Agenda Item: 3.ii

Report to:	**Board of Directors**	**Date: 3 June 2021**
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 April/May 2021

The Chief Nurse and Medical Director would like to bring the following item to the attention of the Board.

Never Event - SUI-WEB39351- Misplaced Nasogastric tube

This was reported at SIERP on 18 May 2021 when the timeline of the patient's NG tube placement was presented. The placement of the tube was not checked prior to medication being given and the post-operative chest x-ray revealed the NG tube was misplaced. This has been reported to the relevant appropriate external authorities and shared for immediate internal awareness. The subsequent investigation will review the circumstances which led to the insertion error and will review the previous 2019 NG tube never event to confirm the recommendations and lessons learnt.

DIPC Report (BAF 675)

Infection Control RCA and Alert Organism Report from Olly Allen, Consultant Microbiologist, for the IPCC meeting held 18th May 2021 is available within Appendix 1. These graphical reports are based within the timescales of the pandemic peaks April 2020 – April 2021.

Internal mock CQC inspection of End of Life services 26 October 2020

Following the mock CQC inspection of the End of Life (EoL) Services in October 2020, a robust action plan was drawn up to monitor progress against recommendations. An update on progress can be seen at Appendix 2.

Inquests/Investigations:

Patient A

Patient had a PCI to the right coronary artery in August 2015 and December 2015. A CT scan was performed in 2015 due to a concern of aortic dissection, which was not seen on imaging but did alert an incidental left upper lobe tumour lesion which was not acted on. In 2018 the patient was seen in Thoracic Oncology and a CT/PET scan diagnosed left upper lobe lung cancer, which was inoperable. A

Serious Incident (SUI-WEB27476) was undertaken in 2018 and the findings shared at the time with the patient. Patient sadly died in April 2020.

Inquest – Out of Area (Stoke Coroner)

The Coroner was assured regarding actions put in place, not to issue a Prevention of Future Deaths (PFD) report.

Medical cause of death: 1a Metastatic lung adenocarcinoma

Coroner's conclusion: A natural cause contributed to by neglect

Patient B
Patient transferred for an emergency VATS procedure to evacuate haematoma secondary to multiple rib fractures following a fall at home. Repatriated to DGH post procedure and died.

Medical cause of death:
1a Respiratory failure
1b Chest Trauma
1c Fall
II Parkinsons Disease, Ischaemic Heart Disease

Coroner's Conclusion: Accident

Patient C
Emergency transfer for respiratory ECMO and patient experienced multiple complications related to illness and sadly died.

Medical cause of death:
1a Multi-organ failure
1b Community Acquired Pneumonia and Aspergillosis
II Haemophagocytic Lymphohistocytosis, Veno-Venous Extracorporeal Membranous Oxygenator Support

Coroner's conclusion: Natural Causes

The Trust currently has 77 Coroner's investigations/inquests outstanding with 6 out of area.

Nurses Day Celebrations

Nurses Day celebrations were held on Wednesday 12 May, giving all Royal Papworth staff a chance to reflect on the amazing things we have achieved in the last year and what it means to be a nurse in 2021. At 17:00, the Florence Nightingale Foundation broadcasted a memorial service for Florence Nightingale at Westminster Abbey. This was show in meeting rooms 1 and 2 on the ground floor of the hospital, along with complimentary refreshments and an online link available for all staff members that were at home. Between 18:00-19:00 speakers were invited, who played national roles during the COVID-19 response, to be interviewed by members of the Royal Papworth staff and informally discuss what they last year has been like for them and why they are proud to be nurses.

Caldicott Annual Summary Report

The most recent review of the principles was in December 2020 and recognition was given to the occasion that there are times when it is necessary to share information about a patient for their safety and improved care. Following a consultation, an eighth principle was added:

Principle 8: Inform patients and service users about how their confidential information is used.
A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will be required.

To note for 6 months of the year 2020 – 2021, the position of Caldicott Guardian was held by the Deputy Chief Nurse during a period of acting up into the Chief Nurse Role between October 2020 and April 2021. As part of the action plan, it was noted that resilience needed to be added to the function, and to this end, two deputies were identified and both undertook training.

