CW that now they had been discharged, staff had 		

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	<p>already contacted the porters to see if they could take them to the car park but they were only able to take the patient to the entrance of the hospital.</p> <ul style="list-style-type: none"> • The patient informed CW that if they'd have known they would have caused such a bother, they would have come by hospital transport. • The patient needed a bariatric wheelchair in order to get back to the car park and they were pushed by CW and a porter. The space between the lamp posts and greenery on the path to the car park entrance was narrow and the wheelchair could only just squeeze through the gap. • Once they'd arrived at the car park ticket office, it became apparent that the wheelchair was too big to fit through the ticket office doors and so the car park attendant had to come out of his office to stamp the patient's ticket in front of a number of hospital visitors, etc, – which the patient found embarrassing. • Then, it became apparent that the bariatric chair did not fit into the car park lift. Therefore, the patient had to stand up in the lift with CW (which they were able to do for a short period of time) and the porter had to tilt the chair on its side in order for it to fit into another lift. • CW then had to put the patient back into the wheelchair to find their car. Because the car was not on level 2 as originally thought – nor on level 3, the patient needed to follow the process above to get in and out of the lifts to look on different floors to find their car. Once the car had been found, CW and the porter made the patient comfortable in their car and they were able to drive away. • CW commented that this was a terrible experience for the patient who found it very embarrassing. • CW shared this patient experience with colleagues and the Head of Estates – and informed the Committee that the story highlights the difficulties that patients face when visiting the hospital if they have a disabled badge and need to stay for longer than 4 hours. • CW advised that she had organised for the patient to be allowed to park outside of the hospital in future for the duration needed. • AF: Caroline, thank you for being there for him and illuminating this issue with the meeting. • The Committee expressed surprise that the issue had not been raised before. • EM advised that a charity called Access Able had undertaken a complete assessment of the hospital before it opened and that she was unsure why a bariatric chair wouldn't have been included in the assessment. • RH advised that he would like to raise this story's concerns at the next PPI Committee and invited CW to share the story there. • IS thanked CW for the story and for her public service and advised the Committee that the Trust's entry in the national directory of sleep centres regarded 'terrible parking'. • LP advised that it should be possible to get an annual review from Access Able that includes bariatric wheelchairs and other issues that have been raised. • JA suggested that the Trust also consider technical solutions with car park providers regarding car location services, automatic number plate recognition, etc. 		

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	<ul style="list-style-type: none"> EM to discuss options with Estates and give feedback on issues raised to next meeting. 	EM	11/22
7.2.2	Minutes of Patient and Carer Experience Group 220606 The Committee noted the pre-circulated document.		
7.3	PERFORMANCE		
7.3.1 7.3.1.1	Performance Reporting/Quality Dashboard PIPR Safe – M6 The Committee noted the pre-circulated document, with discussion as follows: <ul style="list-style-type: none"> The meeting noted that the Chair of Performance Committee had commented on safer staffing at the meeting on the morning of 27th October, and the Chair of that meeting’s ambition to have a reliable indicator regarding safer staffing. MS advised that the actual and the demand are closely aligned except for Critical Care, data for which is nuanced. Census data is collected three times a day, broken down into eight hours, but Critical Care actually has thirty-six hours in their day, which is why there is greater difference between actual and demand. The Committee noted that staff in Critical Care are being redeployed which also affects the data. MS cautioned that whilst the data looks as if demand and actual are aligned, that is not how it might feel on the wards, partly due to the difference in the skill mix and some redeployments. MS advised that she was working with the Deputy Chief Nurse on the Trust’s suite of metrics around safer staffing and how it is triangulated and reported. The Committee noted the slide on VTE and that CDC is supportive to having speciality Consultant Champions. 		
7.2.1.2	PIPR Caring – M5 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. <ul style="list-style-type: none"> The Chair requested that the next in-depth focus should be on SSIs. 	AJ/MS	12/22
8.2	Emerging risks There were none to report.		
9.	GOVERNANCE AND COMPLIANCE		
9.1	SIRO Report Q2 22/23 AR led the Committee through the pre-circulated report, with points to note as follows: <ul style="list-style-type: none"> The Committee noted that there were fifty-four information governance related risks recorded on Datix for Q2, with the primary cause being multiple incidents being recorded by the Health Records Department, who have seen an increase in CAFs being returned to the department containing documents pertaining to more 		

