Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 7 December 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: 675, 742**	
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. Surgical Site Infections (SSI)

The confirmed inpatient/readmission rate for Quarter 2 is 6.1%. This data will be submitted to UKHSA in December 2023.

The SSI Stakeholder Oversight Group meets monthly and reviews the assurance dashboard, work and actions undertaken by the task and finish groups. A detailed review of actions, data and evidence of embedded practice is currently being undertaken to guide the improvement work going forward. The assurance dashboard and actions are monitored by the Quality & Risk Committee.

The SSI Dashboard is attached as Appendix 1 for information.

3. Antimicrobial Stewardship Newsletter

The Medical Director and Chief Nurse are pleased to advise the Board that Royal Papworth Hospital remains one of the best performing Trusts in the region for Quarter 2 in terms of antimicrobial stewardship and has achieved the 10% reduction from the 2017 baseline in Watch + Reserve antibiotic (broad spectrum antibiotics) consumption.

4. National Health Care Support Workers' Day

The Trust celebrated National Health Care Support Workers' Day on 23rd November by highlighting the contribution made to patients' lives by its Healthcare Support Workers (HCSW).

Celebrations included quizzes and cupcakes in the Atrium, plus staff and patients were invited to leave a message for the HCSWs. The Trust Charity funded a selection of treats that were delivered to staff rest areas by the Deputy Chief Nurse and the Trust Secretary.

5. Inquests

One inquest heard in October which RPH had assisted the Coroner with but no-one from the Trust was required to attend to give evidence.

Patient A
The patient was referred from a District General Hospital to the virtual Interstitial Lung Disease (ILD) Multidisciplinary Team (MDT) clinic at Royal Papworth Hospital with worsening breathlessness. Case was discussed and a CT scan undertaken previously at the local hospital was reviewed. The patient did not attend Royal Papworth Hospital and only advice was given with the patient being referred back for local follow-up.

The patient died later that month. The Post Mortem report was not definitive for asbestos exposure and RPH was asked to provide their opinion on the comments from the Pathologist and Consultant Histopathologist.

Medical Cause of Death:
1a) Pulmonary fibrosis of uncertain cause

Coroner's Conclusion:
Died of pulmonary fibrosis of uncertain cause.

6. Outstanding Coroner investigations

The governance team have been undertaking an exercise with the Coroner's Offices to determine if any of the open Coroner investigations (not inquests) have been discontinued and closed without Royal Papworth Hospital receiving notification. As a result, 52 Coroners investigations have been closed (these were originally notified to the Trust between the following dates: 27/11/2018 - 28/04/23), of these 50 were open to Cambridgeshire and Peterborough and a further 2 with Bedfordshire coroner's office.

This exercise has also resulted in the Cambridgeshire and Peterborough Coroner's Office listing several Pre-Inquest Review Cases for older cases to agree next steps with the family and Interested Persons. Our oldest case is with the Cambridgeshire and Peterborough Coroner's Office for a transplant patient who died in January 2018. A Pre-Inquest Review Hearing was held in November 2023 where next steps were agreed with all Interested Persons. It is anticipated this inquest will conclude in 2024.

The governance team are reliant on the Coroner's Office informing them a case has been discontinued, however the team will be proactively contacting the different Coroner's Offices on a more routine basis to establish if progress has been made with listings.

There are currently 66 Coroner's investigations / inquests outstanding.

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