Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3iia

Report to:	**Board of Directors**	**4th July 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 25th June 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**	

Chairman's Report Part One:

Matters Arising: The new monthly schedule will mitigate against follow-up drift.

Hospital Optimisation: In future there would be a standing item on each Agenda for Hospital Optimisation. Although the work is being done by another group, nevertheless, the Quality and Risk Committee should be made aware of problems, solutions, and examples of successful different ways of working. The monthly schedule of Quality and Risk meetings will ensure that the Board has sight of any issues in almost real time. The items to be discussed should be wider than facilities management.

Serious Incidents: The Committee discussed the balance to be struck between the no-blame culture that is necessary for openness and mitigating against repeat incidents and the needs of patients and families to identify exactly what has gone wrong. The repetitive nature of the mandated reporting format does not always clearly pinpoint the error that caused the incident. Training needs and follow-up are identified.

The Serious Incidents included:

- a Never Event (Nasogastric tube not in the correct position – but no harm)
- a death of a patient - a series of lapses, involving a detached monitor were discussed, which led to a discussion about alarm fatigue and the possibility of adjusting the Mindray monitoring equipment
- Failure of a dial on an ECMO blender
- a Never Event – retained guidewire

Mandatory Training: Progress was noted and assurances given.

Research – Cardiology: Dr Greg Mellor presented a report on trials in Cardiology. The Committee noted that most of these trials were funded by industry - pharmaceutical and medical equipment companies. Discussion focused on the trial led by Royal Papworth and the Remote Follow-up for SVT/Atrial flutter ablations.

Board Assurance Framework: Risk 2249 was considered. In order to understand the risk and agree its residual rating, the Committee needed sight of the estimate of impact and likelihood. The Deputy Chief Nurse was able to access the information electronically but it would have been useful to include the information in the chart so that it was available in the paper. The Committee accepted the residual risk rating.

Issues for Escalation to the Board: The Board will be asked to consider the balance between safety and throughput/patient flow and discuss the opportunities identified and arising from the work of the Hospital Optimisation Project.

Critical Care Unit: After the meeting, the Chair and the Deputy Chief Nurse visited Critical Care and met members of staff. All comments were positive. The beneficial effect of being able to turn the beds and equipment to face the window were noted.

Susan Lintott
Chair, Quality and Risk Committee
28 June 2019

Recommendation

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