Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 5 May 2022**
Report from:	**Chief Nurse and Medical Director**	
Trust Objective/Strategy:	**GOVERNANCE: Patient Safety, Effectiveness of Care, Patient Experience and DIPC**	
Title:	**COMBINED QUALITY REPORT**	
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

The Medical Director and Chief Nurse would like to highlight the following items in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. Covid-19 Update

In March we experienced a spike in COVID nosocomial infections (n=6), at a time when community prevalence was at its highest. Like most organisations sickness absence amongst all staff groups at RPH was also high and many clinical areas were short staffed. Whilst this impacted on clinical activity no patient harm resulted from either the nosocomial infections or reduced staffing. It is pleasing to note that there have been no further COVID nosocomial infections and as the prevalence of COVID has declined in the community so also has staff absence.

In line with National guidance, we are moving to 'living with covid' and whilst we support this, we also need to balance this with our need to protect patients and colleagues. In recent weeks we have made changes to our patient testing arrangements. This is being communicated to our patients and relatives prior to admission. We will keep the guidance under review in line with COVID prevalence and further guidance.

We recognise how important visiting is to patients at RPH and we have supported limited visiting throughout the pandemic. We are now reviewing patient visiting in line with national guidelines and COVID prevalence and will be communicating our approach to this in due course.

.

3. Safer Staffing

The Trust has been supported by a secondment of a Head of Nursing for Safer Staffing, Emily Watts, to assist with nursing establishment setting processes to ensure alignment with best practice and compliance with national standards. This work has included producing a Nursing Establishment Setting Policy, training in the use of the Safer Nursing Care Tool (SNCT evidence-based tool for establishment setting) and formalising staffing escalation processes.

The work has led to the implementation of an Establishment Setting Policy and a number of processes to support safe staffing and real time staff deployment through the use of safe care. Additionally, work on roster optimisation has been ongoing to ensure effectiveness.

Emily leaves the Trust at the end of April 2022, and we would like to thank her for her hard work and for the difference she has made.

4. Inquests

There have been four inquests held and concluded within the month. The Trust currently has 86 Coroners inquests/investigations outstanding.

Patient A:
Patient admitted as emergency via PPCI route with severe cardiac compromise and sadly died. Read only inquest as RPH not required to attend to give evidence.

Medical Cause of Death:
1a Myocardial Infarction

Coroner's Conclusion:
Patient admitted with triple vessel disease, severe cardiac compromise and required balloon pump insertion. Complications arose from the necessary intervention. Prognosis was extremely poor and the patient continued to deteriorate and died.

Patient B:
Patient transferred to RPH on acute cardiac syndrome (ACS) pathway due to evolving (likely anterior) STEMI on previous days. ECG atypical. Admitted to RPH and echocardiogram indicated full thickness myocardial infarction (MI). Patient suffered a sudden collapse and cardiac arrest on the ward approximately 4 hours following admission due to myocardial rupture secondary to infarct.

Medical Cause of Death:
1a Left ventricular rupture
1b Myocardial infarction
1c Ischaemic heart disease
2 Diabetes mellitus (type 2)

Coroner's Conclusion:
Patient died from natural causes.

Patient C:
Elective aortic valve replacement, despite repeated efforts and coronary artery bypass grafting, patient could not be weaned from bypass.

Medical Cause of Death:
1a Acute cardiac failure
1b Aortic valve disease (operated on) and cardiac amyloid

Coroner's Conclusion:
Narrative - Patient died from recognised complications of necessary surgical procedure.

Patient D:
In house urgent patient requiring coronary artery bypass graft surgery. It is standard practice to give Protamine to reverse systemic heparinisation, following test dose, half Protamine was given

and patient suffered significant and sustained drop in blood pressure. Immediate medical management with a working diagnosis of an adverse reaction to Protamine. Patient went back on bypass and VA ECMO instituted. Patient admitted to critical care unit, critically unwell and returned to theatre for bleeding from vein harvest site. High suspicion of bowel ischaemia, prognosis very poor and patient sadly died. Clinical Review undertaken which concluded patient experienced unexpected anaphylactoid reaction to Protamine (WEB 37395).

Medical Cause of Death:

1a Mesenteric ischaemia
1b Peri-operative myocardial infarction
1c Vasoplegic reaction to Protamine
1d Coronary artherosclerosis (operated on)
2 Hypertension, hypercholesterolaemia

Coroner's Conclusion:
Natural causes.

5. Recommendation

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