Royal Papworth Hospital NHS Foundation Trust

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This Document Supports: *standards and legislation – include exact details of any CQC*	Care Quality Commission (CQC) regulations
Key Associated Documents:	DN665 Patient Safety Incident Response Policy DN153 Duty of Candour and Being Open Policy DN195 Complaints Policy DN139 Risk Management Strategy DN290 Risk Assessment Procedure
Keywords	Patient safety, Incident, investigations, learning responses, PSIRF

Version Control table

Date Ratified	Version Number	Status
23/08/2023 30/08/2023 31/08/2023 07/09/2023	V 1.0	QRMG (Chair Approval) Management Executive Approval Quality and Risk (Q&R) Committee Trust Board
11/03/2025 27/03/2025	V 2.0	QRMG (Approved) Quality and Risk (Q&R) Committee (ratified)

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1.0	**INTRODUCTION (INCLUDING PURPOSE OF DOCUMENT)**
1.1	This patient safety incident response plan sets out how Royal Papworth Hospital Foundation Trust intends to respond to patient safety incidents commencing from April 2025 until March 2026. The plan is designed to be flexible and responsive to allow consideration for unforeseen circumstances or events that may trigger the need for a specific learning response approach. Our plan will always keep those who are affected by a patient safety event at the heart of our learning and improvement.
1.2	The patient safety incident response plan is supported by Trust policies on incident reporting, responding to patient complaints, risk management and being open and is governed by the clinical governance structure from Ward to Board. Summaries of learning responses in the form of a Learning Bite are available to all staff via our organisation's intranet. The Royal Papworth Patient Safety Incident Response Policy (DN665) should be referred to support the delivery of this plan for pathways for escalation, methods of review, safety action development, safety improvement plans and monitoring improvement.
1.3	This annual plan is a 'live document' with the scope to adapt the use of the learning response tools. It is recognised that there is no 'one size fits all' and each safety incident will be approached according to the circumstances of the occurrence and needs of those involved in order to be proportionate, effective and to maximise learning and improvement opportunities. The patient safety incident response plan is subject to an annual review to ensure our focus remains relevant, appropriately focused and effective. It must factor in ongoing improvement work and recognise our patient safety incident profile is likely to change with the health economy and external drivers. This flexibility will also provide an opportunity to re-engage with stakeholders to discuss and agree changes needed.
2.0	**OUR SERVICES**
2.1	Royal Papworth Hospital (RPH) is a regional centre for the diagnosis and treatment of cardiothoracic disease. It is also a national centre for a range of specialist services, including heart and lung transplantation, pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.
2.2	The Trust moved to its new building on the Cambridge Biomedical Campus in May 2019. The hospital encompasses 246 beds, six operating theatres, six cardiac catheterisation labs and two bronchoscopy rooms. In addition, in April 2022, the Heart & Lung Research Institute (HLRI) opened which houses University of Cambridge (UoC) research laboratories, and a Clinical Research Facility.

3.0	DEFINING OUR PATIENT SAFETY INCIDENT PROFILE
3.1	The Trust first implemented Patient Safety Incident Response Framework (PSIRF) in January 2024, this is our second annual plan. The 2025/2026 plan provides a continuation from the safety incident profile identified in the data capture of the 2024/2025 initial 18-month plan, that first went live in January 2024. **Our first year plan identified 5 key focus areas:** 1. Recognised but unintended outcome of treatment or procedure -with adverse consequences e.g. • Misplacement of central venous catheter, • Hospital acquired infections, • Surgical site Infections (SSI's) • Deteriorating patient. 2. Identified Implementation of care or treatment issues within the patient pathway e.g. • -Referral process • -Appointment delays, cancellations • -Access issues (falling outside of Referral to Treatment (RTT) and Harm review) • -Admission, diagnostic errors, or safety incidents relating to patient transfer or discharge (internal or externally). 3. Medication safety incident e.g. omission of critical medication, prescribing, or administration. 4. Unwitnessed falls resulting in fracture or haemorrhage 5. Hospital Acquired pressure ulcers category 3, 4 or unstageable (including medical device related The Five identified key priorities in 2024/25, although broad were able to provide a framework for the first year on areas that we would focus on as part of our plan. Alongside, this we have reflected on the actions taken, learning that has occurred from implementation of this first year's plan and considered what has changed with the governance and oversight of some of the areas detailed in the year 1 plan for patient safety improvement that have since been embedded changes as business as usual. This has helped provided a steer on our opportunities to improve what we focus on for the next year plan for 2025/26. Detailed in the next section is a further focus on the data and processes reviewed to develop our year 2 plan.

3.2	The data reviewed for the 2025-2026 plan included information that was gathered from the Trust Datix incident reporting system for the period between April 2020 – December 2024 (3 years 9 months). This data range includes the period of service delivery changes during and after the COVID 19 pandemic. Within the preparation for the plan, we have considered the themes from the learning responses during year one of PSIRF implementation period, mapping of incidents with current Trust improvement priority works streams, key priorities from the Trust's preceding annual reports and quality accounts. This has provided a broad range of context. The top local patient safety risks from the Trust risk register have been considered, alongside all incidents that are reported to identify opportunities for learning and improvement using the following criteria for the review: **The potential for harm** • People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage. **The likelihood of occurrence** • Persistence of the risk • Frequency • The potential for escalation/deterioration.
3.3	**Key identified areas from the data period April 2020- December 2024 review:** Trust's patient safety incident profile is represented below. The data set reviewed included all patient safety incident and organisational incidents that had or could have led to patient harm, within this data period there were a total of 14647 incidents reported that were related to patient safety using the criteria of potential for harm and likelihood of occurrence as described in 3.2 above. From this review the most significant six types of incidents were identified and subject to a further deep dive.

3.4 The Trust incident profile analysis of the six significant safety incident types is summarised below in Table 1.

Table 1-top incident types identified related to patient safety from Datix from April 2020- December 2024.

Incident categories	No Harm (inc near misses)	Low	Moderate	Severe	Fatal	Total
Medication (Overall Total)	**1855**	**281**	**6**	**1**	**1**	**2144**
Prescribing	433	85	2	0	0	520
Preparation of Medicine/Dispensing	167	14	0	0	0	181
Monitoring	76	31	2	0	0	109
Administration	991	112	2	1	0	1107
Advice	30	7	0	0	0	37
Adverse reaction	10	20	0	0	1	31
Other Medication incidents e.g. includes documentation, storage, patients own drugs	188	12	0	0	0	200
Pressure ulcers (Overall Total)	**23**	**1354**	**6**	**1**	**0**	**1385**
MASD-	4	469	1	0	0	474
Device related injury	1	335	1	0	0	337
Category 1	4	194	0	0	0	198
Category 2	2	56	0	0	0	58
Category 3	0	1	4	0	0	5
Category 4	0	0	0	1	0	1
Other skin injury e.g skin tears,	12	299	2	0	0	312
Accidents (Overall Total)	**582**	**360**	**21**	**0**	**0**	**963**
Patient Falls	516	263	19	0	0	802
Medical Devices (Overall Total)	**785**	**264**	**5**	**0**	**1**	**1055**
Device unavailable	261	42	0	0	0	303
Device malfunction	273	92	3	0	1	368
Assembly/user error	140	32	1	0	0	173
Other e.g. includes product damaged, decontamination/ storage, additional instrument in pack/missing instrument	111	98	1	0	0	210
Implementation of care or treatment within the patient pathway	**1290**	**445**	**6**	**8**	**0**	**1749**
Admission	186	50	0	0	0	236
Appointment/follow up/ waiting list	144	80	1	3	0	228
Discharge	196	54	1	1	0	252
Transfer	189	91	1	1	0	282
Referral	117	23	0	0	0	140
Laboratory diagnosis	153	26	0	0	0	179
Investigation incorrect/not performed	68	21	1	1	0	91
Delayed/missed diagnosis	39	13	2	1	0	53
	198	87	0	0	0	285

	Other pathway/diagnostic e.g. includes, investigation delayed, monitoring not completed correctly/delayed/ECMO pathway						
	Unintended outcome treatment or condition (Overall Total)	**1038**	**601**	**44**	**11**	**1**	**1654**
	Category -Treatment/ procedure **Subcategories**						
	- Infusion injury	12	104	0	0	0	116
	- Treatment/procedure delayed	257	26	1	0	0	284
	- Other treatment procedure- includes complication, sudden cardiac arrest, arterial puncture, amputation, haemorrhage,	286	233	11	8	0	537
	- Treatment process Incomplete/incorrectly (including patient monitoring) performed	79	33	10	1	0	123
	- Incorrect/insufficient Planning/preparation	41	16	0	0	0	57
	- Treatment/Procedure not performed	39	9	0	0	0	48
	- Wrong treatment/procedure	23	8	1	0	0	32
	- Retention of a foreign object						
	- Missing object (needle/swab/Instrument etc)	6	1	1	0	1	9
	-Lower number categories (including unintended injury during treatment, escalation of care, extended stay, unplanned return to theatre, arterial sheath removal, hypoxic brain injury)	22 273	2 169	0 20	0 2	0 0	24 444
							Total 8950

Table 1: Datix Incidents by date of reported April 2020- December 2024

3.5 **Summary and analysis of the six significant safety incident types:**

Medication Safety

Medicines are the most common interventions in the NHS, it is logical that incidents relating to medication are consistently within the highest reported categories for the Trust. Reporting no and low harm incidents is actively encouraged through the medication safety group and promotes identification of opportunities for learning and improvement.

In 2024 a focused review and scoping exercise using the Systems Engineering Initiative for Patient Safety framework was undertaken, exploring work as done within medication processes and the influences of and wider task and system factors. In 2025 we will continue to build on the findings from this and apply the same methodology to gather insight and understanding of factors in prescribing and preparing/dispensing incidents to better understand how our medication processes fit with technology and the hospital environment.

Pressure Ulcers
The Trust has an established process for review and scrutiny of pressure ulcers and pressure ulcer prevention improvement work is part of the tissue viability team core workplan, overseen by the Harm Free Care Panel. The data has shown low incidences of Trust acquired pressure ulcers. For 2025-2026 the Trust will continue to monitor patient harm and potential risk via Harm Free Care, the Trust Quality and Risk Report. Pressure Ulcer prevention will not be part of the focus of the 2025-2026 Patient Safety Incident Response Plan.

Patient Falls
The incidence of patient falls has seen a reduction in the last year. Learning from falls, themes and systems reviews are shared at the Trust falls prevention group. This groups have initiated improvement work, and task and finish groups to continue to the reduction in patient falls. Unwitnessed falls remains a focus for the group. For 2025-2026 the Trust will continue to monitor patient harm and potential risk via Harm Free Care, the Trust Integrated Performance Report and Trust Quality and risk Report. Patient falls unless a new risk is identified will not be part of the focus of the 2025-2026 Patient Safety Incident Response Plan.

Medical Device related incidents
Medical device incidents pose a significant risk to patient safety. Although these have been largely reported as no or low harm, over the data capture period there was one fatality and 5 incidents where moderate harm occurred. For that reason these were highlighted and subject to further analysis. During 2024-2025 risk management of medical devices has strengthened and the medical device committee provide scrutiny further against the risks with the Medical Device Safety Officer and deputy support the committee and with oversight of the potential harm and a direct link to safety and governance. Medical device related incidents, unless a new risk is identified will not be part of the focus of the 2025-2026 Patient Safety Incident Response Plan.