The Caldicott Guardian function continues to be supported by the SIRO and the Information Governance Team.

Caldicott Log:
A log of Caldicott request and queries is kept and reviewed by IGSG once a quarter.

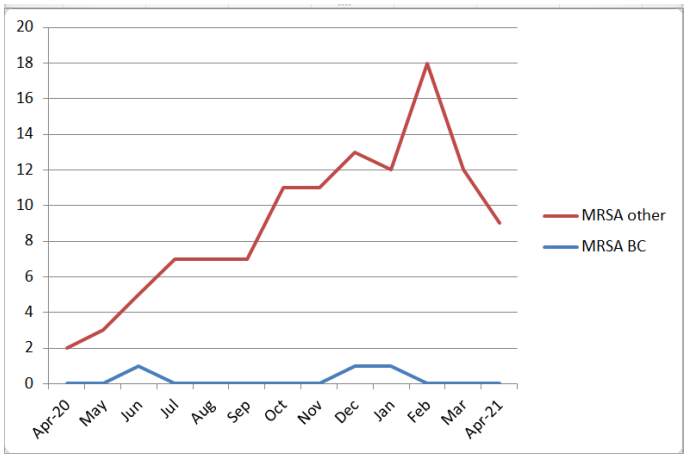
Action plan:
The 2020 – 2021 action plan is available within Appendix 3. It is recommended that this action plan is rolled forward for 2021 – 2022 due to the interruptions in work caused by the pandemic. It is suggested one further action is added, and that is to audit the newly added principle during the year, share the results and implement any learning.

Recommendation:

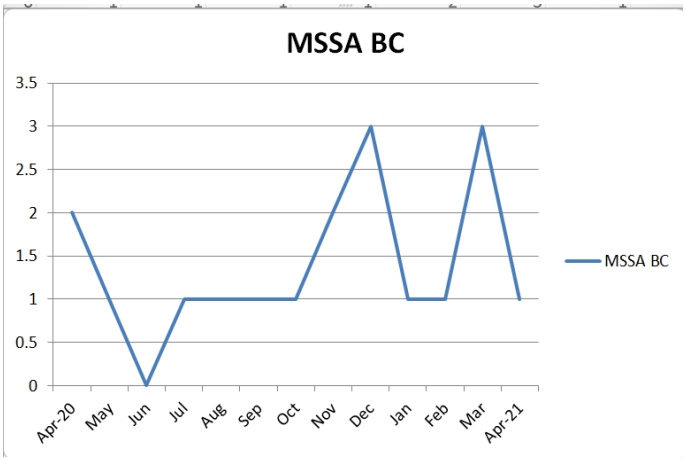
The Board of Directors is requested to note the contents of this report.

Appendix 1
Infection Control RCA an Alert Organism Report for IPCC
Author: Olly Allen

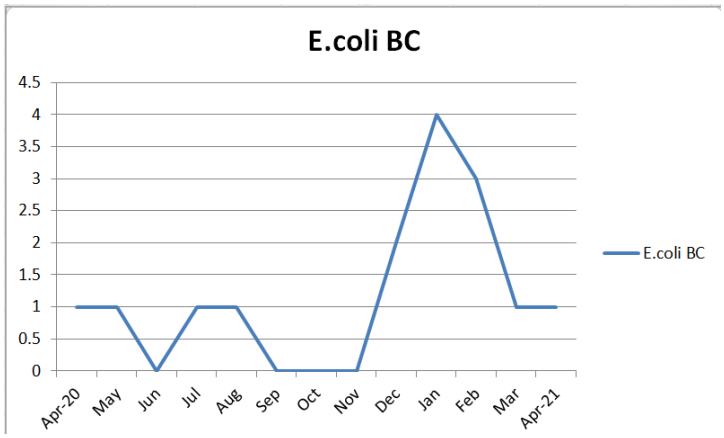
MRSA (April 2020 – April 2021)



