Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 1 June 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 (PIRP) to the Board:

2. Serious Site Infection (SSI) Rates:

Surgical Site Infection Rates remain a high priority for the Trust in respect to quality improvement. Rates for April for inpatients and readmissions remain high at 8.4%. The national benchmark is 2%.

The governance structure in respect to managing SSIs has been reviewed to enable more oversight of key areas of work and this has been very welcomed.

On 12 and 13 June we will welcome infection control experts from NHSE and the ICB who will carry out a peer review.

3. International Nurses Day and National ODP Day:

Thanks to everyone who made International Nurses Day on 12th May and ODP Day on 14th May such a success and to those who joined in the celebrations. All nursing and ODP staff received a cup cake and nursing staff were given the opportunity to share their views and contribute to the development of our future Nursing Strategy. Staff had an opportunity to play Guess Who?, by guessing who RPH nursing staff were from pictures of their formative years, express their thanks and leave messages to nurses and ODPs, and enter the amazing free raffle. Also, we shared and celebrated some fantastic work by our teams that have been participating in conferences both nationally and internationally.

4. Dying Matters Week:

The Palliative and Supportive Care Team ran a week-long stand in the atrium to highlight Dying Matters Week from 9th to 12th May. Themes included: Dying Matters, Managing Legal Affairs, Remember Me Day, and What Matters to Me? and encouraged staff members, patients and visitors to talk openly, share stories and seek advice if required.

The event was led by Hospice UK and supported throughout the week by Barr Ellison Law, the HR team and Health and Wellbeing Practitioners.

5. Inquests

Patient A

The patient suffered with Motor Neurone Disease with bilateral diaphragm weakness and carbon dioxide retention and had been under the care of Royal Papworth Hospital Respiratory Support and Sleep Centre. The patient was admitted to their District General Hospital Emergency Department with Type 2 Respiratory failure and chest sepsis. Whilst in the Emergency Department, the patient underwent a chest x-ray. As a result of human error in the hospital's x-ray imaging processes, another patient's x-ray, which indicated a left pneumothorax, was mistakenly uploaded to the patient's medical notes; this error was not highlighted until the treating team had already attempted to insert a drain into the patient's chest. A subsequent CT scan confirmed the patient had suffered a left sided iatrogenic pneumothorax. The continuing presence of the iatrogenic pneumothorax, despite further medical intervention, meant that the treating medical team were no longer able to continue providing respiratory support for the condition. Although the patient's prognosis had been poor on admission the iatrogenic pneumothorax both contributed to and hastened death.

Cause of death:
Ia Chest Infection
Ib Motor Neurone Disease and Iatrogenic Pneumothorax

Coroner's Conclusion:
Narrative conclusion: The deceased suffered a progressive decline in their health as a result of Motor Neurone Disease; death was accelerated by the effect of an iatrogenic pneumothorax caused by mislabelled x-ray images.

Patient B

During first pregnancy, patient was diagnosed with a dilated aortic root but did not subsequently undergo any follow up or surveillance following this diagnosis. During second pregnancy, patient presented with chest pain and was diagnosed with an acute aortic dissection. Patient underwent emergency aortic surgery with grafting of the aorta and surgery to the right coronary artery. The patient was transferred to Royal Papworth Hospital and underwent a further right coronary artery graft.

The patient recovered from surgery, was followed up at Royal Papworth Hospital for mitral valve regurgitation and was being considered for further mitral valve surgery. In the ten days prior to death, the patient developed atrial fibrillation and was seen by the Cardiology Department at their District General Hospital. The day prior to death, the patient attended hospital again with atrial fibrillation and was reported to be haemodynamically stable, discharged but suffered a further cardiac arrest and collapsed and patient sadly died.

Cause of death:
1a Hypoxic brain injury
1b Ventricular fibrillation due to infarction
1c Previous right coronary artery dissection (operated) secondary to previous aortic dissection (operated)

Coroner's Conclusion:
Narrative Conclusion – awaiting full record of Inquest from Coroner.

Patient C

The patient had a past medical history of myocardial infarction, urostomy and prurigo nodularis. The patient presented to their District General Hospital following a fall at home and was found to have suffered a traumatic pneumothorax with multiple rib fractures. A few days following surgery the patient's condition deteriorated, was admitted to ICU and then transferred to Papworth Hospital for consideration of surgical solution for left sided chest issue/fluid collection. However, on arrival at RPH the patient's condition deteriorated and an esophagogastroduodenoscopy (OGD) was performed to address an upper gastrointestinal bleed. The patient was considered to be in multi organ failure, was moved to palliative care and passed away at RPH.

Cause of death:

1a	Myocardial Infarction
1b	Ischaemic Heart Disease
1c	Coronary artery atherosclerosis

Coroner's Conclusion:
Narrative conclusion – this summarised the patient's past medical history and their fall, treatment at their local hospital, their transfer to RPH critical care and subsequent death. There was no learning for the Trust.

There are currently 109 Coroner's investigations/inquests outstanding.

6. Recommendation

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