Identified Implementation of care or treatment issues within the patient pathway.
This incident type encompasses critical steps along the patient journey, from referral to discharge. Each step has the potential for harm, and incidents are often complex, multi-speciality and involving several providers. The volume reported is large and analysis was undertaken to identify the areas of most risk. These are within our referral pathways, capacity and waiting lists. Individual speciality led workstreams are in place in many areas and through the Patient Safety Incident Response Plan further system analysis will support change and improvement. During 2024 we undertook thematic PSII focussing on our TAVI service. The learning from this is being taken forward as an improvement workstream. The value of applying safety system analysis methodology to other services has been recognised and will be continued as a focus in specific the 2025-2026 plan.

Recognised and unintended outcome of treatment or procedure.
This is a broad type of safety incident which includes known complications of critical clinical conditions, high risk treatment and procedures. Some of which were found to be unavoidable and could be considered under LFPSE an ‘outcome event’. Analysis of these incidents has however, identified areas where we could do better. Reporting of

	these types of incidents is encouraged in conjunction with the morbity and mortality review process clinical audit and outcome measures to identify areas for improvement and learning. A recurrent theme idenfied from learning responses completed in 2024 has been how we monitor and respond to signs of clinical deterioration in patients. Improvement work is continuing through a focused task and finish group. This category will remain in the plan for 2025-2026.
4.0	**OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS**
4.1	Our plan will build on the themes identified in 2024/2025 and continue to embed the principles of PSIRF within the Trust. We will continue to review how we use the learning response methodology for our identified safety incident profile and measure the effectiveness of these within the delivery of the Trust safety improvement plans. Table 2 lays out the 3 focus areas for 2025/2026 and the approach the Trust proposes to take. 1). Medication safety incidents-with a focus on Medication administration. 2). Unintended outcome of treatment or procedure, where there has been a delay in recognition of or escalation of a change in patient condition. 3). Patient pathway issues- Where harm or potential for harm may occur due to the unavailability of appointments and waiting lists.
4.2	Table 2 below lays out the three priorities for 2025/26 PSIRF plan: **Priority 1: Medication**

Patient safety incident type and examples	Planned response	Anticipated improvement route and resourcing
Medication safety incidents. **Examples are:** **Prescribing, preparation/dispensing and administration.**	Administration errors form the largest proportion of reported medication incidents. In 2025 we will continue to build on 2024 learning and carry through to practice via Trust wide improvement project. Applying the same scoping exercise to prescribing and preparation of medicines. Cases where significant risk or avoidable harm is suspected the following responses will be considered: **Tools available** Hot Debrief or After-Action Review (AAR) Gap Analysis completed to determine if events are within the scope of the improvement work. This may include observations of work as done using SEIPS model and whole systems analysis. Consideration of PSII if a previously unknown factor has been identified or current actions do not provide mitigation.	Through Specific Medication Administration Task and finish groups. Overseen by Trust Medication Safety Committee and the Trust Quality and Risk Management Group (QRMG). Outcome from learning response to feed into the Divisional Safety Improvement Plan. Trust Medicines Safety Improvement plan and overall monitored and supported by QRMG.

Priority 2: Unintended outcome of treatment or procedure, where there has been a delay in recognition of or escalation of a change in patient condition.

Patient safety incident type and examples	Planned response	Anticipated improvement route and resourcing
Unintended outcome of treatment or procedure, where there has been a delay in recognition of or escalation of a change in patient condition. Examples are: Inadvertent arterial puncture Unplanned sternotomy Pseudoaneurysm requiring surgical repair Surgical Site infections Unexpected deterioration of patient clinical condition.	The Trust has robust process of reviewing treatment and procedure events through Morbidity and Mortality meetings. Cases where significant risk or avoidable harm is suspected the following responses will be considered: Hot Debrief or After Action Review as soon as incident occurs. Initial review via gap analysis to determine if events fall outside of what was a possible outcome for an individual patient condition. Observations of work as done using SEIPS model and whole system analysis within a clinical review tool. Round Table (MDT) Review with key stakeholders Patient Safety Incident Investigation (PSII) if a new risk to patients or current actions do not provide mitigation.	Reviewed through Speciality Morbidity and Mortality meetings. Oversight by Deteriorating Patient Group and ALERT steering Group Outcome from above learning response to feed into the Divisional Safety Improvement Plan, and Trust improvement plan. Overseen by QRMG.

Priority 3: Patient pathway issues- Where harm or potential for harm may occur due to the unavailability of appointments and waiting lists.

Patient safety incident type and examples	Planned response	Anticipated improvement route and resourcing
Patient pathway issues- Where harm or potential for harm may occur due to the unavailability of appointments and waiting lists. **Examples are:** Referral process Appointment delays, cancellations Access issues (falling outside of Referral to Treatment (RTT) and Harm review) Admission, diagnostic errors, or safety incidents relating to patient transfer or discharge (internal or externally)	The Trust recognises the impact the expanding patient population and referral base has on patient safety. In conjunction with the existing Trust wide demand and capacity initiatives the following responses will be considered: Initial review via gap analysis to determine if events fall short of what was expected for that individual patient. Observations of work as done using SEIPS model and whole system analysis within a clinical review tool. Themed reviews, Patient Safety Incident Investigation (PSII) Escalation if Patient Safety Investigator (PSI) or lead has identified a new risk to patients or current actions do not provide mitigation.	Initiation of a Trust oversight group for pathway improvement work. Consideration of improvement work on patient flow, referral pathways and theatre prioritisation. Outcome from above learning response to feed into the Divisional Safety Improvement Plan or Trust improvement plan, overseen by QRMG. Consideration of cross- organisation or system wide incident response.

5.0	**LOCAL FOCUS CONTINUOUS IMPROVEMENT**
5.1	The patient safety incident response plan does not diminish existing work plans for current groups. The tools outlined in the PSIRF Policy (DN665) can be used to further strengthen the improvement profile, such as embedding the use of thematic reviews of past learning responses to inform the development of their safety improvement plan, or alternatively, a 'horizon scan' may be useful where pathway issues are identified or predicted regardless of whether or not an incident has occurred.
5.2	The Trust will focus is on the continued development of safety improvement plans across our most significant incident types. We will remain responsive and consider improvement planning as required where a risk or patient safety issue emerge from our own ongoing internal or external insights.
5.3	Clinical quality and risk assurance is monitored through an established governance structure. When a new clinical oversight or improvement group is formed, this will be under the umbrella of this governance structure with clear terms of reference and reporting format. These groups are responsive and driven by the recognition of emerging risks and are flexible to ensure we are continuously monitoring and learning. All patient safety workstreams report into the Trust Quality and Risk Management Group (QRMG), through the internal structure to Trust Board.
6.0	**OUR PATIENT SAFTY RESPONSE PLAN: NATIONAL REQUIRMENTS**
6.1	Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII. These are laid out in the Trust's Patient Safety Incident Response Policy (DN665) section 16.
7.0	**ENGAGING AND INVOLVING PATIENTS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY INCIDENT**
7.1	The NHS PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. Our patient safety incident response plan encourages the development of an effective Trust wide patient safety incident response system that prioritises compassionate involvement of patients and /or their families.
	We endeavour to involve those affected in a meaningful way and ensure the standards laid out in both DN665 Patient Safety Incident Response Framework (PSIRF) Policy and DN153 Duty of Candour and Being Open Policy are followed.

7.2	Psychological safety and wellbeing of staff involved with a safety event is integral to our learning and to upholding our Trust Values. When a safety event is identified the Trust will ensure staff are treated fairly and compassionately, with signposting to support during the process.
8.0	**IMPLEMENTING OUR PLAN AND RESPONDING TO CROSS-SYSTEM SAFETY INCIDENTS**
8.1	We recognise that patient safety incidents can often be complex and involve a number of organisations. When this occurs the clinical governance team will ensure appropriate cross system or partnership engagement and that the relevant organisations are identified and information is shared, with partnership colleagues engaged in investigations and learning as required.
8.2	The agreed learning response and duty of candour will be led by the organisation best placed to investigate the concerns and may depend on capability, capacity, or remit. For further details of how we will achieve cross-system engagement and learning see section 15 in DN665 Patient safety incident response Framework (PSIRF).
8.3	System learning across the Cambridgeshire and Peterborough Integrated Care System (ICS) is overseen by the Integrated Board and this will be facilitated through the locally run Community of Practice forum, which is attended by each Trust named Patient Safety Specialist or senior leads. Royal Papworth Hospital also covers other Integrated Care System as part of the work they are commissioned to provide, where incidents link to other ICS this will be also locally agreed with the relevant ICS lead and cross learning shared and agreed.
9.0	**OVERSEEING CONTINUOUS IMPROVEMENT THROUGH OUR DEVELPOMENT OF OUR ANNUAL PLAN**
9.1	The collection of information and insights from learning responses is only part of the safety improvement journey. We must move from identifying the learning to the implementation of the lessons learned and recommendations for change. The Divisional teams will hold recommendations from learning responses and have responsibility to turn these into opportunities for improvement. This may be via specific actions and/or service/system developments or via workstream that has oversight of improvements. Where there are Trust wide themes and commonalities in learning and recommendation, a Trust improvement plan will be initiated. These are key steps in our approach to continuous quality improvement of our care and safety for patients.
9.2	Delivery of these improvement plans will continue to be monitored by the Trust Quality Risk Management Group (QRMG) via their respective specialist subgroup with executive oversight by Quality and Risk Committee to Board.

Monitoring Table

What key element(s) need(s) monitoring as per local approved policy/ procedure or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others.	What tool will be used to monitor/check/ observe/assess/ inspect/ authenticate that everything is working according to this key element from the approved policy/ procedure?	How often is the need to monitor each element? How often is the need complete a report? How often is the need to share the report?	Who or what committee will the completed report goes to. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?	How will system or practice changes be implemented the lessons learned and how will these be shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
Annual Evaluation of PSIRF plan	***Clinical Governance Team***	***Audit of Learning Responses***	*Annual*	*QRMG*	*QRMG who will report to Q&R Committee*	**Required changes to practice will be identified & actioned within a specific time frame. A lead member of the team will be identified to take each change forward. Lessons will be shared with all the relevant stakeholders.*

Rapid Equality Impact Assessment Tool

When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:
In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

EQUALITY IMPACT ASSESSMENT – WHAT IS THE IMPACT TO DIFFERENT GROUPS IN SOCIETY?		
If you believe there has been No impact or a Positive impact, please choose Yes for Negative impact please choose No. Please provide supporting comments, both on positive and negative impacts. You may be asked to complete a FULL EQUALITY IMPACT ASSESSMENT to understand the impact further.		**COMMENTS**
Age: Consider and detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.	Yes	
Disability: Consider and detail on attitudinal, physical and social barriers.	Yes.	
Race: Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.	Yes	
Sex: Consider and detail on men and women	Yes	
Gender reassignment: (including transgender) Consider and detail on transgender and transsexual people. This can include issues such as privacy of data and harassment	Yes	
Sexual orientation: Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people.	Yes	
Religion or belief: Consider and detail on people with different religions, beliefs or no belief.	Yes	
Pregnancy and maternity: Consider and detail on working arrangements, part-time working, and infant caring responsibilities.	Yes	
Marriage and civil partnership status	Yes	
Environment: Consider impact on transport, energy and waste	Yes	
Other identified groups: Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.	Yes	
Were any NEGATIVE impacts identified?	No	
If YES, you will need to complete a full Equality Impact Assessment. Please contact the Equality, Diversity and Inclusion team papworth.edi@nhs.net for the full assessment template.		

