Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 7 July 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 reporting has described RPH as an outlier when compared to all hospitals that submit in respect to SSI with a spike in incidence in Q4 2021/22.

   The incidence of SSI remains high particularly in respect to organ and deep space infections for months 1 and month 2 of 2022/23. As previously noted, whilst many improvements are in progress to address the SSI it remains too early to note reduction in incidence.

   Response and governance oversight
   The Trust declared a serious incident in respect to SSI due to the need for organisational investigation and learning to improve and continues to have a whole organisational response to SSI with increased focus and attention on essentials of IPC practise, environment and systems and processes for actioning and escalating concerns.

   An enhanced governance structure is in place to ensure oversight of patient harm reviews and monitoring of all actions associated with working groups, and a monthly report is given to the Quality & Risk Committee.

   An external review by subject matter expert has been commissioned by the Trust with on-site visit in July.

   External stakeholders are being kept up to date with rates of SSI and progress of actions.

3. Critical Care Transformation Programme

This month's Critical Care Transformation Board was held on 29th June. The Critical Care Transformation Programme is now in week 19 and continues to utilise well established performance and control measures to track the delivery of multiple workstreams including roles and responsibilities, optimisation of the roster, culture and civility, and workforce. Weekly Critical Care Implementation Group meetings continue to be well attended by senior members of the multi-professional team from critical care. As the programme lifecycle moves towards forward, a key milestone in the coming weeks is the completion of a sustainability maturity assessment. This will be undertaken separately with both the STA triumvirate as programme sponsors, as well as with the critical care multi-professional team leads. Critical care bed base is currently at 35 beds, as a positive outcome of the work undertaken through the Transformation Programme.

4. Covid-19 Guidance

Following guidance from NHS England and NHS Improvement, our infection prevention and control (IPC) team have assessed the Trust's mask wearing policy and introduced the following changes:

- Outpatients must wear a mask in clinics and treatment rooms and are encouraged to wear masks in the outpatient waiting area.
- Visitors must wear masks in all clinical areas, including all wards, patient bedrooms, outpatient clinic rooms and treatment rooms.
- Inpatients must wear a mask if confirmed or symptomatic of Covid-19, and when being transferred from one department to another. It is advised for patients to wear masks in clinical areas.
- Staff must wear masks when in patient rooms and bays, in clinic rooms and in day ward bays.

5. Inquests

Patient A

Patient transferred with non-ST segment elevation myocardial infarction (NSTEMI). Background of progressively worsening breathlessness and weight loss. Previous percutaneous coronary intervention (PCI) on right coronary artery, peripheral vascular disease (PVD), chronic obstructive pulmonary disease (COPD), hypertension (incidental lung cancer found on CT scan at RPH). Patient admitted for transcatheter aortic valve implantation (TAVI). Severe aortic stenosis and left sided coronary artery disease. Not suitable for open procedure due to aortic calcification. Patient underwent left main stem PCI and TAVI in 2019.

Patient suffered deteriorating function following deployment of the valve. Contained annular rupture noted. Coronary arteries were patent. Femoral pacing wire and IABP inserted and transferred to critical care. Vascular issues encountered and therefore IABP removed. Patient continued to deteriorate and sadly died.

Medical cause of death:

1a Cardiac failure
1b Aortic valve disease (operated on) and ischaemic heart disease
2 Chronic obstructive pulmonary disease

Coroner's conclusion:

Patient died from a known complication of a necessary surgical procedure.

Patient B

Patient underwent pacemaker insertion (3 wires) for severe heart failure. During follow up it was noted that the left ventricular (LV) pacing lead was not working. The patient had a past

medical history of severe heart failure, chronic kidney disease Stage 4, hypertension, gout, and pulmonary embolism in 2012.

Patient admitted for LV pacing lead replacement but at the time of the procedure, the patient had pericardial effusion and therefore drain inserted and patient admitted to ward for close monitoring. Patient transferred to local hospital for ongoing dialysis, where their condition became palliative with transfer to Hospice where the patient sadly died.

Medical cause of death:
1a) Acute kidney failure
1b) Congested heart failure
1c) Cardiac tamponade

Coroner's conclusion:
Died as a result of rare but recognised complication of surgery.

Patient C
Patient with aortic valve stenosis, angina, congestive cardiac failure was referred for TAVI. Patient had a past medical history of chronic renal failure, hypertension, peripheral vascular disease with previous iliac and renal artery stenting and diabetes. The patient was admitted for a cardiac pacemaker in preparation for TAVI, discharged home and admitted to local hospital with congestive heart failure. Transferred to RPH for TAVI and admitted to Critical Care for non-invasive ventilation. The patient underwent a high risk, difficult TAVI procedure with suspected coronary occlusion leading to myocardial ischaemia and therefore acute cardiac failure. Sadly, the patient died in the cath lab.

Medical cause of death:
1a) Left coronary ostial occlusion
1b) Transcatheter aortic valve implantation
1c) Aortic stenosis
2) Chronic kidney disease. Peripheral vascular disease.

Coroner's conclusion:
Patient died from a rare but recognised complication and deterioration from the procedure.

Patient D
Patient had double lung transplant previously. Past medical history included cystic fibrosis (CF), renal transplant, apical cardiomyopathy, CF related diabetes mellitus, CF related sinus disease and low trauma bone fractures. Patient admitted with probable pneumonia with repeated transient episodes of acute severe oxygen desaturation associated with increased breathlessness on the ward and in critical care. Patient sadly had cardiopulmonary arrest and died.

Serious Incident Investigation – SUI-WEB 38598
Escalation of a deteriorating patient on the ward and critical care investigated as a Serious Incident. This concluded there were missed opportunities and there has been learning for the Trust but concluded the patient's death could not be prevented.

Medical cause of death:
1a) Diffuse alveolar damage
1b) Bilateral lung transplant (2002)
1c) Cystic fibrosis

Coroner's conclusion:
Patient suffered from cystic fibrosis necessitating bilateral lung transplant (2002) and also underwent kidney transplant in 2006 with kidney donated by family member. Both transplants necessitated immunosuppressant medications, that likely exacerbated an infective pneumonia

that caused massive and ultimately un-survivable damage to the lungs, precipitating cardiac arrest and death.

The Trust has 88 Coroner's inquests and investigations currently outstanding.

6. Ivan Graham

Deputy Chief Nurse, Ivan Graham, will be leaving the Trust on 24th July to take up the position of Nurse Director for Urgent and Emergency Care at NWAFT. Ivan's contribution to RPH has been immense during his time here and we would like to thank him for his outstanding work, especially his leadership during the RPH move and more recently during the COVID pandemic. We wish him every success in his new role and future career.

7. Recommendation

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