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	<p>than one patient. AR advised of a recent incident concerning data sent in a miscommunicated email and the lessons learnt that can be shared.</p> <ul style="list-style-type: none"> • The Committee asked whether there was a correlation between the rise in incidents and the turnover/shortage of administrative staff, and noted that this, together with long term sickness could be a contributing factor. • The Committee acknowledged that reporting has also increased in general in Q2 and that if overall instance of reporting had increased then that would also be a contributing factor. Would it be worth having a deep-dive and compare data to pre-pandemic? • AR advised that the investigation of the recent incident was ongoing and that Digital are reviewing the general increase in Q2 in more detail. EM advised that she had seen charts in other meetings highlighting a similar pattern of pressures in recent months in different areas of the Trust. • The Committee noted the Cyber summary and that the Trust had a vacancy for a Cyber Analyst, which is a highly paid role outside of the NHS. The role is currently filled by an agency member of staff. • The Committee noted the document control compliance and noted that 32% of the Trust's documents are out of date. • The Committee challenged the high non-compliance and noted that the Trust is addressing this issue. 		
<p>9.2 9.2.1</p>	<p>Workforce Agenda Management Appendix 1: TOR xxx Workforce Committee Appendix 2: 221021 Trust Governance Structure</p> <p>The Committee noted the pre-circulated documents, with discussion as follows:</p> <ul style="list-style-type: none"> • The Committee noted that following the October Quality & Risk Committee, further discussion and review had taken place regarding the proposed frequency of Quality & Risk Committee meetings. • The Committee discussed whether the Committee should continue to meet monthly due to the number of quality issues that the Trust is currently facing and the importance of giving pressing issues sufficient scrutiny. • The Committee agreed that workforce was integral to quality and safety and deserves sufficient time for discussion and therefore should have stand-alone monthly committee meetings. • AJ advised that the Performance Committee had discussed the possibility of Workforce Committee meeting alternately with SPC. • The Committee noted that workforce issues would still be discussed monthly in Performance and Quality & Risk Committees through PIPR. • The Committee agreed to recommend to Board that a separate Workforce Committee should be created to meet alternately with SPC, and that Quality & Risk Committee continues to meet monthly and is not reduced in time. 		
<p>9.3</p>	<p>Internal Audits: There were none to report.</p>		
<p>9.4</p>	<p>External Audits/Assessment:</p>		

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	There were none to report.		
10	POLICIES		
10.1	Cover – DN807 RTT Harm Review Quality Assurance Policy		
	<ul style="list-style-type: none"> The Committee noted the pre-circulated document. 		
10.1.1	DN807 RTT Harm Review Quality Assurance Policy		
	<ul style="list-style-type: none"> The Committee discussed but did not ratify the policy. The Chair to further review the policy and discuss with LP offline. 	MB	11/22
11	RESEARCH AND EDUCATION		
11.1	Research		
11.1.1	Minutes of Research & Development Directorate Meeting (220708)		
	<ul style="list-style-type: none"> None available 		
11.2	Education:		
11.2.1	Education Steering Group minutes		
	None available.		
12	OTHER REPORTING COMMITTEES		
12.1	Escalation from Clinical Professional Advisory Committee (CPAC)		
	<ul style="list-style-type: none"> No escalation from October CPAC meeting. 		
12.2	Minutes from Clinical Professional Advisory Committee (220922)		
	<ul style="list-style-type: none"> The Committee noted the pre-circulate document. 		
13	ISSUES FOR ESCALATION		
13.1	Audit Committee		
	<ul style="list-style-type: none"> There were no issues for escalation from Part 1. 		
13.2	Board of Directors		
	<ul style="list-style-type: none"> There were no issues for escalation from Part 1. 		
14	ANY OTHER BUSINESS		
	<ul style="list-style-type: none"> None. 		
	Date & Time of Next Meeting:		
	Thursday 24th November 2022 at 2.00-4.00 pm, via Microsoft Teams		



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Signed

24th November 2022

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Date

**Royal Papworth Hospital NHS Foundation Trust
Quality & Risk Committee**