Royal Papworth Hospital
NHS Foundation Trust

Audit Committee
Part 1 meeting
Held on 23 January 2025
0930-1100hrs

via MS Teams
[Chair: Cynthia Conquest, Non-executive Director]

Unconfirmed **M I N U T E S**

Present		
Mr M Blastland	MB	Non-executive Director
Mrs C Conquest (Chair)	CC	Non-executive Director
Ms D Leacock	DL	Non-executive Director
In attendance		
Mr Saqhib Ali	SA	Chair ICB Audit Committee
Ms V Bush	VB	Public Governor (Observer)
Mrs A Colling	AC	Executive Assistant *(minutes)*
Mr M Evans	ME	Local Counter Fraud, BDO
Mrs S Harrison	SH	Chief Finance Officer (Interim)
Ms E Larcombe	EL	KPMG External Auditors
Ms A Mason-Bell	AMB	BDO, Internal Auditors
Mr K Mensa-Bonsu	KMB	Associate Director of Corporate Governance
Mr H McEnroe	HMc	Chief Operating Officer
Mrs E Midlane	EM	Chief Executive
Mrs O Monkhouse	OM	Director of Workforce & Organisation Dev *(to 11am)*
Mr A Nyama	AN	Deputy Chief Finance Officer (Interim)
Mrs L Palmer	LP	Assistant Director of Quality & Risk
Dr H Perkins	HP	Public Governor (Observer)
Mr A Raynes	AR	Director of Digital/CIO
Mr J Shortall	JS	Local Counter Fraud, BDO
Dr I Smith	IS	Medical Director
Mr A Winter	AW	BDO, Internal Auditors
Apologies		
Mrs M Screaton	MS	Chief Nurse

The minutes are noted as per order of discussion, which may differ from Agenda order.

Agenda Item		Action by Whom	Date by When
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
25/01	The Chair opened the meeting, and apologies were noted as above. The Committee welcomed SA to the meeting.		
2	**DECLARATIONS OF INTEREST**		
25/02	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests are appended to these minutes.		

Agenda Item		Action by Whom	Date by When
3	**MINUTES OF MEETING held on 17 October & 26 November 2024**		
25/03	**Approved**: The Audit Committee approved the Minutes of the meeting held on 17 October and 26 November 2024 and authorised these for signature by the Chair as a true record.	Chair	23.01.25
4a	**ACTION CHECKLIST**		
25/04	The Committee reviewed the Action Checklist and updates were noted. The following assurance was noted on closed actions. Ref: 24/108 Raising Issues of Concern: In previous discussions it was noted that the Trust is using software to make reporting more anonymised. DL and OM had met with the Freedom to Speak Up Guardian on 12 December to discuss further, following which DL was happy to close the action. Ref. 24/142 Internal Audit Feedback Survey: BDO had advised that there was a low return rate on the survey. This had been discussed by Executives where SH assured the Committee that updates are being closed down in a timely way, along with a reminder to complete feedback surveys. Action closed.		
4b	**THE ROLE OF TRUSTS AND ICB AUDIT COMMITTEES**		
25/05	**Received:** Verbal update from Saqhib Ali, ICB Audit Chair. **Reported:** SA gave an insight into his current roles: ➢ Audit Chair for the Cambridgeshire & Peterborough ICB; he has been in this role for two and a half years. ➢ Audit Chair at Buckinghamshire, Oxfordshire & Berkshire West ICB. ➢ NED at Queen Elizabeth & King's Lynn which feeds work into our local ICB and CUH. ➢ Due to start a NED role at Norfolk & Suffolk NHS FT. During discussion, SA highlighted the following areas: • Added value in understanding what we are doing, how the ICB is delivering, linking into Lord Darzi report, particularly on digital issues and prevention. • How the ICB deals with issues with patients in different Trust boundaries. • Fits well with working collaboratively with internal and external auditors. Helps learning across different patches. • Some areas to work more closely together at ICB and provider level: cyber, BAF, etc.. • Third sector (partnerships and charities) and greater system working and integration. • Keen to see reaching harder to reach groups (ethnicity, travellers, migrants). • SA referred to the fourth limb (sometimes forgotten) of the ICB, being economic development, and is keen to see further progress in this area. He is hoping to see another coming together of audit chairs at ICB in forthcoming weeks with specialist speakers invited.		

Agenda Item		Action by Whom	Date by When
	Discussion: CC thanked SA for attending the meeting today and giving an insight into his roles. She would welcome the opportunity to meet with other audit chairs at a forthcoming ICB meeting. During discussion the following areas were noted: • Direction of travel of ICB relating to strategic objectives and collaborations. • Cyber security and shared care records across the system. • Collaborative working with the many NEDs across the region and working to a unified approach. • Ongoing dialogue with CEOs for organisations to step up and take forward issues on behalf of the whole system. **Noted:** The Audit Committee noted the verbal discussions.		
5.1	**BOARD ASSURANCE FRAMEWORK (BAF)**		
25/06	**Received:** Assurance around the operation of the Board Assurance Framework (BAF) since the last report in October 2024. • Appendix 1 – Cyber Security Risk (BAF 1021) – Assurance Update • Appendix 2 – December 2024 BAF Tracker Report • Appendix 3 – December 2024 BAF Report **Reported:** KMB The report was taken as read. **Discussed:** CC requested that Appendix 3 be saved to the Reference Pack for future meetings. CC referred to Risk 3536 and comments at other Committees suggesting that 9 was too low an assessment; she felt it should be noted that this discussion had taken place. She asked for the risk to be adjusted sooner rather than later. AR confirmed that action has been taken, and the risk has been increased from 9 to 16. CC – Typo noted on page 22, where 'July' update should say 'October 2024'. KMB to adjust. CC referred to Risk 678 for Waiting List Management which is reported as 'no change since Sept 2024'; this has been discussed at Performance Committee in October and November; therefore, CC was surprised that there is no update on this. HMc noted there has been conversation at Board for a full review of this to report to Performance Committee in February, then to March Board. This will provide an update in line with the 21 new national priorities. CC was expecting for risks 20+ on the BAF, to see an update in the paper not just a verbal update at the meeting. It is important to see the assurance that these are being progressed and included in the paper. MB referred to risk 3223, Activity, Recovery & Productivity: there is a large gap between target and current status. He asked if current plans	KMB KMB	13.03.25 13.03.25

Agenda Item		Action by Whom	Date by When
	are ever going to enable us to meet these targets set? It is hard to see how productivity efforts are going to achieve reductions implied in BAF. He cannot see how current practice can reduce the risk to 8 as noted. For assurance, he asked to see the thinking behind this and articulated in the report on current risks and targets. OM asked for clarity on reporting requirements for risks 20+: is a separate report being asked for these? CC clarified that she could see that OM risks are updated correctly, and separate reports are not required. The query refers to risks for cyber security and waiting list management where assurance is not being reflected in the report. EM – suggested that owners of risks 20+ supply KMB with a summary update to include in BAF report. HMc explained that the RTT space narratives speaks to what is being done. We now have to pivot on these to meet new national expectations on productivity and elective standards, which is still work in hand. MB felt that these were pressing questions and a need to understand how they are presented to NEDS. Again, he questioned whether our actions are sufficient as this is where the difference between target and achievement is striking. This needs to be acknowledged with this report. **Noted:** The Audit Committee noted the Board Assurance Framework.	HMc NEDs/ HMc, KMB	13.03.25 13.03.25
6	**GOVERNANCE ASSURANCE OVERVIEW**		
6.1	**Chair's Reports**		
25/07	**Received:** Chair's reports from the Committees below, which have been submitted to Board of Directors'/Trustee Board meetings, since those last reported to the Audit Committee meeting on 18 July 2024: 6.2.1 Quality & Risk Committee 6.2.2 Performance Committee 6.2.3 Strategic Projects Committee 6.2.4 Charitable Funds Committee 6.2.5 Workforce Committee **Discussed:** The report was taken as read with no comments. **Noted**: The Audit Committee noted the Governance Assurance Overview.		
7	**LOCAL COUNTER FRAUD – BDO**		
7.1	**Progress Report**		
25/08	**Received:** Counter Fraud Progress Report to January 2025 **Reported:** ME Highlights: • No changes to the work plan • Main item on the agenda is review of DN605 Anti-fraud & Bribery policy later in the meeting. • The local proactive exercise into procurement fraud has been completed with the briefing report coming to the next meeting • Adjusted workdays in the plan to allow for deliverables on the workplan. • Page 62 included and set out the anticipated improvements against CFA functional returns.		

Agenda Item		Action by Whom	Date by When
	Discussed: CC referred to page 62, access to and completion of training – is there any update on this? ME – this was rated as 'green' in 2023/24 but there is a suggestion that unless the Trust makes the fraud awareness training mandated the green rating may not be held. BDO have had engagement sessions with CFA and explained how rating is made up and will look into making it part of the mandatory training. This has been picked up with Workforce and then with SH and possibly looking to factor into next year's workplan/induction sessions. SH noted discussions with the Workforce team on how we can include parts of our counter fraud and anti-fraud policies into training. She suggested an update to the May or July meeting. DL noted the number of workdays left over and the low number of referrals received to date. She asked for assurance that we are capturing everything we need, and that people are speaking up; how do we compare to other Trusts? JS explained that days are ringfenced to deal with allegations; this can lead to days not being used if referral numbers are low. The proactive side of the plan carries on with work on CFA, procurement fraud, induction, fraud awareness week, alerts cascaded etc. He has benchmarked with another Trust to show a comparison with all other Trusts in England. Approx 12 Trusts refer up to 80% of allegations, then approx. 40 Trusts with low referrals, which RPH is part of, make up the rest. When RPH allegations do come through they are investigated seriously. He feels there is good engagement on referrals with staff, training and Comms team. OM added that any training would need a costing versus risk. SH confirmed this is part of the discussions with LCFS. CC queried that whether this training needs to be mandated as staff are so busy? JS explained that it is up to the Trust to decide if it should be mandated or should not be mandated. The training is 30 minutes over 3 years and is this is not seen to be onerous the CFA may challenge the decision of non-mandated and ask for other assurance to ensure that the training is done. It is the Trust's self-assessed return and fine to take a balanced judgement on whether a green or amber rating is applied. CC understood the explanation re. green or amber ratings and suggested discussion outside of meeting and to bring this back. EM suggested this asks where we put our prioritisation and emphasis on non-clinical elements of mandatory training; this may need to be reviewed. **Noted:** The Audit Committee noted the Local Counter Fraud Progress Report.		
7.2	**LCFS Workplan - Draft**		
25/09	**Received:** Draft Counter Fraud Strategy & Annual Plan 2025/26 **Reported:** ME This plan mirrors previous plans to meet mandatory standards and is reflected in the resources allocated. The plan has been drawn up using		

Agenda Item		Action by Whom	Date by When
	knowledge from emerging fraud risk which is factored into the plan along with recommendations for focus areas. They would like to run a refreshment of the full risk assessment in the first quarter; then any findings will be shared and used as a discussion point to identify any additional action or focus on training going forward. **Discussed:** CC queried the possibility to transfer ten unused days from the 2024/25 plan to use for internal audit work. JS advised the total 2024/25 allocation is 60 days and suggested that any unused days are transferred forward to 2025/26; suggesting these are used for a bespoke exercise to the Trust on any weakness or vulnerable areas. CC asked if the unused days could be split with some moving to Internal Audit. JS advised that splitting over the two areas would not be usual practice as it runs over separate lines of service. **Noted:** The Audit Committed noted the draft 2025/26 LCFS workplan.		
8	**INTERNAL AUDIT – BDO**		
8.1	**Progress Report**		
25/10	**Received:** Internal Audit Progress report. **Reported:** AW Work remains on track to complete the internal audit plan for the year. The remaining work is planned for this quarter; AW is confident on completion to enable the Audit Opinion to be ready for early summer. The final review of DSPT Toolkit is work in progress; he referred to the briefing paper on changes in DSPT reporting contained in the reference pack. Regarding the changes, he confirmed that BDO will support the Trust in completion of this submission. **Discussed:** AR thanked AW and team for their work on DHSP toolkit CC was concerned on how this transition would work and thanked BDO for work on this which gave assurance on this. CC noted that in the summary on page 94, CIP design is classed as being medium assurance, where it should be substantial assurance. Can this be amended please. CC asked how many workdays have been used for internal audit work and how many are left? Can this information be included in future progress reports ongoing. **Noted:** The Audit Committee noted the Internal Audit Progress Report.	AW	13.03.25
8.2	**Internal Audit Follow Up of Recommendations Report**		
25/11	**Received:** Update on Internal Audit Recommendations **Reported:** AW A further three recommendations are complete, nine in progress and one overdue. There has been a drop in overall implementation rates; BDO are following up on those outstanding and confident that by end of year all follow-ups will all be complete.		

