Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.i

Report to:	**Board of Directors**	**Date: 2 September 2021**
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**	
Board Assurance Framework Entries	**675, 730, 742, 1929, 2532**	
Regulatory Requirement	**Well Led/Code of Governance:**	
Equality Considerations	**To have clear and effective processes for assurance of Committee risks**	
Key Risks	**None believed to apply**	
For:	**Insufficient information or understanding to provide assurance to the Board**	

This report combines meetings in July and August.

1. Significant issues of interest to the Board

1.1 In line with the committee's decision to devote more time to specific areas, we focused most recently on VTE risk assessment. Previously, RPH sampled 30 patients to check assessment rates. This being the only data we had, we sometimes found ourselves discussing monthly changes in the proportion assessed which were within the range of sampling error. Now, all patients are included – a positive change - though this has shown that a lower proportion have completed assessments than previously, down from percentages in the 90s to the 80s. We have been keen to understand the reasons for this and heard from Wayne Hurst and Karen Shears that this does not mean a decline in performance but is due to a combination of new methodology and incomplete record keeping, notably on Metavision. Measured compliance in CCA in particular is well below the required standard, however assessment rates are probably higher in practice as the clinicians tend to record in the narrative section rather than on the audited form. Critical care has identified medical and nursing staff to lead on improvement in compliance. It's also worth emphasizing that incidents relating to VTE remain low, though there have been some in cases of Covid-19, plus instances of bleeding. RPH was accredited VTE exemplar status in 2017, one of 36 hospitals in the UK. Wayne advised that revalidation in 2022 will depend on robust and sustained improvement of VTE risk assessment. A number of actions are planned or already taken to improve measured compliance. We accept that there has been no deterioration in performance but cannot have full assurance of our position until performance is properly reflected in the data.

1.2 The committee discussed the frustrations of cancelled operations and restricted flow of routine patients because of continuing pressure from Covid and the high demand for ECMO, higher patient acuity, and also the need for high levels of headroom on rotas to allow staff time to recover. In particular, we feel a need to understand the pressures in critical care in light of reported comments to the wellbeing coordinator that some staff feel persistently understaffed

and unsupported, for example – comments that suggest a degree of disquiet we've not previously been aware of. We recognize that experience will be mixed, some positive, some not, not least because one part of the hospital is still in Covid surge and the other is beginning to operate more normally. We also appreciate that the available data does not support a claim of persistent and serious understaffing and take some assurance from this, and from explanations of the mixed contexts in which many staff still work. Nevertheless, from an assurance point of view, we feel that we cannot ignore this anecdotal evidence, and would like to know that it does not reflect a widespread perception. We note that there is continuing work in this area in critical care and we're deeply grateful for the continuing efforts of all staff to achieve a balance between unforgiving pressures on all sides.

1.3 We discussed the classification of incidents, noting that 'near miss' or 'no harm' can range from the innocuous to something that very nearly resulted in a serious incident. We were pleased to hear that all incidents are properly reviewed but remain interested in how they are reported to the committee. We have no reason to suspect a hidden problem but have suggested as a further source of assurance either a periodic review to highlight those incidents that might give more cause for concern, or a split in the way they are reported.

1.4 We received a presentation from Sumita Pai on efforts to reduce antibiotic use at RPH. These appear to be making a dramatic difference, and we applaud the team's innovations including training and ward rounds to review prescribing. We are curious about the reported 71% reduction in systemic antibiotics, which seemed extraordinary, imply that RPH was formerly prescribing nearly 4x the level of use in the recent past, and we wonder if this figure is affected by a change in case mix or a result of unusual fluctuations in use for other reasons, perhaps around Covid. We feel the best justification for continuing this work – which would require funding - is the quality of patient care offered and the control of antimicrobial resistance.

1.5 The committee has discussed priorities for focus over the coming months, including digital clinical safety, data analytics capability, health inequality, quality improvement methodology, and the impact of any ICS quality priorities or structures on RPH's own quality priorities and governance. We welcome other suggestions as we seek stronger assurance through a deeper understanding of specific areas.

1.6 We thanked Ivan Graham for his work and tireless commitment deputizing as chief nurse, and have now welcomed Maura Screaton to her first Q&R.

2. Key decisions or actions taken by the Quality & Risk Committee

We approved the WRES and WDES reports and actions for referral to the board. We discussed with Oonagh areas of strength and weakness, noting that some remain seriously concerning, especially the perception of opportunities for promotion among BAME staff. We recognised the efforts being made to ensure fairness, and also the ease with which isolated incidents can erode trust. We also noted that WDES data is hard to judge when so many staff don't declare their status.

3. Matters referred to other committees or individual Executives

See part II item.

4. Recommendation

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