Agenda Item: 3.iii

Report to:	**Board of Directors**	**Date: 4 February 2021**
Report from:	**Acting 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 December 2020/January 2021**
   The Chief Nurse and Medical Director have no matters to escalate to the Board as the information are sufficiently summarised in Chair's Reports.

3. **DIPC Report (BAF 675)**
   In addition to the Chair's reports the Chief Nurse and Medical Director would like to report the following:

   Nosocomial Infections
   There have been no nosocomial infections since April, when restricted visiting was introduced.

4. **Inquests/Investigations:**

   Patient A
   Delay in admission for PPCI
   A two day inquest was held and the delay in admission had been previously investigated as a Serious Incident (WEB 32356). The family were represented by Solicitors and submissions were put to the Coroner in terms of a conclusion of neglect.

   Coroner's Conclusion: **Natural Cause**

   There was an acknowledgement of failings but none considered to be causative of the death. There has been learning for the staff involved in the PPCI pathway and improvements to processes to prevent a future event. This learning was shared with the Coroner.

   Patient B
   Patient died at home and was being treated at RPH for progressive pulmonary fibrosis. Inquest held due to occupational exposure.

   Coroner's Conclusion: **Industrial disease**

Patient C
Patient with heart failure and sever left ventricular systolic dysfunction listed for urgent heart transplant. Heart transplantation performed. Following transplantation, it was not possible to sustain adequate cardiac output on weaning from cardiopulmonary bypass. The heart was then rested and proceeded to veno-arterial ECMO support. Unfortunately over the next few days there was no sign of donor heart recovery and primary graft dysfunction was extremely severe and would not be recoverable. Discussed at M&M and agreed for future DCD heart retrievals would not accept heart with rising lactate and high aortic pressures regardless of donor age.

Coroner's Conclusion: Patient died from a recognised complication from an orthotopic heart transplant procedure.

The Trust currently has 68 Coroner's Investigations/Inquests pending with 3 out of area.

Recommendation:

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