Royal Papworth Hospital
NHS Foundation Trust

Part 1 Agenda Item 4i

Report to:	**Board of Directors**	**2 August 2018**
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 at the meeting on 17th July 2018**	
Board Assurance Framework Entries		
Regulatory Requirement	**Regulator Requirement**	
Equality Considerations	**Equality has been considered but none believed to apply**	
Key Risks	**Non-compliance resulting in financial penalties**	
For:	**Information**	

1. I was pleased to see that an analysis had been made of moderate harm incidents and above where skill mix was a contributory factor (6/36) or a root cause (2/36). It was difficult to interpret without any benchmarks and we agreed to continue with this going forward to ensure that there were no adverse trends.

2. We were briefed about CQC's insistence that we use NEWS2 as a tool for the detection of deterioration in a patient. Our understanding is that while acceptable in other areas, NEWS2 is inferior to what we use already for specialist cardiac surgery patients, and that evidence exists to show that some patients may come to harm if we were to change to the measure favoured by CQC. This is a quality and safety issue and I am not content that we should be forced to use an inferior tool at the expense of patient safety. I have asked for this matter to be formally escalated to the Board.

3. We were made aware of some problems in governance in transplant. Although in part due to the high volume of recent activity, this needs to be rectified. And I am assured that the necessary steps are being taken.

4. We saw the End of Life Steering Group minutes and discussed the growing importance of this topic. I have asked for a more in depth discussion with a paper at a future meeting. I requested further information on the Gosport implications, we received reassurance that the Board has engaged with any palliative care returns that have been requested.

5. We discussed two serious incidents and saw both reports. I would just like the Board to be aware of the detail set out during such investigations and the sensitivity shown to relatives during the process, a matter for which all involved deserve congratulations. They exemplify the best of Papworth.

6. We were given the set of operational corporate risks and were concerned to see that a subset had direct impact on patient safety. Examples include the fact that the cardiac monitoring system is unable to record or store rhythm disturbances, that In-Health staff may not be adequately trained to implant various devices, and that there could be inadequate pre-operative assessment of high risk patients. These examples led to a discussion about the use of clinical judgement in the assessment of risk, and whether and to what extent it might be desirable to categorise those risks that might have a direct effect on patient safety and clinical outcomes.

7. The Hospital is apparently not registered for patients to be sectioned under the Mental Health Act to remain at the Hospital. A report from the Liaison Psychiatrist has recommended that we should seek such registration as soon as possible detailing the reasons for so doing.