

Agenda item 3.ii

Report to:	Board of Directors	Date: 9 June 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. Surgical Site Infections:

Surgical Site Infection (SSI) reporting (internally and to UKHSA) consists of identifying coronary artery bypass graft (CABG) patients with a surgical wound infection that meet defined SSI criteria. As part of reporting, patients are grouped in terms of when their infections are identified:

- Inpatient (during current surgical admission) or readmission due to wound infection
- Other post discharge follow-up e.g., outpatients/ community team
- Self-reported by patients

UKHSA produce quarterly SSI summary reports comparing RPH rates to all hospitals that submit their CABG SSI rates. The UKHSA benchmark comprises of inpatient and readmission data for CABG patients only. RPH do however report on all categories of surveillance i.e. post discharge presentations and patient reporting. This is encouraged by UKHSA, to allow Trusts to understand their true infection rates however for the purpose of benchmarking only inpatient and readmission data is used.

Since moving to the Cambridge Biomedical Campus in May 2019, RPH has seen a higher than previous SSI rate. In addition, Q4 2021, surveillance indicates a further spike in surgical site infections.

The surgical site infection stakeholder group was set up in 2019. The group has multi professional membership and has increased frequency of meetings to ensure actions are progressing in a timely way. The focus of actions is on education, attention to ensuring best practise principles are adhered to an organisational approach to getting the essentials in respect to infection prevention and control right.

3. Critical Care Transformation Programme

The Critical Care Transformation Programme is 14 weeks into its duration.

The critical care multidisciplinary team are continuing to work with the transformation lead and programme manager on four key areas, roles and responsibilities, roster optimisation, workforce education and development and culture and civility.

So far, the work of the group has ensured the sustained opening of 33 beds on critical care with the aim to progressing to 36 beds over the next few months. The main area of focus for the coming weeks will be roster optimisation to ensure systems and processes are in place to deliver optimal staff utilisation at the same time as providing staff with a positive work life balance.

4. Inquests

Patient A

Patient discharged with epithelioid malignant mesothelioma of the right pleura, being medically managed.

Medical cause of death:

1a Mesothelioma

Coroner's conclusion:

Industrial disease

Patient B

Patient required thoracic surgery and had a complicated recovery period before transfer to critical care where they further deteriorated and died with bronchoaspiration.

Medical cause of death:

1a) Hepatic and intestinal infarction (operated on)

1b) Rupture of right hemidiaphragm

1c) Right upper lobectomy lung volume reduction surgery for chronic obstructive pulmonary disease.

Coroner's conclusion:

Died from recognised complications of surgery.

The Trust has 85 Coroner's inquests and investigations currently outstanding.

5. Recommendation

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