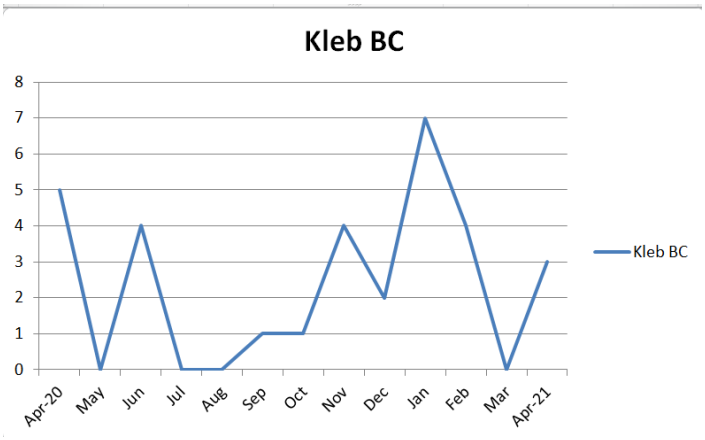
MSSA BC (April 2020 – April 2021)



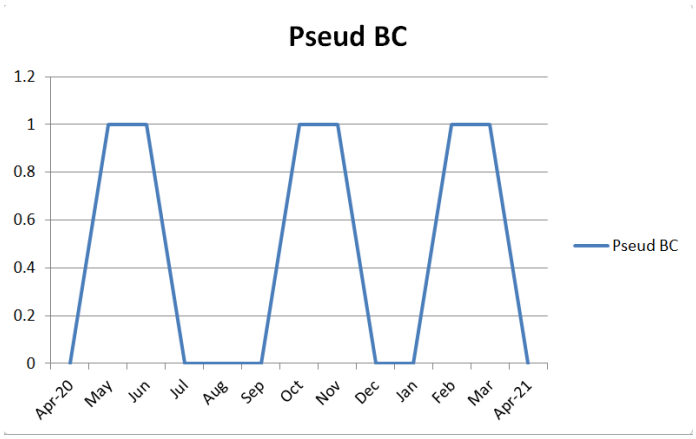
E.coli BC (April 2020 – April 2021)



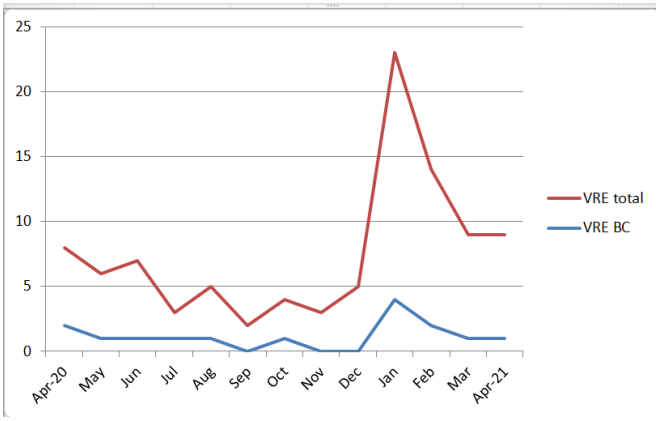
Klebsiella BC (April 2020 – April 2021



Pseudomonas BC (April 2020 – April 2021)