Agenda Item		Action by Whom	Date by When
	Discussed: DL noted that several recommendations have dates deferred. What level of confidence is there that these will be completed to the revised timetable. AW advised that recommendations will not close until all issues are finalised. He is confident of progress and completion of these items. CC asked for assurance on EDI which is overdue. OM advised that work is on track and actions will be completed in line with the plan. AMB suggested that in future updates, BDO could add a sentence on the level of confidence in meeting action timelines. CC and DL welcomed this suggestion. **Noted:** The Audit Committee noted the update on Internal Audit Recommendations.	AMB	13.03.25
8.3	**Annual Internal Audit Plan 2025/26**		
25/12	**Received:** Draft Annual Internal Audit Plan 20252/29 - for approval. **Reported:** AW AW noted that AMB has worked hard with the Trust on this. AMB has spoken to NED Chairs of each Committee and met with the Executive Team to reflect on these discussions, emerging risks, BAF and wider sectors. Included in the plan this year is a focus on where the Trust is within their own plans i.e., sustainability, along with related financial cost and workdays. He referred to the Internal Audit Charter; this is the first year (from 01.04.2025) of the new global internal audit standards for the public sector. The detailed document was included in the pack for information. BDO are familiar with this along with the changes and can incorporate requirements into the plan. **Discussion:** CC gave thanks to BDO for the discussions with Execs and NEDs on the plan. This has resulted in a collaborative plan and covers the main areas of risk. MB echoed this. It gave assurance that the internal audit resource is focussed on the biggest priority areas. CC queried that the core assurance days only totalled to 56 out of 67 days allocated. What do these missing 11 days relate to? CC also questioned the definition of future focussed reviews and core assurance. She asked for clarity on this. *Note: AW referred to the 11 days missing in the plan; this is an error in the PDF report where the final page is missing – he confirmed that the 11 days relate to CT reporting backlog review which has been agreed. **Approved:** The Audit Committee approved the annual internal audit plan 2025/26.		
8.4	**Internal Audit Report: Key Financial Systems - Cost Improvement Plans (CIP)**		
25/13	**Received:** Final Internal Audit Report		

Agenda Item		Action by Whom	Date by When
	Design opinion: Substantial Design Effectiveness: Moderate **Reported:** AMB She will amend the error in the Progress Report summary to ensure this is marked as 'substantial'. Overall, a positive outcome on the audit. Main issue was the routine completion of QIA (quality impact assessment) forms to evaluate CIPS before they are approved. **Discussed:** MB raised a query regarding an item which was not in the original scope but the background states we do this to raise productivity. He feels puzzled that cumulative CIP benefit to productivity should be substantial but cannot see this. Does this triangulate to the savings that we think we are accruing actually find their way to improve productivity, and if not, why? AMB agreed this is outside scope and not considered but interesting. SH added that the Trust has been debating this over the last year. The core CIP programme remains focussed on schemes that take cashable cost reductions into the organisation. This is what the Internal Audit report looked at. This year there has been enhanced focus on productivity to allow assessment of this into CIP programme. It is a complex issue and SH explained this in greater detail and why it is not referred to this year. HMc added that it is not in the scope as this is not currently how CIP is managed. Over the next few years this will require alignment with the flow programme, and this will be complex work to do. MB queried if the point to need to be clear on our CIP benefits relates to the priorities in the organisation? EM added that not all of CIP schemes are productivity related (i.e, procurement/contract negotiation). AR highlighted the acknowledgement of digital technology as way of improving productivity and driving benefits. CC requested that this Internal Audit report be sent to the Performance Committee for information only. **Noted:** The Audit Committee noted the Internal Audit Report on CIP.	AC	30.01.25
8.5	**Update on DSPT Toolkit (in reference pack)**		
25/14	**Received:** Briefing paper on New Data Security and Protection Toolkit and Internal Audit Approach. **Reported:** The report was for information and taken as read. **Discussed:** CC noted that the Audit Committee should receive regular updates on DSPT compliance and suggested adding this as a standing item for the next few meetings to ensure clear updates are received. **Noted: The Audit Committee noted the update.**	**AC**	**23.01.25**

Agenda Item		Action by Whom	Date by When
9	**EXTERNAL AUDIT**		
9.1	**24/25 Audit Planning update**		
25/15	**Received:** Draft Audit Plan **Reported:** EL KPMG have started planning work for audit this year, with a full plan to be presented at the next Audit Committee. Interim work is due to start in the next couple of weeks with the audit planned for the May and June period. Sign off date is 30 June and KPMG aims to have the substantive testing complete by end of May/early June. **Noted:** The Audit Committed noted the draft External Audit Plan 24/25		
9.2	**Health Technical Update (in Reference Pack)**		
25/16	**Received:** KPMG Technical Update (for information). **Noted:** The Audit Committee noted the Health Technical update.		
10	**WAIVER TO STANDING FINANCIAL INSTRUCTIONS**		
10.1	**Q3 Report 2024/25**		
25/17	**Received:** Report to the Committee on any outstanding waivers to Standing Financial Instructions made for the Q1 and Q2 period of 2024/2025 that were pending at the October 2024 Audit Committee. Report to the Committee on any waivers to Standing Financial Instructions made for the Q3 period of 2024/2025 **Reported:** SH The report was taken as read. **Discussed:** CC referred to Waiver 785 as the status has been pending since October 2024. SH advised that the original Waiver was cancelled, and a new one issued which will be seen coming through in Q4. **Noted:** The Audit Committee noted the update on Waiver to Standard Financial Instructions.		
11	**ANNUAL REPORTS**		
11.1	**Changes to Standing Orders**		
11.2	**Changes to Standing Financial Instructions**		
11.3	**Changes to Scheme of Delegation**		
25/18	**Received:** Revised versions of the three documents had been circulated prior to the meeting showing tracked changes of the proposed amendments. **Discussed:** No queries were raised regarding the amendments. **Approved:** The Audit Committee approved the proposed amendments, as per the tracked changes, to the three documents.		
11.4	**Annual Committee Self-Assessment**		
25/19	**Received:**		

Agenda Item		Action by Whom	Date by When
	12 Committee members and attendees were asked to provide a rating between 1 to 5 for each question (1 = strongly disagree, 5 = strongly agree) to each of self-assessment's 42 questions. 8 out of the 12 provided responses (as well as comments) and the combined version of these responses was attached as Appendix 1**.** **Reported:** KMB The report was taken as read. **Discussed:** CC noted two amber responses on: Q6 'Equal prominence is given to both quality and financial assurance'. This is being looked at as part of the Committee objectives, with the aim to improve in this area. Q39 'Changes to the Committee's current and future workload are discussed and approved at Board level'. During discussion it was noted that some members were unsure if this was undertaken at by the Board as a whole for all Committees. It was suggested that the question could be re-worded in future to make the interpretation clearer. EM suggested that this is added to the Board Part 2 forward planner for consideration on an annual basis. Q43 'What is your overall assessment of the performance of the Audit Committee'. Four people had responded and four had skipped the question. CC asked if this flagged any concerns which the Audit Committee should be aware of? EM had discussed the question with KMB regarding the wording of this and the required format of the response. It was agreed to review wording of this question in the future. **Approved:** The Audit Committee reviewed and discussed the findings from the Committee self-assessment exercise and approved the report.	KMB KMB KMB	13.03.25 13.03.25 13.03.25
12	**AD-HOC REPORTS**		
12.1	**Salary Overpayments Update**		
25/20	**Received:** An update regarding the Trust's position with respect to the volume and cost of overpayments. This report highlights areas of concern, outstanding issues, potential opportunities for improvement and how we can track progress with reducing overpayments and the errors that cause overpayments. **Reported:** OM The report was taken as read. **Discussed:** In response to MB previous query, the trend over two years is now included. MB did not receive assurance from the information presented, where the data is very sensitive to movement by small changes and therefore not conclusive. He suggested to look with an open mind at what the data tells us. OM referred to underpayments, where the driving factors for this are late		

Agenda Item		Action by Whom	Date by When
	appraisal on pay progression and late sign off of job plans for doctors. DL referred to page 332 (page 5 of the report) and the phrase "*With any luck we will continue to see the trend in 2025 with a further decrease in the Overpayment"*. She would like to see control in this area and not references to 'luck'. OM will feedback to HR colleague who compiled the report. She suggests moving away from giving comments and trends and just present the data to Committee. By way of assurance OM advised that recommendations from Internal Audit are factored in and rates are low in comparison to other organisations. Management of the process by the Trust and payroll is tight. MB felt this was a sensible way forward. CC asked if it was possible to take firmer action? OM suggested a discussion at the weekly Executive Director meeting regarding any further action or performance management issues. EM agreed that Executives can pick up this conversation as suggested. **Noted:** The Audit Committee noted the update on Salary Overpayments.	OM EM/OM	13.03.25 13.03.25
12.2	**Compliance with Clinical Audit**		
25/21	**Received:** An update on progress with the Trust's clinical audit annual plan 2024/25 over the past six months. A summary of progress was presented at Appendix 1. **Reported:** LP The report was taken as read. **Discussed:** MB confirmed that this report is seen at Quality & Risk Committee; he has no concerns regarding this and feels there is a good overview. CC suggested that it would be helpful in Appendix 1 to indicate which clinical audits on the list are mandated. LP advised that it could also be noted which are national and which are clinical. DL noted that some clinical audits were planned for November – did they take place? LP confirmed yes, the national clinical audits are on target. The Trust wide audits have clustered into Q3 and Q4, due to manpower issues in the Clinical Governance team where extra resource has now been put in. Key audits have been prioritised. **Noted:** The Audit Committee noted the update on compliance with clinical audit.	LP	13.03.25
13	**POLICY REVIEWS**		
25/22	**DN605 Anti-fraud and Bribery**		
	Received: Revisions to the policy were shown via tracked changes. **Reported:** ME The report was taken as read. **Discussed:** CC – the tracked change version had not been sent out until 22 January so people may not have had time to read. However, she had compared the untracked version to the tracked changes version. It was noted that ME had suggested for Section 11.16 wording about staff member access		

Agenda Item		Action by Whom	Date by When
	to internet; the new tracked version did not show these comments. ME will double check this in the versions sent. SH confirmed that we did accept this suggested wording. CC requested the 'footer' to reflect the Change footer to show the correct title of the policy. **Approved:** The Audit Committee approved the changes to DN605 Anti-fraud and Bribery policy.	ME ME	13.03.25 13.03.25
14	**ANY OTHER BUSINESS**		
25/23	No items were raised.		
15	**FORWARD PLANNER AND MEETING REVIEW**		
15.1 25/2	**Noted:** The Audit Committee noted the meeting forward planner.		
15.2	**Review of meeting agenda and objectives**		
25/2	All items were covered and discussed in relevant detail. CC apologised for the overrun on timing. There now follows a short Part 2 meeting for Audit Committee members, excluding Auditors.		
15.3	**Next meeting:** 13 March 2025, 0930-1130hr, in person meeting, HLRI Room 89.		
25/26	The meeting finished at 1118hrs.		
	FUTURE MEETING DATES: 2025		

2025 dates			
23 January	0930-1130hrs	MS Teams	
13 March	0930-1130hrs	F2F	HLRI building room 89
13 March (NEDS Private meeting with Auditors)	1130-1200hrs	F2F	HLRI building room 89
22 May (AR & A/cs sign off)	0930-1130hrs	MS Teams	
12 June (Audit Cttee NEDs review Accounts)	1000-1030	MS Teams	
19 June (AR & A/cs sign off final)	1000-1100hrs	MS Teams	
24 June (Board sign off AR & A/cs)	1230-1330hrs	MS Teams	
17 July	0900-1100hrs	MS Teams	
16 October	0900-1100hrs	MS Teams	

Signed: …….

