Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.i

Report to:	**Board of Directors**	**Date: 3 March 2022**
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, 3040	
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	

1. Significant issues of interest to the Board

1.1 Critical Care Improvement Plan. The committee welcomed the first outline of the plan and Jennifer Whisken's appointment to lead it. We heard that the response has been mixed, some enthusiastic, others nervous, and that the emphasis is on offering support to staff to make the job as fulfilling and manageable as possible whilst optimising what critical care can deliver. It was interesting to hear that some staff seem unaware of the deep appreciation of their efforts especially over the past two years. We note the ambition is to open 36 beds and will receive regular updates on progress.

1.2 M.abscessus. The committee reviewed the new governance structure for M.abscessus and was satisfied it would help formalise existing work and provide clear lines of accountability, especially to external stakeholders. We noted data suggesting that overall surgical outcomes since moving to the new site have shown no indication of worsening mortality and possibly signs of improvement - which although not conclusive, is an informative indicator for use in reviews of lung transplantation services at RPH. We also noted that we have not yet received a reply to our letter to NHSE/I detailing our response to the outbreak. We feel the committee has had consistently strong assurance that this distressing and frustrating problem has been managed responsibly and openly.

1.3 Decision Making. Following a request from the Performance Committee, we asked for clarification of the process of decision making when balancing competing pressures. We noted the formal parts of the process but accepted that much is informal, depending on shared professional judgment in forums such as the CDC. There are clear cases – accepting emergencies, for example – when RPH prioritises these patients above the risks of additional pressure on beds and staffing. At other times, safety within the hospital is held paramount. We welcome this evidence of flexible decision-making within an overall structure. We remain interested in the balance of risk between waiting patients and

pressure within the hospital more generally, recognising the difficulty and sensitivity of the judgements. Whilst there is a clear system of triage for waiting patients, we feel this overall balance should remain under review. We welcome the critical care improvement plan as part of this balancing process.

1.4 Interoperability. We remain frustrated by problems coordinating Metavision and Lorenzo which have resulted in prescribing incidents. We understand the technical difficulty and accept that there have been no serious incidents, but also feel that no-harm/ low-harm etc., does not rule out high risk. In future, we hope to distinguish no or low-harm but high risk incidents in our reporting. MS has agreed to look at where exactly the problems are arising.

1.5 Monthly scorecards. The committee noted that these summaries of ward-level performance do not appear to be consistent with other data about overall staffing levels etc. We agreed that the scorecards should be a useful quick reference for ward sisters but in some respects are not at present a plausible reflection of conditions as we understand them. MS will investigate.

1.6 Surgical site infections We've noted before that surgical site infections for CABGs have been running higher than we'd expect. In the past, no clear cause was identified. MS has suggested - and the committee agreed - that the persistence of the problem warrants further investigation. Infection control is now less occupied by Covid and will take a closer interest, for example by reviving routine audits of parts of the process.

1.7 Q&R annual review. We reviewed the performance of the committee and felt that overall it was strong. For example, we judged that the new workforce reporting was working well. There are elements of the Q&R brief – quality improvement for example – which we readily acknowledge have suffered during the Covid epidemic. We discussed how to regain momentum and have ambitions to produce clearer mapping of the full range of current quality and audit initiatives so that we can identify gaps and track progress. EDs have agreed to look at how to carry this forward. Otherwise, we felt the committee had effectively discharged its brief.

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

The committee agreed its terms of reference, including the new responsibilities for workforce.

We also approved a 1-year extension to the Consent Policy. It will be more fundamentally revised next year alongside development of a shorter teaching version.

3. Matters referred to other committees or individual Executives

We have asked for the briefing note on decision making to be made available to the Performance committee.

4. Recommendation

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