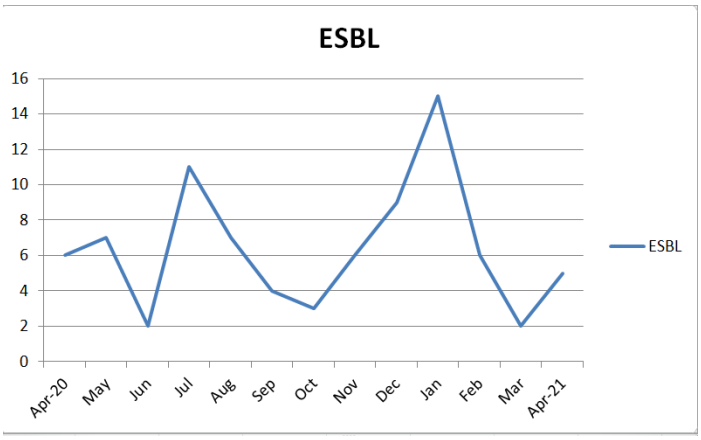


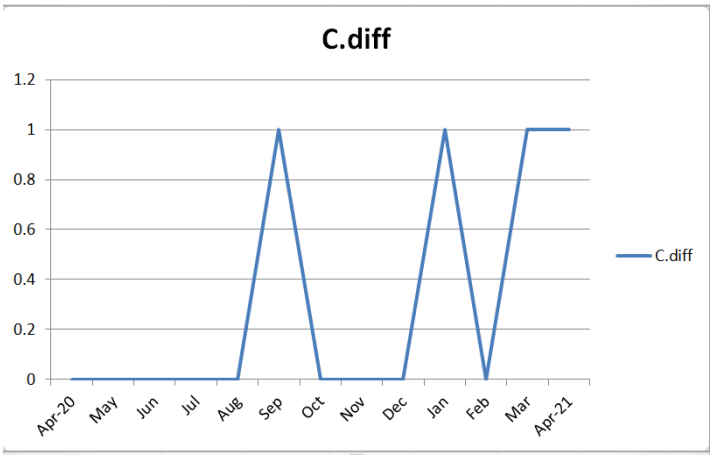
VRE (April 2020 – April 2021)



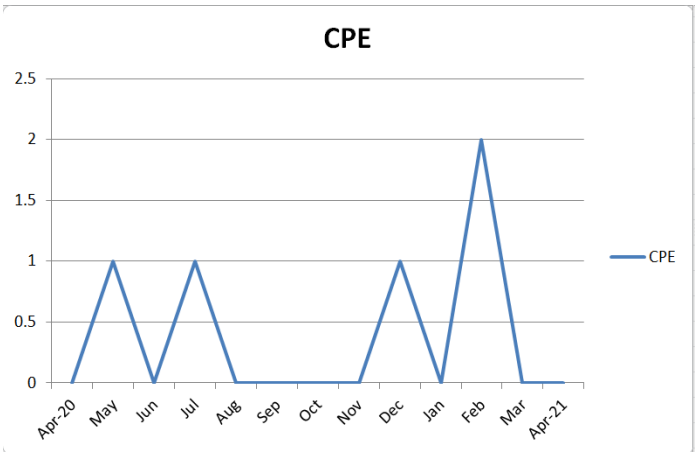
ESBL (April 2020 – April 2021)

C.difficile (April 2020 – April 2021)

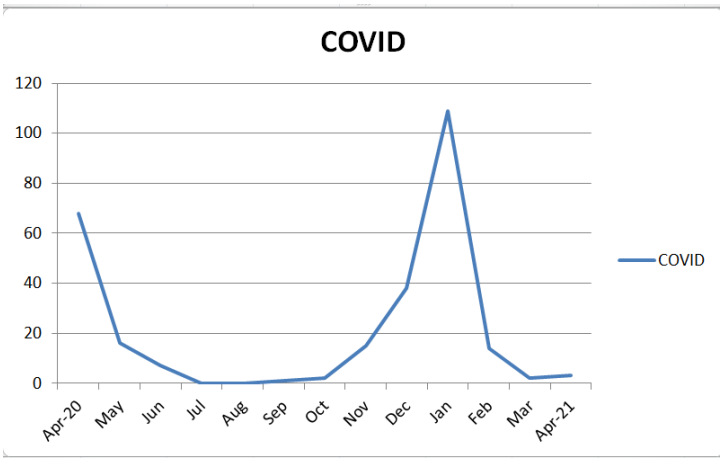




CPE (April 2020 – April 2021)



COVID (April 2020 – April 2021)



Appendix 2

Update - Internal mock CQC inspection of End of Life services 26 October 2020

There were several concerns highlighted, including around the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). The Trust has established a multidisciplinary steering group in relation to ReSPECT.

