**Agenda item 3.ii**

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| **Report to:** | **Board of Directors** | **Date: 2 March 2023** |
| **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. **Non-Executive Director and Governor attendance at Visibility Rounds at the Trust**
   On 2nd February, Non-Executive Directors and Executive Directors took part in a 'Step In Your Shoes' Visibility Round, visiting Cardiac Rehabilitation, 5 North and Clinical Engineering. Additionally, on 9th February, Governors were invited to attend a Quality Visibility Round and visited 5 South and Day Ward. These rounds are part of an initiative to increase visibility of EDs, NEDs and Governors in the Trust, to showcase the work that we do and to give an increased opportunity for senior staff, NEDs and Governors to talk with members of our staff and our patients.

   The visits were a positive experience for both visitors and staff working in the areas. Staff were very welcoming and proud to showcase their areas.

   Visibility Round reports are shared with relevant areas with learning and ideas for improvements welcomed. Additionally, patient stories from the visits are captured and shared at Committee, Sub-Board Committee and Board meetings.

   Visibility Rounds are held weekly and attended by the Chief Nurse, Deputy Chief Nurse, Heads of Nursing and Matrons and are open to NEDs, Governors, EDs and all staff.

3. **RN and HCSW Vacancies**
   The Trust continues to have very high vacancies in Registered Nurses (12%), which is affecting roster fill rates.

   It is recognised that staff put many measures in place so that there is low impact on patients' quality and safety, as can be observed in our PIPR report. However, the Trust does recognise the potential impact that sustained vacancies have on our staff.

   Unregistered vacancies and turnover figures have improved through focused recruitment over the last few months, with vacancy rate now at 16.1%. There has been positive interest and

recruitment from recent recruitment events, and we look forward to new staff joining us over the coming months.

## 4. Inquests

**Patient A**

Past medical history of chronic obstructive pulmonary disease (COPD), high blood pressure and ischaemic heart disease with patient undergoing aortic valve replacement and coronary artery bypass graft surgery. The following year, the patient required sternal fixation and subsequently experienced sternal dehiscence and non-union of the sternum. This was a recognised complication of previous medical procedures. Despite treatment at Royal Papworth Hospital and West Suffolk Hospital, the complication led to osteomyelitis, sepsis and ultimately multi-organ failure, resulting in the patient's death.

**Cause of death**:

1a Multi-organ failure
1b Sepsis
1c Sternal osteomyelitis following sternal plating
2 Non-union sternum following coronary artery bypass graft and aortic valve replacement, COPD (ex-smoker), hypertension, ischaemic heart disease

**Coroner's Conclusion**:

Died as a result of recognised complications of necessary medical procedures.

**Patient B**

Past medical history of atrial fibrillation (requiring Warfarin) and pulmonary hypertension. Patient underwent elective aortic and tricuspid valve replacements. A number of issues addressed post operatively in critical care but significantly had a large left retroperitoneal haematoma with mass effect and active bleeding. General Surgeon's advice sought and given. Patient transferred to local hospital for further rehabilitation. Due to a lack of progression to a respiratory wean, patient was re-referred to the long-term weaning unit at Royal Papworth Hospital. Before transfer patient had an episode of acute deterioration (bilateral retroperitoneal haematomas), not treatable and sadly the patient died.

**Cause of death**:

1a Retroperitoneal haematoma
1b Aortic valve regurgitation and tricuspid valve regurgitation (operated on)
2 Atrial fibrillation and anticoagulation therapy

**Coroner's Conclusion**:

Died from a spontaneous retroperitoneal haematoma (having undergone elective surgery) as a likely consequence of a necessary anticoagulation treatment regimen and in the presence of other risk factors of vessel weakness and renal failure.

**Patient C**

Patient had non-ST elevation myocardial infarction, transferred to Royal Papworth Hospital and angioplasty with stent carried out. Patient died six months later from a traumatic subdural bleeding following a fall.

**Cause of death**:

1a Traumatic subdural bleeding
1b Head injury
1c Fall
2 Atrial fibrillation, myocardial infarction, Type 2 diabetes mellitus, high cholesterol

**Coroner's Conclusion:**
Accident

**Patient D**
Patient transferred for VV ECMO in respiratory failure due to SARS-CoV-2. Despite intensive treatment patient suffered irreversible catastrophic brain injury and died.

**Cause of death**:
1a Sub-arachnoid haemorrhage
1b Multi-organ failure
1c COVID 19 pneumonia

**Coroner's Conclusion**:
Natural causes – awaiting full conclusion

**Patient E**
Patient had planned AF ablation and discharged home. Three weeks later attended local A&E due to chest pain, referred and transferred to RPH Interventional Cardiology Team. Patient managed overnight in Cardiology High Dependency Unit and despite on-going intervention, the patient did not respond to treatment and sadly died. Post mortem examination confirmed cause of death was related to an atrio-oesophageal fistula. This was reported as an incident and a serious incident investigation undertaken.

**Serious Incident learning (SUI-WEB 26431)**
Conclusion – Atrio-oesophageal fistula is a rare complication associated with a very high mortality and the patient's survival is highly dependent upon the timing of presentation, early recognition of symptoms and prompt intervention. There was a failure to recognise the complication and therefore, although treatment was initiated with the intention of correcting the presenting symptoms, had the actual cause been established earlier, more intensive treatment could have been commenced. Requesting an opinion from the on call Electrophysiology Consultant may have supported an earlier diagnosis and intervention. Earlier escalation to Critical Care would have initiated more intensive treatment and support. However, evidence from the literature reviewed for this investigation demonstrates that, even with early intensive support, mortality as a result of this complication remains very high.

**Learning and actions**:
- These were managed and completed in 2018/19 by the Cardiology division
- The Trust met with the family in 2019 to discuss the findings and actions.
- An alert card was developed for patients to highlight the symptoms of atrio-oesophageal fistula post AF ablation.

**Cause of death:**
1a Purulent pericarditis
1b Oesophago-pericardial fistula
1c Ablation therapy for atrial fibrillation
2 Reflux neuropathy. Secondary hypertension

**Coroner's Conclusion: Narrative**
Agreed to make patient's alert card a formal card in honour of the patient.

**Patient F**
Patient with asbestos related usual interstitial pneumonia (UIP) disease. Significant progression of disease and patient died.

**Cause of death:**

1a Pulmonary fibrosis
1b Asbestosis

**Narrative conclusion**:
Died from an industrial disease, although the exact location and timing of exposure to asbestos fibres could not be ascertained on the available evidence.

The Trust currently have 105 inquests pending.

## 5. Recommendation

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