Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.i

Report to:	**Board of Directors**	**Date: 06 March 2025**
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**	
Board Assurance Framework Entries	675, 742, 3040	
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	

Part 1 Summary report from meetings in January and February

1.Significant issues of interest to the Board.

1i. Harm to waiting patients. Reflecting on the major safety risks coming to Q&R, we increasingly feel that safety within the hospital is in reasonably good shape, and that perhaps the greatest risk to safety is now among waiting patients. There've been discussions before about how to control this risk, but if it is now one of the most significant, are our controls equal to it? We're not sure. We continue to feel that we don't have clarity, for example, about what the objective should be of reviewing harm of this kind, and whether the heavy workload of continually monitoring many thousands of waiting patients for deterioration would be a good use of time. We suspect that it would be more useful to assess harm across whole categories of patient, or whole patient pathways, so we can identify those for whom the risks of waiting appear to be greatest, rather than trying to assess individuals. We can then ask if this warrants a shift of resources. TAVI and the recent deaths of waiting patients, raising questions about whether we should do more TAVI – and less of something else – illustrate the issue. That said, we noted that reports of patient harm as a result of waiting are not coming through the medical examiner, for instance.

Harm to waiting patients is a quality account priority for the coming year, so this is a good opportunity to address what the committee feels is currently a **limited assurance**.

1ii. Tavi pathway report. In January, we received the PSII following three reports of patients who had died at local hospitals whilst waiting to go to Papworth for urgent TAVI procedures. The report was thorough, commended by the committee, and usefully identified issues with how information is passed between hospitals, which the committee's discussion elaborated. Creating additional capacity remains the biggest problem, and this is being considered by Performance.

1iii. Scan4Safety. We discussed the safety aspects of this initiative, including whether the common standard on which it works is compatible with options for the new EPR. At the moment, there seems some uncertainty, so we have referred the question to SPC, and also the execs, who have agreed to report back.

1iv. SSIs. We continue to be cautiously optimistic that rates are moving in the right direction. Last quarter was significantly down, January's provisional figures are similar. Our guess is that multiple factors are playing a part. But we also feel that standards easily slip back if not continually reinforced, and that at some point teams are going to have to take up this challenge themselves rather than relying on executive oversight. **Assurance** on the design of controls is good, in that we believe the right policies are in place, **assurance** on outcomes is still limited as we are still above target.

1v. M.Abcessus. New cases remain rare. But the risk control is still evolving. We are conscious, for example, that one of the risk mitigations - water filtering – restricts water flow which can have unintended consequences elsewhere, and so there is a case to move to a judgement of risks around water safety as a whole, not only in respect of M.Abscessus. **Assurance** on design and outcomes remains **good.**

1vi. PIPR/Ward supervisory time had been rising slowly**.** But lately it has shown a much sharper improvement. This has been a long effort and it's good to see results. Although we are not quite at target, we are not far off, and our focus will move more to whether the extra time produces practical improvements in quality of care, as this is an enabling target, not an end in itself. So we will now be seeking evidence that the time is used effectively.

1vii. Surgical outcomes. The committee has been interested in how we monitor cardiac surgical outcomes relative to other centres, so we were pleased to welcome Narain Moorjani to talk about NICOR (National Institute for Cardiovascular Outcomes Research). Overall, we took assurance from the attention given to the data, plus Narain's acknowledgement of areas for improvement. And whereas in the past there was a long delay before comparative data became available, it should be increasingly possible to use interactive tools to interrogate more up-to-date data so that we're alert to any new shifts in relative performance. **Assurance**: good.

1viii. Antimicrobial Stewardship, Q2. On targets to reduce antibiotic use, RPH is performing well relative to others. However, we also heard that there has been a rise over the long term in cases of post-op (i.e. hospital acquired) pneumonia. These are possibly related to patients moving and talking less in single rooms, possibly to more resistance. The team are investigating. **Assurance** on AMS in general is good.

1ix. Medicines incidents. These are rising as a proportion of all incidents, though they have all been no/low harm or near-miss. We suspect this rise is a result of increased awareness and sensitivity after a QI project, which is producing more reporting - a healthy development. So we have no particular concerns. But we also feel that we need more detail about the composition of these incidents in order to identify areas for improvement.

1x. Q&R. The committee workload has eased recently as previous problems have abated, and so we've begun discussing areas to which we could give more attention. Quality improvement is one candidate. As the committee composition changes, this will be a continuing conversation. In January, the committee completed its self-assessment, with results generally

good and two areas noted: the need for better onboarding of governors, which is being addressed, and discussion of the composition of the committee, which is referred to the board.

2. Policies etc, approved or ratified. DN932 Pharmacy Vision; DN168 Chaperone Policy; DN307 Safeguarding Adults Policy and DN931 Delivering Same Sex Accommodation Policy

3. Matters referred to other committees or individual Executives. Scan4Safety compatibility with EPR systems referred to SPC following January meeting. Discussion of the composition of committees referred to board.