Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3iiia

Report to:	**Board of Directors**	**6th June 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 28th May 2019**	
Board Assurance Framework Entries	**675, 690, 742, 1787, 744, 1929, 1511**	
Regulatory Requirement	**NHS Foundation Trust Code of Governance** **Scheme of Delegation/ToR**	
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**	

1. Chairman's Report Part One:

Structure of the Agenda and Discussion
The Committee now meets monthly and has agreed a template for future meetings. Papers will include all the minutes of the committees for which Quality and Risk is responsible but will include an exception report or a cover sheet to guide discussion. An additional heading on Workforce will be introduced next month, resulting in the following standing items:

- Quality
- Safety
- Performance (only the sections for which Quality and Risk is responsible)
- Workforce
- Risk (including the risks in the Board Assurance Framework for which the Committee is responsible)

followed, as necessary, by:

- Governance, including Information
- Assurance - internal and external clinical audits, with a quarterly presentation on one area
- Policy and Strategy
- Research, Development, and Education

Throughout this meeting, issues resulting from the move into the new Hospital were discussed, but a focused discussion under the heading "Optimisation of the New Hospital", might be a useful prompt. In addition, a series of quarterly reports and topics were approved.

Substantive Matters.

- The Committee received assurance that each in-hospital death is subject to a full review. A system of triangulation - including the NHS Just Culture tool - ensures that lessons can be learnt and relatives given the fullest explanation. "Known complications" is no longer accepted as a cause.
- Serious Incidents - one new (the failure of an ECMO blender dial) and four Serious Incidents are still under investigation. The machine had been checked as part of the move. The Board may wish to satisfy itself that the machinery had not been affected by the move.
- The point was made that coroner investigations, especially those out-of-area, required considerable resource.
- Bookings - the move to the new switchboard had caused additional problems.
- VTEs - the introduction of a mandatory field had been authorised.
- Lorenzo - efforts were being made to identify urgent alerts to clinicians.
- Lessons had been learnt from other hospitals that had moved. Royal Papworth would make its own contributions to help the next hospital on the move.
- Critical Care - because of the single rooms, it was more difficult for nurses to cover for each other on necessary breaks; the psychological effect of isolation on the nursing staff needed consideration
- Workforce - whereas the Trust was a net recruiter, the Chief Nurse estimated that at this rate it would take four years to fill all vacancies
- Strategy - the effect of change in the NHS on ways of working might be included under the standing item on research, development, and education

Recommendation

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