Date: ……..
Royal Papworth Hospital NHS Foundation Trust
Audit Committee meeting
23 January 2025

Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Quality and Risk Committee, Part 1
Thursday 27th February 2025 – 14:00-16:00
Chair: Michael Blastland
(Quarter 4, Month 2) – via Microsoft Teams

PART ONE

Present	**Role**	**Initials**
Blastland, Michael (Chair)	Non-Executive Director	MB
Fadero, Amanda	Non-Executive Director	AF
Glenn, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG
Midlane, Eilish	Chief Executive	EM
Palmer, Louise	Deputy Director for Quality & Risk	LP
Powell, Sarah	Clinical Governance Manager	SP
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
In attendance		
Cooper, Deborah	Trust Governor	DC
Halstead, Abi	Lead Governor	AH
Hurst, Rhys	Staff Governor	RH
McCorquodale, Chris (item 12.2 – from 14:52-15:23 hrs)	Chief Pharmacist	CMc
Martin, Graham	Non-Executive Director (newly appointed)	GM
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
Moorjani, Narain (item 6.2 – from 14:29-15:02 hrs)	Cardiac Surgeon and President of the Society of Cardio-Thoracic Surgery in Great Britain and Ireland	NM
Pai, Sumita (item 6.4 – from 14:57-15:16 hrs)	Microbiology Consultant	SP
Watson, Alice	Executive Assistant	AW
Apologies		
Wilkinson, Ian	Non-Executive Director	IW

Discussion did not follow the order of the agenda, however, for ease of recording these have been noted in the order they appeared on the agenda.

Item		Action by whom	Date
1.	**Welcome & Apologies** The Chair opened the meeting, and apologies were noted as above. Attendees were noted to be Narain Moorjani, Sumita Pai and Chris McCorquodale. Graham Martin was introduced as a newly appointed Non-Executive Director (NED), commencing in post in October 2025, and would succeed the interim Chair of Q&R, from January 2026.		
2.	**Declarations of Interest** No declarations of conflict of interest were raised.		
3.	**Committee Member Priorities** There was nothing to note.		
4.	**Ratification of Previous Minutes Part 1 (30.01.25)** The minutes of the 30 January 2025 Quality & Risk Committee (Q&R) (Part 1) meeting were agreed to be a true and accurate record of the meeting and would be signed as such.		
5.	**Matters Arising – Part 1 Action Checklist (30.01.25)** MS highlighted that actions **086** and **089** were identical and had been duplicated on the log. **Action:** AW to remove one entry, as necessary. ***076 – National cardiac audit programme data.*** Narain Moorjani (NM) to be invited to the February Q&R meeting to provide an example of the National Cardiac Audit Programme and its use. Alternatively, a member of the audit team would be invited. NM would present at today's meeting. To be **CLOSED**. ***081 – Produce a report on the QUACS study findings.*** The decision had been taken by the Board to invite Sam Nashef to a Board workshop to discuss this issue (date TBC). To be **CLOSED.** ***083 – Gemma Bibby to be invited to attend an upcoming Q&R meeting for a focused session on mouth care, work undertaken and areas of progress.*** A date in April was being secured with Dietitian Assistant, Gemma Bibby, to attend for a focused session on the work undertaken and progress made in relation to mouth care. To remain **OPEN**. **085 –** Clarity and assurance to be provided at the March Q&R meeting to understand how well RPH was performing compared to other centres. To remain **OPEN**. ***086 – M.abscessus Dashboard: A briefing to be provided at the end of March 2025 to review progress.*** This item would be heard at the March meeting. To remain **OPEN**.		

	087 – Scan4safety initiative: Executives to raise the issue of compatibility applications such as Scan4safety in relation to the new EPR. MS advised that GS1 standards would form part of the EPR procurement and suggested the matter could therefore be closed. The Chair added that contact had been made with the Chair of SPC to advise of recent discussions around the subject, and assurance had been received that it would continue to be on the radar of the SPC. AF sought clarity as to when and how the work on waiting list and harm reviews would appear. MS responded that a relevant report had been brought back previously; a process was in place but required embedding. As part of quality priorities 2025/26 this had been identified as a priority to take forward, with a focus on reducing the time to treat, to ensure harm did not arise, and to assess any harm on this part of the pathway. LP advised that a more comprehensive version of the quality account priorities would be presented to Q&R in April 2025. The Chair highlighted the significant safety risk of patients on the waiting list, for which proportionate attention was required, and questioned whether the harm-free work being undertaken to assess the situation was sufficient to provide the reassurance. MS responded that there may be a need to reconsider the approach and the process, but an opportunity may lie in work currently underway on RTT recovery. In addition, a session for the Executives to look at the BAF on Monday (03 March), may be an appropriate forum at which to consider the issue. EM noted the 7,500 patients on the RTT waiting list, which was an increase of 3,500 from the pre-pandemic position. However, the largest cohort of patients were not on RTT pathways, but rather on open pathways for continued care; a figure of 4000-4500 individuals. A meaningful review would therefore be a significant undertaking. What had been and remained in place, was a prompt response to an escalation of care, relying on the patient's local physician to escalate, should any deterioration be observed. The patient was also in a position to make contact, should they feel they were deteriorating. AF appreciated the clarity provided but stressed the need for a robust approach to those on the waiting list, for which assurance was required. DM confirmed the undertaking of risk assessments of patients reaching pathways, which was conducted after the pathway had finished and treatment had been provided to ensure full assessment of harm, which was dependent on the metric used. Clinicians had been empowered to make those assessments when seeing patients, rather than conducting these by telephone, to establish a genuine assessment of harm. When a cluster of patients passed away on the emergency TAVI waiting list, a PSII had been initiated and had been reviewed, thus reaction was appropriate when such clusters emerged. DM added that the time required to undertake the reviews was significant.		

	LP clarified the changes to the harm review process and highlighted the capacity issues around undertaking waiting list harm reviews. AR referred to automation tools which may assist in this regard, as part of digital and data strategy, moving forward. DM responded that cancer pathways were operated through a different digital system (Somerset) which identified where delays and other relevant timeline data featured. IS considered that within the whole spectrum of work, a decision should be taken as to which pathways should be under special scrutiny, as there were certain areas where there was no capacity and nothing which could be done for the patient in terms of wait-time. Adopting this position would narrow the number of cases to be addressed and enable focus where it was possible to achieve an outcome. LP concurred that further work was required and highlighted the extent of the January data needing review; both waiting list and harm reviews were required. The Chair noted the scoping work and considered the reviews to have a dual purpose; to identify those for whom intervention could prevent further harm, and to understand the burden of waiting, in order to balance Trust priorities. EM alluded to previous Executive Director (ED) conversation where it was noted that intervention would feature at the front end of the pathway, so patients did not wait for a long time. The harm review was retrospective, at the end of the pathway, to ascertain where excessive wait times had arisen. EM clarified that there was no in-waiting time deployment of clinical staff to be reaching out at intervals to support an assessment whilst patients were waiting. IS added that for the individual patients it would not alter the escalation but may change the escalation for a category of patients if a number of harm reviews were flagged in one area. Item to be **CLOSED**. **088 – PSII-WEB52388 – Organisational – Cardiology TAVI pathway.** Progress with this action as identified from the PSII WEB52388 in relation to the TAVI pathway to be brought back to Q&R in July 2025 for update. To remain **OPEN**. **090 – Annual Quality and Risk Committee Self-Assessment.** The Board was active in its consideration of the Committee composition; a uniform and not entirely supportive response had been received through self-assessment across a number of committees. As participants undertaking self-assessment did not attend Board, consideration was to be given as to how this should be addressed in the assessment, to ensure accuracy of response. Escalation to Board for consideration. To remain **OPEN**.		

	091 – Committee priorities: to be placed on agenda for formal discussion, with a view to including a Quality Improvement item on the agenda going forward. MS had addressed with programme of improvements. To be **CLOSED**. The Committee **reviewed** and **noted** the Matters Arising – Part 1 Action Checklist.		
6.	**Quality & Safety**		
6.1	QRMG and SIERP Highlight and Exception Paper LP presented the QRMG and SIERP Highlight and Exception paper, which was taken as read. The below was of note: • There had been no formal escalations from either QRMG in February or SIERP meetings held in January. • Patient safety incidents were being reported at similar levels to last year, however medication incident numbers had increased in number slightly, overall. However, the Medicines Safety Group had no concerns about the increased reporting rate, or the types of incidents being reported. • Controlled drug (CD) errors remained at a higher-than-average proportion of all medication errors. There were two high-profile controlled drug incidents around June/July 2023 which the Chief Pharmacist considered may correspond to the change in reporting. At the time of the CD drug events, a campaign had been rolled out, to encourage staff to report all controlled drug-related incidents (including storage and security of medications) and the CD incidents continued to be mostly low harm/no harm. • Attention was drawn to the extent of the work that had been undertaken relating to quality and risk, as detailed in the Q3 report data. • In January 2025 there were 271 safety events involving patients reported on Datix incident reporting system. 239 were attributable to RPH, and 32 occurred outside RPH. • There was one incident graded as moderate harm or above discussed at SIERP in January 2025, within Cardiology. • During January 2025 there were two RIDDOR reportable incidents, all others were Near Miss (4), Low (49) or No Harm (69). The two reportable staff injuries were WEB54942 mild concussion following head injury and WEB55018 needlestick injury from Hep C+ patient. These were reported to the Health & Safety Executive (HSE) within the deadline. **Discussion:** The Chair referred to medicine safety, being of the view that the trend did appear to relate to issues around controlled drugs. LP concurred, noting the factors within the reporting to support this theory; areas for improvement in the reporting were noted, that would assist in providing further clarity in the Q4 report, and going forward. MS advised of the appointment of a Medicines Safety Governance Pharmacist which had improved oversight reporting of medicine incidents and raised awareness generally.		

	AF referred to the CD incidents and requested that there be clarity on their detail in future reports, sentiments echoed by DM; LP confirmed that further drilling-down of the data would be evident in the next report. The Chair expressed confidence that the matter related to reporting culture rather than any prominent issue and suggested a "good" assurance level be relayed to the Board, which was agreed by those present. AF referred to the coroner's reports and sought clarity on the phrase "Not an Interested Person (IP)" on page 10 of the report. LP explained that as a Trust, if invited to Court to represent a death review, one was either the Trust of an interested person, or not. If not an interested person (non-IP), there were no concerns about the Trust, but it was noted as having been part of the care pathway. The Chair referred to the table demonstrating the extreme risks category and questioned whether this should have more detailed tabulation to display the date first identified, current status and expected resolution. LP confirmed this was already received by Q&R, within the quarterly Corporate Risk Register. AF noted that 'projects' contained four extreme risks. LP clarified that these related to Nexus project risks. LP suggested that, going forward, this particular table was removed from the monthly report, but received greater focus within the quarterly report. The Committee **reviewed** the QRMG and SIERP Highlight and Exception Paper.		
6.1.1	Serious Incident Executive Review Panel (SIERP) minutes (07/01/25, 14/01/25, 21/01/25, 28/01/25). The Committee **noted** the SIERP minutes.		
6.1.2	Harm Free Care Report, Q3 LP highlighted that this was in the reference pack for noting quality improvement work. The Chair noted an improved position in many areas and extended thanks to LP for the work involved. The Committee **noted** the Harm Free Care Report, Q3.		
6.2	NICOR Presentation SP introduced the NICOR presentation. It was noted that the paper had not been included in the pack. SP provided relevant context to the committee and introduced NM. NM explained his role as Cardiac Surgeon at RPH, and nationally as President of the Society of Cardio-Thoracic Surgery in Great Britain and Ireland. Relevant data relating to NICOR outcome reporting was explained to the committee, demonstrating what had transpired in the last 12 months. Different outcomes, process measures and mortality/morbidity were also noted to be included within the report.		

