Agenda Item: 3.iii

Report to:	**Board of Directors**	**Date: 1 April 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 February2021/March 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 Acting Chief Nurse and Medical Director would like to report the following:

   3.1 COVID-19 Nosocomial Infections
   Our last positive sample at RPH was 17.04.2020. Overall from March 2020 we have had five patients identified as meeting the nosocomial criteria. These cases all occurred in the last week of March (n=2) and the first few weeks of April (n=3). All of these infections occurred in different areas of the Trust. Nationally all NHS visiting was suspended with immediate effect 08.04.2020 which indicates a possible correlation between the stopping of visiting and nosocomial infection rates. We have sustained the same strict visiting since (with reasonable adjustment where required, and this has worked very well).

   3.2 HSE letter: COVID-19 spot check inspection findings
   On the 02.03.2021, the HSE wrote to Chief Executives of all NHS acute trusts, foundation trusts and health boards (Appendix 1, 'covering letter') to advise of some work that they had undertaken as Britain's regulator for workplace health and safety, through a COVID-19 spot inspection programme. As part of this programme, 17 acute hospitals were inspected by HSE across Great Britain during December 2020 and January 2021. They analysed the outcomes from the inspections so that they could use the opportunity to share learning and enable organisations to swiftly identify any common areas that may need improvement.

   Following this, the HSE provided a summary of their findings (Appendix 2, 'summary of findings') along with a number of recommendations, which they anticipate organisations will use in a constructive way alongside other quality improvement approaches to ensure COVID-19 arrangements are as robust as they can be. The HSE advise that whilst the inspections were carried out in acute hospitals the common themes they identified may also be applicable across a variety other health and social care settings and services. The Acting Chief Nurse reviewed the information and presented an initial summary position paper to the Trust EDs meeting for information on the 09.03.2021. RPH appears to

be compliant with all of the recommendations. RPH also meets a number of the 'examples of good practice', summarised by HSE in Appendix 2.

The Acting Chief Nurse circulated the information to key leads across the Trust (03.03.2021) to consider the findings and provide any further information where necessary. The Acting Chief Nurse is in the process of collating any further information provided and will triangulate this with the initial report to provide a final position document.

3.3 COVID-19 Board Assurance Framework
The NHS developed this framework to help providers assess themselves against the national guidance as a source of internal assurance that quality standards are being maintained. It was also designed to help identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The latest version was published during February 2021 (version 1.6). This has been reviewed by the RPH IPC team and RPH is compliant with all aspects of the document.

4. Inquests/Investigations:

Patient A
Patient transferred from District General Hospital with severe aortic stenosis and following MDT discussion patient had TAVI procedure. There was successful deployment of prosthetic valve however the patient experienced a significant drop in blood pressure and cardiac arrest. The reason for the complication was extensively discussed at the Cardiology M&M and the clinical impression was that there had been a period of coronary hypoperfusion whilst the prosthetic valve was passed through the patient's heavily stenosed aortic valve.

Cause of Death:
1a Acute cardiac failure.
1b Myocardial hypoperfusion
1c Aortic stenosis (operated on)

Rule 23 – RPH did not need to attend inquest.

Coroner's Conclusion: Died from a rare but recognised complication of a necessary surgical procedure

The Trust currently has 76 Coroner's Investigations/Inquests pending with 6 out of area. Our Clinical Governance Team are in regular liaison with the Coroner's Office and a number of these pending cases are listed for inquests or Pre-Inquest Reviews in 2021/22.

Recommendation:

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