Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 7 May 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 meeting dated 30 April 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 Normal surgical Morbidity and Mortality meetings (M&M) have been changed to an online M&M taskforce to avoid physically crowded meetings. Whilst not ideal, we're assured that it is a safe compromise. We have asked for an update on working arrangements in areas other than surgery, with the suggestion that this surgical model might also be adopted there.

1.2 We have confirmation that additional indemnity cover has been introduced to cover healthcare workers working as a part of the coronavirus response where existing arrangements do not cover particular activities.

1.3 The final report on an SI into a case of mesothelioma which was late to be identified found that changes in results reporting had led to the delay. The patient outcome was unaffected, but there are several actions arising from this SI - and from concerns elsewhere - which should help make it easier both to highlight important results, and to reduce the volume within the system of routine reporting and acknowledgment – in order that urgent results can be spotted more readily.

1.4 We've been delighted to hear of the innovative and highly-praised work of the Essential Care Teams – AHP colleagues who have teamed up to provide proning (repositioning), personal hygiene and other assistance to COVID patients in critical care. The ECTs have also proved a useful route for some staff into critical-care familiarisation.

1.5 We received PIPR and the COVID performance report and recognised the current difficulty of tracking performance when so much is changing but took great assurance that the Trust is reacting quickly and skilfully to new developments. We noted that RPH outcomes have been good.

1.6 We discussed at length the fact that many risks to performance will inevitably rise as the Trust deals with additional pressure from COVID for some time to come, especially given a big demand for ECMO. A key task in this new environment will be to juggle the many risk trade-offs between COVID and non-COVID patients, together with safety within the hospital and staff pressure. Normal metrics such as 18-week RTT which we have used in the past to help guide these trade-offs might no longer be appropriate.

In the short term at least, we also felt that judgment about risk-priorities will be fluid. Ideally, this should not mean that priorities will be resolved by ad-hoc clinical judgement at the moment of potential admission, but nor can priorities easily be prescribed at this stage. Clearly, this will be a substantial on-going discussion. In light of the difficulty, we welcomed the following developments.

1.6 i) a new patient triage and flowchart to guide admissions for non- COVID patients. This is a lengthy process, but in our judgement necessary initially. Not least, speed for non- COVID patients will depend on the availability of staff as they redeploy from COVID critical care. We expect it to become more streamlined with time.

ii) a review of all current patients to assess the urgency of treatment,

iii) a surgical review of waiting patients at 35 and 52 weeks to help assess the degree of harm that waiting causes.

1.7 BAF. We considered a potential additional risk, namely that our ability to identify and evaluate risk is currently impaired because so many new risks are arising and the hospital model is changing at a time of acute pressure.

1.8 We discussed the sensitivity around workforce risk, especially to BAME employees, and the need to discuss openly how to manage this heightened risk and the various risk factors that might contribute to it. We also discussed the need to distinguish between how much additional risk is specifically a result of being a healthcare worker, and how much is an elevated background risk.

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

2.1 None

3. Matters referred to other committees or individual Executives

3.1 None.

4. Recommendation

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