Agenda Item: 3iii

Report to:	**Board of Directors**	**Date: 7th May 2020**
Report from:	**Chief Nurse and Medical Director**	
Principal Objective/ Strategy and Title:	**GOVERNANCE: COMBINED QUALITY REPORT Patient Safety, Effectiveness of Care, Patient Experience and DIPC**	
Board Assurance Framework Entries:	**Unable to provide safe, high quality care BAF numbers: 742, 675, 1511 and 1878**	
Regulatory Requirement:	**CQC**	
Equality Considerations:	**None believed to apply**	
Key Risks	**Non-compliance resulting in poor outcomes for patients and financial penalties**	
For:	**Information**	

1. **Purpose/Background/Summary**
   The Medical Director and Chief Nurse would like to highlight the following in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. **Quality and Risk Committee Exception report and Escalation April 2020**
   The Chief Nurse and Medical Director have no matters to escalate to the Board as the information is sufficiently summarised in Chair's Report. We would like to inform the Board that the submission date for the annual Quality Accounts has been postponed until the end of the year.

3. **DIPC Report (BAF 675)**
   Guidance has been issued to support organisations to resume services. Due to the design of the hospital we will be able to resume some services alongside fulfilling our role during the COVID 19 pandemic. The infection prevention and control team has produced a set of principles to allow colleagues to start planning service restarts. With good use of PPE and maintaining excellent Infection Prevention Control standards it is felt that this can be achieved safely.

4. **Safer Staffing**
   It is noted that in PIPR the safer staffing metric is red. This is due to ward areas deploying staff to Critical Care. As we reduced and stopped routine services, ward areas have been able to significantly reduce the number of beds. Staffing has been reviewed at the daily safety briefing which has continued throughout the pandemic along with the Duty Matron role to ensure site safety.

5. **Patient and Family Experience**
   A number of initiatives have been introduced since stopping visiting in the hospital. These include the family liaison service and the use of IPADs to allow patient to family communication. We have maintained our position of patients not dying alone.

6. **Clinical Professional Advisory Committee (CPAC)**
   The Clinical Professional Advisory Committee has continued to meet on a virtual and regular basis to ensure staff are supported through a good governance process when they are adapting to new roles and responsibilities. The Q+R committee received a list of developments that have been agreed to date.

7. Inquests/Investigations:

Patient A

Patient had been under the care of the interstitial lung disease service for many years with progressive pulmonary fibrosis and was being considered for a lung transplant prior to death. The patient did not die at Royal Papworth Hospital. Suffolk Coroner heard inquest with no witnesses from Royal Papworth Hospital.

Coroner's conclusion:
Patient died from an industrial disease.

The Trust currently has 39 Inquest investigations/open cases – 1 of which is with an out of area Coroner.

Recommendation:

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