Royal Papworth Hospital
NHS Foundation Trust

**Agenda item 3.i**

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| **Report to:** | **Board of Directors** | **Date: 09 Jan 2025** |
| **Report from:** | **Chair of the Quality & Risk Committee** | |
| **Principal Objective/ Strategy and Title** | **GOVERNANCE:**<br>**To update the Board on discussions at the Quality & Risk Committee** | |
| **Board Assurance Framework Entries** | 675, 742, 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 | |

**Part 1 Summary report from meetings in November and December**

**1.Significant issues of interest to the Board.**

**1i. SSIs**. We've now seen improved figures for a full quarter (about 4% compared with previous figures around 8%). Some of this might be a result of more rigorous infection control during the CPE outbreak. Four per cent is still significantly above target, and we take nothing for granted, but the committee expressed cautious optimism about the trend. The main focus remains numbers and footfall in theatres. We also heard a presentation on the use of the incisional VAC (a suction dressing) against SSIs. This can be an effective tool, especially for high risk patients, but it's expensive and its use reflects a less than ideal environment. Our aim should be not to need it for all patients. **Assurance** overall on SSIs, **on governance, good; on outcomes, limited.**

**1ii Surgical mortality.** In recent years, we have investigated evidence of rising raw mortality and we were able to conclude that it reflected rising patient acuity. Any increase in mortality is a concern, but it's not unique to RPH, and there are no concerns about the quality of our care. However, looking at recent data which compares providers, we have become curious whether RPH's historically outstanding results have been maintained relative to others; that is, our impression is that we used to be ahead of the pack, but are we still? So, whilst **assurance** on mortality remains **good**, we will seek to understand long-term trends relative to others.

**1iii M. Abcessus.** We have seen one new case linked to the RPH outbreak, but it plausibly originated some time ago and gives us no reason to change our view that the numbers are very low, given that we would expect some even in normal circumstances, and **assurance** remains **good.**

**1iv. PIPR/Ward supervisory time,** which has been inching up**,** has shown more marked improvement recently, which is pleasing after a long effort, with anecdotal evidence that staff

are seeing benefits. Overall, the safe domain in PIPR is RAG-rated red, partly owing to the high standards we have set for this and other metrics. We do not feel that red is a just summary of safety at RPH, which we feel is good. But having discussed the metrics, we do not propose any changes for now.

**1v. The quality and risk report** is now bi-annual (previously quarterly) partly to ease the reporting burden, but also because we do not expect significant short term variations, and any that do arise which are of concern can be raised separately. **Assurance** on quality and risk as reported was felt to be good.

**1vi** A review of **PSIRF** within the 6-monthly quality and risk report continues to give confidence that the new system is working well overall. In planning for future years, we discussed a potential focus on patient pathways into RPH, where we have seen a few safety incidents lately.

**1vii Quality Account Priorities.** We reviewed progress on the priorities for 2024-25 (relating to diabetes, nutrition and hydration, and delirium and dementia), and felt that it was overall good.

**2. Policies etc, approved or ratified.** Terms of Reference, Quality & Risk Management Group, TOR011.

**3. Matters referred to other committees or individual Executives.** None.