	It was noted that an interactive tool was now available which enabled scrutiny of different outcomes, as data was uploaded every three months; an example was shared on screen for the benefit of the committee, as well as slides relating to breakdowns in mortality and morbidity data. This information enabled comparison with national averages and identified any areas for improvement. LP advised that she had circulated the paper which contained the necessary link to NM's presentations. TG considered that the data analysed how well patients were being treated at RPH and also the challenges of the waiting list but questioned whether consideration had been given to impact on the population rather than the individuals who had been able to reach the Trust. NM advised that at the East of England Network, how patients were served in areas of social deprivation had been a topic of conversation. In addition, this work would happen at national level, via the Cardiology Societies. AF referred to NM's observation that RPH had been a top performer in respect of volume of procedures, but was now third in the table, for multiple reasons. AF questioned these reasons and whether it was important to be at the top of the list. NM responded that this related to activity, but more importantly, to outcomes, which remained of a high standard. In respect of activity, one reason was the fact that one of the centres in London had merged, with numbers predicted for the new establishment having not yet manifested. It was felt there were opportunities at RPH to increase activity, such as the ERU which had allowed for a greater grasp on facilities and infrastructure, green lists and virtual ward. NN explained that the numbers did identify recruitment and retention issues nationally, both nursing and medical. Initiatives were being developed at RPH to make the most of a challenging situation and to try to ensure as many patients as possible were put through the infrastructure, as possible. The Chair had scrutinised the NICOR data and queried for whom the presentations had been prepared. NM explained that NICOR produced the presentations, being mandated by the Department of Health to monitor cardio-vascular outcomes. This was produced for both public and professionals. NM had been through three areas where data was monitored and could be cross-referenced, namely NICOR (which detailed every hospital), the Society of Cardio-Thoracic Surgery in Great Britain and Ireland (from which RPH data had been extracted) and RPH waiting list and morbidity/mortality outcome data. The Chair questioned the statement that NICOR data was 18 months old. NM confirmed this to be the case but advised that information was produced on three different levels, to ensure an adequate level of responsiveness to any issues arising. The Chair further queried whether a tracking exercise had been undertaken regarding outcomes compared to other organisations. NM advised that there had always been room for improvement and the point of monitoring was to identify those areas. The concept that delivery of care was by teams,		

	rather than one surgeon as reported historically, and the associated dynamics of that group of individuals, was key. Infection was noted to be an area requiring improvement at RPH and much work had been undertaken to improve the position in this regard. The Chair questioned the appropriate level of detail that should be received by Q&R committee and suggested this formed part of a conversation at a future meeting. The Committee **noted** the NICOR presentation.		
6.3	SIRO Report 2024/25 AR presented the SIRO Report 2024/25, which was taken as read. The following key points were noted: • Work on the Trust's 2025 Toolkit submission was underway and the audit scheduled to start in April. This year's toolkit had been redesigned to align with the Cyber Assurance Framework, and the audit had also changed; in addition to the mandatory items, the Trust was to pick four additional items, each of which were noted within the report. • It was clarified that the action plan for cyber-security was monitored through the Performance Committee; this was brought through Q&R as the SIRO report. • Document compliance was improving, standing at 84%. • There were 28 information governance related issues recorded on Datix for Q3, of which 4 were actual incidents, with the remainder classed as 'near misses'. Those related to wrong-patient details were highlighted. • Zivver statistics for Q3 revealed prevention of 959 potential data leaks. • Freedom of information requests continued to be received, with over 2000 being addressed in the last quarter. • Privacy impact assessments were noted to be pivotal. **Discussion:** The Chair referred to Zivver, which AR confirmed acted as a prompt for staff and was noted to be a useful tool. For training purposes, its use was monitored in those areas of higher risk. **Action -** the Chair requested that a trend be included in the report, in respect of the percentages, as for other areas, to demonstrate practice being spread across the organisation. AF expressed concern regarding document compliance figures and specific compliance areas and sought explanation in respect of the 'IGSG Attendance Grid'. AR shared AF's concern regarding document control figures, but necessary escalations were going to leaders in the organisation for support with teams, and this had made a difference. With regard to the IGSG, this table was used to raise awareness and as a prompt to departments and divisions to ensure their attendance. MS noted further queries would be raised offline regarding inaccuracies in the IGSG table in terms of attendees. DM also raised that he had not been	**AR**	

	invited to these meetings as Clinical Governance Lead, and this would also require amendment. The Committee **noted** the SIRO Report 2024/25		
6.4	AMS (Antimicrobial Stewardship) Trust Board Report SP presented the AMS Trust Board Report. The following was noted: • RPH was meeting the national 10% reduction target in Watch and Reserve DDDs/1000 admissions (vs 2017 baseline). Latest data produced revealed a 21% reduction. Currently only 33 Trusts in England were reaching this target and RPH was sitting 12th out of the 33 Trusts. • RPH was meeting the England-wide non-mandatory IV antibiotic switch to ORAL antibiotic (IVOS) CQUIN whereby inappropriate IV antibiotic use should be less than 15%. Q1 = 10%, Q2 =14%, Q3 =9%. • AMS Guidelines were now hosted on RPH intranet and the Eolas app. Microsoft had been unable to support the MicroGuide platform from September 2024. All guidelines had been successfully migrated across to new Eolas platform, Eolas Medical. • Trust Fungal Guidelines (DN816) had been updated. • A poster had been accepted for presentation as FIS2024. • The AMS Team pharmacists had provided clinical support to the Critical Care Team, Surgical and Cardiology pharmacy teams (due to pharmacist shortages) and to the pharmacy dispensary team. **Discussion:** MS referred to the review of antibiotic resistance data of sputum samples under 'Service Review', highlighting a current improvement project around the post-operative pathway in preventing hospital-acquired pneumonia. MS questioned how much of this data was related to those patients and the trend. SP advised that there had been a significant rise in hospital-acquired pneumonia over a period; this was not post-surgical and spanned the Trust. Work was underway to investigate further, from which issues around patient behaviours and reduced standards in mouth-hygiene had been identified and were being addressed. In addition, work was underway with OTs, physiotherapists and the pain team, with ward nurses, to encourage patient confidence in moving, post-operatively. In respect of antimicrobial resistance, establishing whether patients had a true chest infection was a challenge, and enhanced education for registrars and junior doctors, in the form of a video, had been created, to reiterate good practice. **Action:** MS requested that a presentation regarding this quality improvement work be brought back to Q&R in six months' time, to assess progress. The national concern of antimicrobial resistance was highlighted as extensive and required addressing for RPH patients but also for the wider health economy. AR referred to the Eolas app and questioned if this had been through a privacy impact assessment. SP confirmed that this had previously been	**SP**	

	named MicroGuide; there had been liaison with IT and it was thought that the necessary assessment had been undertaken. **Action:** AR requested that SP speak with Cath Wilcox, to confirm. The Chair concurred with MS that it would be helpful to see the quality improvement work relating to hospital acquired pneumonia going forward. It was also requested that the data be provided, across as long a period as possible, to establish the trends over time. SP confirmed that this could be produced from April 2017. The most significant impact was thought to be CFTR modulators in cystic fibrosis patients, and levels of activity on wards, particularly for surgical and cardiology patients, in changing patients from IVs to orals. The Chair suggested that this type of explanation would be helpful to receive in future reports. The Committee **noted** the AMS (Antimicrobial Stewardship) Trust Board Report.	SP	
6.5	Health and Safety Highlight Report MS introduced the Health and Safety Highlight Report, which was taken as read. The following was highlighted: • A site-wide fire risk assessment had been completed, with a report awaited. • Test training sessions had been delivered to specific groups and had been well evaluated. • Fire safety training analysis had been conducted by an authorised engineer. Work was underway to facilitate more widespread training provision and engagement, with additional fire modules identified to be required. There had been a request by the committee to understand the timeframe by which the Trust was likely to meet an acceptable compliance level of fire safety training. • The committee received and approved a proposal to aid improvement of department representatives' education and training. It was expected this would show an improvement throughout Q4 and Q1 (2025/26). **Discussion:** OM highlighted the omission of violence and aggression against staff within the report and advised of revised NHSE guidance on the subject. A number of departments were working together to address the issue, and there was a plan in place to undertake a risk assessment using the new assurance toolkit, over the coming months. Updates would be provided in future reports. The Committee **noted** the Health and Safety Highlight Report.		
6.6	SSI Quality Monitoring Dashboard MS presented the SSI Quality Monitoring Dashboard, which was taken as read. • Q3 2024 consolidated data had recorded 3.9%, being the best position achieved since 2017. • Quality metrics required ongoing monitoring. **Discussion:**		

	The Chair expressed concern that identification of a trend of consistent improvement within the environmental dashboard was unclear. The Committee **noted** the SSI Quality Monitoring Dashboard.		
6.7	M.abscessus Dashboard (Jan 2024 data) MS presented the M.abscessus Dashboard (Jan 2024 data), which was taken as read. A more detailed report would follow at the March Q&R meeting. The following was of note: • One new patient WEB55250 (7) under the care of the transplant team had received a positive result for M. abscessus in January 2025; relatedness results had been requested. • Work was being undertaken with the microbiologists regarding processes with UK HSA/Great Ormond Street (GOS) and where RPH was positioned between the two. MS noted that companies were not finding M.abscessus within environment samples, but this was being identified by the refence lab. Commercial labs were therefore not being used for this purpose. • Water safety work fed into the above in terms of the measures being taken and treatments being adopted. The Water Safety Group would attend the IPCC meeting with a plan to describe these measures, to ensure there was adherence to a water safety plan in its totality. • A thorough risk assessment was being undertaken around M.abscessus. • A new Authorised Engineer for Water post was in place, which had proved insightful. • Retaining the confidence of staff and patients was considered key. The Committee **noted** the M.abscessus Dashboard (Jan 2024 data).		
6.8	Safeguarding Quarterly Report MS advised that the quarterly report was in the pack for information. AF referred to the previous case of a patient who had disconnected themselves from a cardiac monitor, walked to the bathroom and had subsequently fallen; the patient had capacity, but struggled to take medical advice from staff. AF wished to know if this was considered a safeguarding matter and how was this balanced. MS responded that this case was not obviously a safeguarding issue, but there were other conversations to have with staff at different levels, to support with identification of such vulnerable individuals. Supervisory Sister roles would assist in this regard and in helping patients to understand risk. The Committee **noted** the Safeguarding Quarterly Report.		
7.	**Patient Experience**		
8.	**Performance: Performance Reporting: PIPR M10** MS introduced the PIPR M10, which was taken as read. Questions were invited. **Discussion:** The Chair considered there to be nothing of particular concern within the report.		

