Agenda Item: 3iii

Report to:	**Board of Directors**	**Date: 1 August 2019**
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 July 2019

In addition to the Chair's report, the Chief Nurse and Medical Director would like to escalate the following to the Board:

Safer Staffing metric is red in PIPR this month. This red is partially due to the inflexibility of the current roster templates for the ward areas, this does not take into account the closed beds as mitigation for reduced staff availability. Please note the green Care Hours Per Patient Day metric. This metric is the care hours delivered per patient (average) and flexes up and down depending on numbers of patients actually admitted. This demonstrates a safe picture for staffing.

3. DIPC Report (BAF 675)

There were no bed closures for IPC issues in July 2019.

4. CQC Well Led Inspection

The CQC have undertaken their Well Led inspection on the 25th – 26th July and following this visit we are likely to receive our final rating in the autumn. Initial feedback was given verbally to Board members and will be followed up in writing ahead of the formal report publication.

5. Inquests/Investigations

Patient A

Patient underwent TAVI and pacemaker insertion at Royal Papworth Hospital (RPH), was discharged and re-admitted to local District General Hospital where they sadly died. Two Consultant Cardiologists from RPH attended the inquest to give evidence.

Coroner's Conclusion: Natural causes

Patient B

Patient underwent aortic valve surgery and developed iatrogenic dissection at the point of the cannulation of the aorta for cardiopulmonary bypass within 24 hours post operatively. Patient returned to theatre with no obvious external tear to suggest the underlying dissection. The aorta was repaired and the patient returned to the ICU. Patient sadly died on ICU.

Cause of death:
1a) Intestinal infarction
1b) Iatrogenic aortic dissection (operated on)
1c) Aortic valve disease (operated on)

Coroner's Conclusion – Medical misadventure – patient died as a result of a known, albeit rare complication of a necessary aortic valve replacement.

Medical misadventure relates to the fact that essentially the medical treatment caused the death ….. arising from some unnatural event which was neither unlawful nor intended by the deceased to result in death.

Patient C
Case re-opened of patient who received dual chamber pacemaker and repatriated to Hinchingbrooke Hospital. Patient re-admitted to Hinchingbrooke two months later and transferred to Royal Papworth Hospital with infected pacemaker site. Pacemaker explantation carried out but sadly patient died a few days post op.

Cause of death: Multi-organ failure secondary to hypo-perfusion and sepsis.

A pre-inquest hearing is being arranged for this case.

The Trust currently has 29 Coroner's investigations/inquests pending with 5 out of area. One further case has been closed by the Coroner at the investigation stage.

Recommendation:

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