Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 6th June 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. **Surgical Site Infections (SSI)**
   There has been progress in many areas of IPC compliance through 2023/24, however the average rate of infections remains above target. Following a further deep dive into a spike in March, a half day summit is being organised to include and involve wider teams in 'Next Steps'.

3. **Safer Staffing**
   The improved position with Safer Staffing fill rates for daytime and nighttime staffing (Registered Nurses and Health Care Support Workers) has been maintained throughout March and April.

4. **Nurses' Day**
   We celebrated Nurses' day on May 10th this year with teams showcasing their services and disciplines, coming together for bring and share lunches and highlighting where in the world staff had come from.

5. **Congratulations**
   Congratulations go to Judy Machiwenyika on her appointment to the substantive role of Head of Nursing in STA. Judy has been in an 'acting up' position for the past 10 months.

6. **Inquests**

   Three inquests where heard in March 2024. The Trust also attended one Pre-Inquest Review Hearing (PIRH) with the C&P Coroner and with our legal team in attendance The purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest. The Coroner is planning to have a further PIRH in September for this case with the final hearing expected at the end of the year.

   Two inquests were heard in April 2024. The Trust also attended one PIRH with the C&P Coroner and statements from clinicians were provided to the Coroner. However, prior to the

PIRH, it was agreed that the Trust was not an Interested Person (IP) in this case and attendance was not required.

There are currently 88 Coroner's investigations/inquests outstanding.

Patient A (March)
Patient diagnosed with Obstructive Sleep Apnoea (OSA) in 2009 and under the care of RPH. The patient's OSA was considered to be within the mild category, due to oxygen desaturation index, at the time of diagnosis. The patient did not report an escalation or worsening of their OSA and was last seen by RPH team in November 2019. The patient was referred back to RPH in November 2021 following a visit to their GP reporting that they had lost their CPAP equipment and requesting a replacement.

In 2019 the patient was seen at their DGH reporting 2 attacks having been found unresponsive by a family member and was assessed as suffering a dissociative attack which was not epileptic in origin. Two months later, the patient departed the UK for an extended stay abroad, returning in 2021. Eight months later, the patient reported to their GP a repeat of the night-time attacks when abroad, where medical checks advised that all findings at that time were normal.

The patient was found deceased at home the following month by a family member. A Post Mortem report found a previously undiagnosed mass within the septum of their heart, and on the balance of probabilities, experienced a sudden fatal arrhythmia with a cardiac cause leading to death.

Medical cause of death:
1a Sudden arrhythmic death

Coroner's Conclusion:
Natural causes.

Patient B (March)
The patient was first discussed in the Interstitial Lung Disease (ILD) virtual clinic in 2019 and attended ILD clinics in 2020 and 2022. They were admitted to their DGH in May 2023 with chest pains and a productive cough. Despite investigations and ongoing treatment for interstitial lung disease, the patient died in hospital.

RPH were asked to support the Coroner's investigation and provided a statement in relation to the patient's condition and potential work related exposure to toxic substances.

It was concluded the patient died of acute respiratory distress syndrome, secondary to interstitial lung disease and bronchopneumonia and also had an enlarged heart.

Medical cause of death:
1a) Acute Respiratory Distress Syndrome
1b) Interstitial Lung Disease and Bronchopneumonia
II) Pulmonary Thromboemboli and Cardiomegaly

Coroner's Conclusion:
Natural causes.

Patient C (April)
Patient presented to his DGH in May 2022 with symptoms of abdominal pain and diarrhoea. On the basis of an abnormal ECG reading the patient was transferred to RPH with suspected acute coronary syndrome (ACS). The patient was assessed and given the presentation, observations

and test results, ACS was ruled out. The patient was admitted to RPH for ongoing observation and the following day took the decision to self-discharge, contrary to medical advice. Patient was found deceased at their home address three weeks later. Resuscitation attempts were unsuccessful.

Medical Cause of death:

1a) Near total occlusion of left anterior descending coronary artery
1b) Atherosclerosis
2) Hypertension and Type 2 diabetes mellitus

Coroner's Conclusion:

Natural causes

Patient D (April)

Patient referred from their DGH in November 2021 for aortic valve replacement surgery, which was performed in April 2022. The operation was uneventful and the patient was stepped down from critical care to the ward the next day. The patient continued to make steady progress and was discharged home a few days later. The patient attended an outpatient clinic three months later, was found to have recovered well and was discharged from RPH care. Nine months later, the patient was holidaying abroad when they became unwell, was admitted hospital there and underwent surgery for an infected prosthetic aortic valve. However, the patient developed post operative complications and died.

Medical Cause of death:

1a) Hypovolaemia shock
1b) Anastomotic haemorrhage
1c) Aortic valve and aortic replacement for prosthetic valve infective endocarditis
II) Aortopathy and cardiomegaly due to aortic valve disease.

Coroner's Conclusion:

Died from catastrophic postoperative haemorrhage after repair of an infected aortic valve.

7. Recommendation

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