Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 6 July 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:

The Trust saw an improved position in May, as can be seen in appendix 1, with the post CABG surgery rate of infection currently at 2.6%. This will be updated as necessary throughout the Quarter.

The new governance structure and workstreams for the Trust's ongoing work on SSIs are in place as we continue to progress the quality improvement work relating to SSIs.

On 12th and 13th June, the Trust welcomed five infection control experts from the NHSE and ICB who visited the Trust to carry out a supportive peer review of IPC practice. The visiting team found all staff to be very welcoming, open and honest and we are expecting to receive their written report within the next week.

3. Learning Disabilities Awareness Week:

The Trust celebrated Learning Disabilities Awareness Week from 19th – 23rd June, which included a focus on patient experience.

Good practice was observed, including good communication between ward nursing and specialist nursing, the use of passports and adjustments for individualised care. On 3 North, excellent individualised care of a long-term patient was observed regarding adjustments and involvement of carers in the patient's care and planning for discharge after a long-term stay in hospital.

The Learning Disabilities Awareness Week highlighted the importance of understating patient and carer experience and an opportunity for improvements to be actioned, such as clearer documentation for Mental Capacity Assessments.

4. Head of Nursing Appointments

From 1st July 2023, Lisa Steadman will take up the position of Head of Nursing Thoracic Medicine and Ambulatory Care and will be joining Dr Michael Davies and Zoe Robinson as part of the Triumvirate. As a skilled Head of Nursing, Lisa has a wealth of knowledge to bring to the division and is excited about expanding her knowledge and expertise.

Also from 1st July 2023, Judith Machiwenyika will commence in the role of Head of Nursing STA until the post has been substantively filled. Judith will bring a wealth of experience as a clinical leader and nurse consultant to the role.

5. Inquests

Patient A

Patient had a previous history of multiple deep vein thrombosis and pulmonary embolus for which they were anticoagulated. Diagnosed with chronic thromboembolic pulmonary hypertension and underwent pulmonary endarterectomy surgery. Surgery was unremarkable with satisfactory clearance. In Critical Care, the patient desaturated needing paralysis and ventilation. Chest x-ray was initially clear. A CT scan showed complete collapse of the right middle and lower lobes. The endotracheal tube (ET) was too low and there was also a large pneumothorax. The ET tube was withdrawn and repeated fibreoptic bronchoscopy was performed in an attempt to clear the bronchi.

As arterial oxygenation did not improve, a repeat CT scan was performed which showed features of infection within the right middle and right lower lobe. The ET tube was still low with the tip at the level of the carina. Distension of the gall bladder and mild intra and extra hepatic biliary ductal dilatation. A bronchoscopy showed an occluded right main bronchus with pus and slough. The ET tube was retracted under direct vision. The patient had ongoing difficulties with oxygenation and ventilation requiring paralysis. Patient required escalating doses of inotropic support and vasoconstrictor therapy. Inflammatory markers were increasing, rising lactate, and CT scan showed multiorgan ischaemia/infarction involving the bowel, liver, kidneys, pancreas and spleen and a progressive cavitating pneumonia. The CT head showed findings consistent with a hypoxic ischaemia encephalopathy. Patient kept comfortable but sadly died.

Incident investigation

Initially, malpositioned ET tube (corrected) was reported in cause of death as 1b. Reported as an incident and investigated by the Trust's Airway Management Lead.

An ET tube needing repositioning within the trachea is a common ICU issue. It appears to have been appropriately addressed and documented by medical and nursing staff. Medical and nursing care in this regard appears to be of a good standard and appropriate checks were performed. Radiological findings at no point demonstrate an endobronchial intubation, although the ET tube was initially too close to the carina. The ET tube carina position is dynamic and it is possible for the lungs to move up onto the ET tube when lying flat.

From evaluation of the notes and the imaging, the ET tube positioning does not appear to be sufficiently significant to be a 1b cause on the death certificate. From the notes, all appropriate procedures were followed.

This review was shared with the Coroner and discussed at inquest between the Airway Lead and Pathologist, the cause of death was amended to 2. Malpositioned endotracheal tube (corrected),

Cause of death:
1a Pneumonia
1b Pulmonary thromboendarterectomy
1c Chronic thromboembolic pulmonary hypertension
2 Malpositioned endotracheal tube (corrected)

Coroner's Conclusion: Narrative Conclusion
The patient underwent pulmonary thromboendarterectomy surgery and immediate post operative recovery progressed well. On the second post op day the patient's O_2 level requirements increased. Investigations found that the patient had a developing pneumonia and despite active treatment continued to deteriorate and died.

Patient B
Patient with a number of complex co-morbidities being managed by local hospital and referred to RPH for obstructive sleep apnoea assessment. Patient required admission to RPH for six weeks due to significant fluid overload. Pulmonary hypertension diagnosed and at discharge ongoing management to continue by local hospital. Patient admitted to local hospital four months later and sadly died.

Cause of death:
1a Right ventricular failure
1b Pulmonary hypertension, obesity, obstructive sleep apnoea and tricuspid valve disease

Coroner's Conclusion – Natural causes

There are currently 111 Coroner's investigations/inquests outstanding.

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