Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 5 October 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:

Please note the SSI Dashboard as appendix 1.

Improvement work continues on SSIs and the Board is asked to note that the consolidated rate for Quarter 1 2022/23 is 6.3%.

As part of the continuing SSI improvement programme, the Director of Infection Prevention and Control (DIPC), IPC Lead and Deputy Head of Nursing STA visited the Liverpool Heart and Chest Hospital on 5th September for shared learning. Key learning is being considered and actioned through the SSI stakeholder group.

3. NHS Adult Inpatient Survey 2022 Results

The NHS Adult inpatient survey 2022 was published on 12 September 2023 and looks at the experiences of people who stayed at least one night in hospital as an inpatient.

Royal Papworth Hospital has again been named as one of the best NHS hospitals in the country for inpatient care and is one of eight Trusts classed as much better than expected and received 76% of positive responses. In addition, a response rate of 62% was recorded, which was well above the national average of 40%, therefore more representative and offering more assurance and reliability of the survey results.

Whilst we celebrate our achievement in maintaining a ‘better than expected’ rating, we will be reviewing the results to build an understanding of those areas rated ‘somewhat better’ and ‘about the same’. This will enable us to identify areas for improvement based on this feedback and make any necessary changes to improvement the experience of our patients who use our services.

Please see appendix 2.

4. 15 Steps and Visibility Rounds

Visibility Rounds in September have had a focus on staff wellbeing and safeguarding vulnerable people.

Staff wellbeing rounds looked at whether staff are getting what they need in terms of having regular 1:1s, team meetings and appraisals. Training requirements are also discussed to ensure that they are given the opportunity to attend appropriate training and feel they have the right skills for their role, in addition to ensuring that staff feel informed and involved in the main Trust priorities, for example SSIs.

Governors and non-executives joined the senior nurses for 15 steps round on 11th September. The group visited Phlebotomy, Respiratory Physiology and 4South. Staff working in the areas visited were very welcoming and proud to showcase wards and departments and the continuous improvement work being caried out. Highlights included calm and clean environments, good communication between staff and patients, good signage, including chaperone posters. Areas for improvement which included attention to supply of hand sanitiser and correct storage of equipment are being addressed by relevant wards and departments.

5. Inquests

Patient A

Patient underwent a bilateral lung transplant in early 2022. Post operative recovery was slow and 10 days post op, it was reported that the explanted lung showed evidence of a pulmonary embolus. Further tests ruled the patient was suffering from pulmonary emboli at that time and the patient received appropriate anticoagulation whilst in hospital. However, there was no evidence of a DVT on ultrasound of the leg veins and balancing risks, the decision was made against oral anticoagulation on discharge. *

Patient discharged home 3 weeks after transplant. A clinic follow up appointment a week after discharge showed post operative tests were clear and the patient was continuing to make progress. The following day the patient collapsed at home and died the following day from pulmonary emboli.

Medical Cause of death:

1a Pulmonary emboli
2 Lung transplant

Coroner's Conclusion:

Natural causes.

*Note added after review in Q and R committee.

Patient B

Patient was admitted to the Critical Care Unit for veno-venous extracorporeal membrane oxygenation (ECMO) in the setting of acute respiratory failure due to aspiration pneumonitis. The patient had clinical history of a fall necessitating surgical fixation of cervical spine injury.

Following admission to Royal Papworth Critical Care Unit, the patient remained critically unwell in multi-organ failure despite ECMO support. The clinical features were in keeping with profound septic shock with acute liver failure and coagulopathy. Sadly the patient did not respond to maximal organ support and the decision was taken to stop treatment in agreement with the patient's family and the multidisciplinary ICU team at Royal Papworth Hospital.

Medical Cause of Death:
1a Multi-organ failure due to sepsis
1b Aspiration pneumonia
1c Fall
2 Obesity, hypertension

Coroner's Conclusion
Accidental death

Patient C
The patient underwent successful heart transplant surgery in 2017 but subsequently developed further cardiac complications and chronic kidney disease. These conditions significantly impacted on their immune system and quality of life. The patient subsequently contracted an infection, deteriorated, was admitted to the Critical Care Unit for further intensive electrolyte support and placed on a ventilator from which they did not recover and sadly died.

Medical Cause of Death:
1a Multiorgan Failure
1b Neutropenic Sepsis of unknown origin
2 Cardiac transplant, chronic kidney disease, Type II diabetes mellitus

Patient D
Patient had a complex past medical history, including previous cardiac surgery (coronary artery bypass graft in 2013), diabetes, systemic hypertension, atrial fibrillation, pulmonary embolism and previous heart attack. The patient previously developed pneumococcal meningitis and septicaemia, with mitral endocarditis and consequent severe regurgitation.

Initially patient was referred to Manchester for mitral valve repair, but requested referral to Royal Papworth Hospital and underwent surgery in January 2020. Operation and recovery were uneventful and patient was discharged home a week later. The patient had follow up care and appointments at Manchester and there was no further correspondence with RPH. The patient died of cardiac failure due to the rupture of the prosthetic mitral valve that had been inserted in 2020. The patient was too unwell for open surgery to repair the valve; at the time of death the patient was being assessed for potential key hole surgery.

Medical Cause of Death:
1a Congestive cardiac failure
1b Mitral regurgitation (Perforation of tissue valve inserted in 2020)
1c Structural valve degeneration

Coroner's Conclusion:
Died of cardiac failure due to a ruptured prosthetic heart valve.

The Trust has currently 116 Coroner's investigations/inquests outstanding.

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