Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3ii

Report to:	**Board of Directors**	**Date: 6 February 2020**
Report from:	**Chair of the Quality & Risk Committee**	
Principal Objective/ Strategy and Title	**GOVERNANCE:** **To update the Board on discussions at the Quality risk meetings dated 17th December 2019 and 28th January 2020.**	
Board Assurance Framework Entries	**675, 684, 730, 742, 1787, 1929, 2249**	
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 The clinical audit plan has been affected by the move with a number of audits delayed. The function also needs refocussing to align with our quality and improvement strategy with its new emphasis on continuous improvement. We have a new clinical audit and improvement manager in post – Mike Bates - who advised that the process needed revitalising and seems to be tackling this vigorously - but with cautions that the team was finding its feet. We will be tracking progress. The audit committee is aware of the issues. Building quality improvement capability is a key element of the quality accounts, as also reported to Q&R in a six-monthly update.

1.2 Mike Davis, Clinical Director of Thoracic, reported on a significant dip in activity and sharp increase in waiting lists, which he attributed partly to the move, partly to recruitment in this directorate being one of the last to see improvement, but also to booking issues with clinics and inpatient areas often well below capacity. He hopes for some progress on this through our various optimisation projects.

1.3 The diabetic specialist nurse has reported a number of concerns around diabetes care. We do not currently fully comply with any of the 25 best-practice Diabetes UK standards, and have limited specialist support from CUH. The principal problem seems to be that diabetic patients' insulin levels are further disrupted by treatment rendering their normal regime inappropriate but that they are so diverse that a full re-assessment of each patient's needs whilst at RPH is not feasible. Our options are limited. Further specialist recruitment seems unrealistic. Streamlined guidance and regimes based on specialist advice might be the best course – perhaps supported through e-learning - which we have agreed to explore. The clinical advice

to the committee was that this was not a high risk to patients, but that there had been some near misses.

1.4 We have been reminded again of cyber risk following recent alarming incidents elsewhere. Another phishing exercise is planned to test staff awareness. Attendance at IGSG meetings is not as healthy as we would like, no doubt because of time pressure, but needs encouraging.

1.5 The main discussion has been related to activity levels, in particular the question of how to maximise activity in CCA where we have struggled to open all available beds. Although 'responsive' and 'effective' are not Q&R domains, we are conscious that delays to treatment, theatre cancellations and so on, do have patient-safety implications. We have therefore linked discussion of PIPR to the optimisation programme in CCA - and discussed at length the difficult trade-offs between activity levels and safety. A few points from our discussions might be worth highlighting: 1. Above all else, that we wholeheartedly support and encourage the optimisation work so far. We commend the efforts of staff to meet the challenges, and especially to respond to the rostering and other issues that have been diagnosed. 2. That some of us nevertheless feel that we do not have adequate information to judge the competing pressures between, on the one hand, the need to maximise the safety of patients in CCA (which can constrain capacity), and, on the other, the overall wellbeing of patients who are delayed or cancelled and who require speedy treatment. We recognise that risks are relative, and that avoiding risk in one area can raise it in another. However, balanced information about potential patient harms from delay can be hard to gather and assess. This leaves us uncertain whether we can have assurance that the correct balance between risks is being struck. Perhaps the best we do at this stage is to judge whether the proposed balance seems reasonable in the absence of good data. 3. We are acutely aware of the stresses on staff and the need to try to ensure that changes have broad acceptance - and we recognise the work of their senior colleagues to support them through a challenging period.

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

2.1 We have ratified terms of reference for the Fundamentals of Care Board, the Quality and Risk Management Group, Safeguarding Committee, Clinical Education Advisory Committee and Education Steering Group.

3. Matters referred to other committees or individual Executives

3.1 The Committee wanted to note their recognition and support for the work being undertaken by staff to address CCA concerns.

4. Other items of note

4.1 We have one new SI of significant note when an elderly patient tripped over monitoring wires and fractured a femur, which cannot be repaired. He has returned home bedbound. The investigation has been thorough, but there is an outstanding question about the case for intervention for the condition with which he presented, which – for a man of his age and frailty – might have been best left alone given the risks of hospitalisation and treatment.

5. Recommendation

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