Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3iia

Report to:	**Board of Directors**	**5 December 2019**
Report from:	**Chair of the Quality & Risk Committee**	
Principal Objective/ Strategy and Title	**GOVERNANCE:** **To update the Board on discussions at the Quality & Risk Committee meeting held on 26 November 2019**	
Board Assurance Framework Entries	**675, 684, 730, 742, 1787, 1929, 2249**	
Regulatory Requirement	**Well Led/Code of Governance:** To have clear and effective processes for assurance of Committee risks	
Equality Considerations	**Equality has been considered but none believed to apply**	
Key Risks	**Insufficient information or understanding to provide assurance to the Board**	
For:	**Information**	

Chairman's Report Part One:
Amidst a large volume of quarterly reports, the committee noted the following:

1. That work continues to try to understand why Royal Papworth is a periodic outlier for the proportion of patients who are readmitted to critical care. At the moment, the numbers have fallen back to within the expected range, but we are not yet sure what drives the variation.

2. That overall patient safety incidents have risen around the move and subsequently, that they may be returning to more normal levels, but we remain keen to monitor progress to ensure that the rise is genuinely temporary and not the permanent result of new ways of working.

3. That the M Abscessus outbreak continues to be investigated but we have not yet been able to identify the source. Estates will be taking steps to enhance water filtration as a precautionary measure.

4. The improvement in PIPR to green on Caring, with an improvement in FTT scores and a fall in complaints to more normal levels.

5. In two connected items, we agreed with the proposal to explore the repatriation of the bereavement service, which is currently run by CUH, but has not been operating smoothly. We also heard from Dr Sarah Grove about our strategy for end-of-life care and the plans to continue to improve the service in line with NICE guidance. The

service is unusual in its case mix as the majority of our workload is in non-malignant disease.

6. More immediately pressing, we considered compliance with information governance training, which has dropped recently, and whether – in light of the recent test of our phishing resilience – the training is sufficiently focussed on this kind of risk. The Executive team has agreed to look at this. We have also asked for communications to be re-issued to staff who delegate access to their emails.

7. Finally, and perhaps most fundamentally, we discussed concern that critical care has been thus far unable to recover hoped-for levels of activity, with a number of instances of bed closures that have reduced capacity. Some of this may be remedied with changes in rostering, which is to be revisited. We agreed that the problem needed to be seen in part as a safety issue, so that the temporary closure of beds for safety reasons is weighed against the safety of prospective patients or, for example, IHUs whose admission might be delayed.

Recommendation

The Board of Directors is asked to note the contents of this report.

Michael Blastland
Chair, Quality and Risk Committee
29 November 2019