	The rate of improvement in Matron performance was noted to be outstanding, which it was expected would yield positive outcomes going forward. One complaint had changed the rating in relation to 'caring' and the importance of getting complaint responses correct for patients was noted to be pivotal, even if this took time and resulted in missing targets. Consideration was being given as to how the PIPR metrics were serving the Trust and whether it was possible to be more proportionate with the data. The Committee **noted** the PIPR M10.		
9	**Risk**		
9.1	Board Assurance Framework (BAF)		
9.1.1	Appendix 1: BAF Report KMB advised that this represented the update on SSI risks for the quarter. The document was taken as read. The Committee **reviewed** the Board Assurance Framework (BAF).		
9.1.2	Appendix 2: BAF Tracker The document was taken as read. The Committee **reviewed** the BAF Tracker.		
10.	**Governance & Compliance**		
10.1	Review of Terms of Reference (ToR). The ToR were taken as read. LP was of the view that there was terminology included which required updating and wished to amend this further. In addition, some reporting-in committees did not feature. **Action:** LP would liaise further with KMB to make the necessary amendments, and the ToR would come back to Q&R. The Committee **noted** the Review of the Terms of Reference (ToR).	**KMB/LP**	
10.2	Internal Audits: There were none to review.		
10.3	External Audits/Assessment There were none to review.		
11.	**Quality Accounts** There were none to review.		
12.	**Policies & Procedures**		
12.1	DN931 New Delivering Same Sex Accommodation Policy The DN931 New Delivering Same Sex Accommodation Policy was taken as read. MS advised that this was a new policy based on the NHSE framework for mixed sex accommodation, which would provide assurance and assist in raising awareness. The Committee **ratified** and **approved** the DN931 New Delivering Same Sex Accommodation Policy.		

12.2	DN932 Pharmacy Vision CMc presented the DN932 Pharmacy Vision, which was taken as read. It was noted that the document had been presented one year previously as a strategy and had been reformulated. **Discussion:** The Chair questioned whether CMc was of the view that the vision would evolve into a strategy. CMc suggested that the document would serve as a 'compass'; those elements of the vision which could be, were being delivered already. Detailed timelines and Gantt chart-type project documents had been produced, to depict to how elements of the vision might be delivered, which were noted to be resource-dependent. The Chair considered it would be useful to view this information to establish how aspirations might evolve into practical action and questioned whether there was an associated schedule of reporting, which MS confirmed to be the case and had received recent revision, to include the Pharmacy vision. AF commended the ambition and aspiration behind the document. How this linked to the strategy refresh and business priorities, and the business plan for the year, was key. OM questioned the section relating to workforce, noting targeted action in this regard, and queried whether there was opportunity to include the inclusive leadership vision and developing skills for leadership teams. CMc acknowledged that this level of detail in terms of skills had not been included, although the document had been written prior to production of the leadership framework. Moving forward, this, and the strategy work, could all be pulled together. The Committee **ratified** and **approved** the Pharmacy Vision.		
12.3	DN168 Chaperone Policy The DN168 Chaperone Policy was taken as read. MS advised that this had been included in other safeguarding policies, but it had been felt required to be a stand-alone policy. It was noted to have received sufficient scrutiny over the period of a year. The Committee **ratified** and **approved** the DN168 Chaperone Policy.		
12.4	DN307 Safeguarding Adults Policy The DN307 Safeguarding Adults Policy was taken as read. MS noted that this had been updated with changes to legislation and policy and had been reworked to be more readable and user-friendly. It had been through various iterations over the past few months. The Committee **ratified and approved** the DN307 Safeguarding Adults Policy.		
13.	**Research and Development**		
13.1	Minutes of the Research & Development Directorate meeting (No December Meeting, 10/01/25 minutes to come to March Q&R).		

	The Committee **noted** the Minutes of the Research & Development Directorate meeting.		
14.	**Other Reporting Committees**		
14.1	Escalation from Clinical Professional Advisory Committee (CPAC) There were no escalations from the Clinical Professional Advisory Committee (CPAC).		
14.2	Minutes from Clinical Professional Advisory Committee (18/12/24) The Committee **noted** the minutes from CPAC.		
15.	**Areas of Escalation and Emerging Risk**		
15.1	Audit Committee There was nothing to report.		
15.2	Board of Directors There was nothing to report.		
15.3	Emerging Risks There was nothing to report.		
16. 16.1	**Any Other Business** The committee did not consider that any areas of assurance had been lacking within the items delivered at the meeting. However, TG contended that harm on the waiting list required escalation due to a lack of assurance on the issue. The Chair concurred that whilst this had been moved into longer-term review via the Quality Accounts, the scope of what was trying to be achieved was unclear. AF echoed TG's sentiments and was of the view that the matter should be tracked via Board and Committee. LP noted that this issue had not come through any Medical Examiner review, which was now statutory. Should there be a death on the waiting list, the Trust would be notified, but no such notification had been received. As such, there was a need for triangulation of data.		
17.	Date and time of next meeting Thursday 27th March 2025, 14:00-16:00 - Microsoft Teams		

Royal Papworth Hospital
NHS Foundation Trust

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

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

PART ONE

Discussion did not follow the order of the agenda, however, for ease of recording these have been noted in the order they appeared on the agenda.

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

4.	**Ratification of Previous Minutes Part 1 (27.02.25)** The minutes of the 27 February 2025 Quality & Risk Committee (Q&R) (Part 1) meeting were **AGREED** to be a true and accurate record of the meeting and would be signed as such.		
5.	**Matters Arising – Part 1 Action Checklist (27.02.25)** ***083 – Gemma Bibby to be invited to attend an upcoming Q&R meeting for a focused session on mouth care, work undertaken and areas of progress.*** A date in May was being secured with Dietitian Assistant, Gemma Bibby, to attend for a focused session on the work undertaken and progress made in relation to mouth care. To remain **OPEN. Post meeting note: We closed this as date has been confirmed**. **085 –** ***Clarity and assurance to be provided at the March Q&R meeting to understand how well RPH was performing compared to other centres.*** IS updated the committee that there had been a meeting at which data sources had been considered. Further to a deep dive in raw scores, improvements in cardiac surgery performance were noted. In respect of other services, Transplant, which came through the National Institute for Cardiovascular Outcomes Research (NICOR), had identified issues which had subsequently been flagged by NHSBT, for which necessary mitigations had already been put in place; figures had improved as a result. Thoracic surgery also came through NICOR and the numbers were reassuring, although cases were acknowledged to be small. Primary Percutaneous Coronary Intervention (PCI) was recorded in NICOR, which had enabled scrutinization of the data, with positive results. In respect of Transcatheter Aortic Valve Implantation (TAVI), where there were areas of concern, data was examined and acted upon. The Chair acknowledged the positive assurance regarding consistency of the Trust's own standards and questioned performance relative to other centres, which had initiated the debate. IS confirmed that with the exception of TAVI, all of the data had national comparators and an associated report would be produced. IS added that a more rigorous metric had been given to RPH, due to the Trust performing above its peers and as a result, an alert had been generated by NHSBT advising of a 'dip' in performance. This alert would not have been received by another centre with a more moderate metric.		

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

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

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

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

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

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

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

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

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

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

Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Workforce Committee (Part 1)
(Sub Committee of the Board of Directors)

Held on Thursday 30 January 2025, 11.15-13.15
Via Microsoft Teams

M I N U T E S

Present	Fadero, Amanda	(AF)	Non-Executive Director (Chair)
	Harrison, Sophie	(SH)	Chief Finance Officer
	Howard-Jones, Larraine	(LHJ)	Deputy Director of Workforce and OD
	Leacock, Diane	(DL)	Non-Executive Director
	Mensa-Bonsu, Kwame	(KMB)	Associate Director of Corporate Governance
	McEnroe, Harvey	(HM)	Chief Operating Officer
	Midlane, Eilish	(EM)	Chief Executive Officer
	Oonagh Monkhouse	(OM)	Director of Workforce and OD
	Eilish Midlane	(EM)	Chief Executive Officer
	Norman, Claire	(CN)	Assistant Director of Workforce and OD
	Paddison, Charlotte	(CP)	Associate Non-Executive Director
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
In attendance	Abdoul, Ali	(AA)	Head of EDI
	Billur, Sunanda (left 11.35)	(SB)	Co-Chair, REN Network
	Brodowski, Naomi	(NB)	Executive Assistant (minutes)
	Butler, Jade	(JB)	Workforce Retention Lead
	Fofana, Adama (left 11.35)	(AF)	Co-Chair, REN Network
	Galen-Bisping, Rikki	(RGB)	Observer
	Hotchkiss, Marlene	(MH)	Public Governor
	Iles, Steve	(SI)	Recruitment and Temporary Services Manager
	Lonsdale, Jon	(JL)	Assistant Director Clinical Education
	McClean, Josevine	(JM)	Staff Governor
	Preston, Stephen (arrived 12.15, left 12.40)	(SP)	Guardian of Safe Working
	Radwell, Adam	(AR)	Head of Workforce Information
Apologies	Atkinson, Angie	(AA)	Public Governor
	Taylor, Elizabeth	(ET)	Head of Workforce Operations

Agenda Item		Action by Whom	Date
1.	**Apologies for Absence** The Chair opened the meeting and apologies were noted as above.		

Agenda Item		Action by Whom	Date
2.	**Declarations of Interest** There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda.		
3.	**Committee Member Concerns** No concerns reported.		
4.	**Minutes of the Previous Meeting – Part 1 – 28 November 2024** The minutes of the previous meeting held on 28 November 2024 were **approved.**		
5.	**Matters Arising and Action Checklist – Part 1 – 28 November 2024** Action checklist updated.		
6.	**Board Assurance Framework (BAF)** • All BAF risks have been reviewed. • BAF 3261, which was transferred from the Performance Committee to the Workforce Committee, has been comprehensively updated. • BAF 1853 will be re-reviewed once the Staff Survey benchmarked results are available.		
7.	**Staff Story** *Given by Sunanda Billur and Adama Fofana, Co-Chairs of the Race Equality Network (REN)* • SB jointed the Trust in 2018 and has been involved in the REN for the last 3 years. SB is a specialist nurse in Critical Care. • The network has been a great platform to have a voice and SB decided to become a co-chair to help others to share their experience and break down barriers for them. It has also been a great way of celebrating different cultures and festivals. • AF joined the Trust in 2007 and is currently working as the Equality and Diversity project manager in Research and Development and in Health Inequalities. • Being a co-chair of the network will enable promoting and engaging meaningful work across the Trust and it is good to see the Trust is fostering an environment for those from different cultures and parts of the world. • SB raised that it is difficult for her to be involved in things when rostered for a clinical shift. MS said that she supports giving SB and AF protected time to be able to undertake their work for the network, and that it has been raised by staff numerous times in the Behaviour and Leadership Framework masterclasses that staff are struggling to have the time to attend things outside of their clinical roles.		

