Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 1 September 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:**
   The Trust continues to respond to the increased incidence in surgical site infections with a focus on ensuring essentials of infection prevention and control are being adhered to. Monitoring and improvement actions are being addressed through a robust audit programme which has oversight from the surgical site response group and the infection prevention and control committee. The Trust welcomed Mr Simon Kendall on August 10th to provide an external review of the surgical patient pathway in light of the current high incidence of SSI. Mr Kendall is President of the Society of Cardiothoracic Surgeons, previous cardiac surgeon at South Tees NHS Foundation Trust and current MD NHSEI, North East Yorkshire and North Cumbria. The SSI response group will consider and action recommendations from the review which includes consideration of evidence based practice measures, compliance with infection prevention control standards and theatre ventilation system. Whilst the quarter 1 (2022/23) incidence of SSI remains high, month 3 shows signs for improvement.

3. **Water safety:**
   Routine water sampling has identified legionella in water samples from some water outlets. The water safety group with representation from stakeholders including Skanska, OCS and water authorised engineers, clinical and estates staff are meeting twice weekly and addressing a number of actions to ensure water safety is maintained for patients and staff. Filters are fitted to taps to maintain safety whilst eradication measures including chlorination of affected outlets, enhanced flushing and further testing are underway.

4. **Congratulations**
   Congratulations to Jennifer Whisken on being appointed to the post of Deputy Chief Nurse at Royal Papworth following a competitive recruitment process. Jennifer has extensive experience across nursing specialities combining clinical and leadership responsibilities at CUH and more recently at RPH. We look forward to working with Jennifer in her new role and wish her every success.

We are also delighted to announce the appointment of Dr David Meek as the new chair of the Quality and Risk Management Group. Dr Meek has an outstanding track record of patient care in the Thoracic Oncology service and is a very welcome addition to the Medical Directorate team.

5. Inquests

Patient A
On postoperative day 1, patient suffered a respiratory arrest after choking on their dinner. Significant period of low or absent cardiac output resulting in a hypoxic brain injury and patient sadly died.

Serious Incident SUI-WEB 36518
Cause of choking and response to arrest investigated as Serious Incident, which concluded that no acts or omissions in care contributed to the patient's deterioration. However, it did identify opportunities for improvements in practice with a number of actions which have been completed with support from the Lead for Dietetics and SaLT.

Cause of death:
1a Hypoxic brain injury
1b Resuscitation related injury to the heart and blood loss
1c Aspiration and respiratory arrest
1d Aortic valve disease and coronary artery disease (operated on)

Coroner's Conclusion
Misadventure (*unintended consequence of an intended act*)

At inquest the family were keen to understand lessons learnt and actions taken by the Trust. They felt reassured that learnings and actions had happened.

The Trust has 97 Coroner's inquests and investigations currently outstanding.

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