The ReSPECT steering group is attended by senior clinicians and nursing staff from each division. It has updated the procedure for ReSPECT (DN751) and this is in the process of being ratified by the Quality and Management Risk Group, following which it will be distributed across the trust, through various forums (CPAC, PMAC, Alert Steering Group, End of Life Steering Group).

There is ongoing education surrounding the ReSPECT process across the Trust. It forms part of induction training for all new starters and an e-learning module is in the final stages of development, which all staff within the trust will be able to access. There is monthly audit of ReSPECT documentation and this is also used as an opportunity to deliver contemporaneous feedback and additional training where necessary.

In addition to the above, members of the ReSPECT steering committee have been attending morbidity and mortality or educational meetings in all divisions to promote the ReSPECT process, offer training and discuss ways that it can be included into current pathways. There is a plan for it to be trialled in a cohort of surgical patients and it is also due to be discussed at next month's surgeons' meeting.

Good digital engagement has offered increased flexibility with the electronic patient record to facilitate a more accurate completion of the digital ReSPECT form.

Attendance at the EoL Steering Group has greatly improved, with representatives from each Division.
As had been planned for some time, an individualised care plan for a patient at the end of life was been added to Lorenzo in October 2020 to support and exceed the NICE quality standards for Care of Dying Adults. This has been communicated via the Weekly Briefing and the Nursing Message of the Week and will continue to be promoted by the Supportive and Palliative Care (SPC) Team. The Guidance for the Care of the Deceased Patient (DN825) has also been reviewed and updated.

A quarterly SPC Newsletter has been introduced and education links on the SPC intranet pages have been reviewed and updated. The SPC team continue to provide teaching to a broad range of staff on a regular basis.

Trust-wide EoL care Champions already exist and participate in regular meetings. ReSPECT champions are being actively recruited Trust wide. The Champions in both areas help ensure continual two-way flow of information and education. Whilst there are few incidents related to EoL Care reported, these are reviewed at the EoL Steering group and any learning is disseminated through the Ward Champions.

The EoL Care Strategy for 2021-2024 has been rewritten to reflect the new Trust Strategy and will be published shortly.

The SPC team already has good links with consultants in other transplant centres and have recently started developing links with the nursing team in another specialist cardiothoracic centres.

Redefining the allocated dedicated safe spaces on wards for difficult conversations still remains challenging whilst extra space is required for staff to work safely and socially distanced, however this is mitigated by the use of other ward spaces (bedrooms/office) when necessary.

Ongoing monitoring and progress against the action plan is led by the Quality Compliance Officer in partnership with the SPC Team and ReSPECT Steering Group. It is reported through the EoL Steering Group, ReSPECT Steering Group and Fundamentals of Care Board.

Appendix 3

Caldicott Guardian Action Plan April 2020

Action Required	Lead	Timeline / Status	Comments
Refresh log template to identify evidence and record of decision, and place where this is recorded	JR/DH	1st October 2020	EG has made a start on this using sharepoint however no further progress has been made due to the pandemic. The existing log is still in place. Liaison with EG is required to progress this.
Identify Caldecott Guardian deputies and enable them to attend a training session	JR/CS	1st April 2021	• Ivan Graham, Deputy Chief Nurse – training booked for 18th September 2020 • Eamonn Gorman, Chief Nursing Information Officer and Deputy Director of Digital - training booked for 18th September 2020 Action completed.
Share Caldicott principles to refresh organisational knowledge	JR	1st December 2020	No progress made due to the pandemic.
Review IG training and ensure this is up to date	JR/DH	1st October 2020	No progress made due to the pandemic.
Quarterly report to IG steering group, and then to Q+R	JR	1st November 2020	JR attended IGSG to present Quarterly Caldicott report: • 1st July 2020 • 2nd September 2020 • 13th May 2021 Quarterly Caldicott report to be presented to Q&R: • 27th May 2021
Annual report to the Board	JR	3rd June 2021	Caldicott Annual Summary Report included within Combined Quality Report to be presented to Board on 3rd June 2021.