Agenda Item		Action by Whom	Date
	• OM has been working with AA on looking at protected time for network leads, and once this is confirmed OM and AA will meet with the network leads' managers to put a plan in place for them.		
8.	**Workforce Directors Report** • Turnover has been on an improving trend over the last 12 months. • There were additional induction sessions run in 2024, which meant more staff could be onboarded during some months. • The focus on JB's role has helped focus on some drivers for turnover. • The Trust will likely always be slightly above the average for turnover due to the size and nature of the hospital. • The Trust is working to the national standard of 48 days with regards to time to hire. November's time to hire decreased to 40.8 days and a total of 69 candidates were given unconditional offers in November, with over 56 people waiting to come onto Trust inductions. • AF raised the starter/leaver net deterioration as a concern, especially with a large number of leavers moving to CUH. OM responded that it wasn't a surprise to her and MS responded that she doesn't have a problem with it as it means staff get different experience from doing this and gaining contacts and often then returning to RPH. • DL asked that from the recruitment auditing, with has now been going on for around 6 months, what is the information saying about the Trust's recruitment practices. OM responded that is has been a resource intensive process. Some of the practice around shortlisting has been poor, often due to time restraints, and the full panel aren't always involved in the shortlisting due to lack of time/availability. OM and AA have also been discussing the representation of the panels, in terms of diversity, and whether this is being meaningfully engaged or employed by managers. OM, MS and Judy Machiwenyika (Head of Nursing, STA) have been discussing building confidence for staff, particularly those who English is not their first language and the impact this can have, and they have been working on a new approach on Level 5. <u>Appraisal Process Review</u> • Following the Staff Survey results in 2023, a workstream around appraisals started in August 2024, specifically looking at the quality of the discussions and how meaningful they are to staff. • The first month was spent speaking with managers, staff-side representatives, general staff, transformational reciprocal mentoring programme cohorts and staff networks, to collate feedback on the current process and how it could be improved. There were also additional focus groups held for staff to partake in. • The team also did some benchmarking against different appraisal processes, both nationally and regionally, and it was clear from this than many NHS organisations are facing the same difficulties as RPH when it comes to appraisals. • From all the conversations, it is clear that what people want to get out of their appraisal process is different from everyone,		

Agenda Item		Action by Whom	Date
	depending on their life and career goals. • It was felt that there needed to be more input from the appraisee to be able to lead the conversation and focus on the factors that are most important to them, and then to allow the manager to tailor that conversation accordingly. • In order to do this, an additional part to the appraisal process has been added, an appraisee self-assessment form. This form will be completed in advance of the appraisal and give the manager chance to tailor the conversation to that particular individual. • For 360 feedback, all Band 8A+ roles will need to complete 360 feedback every 2 to 3 years, and for those Band 7 and below this will be optional. • There will be a big focus on training for managers, using a hybrid approach including a bitesize training, giving 360 feedback and objective setting. • The appraisal process will eventually be made digital, to allow data to be taken from appraisals. • Protected time needs to be put in for this. • The recommendation for the new appraisal process is to stick with the current approach but add in these additional tools for the appraiser and appraisee, particularly the pre-assessment form. • CP suggested that the Trust values should be imbedded into the pre-assessment form, as the work around the values and really important to the organisation. • CP asked about the data on appraisals, and why cardiology have 81% completed but finance, estates, and facilities only 64%, as surely it is harder for clinical staff to undertake due to time factors. SH responded that finance, estates and facilities are all together but they show very different pictures, and it is a particular challenge for the housekeeping team which sits within estates and facilities as there are also out and about across the hospital and part of the ward teams and therefore face the same challenges as clinical staff. The team are looking to take a different approach for them and are looking are trialling a more grouped model for them. • OM raised that protected time for appraisals does need to be thought through and giving time for this as it is important for staff and the organisation. OM will take this to the Executive team for further discussion. <u>Violence prevention and reduction standard</u> • A revised standard has been published, alongside new legislation, with a big focus on sexual violence. • OM, MS and Steve Rackley have joint responsibility for this across their different areas and have been working the way through the frameworks and legislation, ensuring that the Trust policies align with the changes. • OM and MS will bring this back for further discussion/assurance once the documentation has been fully reviewed, to the July meeting.	**OM/MS**	**31.07.25**

Agenda Item		Action by Whom	Date
9.	**Equality, Diversity, and Inclusion** <u>2023/24 WRES and WDES reports</u> • The reports are prepared for Trusts by NHSE. • The current reporting year for the purpose of the reports are 2024. The reports are helpful but they are always a bit delayed in terms of using them to put together plans for improvement. • There has been some improvement in the data, particularly around career progression and bullying, but not around discrimination.		
10.	**Modern Slavery Statement** • Under the Modern Slavery Act of 2015 all NHS Bodies are required to advertise their Modern Slavery statement in a prominent place on the Trust external website and to register the statement on the Modern Slavery Statement Registry. • DL asked how the Trust checks it's supply chain makes sure the suppliers are compliant with the act. SH responded that the Trust has a number of provisions within existing NHS contracts and contracts that are put in place with other suppliers which talk to modern slavery around the Trust's direct relationship. Beyond the immediate supply chain, we don't have obligations and don't do due diligence beyond that immediate relationship. The vast majority of things are from the NHS supply chain, but the chunk that sit outside of this is tricky. • EM added that is some work going on led by the Chamber of Commerce in Cambridge, who are working on Cambridgeshire and Peterborough pledge that all organisations would sign up to. This will go through the Board once in place. • The statement was RATIFIED and AGREED with the caveat that most suppliers come through NHS routes.		
11.	**Workforce Committee self-assessment 2024-25 report** • DL raised that the question around the Board considering and discussing workloads of the committees is a bit ambiguous in some cases, and the Board doesn't really look at individual committee workloads. • AF agreed- should the question be re-written or does the Board need to start discussing the workload of committees to ensure the distribution of committees is the right distribution. • EM agreed and said that the summary assessment needs changing as people interpreted it as a qualitative rather than quantitative assessment. • AF said that if the Workforce Committee is going to remain as bi-monthly, which seems right, then more needs to be done on the balance of the assurance elements and what's information or reassurance. • DL said that the Workforce Directors report is really rich in content and DL is keen that this is not lost. Perhaps this could be moved into a reference pack if necessary. • AF suggested that there is a reflective piece at Board on the self-assessments, and will feed this into Part 2 of Board, and then AF		

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	and OM will look at agenda setting and report content at their bi-monthly sessions.		
12.	**PIPR M09 PM&C** • DL asked why there is no pipeline for Theatre ODPs and what the Trust is going on recruitment for these roles, or is it too specialist. MS responded that it is a national problem in terms of workforce. The Trust are looking at the skill mix, and towards a model of recruiting nurses with an interest in anaesthesia, who can then undertake further training towards becoming an ODP. This will take time as the nurse would then need to undertake a course to be able to go into this role.		
13.	**Update on the role of Anaesthetic Associates at RPH** • An independent review of physician associates (PA's) and anaesthetic associates (AA's) has been launched by the Health and Social Care Secretary to consider how these roles are deployed across the health system, in order to ensure that patients get the highest standards of care. • The review will look into the safety of these role, how they support wider health teams, and their place in providing patients with good quality and efficient care. It will also look at how effectively these roles are deployed in the NHS, while offering recommendations on how new roles should work in the future. • The outcome of the review is due in be published in Spring 2025. • Whilst awaiting this review, the Association of Cardiothoracic, Anaesthetists and Critical Care produced a statement which clearly says that there isn't a role for AAs in cardiothoracics. The Trust has 3 AA's in post at present, and there is a good governance framework around their practice currently. • This statement is with the theatres and anaesthetics business unit to review and come up with a set of recommendations moving forward. There is assurance that they will have a job at RPH as they have qualifications in other areas.		
14.	**Job Planning review** • Job planning is a focus of attention for NHSE who have recently published a job planning guide with input from NHS Impact and GIRFT. The guide identifies goals and challenges and provides a self-assessment methodology for Trusts to assess their processes against an aspirational model. • Against this background, the East of England Regional Team organised a day long job planning event at Duxford on 12 December 2024 hosted by the EoE Medical Director Eddie Morris and led by the national Medical Director for Secondary Care, Stella Vig. • As a benchmark Stella Vig said that 55% of consultants across the NHS have a job plan. The ambition from the centre is that each hospital will have an electronic system for job planning. A move to team job plans is encouraged. There should be a job planning		

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	committee chaired by the Medical Director (MD) for transparency and consistency across speciality groups. There will be reports presented to Trust Boards. There is a target for 95% of consultants to have a job plan by 04 April 2025. • The national Medical Director said that Trust's should be aiming for a limit of 14 PAs and the Trust's limited is currently 15. • RPH established a Job Planning Committee several years ago. This has been MD led with oversight from the Board. Team job planning is the norm within sub-specialty groups. The last report to the Workforce Committee was in May 2024, that is shortly after the watershed of the new financial year when there is a drive to update all job plans. Compared to that high point there has been a deterioration in some of the statistics, but it is anticipated that by April we will have made good that decline. There are 129 consultants currently working at RPH. In the Allocate system there are a few people still registered who no longer work in the hospital. 126 have a job plan (98%). • The call for applications for/recognition of research and educational sessions will be circulated imminently with a plan to update job plans in the next 2 months. The goal is to achieve 100% of consultants with a job plan and for > 95% to be < 12 months old. • The new Clinical Director in the Thoracic and Ambulatory Directorate, Chris Johnson, has piloted closer scrutiny of delivery against plan looking at available data for, in particular, delivery of outpatient sessions both the number attended by the consultant and the number of patients seen as measured by outcoming in Lorenzo. After some initial questioning from the Thoracic consultants this has been widely accepted and has shown that commonly consultants are delivering 44 to 46 weeks of clinical work against a 42-week plan. This year surgical job plans are being reduced in year where annualised delivery targets will not be met. The closer linkage of job plans to delivery will be the norm going forwards. • For the National Clinical Impact Awards, the final tally was 8 applications including 2 women from RPH. Five of the applications were successful including one of the women such that the proportion of female consultants with awards has risen from 5% to 12.5% in the last 2 years. The ethnic diversity of the consultant workforce has also been increasingly reflected in the NCIA process over the last couple of years. Three of the 5 consultants recognised this year were from ethnic minority backgrounds and none were 'White British'. • DL said it was good to see the diversity of the successful applicants for the awards, and that a female consultant has been awarded.		
15.	**Guardian of Safe Working Hours Q2 report** • The biggest issue at present is exception reports. These have increased since the last quarter but remain at a low level. • The most common reason to exception report is hours of working and it appears a number of people aren't getting TOIL and paid for		

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	the additional. SP is working through this to action and close them, and into possible automatic payments. • The doctors' mess is progressing, and plans are in place for the refurbishment. Resident doctors have been closely involved with the design, so it is hoped that it will meet their needs and provide a boost to this staff group. • SP doesn't have information on what proportion of the Trust's locum shifts are getting filled. SP is going to look into the possibility of starting to record this. • OM said that there isn't a rostering system for locum shifts and this are allocated by individual teams. OM will speak to Karen Panesar (KP), Head of Medical Staffing, to look at options. We are moving to the ePay system for paying bank shifts so this should give a better oversight. • DL asked about the automatic payment for exception reports and how this would affect the budget. OM responded that a process needs to be put in place to validate the hours claimed. OM, KP and SP to meet to discuss further. • AF asked how the resident doctors are feeling and what has the mood during inductions been. SP responded that the inductions are quite low mood and it is difficult to get interactive engagement from them. Some of the things we are doing locally, like a good mess facility, demonstrates value, but they are quite difficult to motivate. • EM said that as a group of staff within any NHS organisation, they are quite nomadic. One of the things that has been identified if that the flow of information doesn't always get picked up as it does through other staff groups. There is going to be electronic signage in the new mess to give them a chance to see messaging that they have missed elsewhere.	**OM,SP**	**27.03.25**
16.	**Policies and Strategies** <u>Progress report 24/25</u> • Resolution Policy – it is expected to be ready by the end of February and LHJ will bring the policy to the March meeting.	**LHJ**	**27.03.25**
17.	**Sub Committee minutes** <u>EDI Steering Committee</u> For information.		
18.	**Committee dates and business forward planner** For information.		
19.	**Issues for escalation and Emerging Risks** There were no issues for escalation or emergency risks.		
	Date & Time of Next Meeting: **Thursday 27 March 2025, 11.15 to 1.15pm, via MS Teams**		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Workforce Committee