Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 1 December 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. **CQC IR(ME)R Inspection**
   The CQC carried out an IR(ME)R Inspection on 2nd November 2022 at the Trust. The inspection was part of a proactive inspection schedule in the region.

   Following the inspection, the Trust has received two Improvement Notices from the CQC, relating to the Trust's duties to:

   IR(ME)R Regulations 2017 Regulation 6: Employer's duties: establishment of general procedures, protocols and quality assurance programmes; and

   IR(ME)R Regulations 2017 Regulation 8: Employer's duties: accidental or unintended exposure.

   The Trust had identified a number of gaps in compliance prior to the inspection and commenced actions to rectify. The action plan is being led by Cardiology and Radiology.

3. **HCSW Celebration Event**
   The Trust celebrated the work that its Healthcare Support Workers (HCSW) do and showed its appreciation by holding a few events during the week of 21st November, including a display in the Atrium and entry for all HCSWs in a raffle, winning prizes such as champagne, self-care packages and hampers, which were donated by local businesses and local individuals.

   On Wednesday 23rd November, the Chief Executive and Chief Nurse spent time walking round the hospital giving all HCSWs a letter of thanks and a gift voucher as a small token of appreciation.

4. **Inquests**
   Patient A
   Patient diagnosed with mesothelioma and managed by oncology services.

   Coroner's Conclusion: Industrial disease

Patient B

Patient transferred as IHU for aortic valve replacement (previously delayed due to MRSA colonisation and required treatment). Patient's clinical condition deteriorated at induction of anaesthesia, complex operation and recovery requiring haemofiltration and maximum inotropic support.

Cause of death:
1a) Multi-organ failure
1b) Aortic valve disease (operated on)

Coroner's Conclusion: Patient considered to be high risk and condition quickly declined from the outset of the operation despite the efforts of two experienced senior surgeons. Patient remained stable for the following few days without clinical improvement and died.

Patient C

Patient with severely dilated left ventricle and severe aortic regurgitation. Cardiac surgery (Ross procedure) was performed in 2016. Patient recovered well and was discharged home. However, the patient suffered an unexpected cardiac arrest at home three weeks later, admitted to Addenbrookes Hospital and transferred to Papworth ICU. Emergency surgery was performed and a mechanical circulatory support device inserted.

Investigation undertaken (WEB21590) which identified clinical service issues in relation to two postponements of surgery. A third postponement occurred due to patient being clinically unfit. The investigation was unable to identify a link between the unexpected cardiac arrest and the postponements of surgery.

Cause of death:
1a) Peri-operative myocardial infarction
1b) Ross procedure for aortic valve disease

Coroner's Conclusion: Narrative
Awaiting full conclusion from Coroner's Office

5. Recommendation

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