Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 1 February 2024**
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. Safe Staffing

It is pleasing to see a consistent improvement in safe staffing fill rates for both registered and unregistered staff. In December we supported opening uncommissioned bed capacity to support the system capacity pressures. We recognised and thanked staff for their support and flexibility in response to this initiative. Safe staffing levels were maintained through the use of increased overtime when necessary.

3. Surgical Site Infections (SSI)

We continue our focus on surgical site infections, and it is pleasing to see an improvement in our UKHSA reporting (SSI rate 5.3%) however rates remain higher than the UKHSA benchmark. Areas of particular focus for continued improvement are pre-operative skin decolonisation, environmental cleanliness on the surgical wards and theatre footfall.

4. 15 Steps Visibility Round

A positive 15 Steps Visibility Round was undertaken on 11th January with the Chair and Governors in attendance. Areas visited included Radiology and Outpatients. Key points to note were the friendly staff at both the Atrium and Outpatients receptions, good patient experience expressed by patients spoken to on the Round, and calm and organised environments. Learning points were taken with regard to larger signage, the possibility of a linen trolley being available in Radiology changing rooms, night cleans and the importance of increased communication when equipment was due to be tested.

Staff spoken to expressed that they were happy and were undertaking training. However, some raised concerns about staff retention as Cambridge is an expensive place to live.

5. Inquests

One inquest heard in December 2023 and 2 pre-inquest review hearings with the Cambridgeshire & Peterborough Coroner. The purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest.

There are currently 71 Coroner's investigations/inquests outstanding.

Patient A

Patient referred to Royal Papworth Hospital for pacemaker insertion. The patient suffered a number of underlying medical conditions and due to repeated falls, was looked after in a Care Home. After an unwitnessed fall at the Home, the patient was taken to their DGH and diagnosed with a pubic rami fracture. While in hospital they suffered a further fall, but no further injury or change to the existing pelvic fracture was noted. The plan was to mobilise and then discharge the patient, however blood cultures confirmed Methicillin Resistant Staphylococcus Aureus (MRSA). Treatment was commenced for this but the patient continued to deteriorate and died in the DGH.

Medical Cause of Death:

1a) Infective Endocarditis
1b) Methicillin Resistant Staphylococcus Aureus Septicaemia
1c) Ischaemic heart disease (operated on)
2) Dementia, Parkinson's Disease, Atrial Fibrillation, Frailty of Old Age, Pneumonia.

Coroner's Conclusion:

Died due to the consequences of hospital acquired MRSA.

6. Recommendation

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