Agenda Item: 3ii

Report to:	**Board of Directors**	**Date: 6th June 2019**
Report from:	**Chief Nurse and Medical Director**	
Principal Objective/ Strategy and Title:	**GOVERNANCE: COMBINED QUALITY REPORT Patient Safety, Effectiveness of Care, Patient Experience and DIPC**	
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/Background/Summary

The Medical Director and Chief Nurse would like to highlight the following in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. Quality and Risk Committee Exception report and Escalation May 2019

The Quality and Risk Committee is now monthly – updated TOR attached for approval (includes new monthly focus). This was in response to the move to the new hospital and the need to monitor quality of care and treatment delivery closely in the new environment and the work load of the committee.
The board are asked to note the following exception items from Q+R.

2.1 Venous thromboembolism (VTE) risk assessment compliance; the Trust has not been compliant with VTE risk assessment targets for 5 quarters. A harm assessment has been completed, and it is noted that patients are still receiving appropriate prophylaxis. The Chief Nursing Information Officer (CNIO) has been working with DXC, the Lorenzo EPR provider and has secured a commitment to make the risk assessment a mandatory field. We are waiting for a timeline for completion. This will continue to be monitored at Quality and Risk Committee.

2.2 The committee noted that workforce issues continue to flag red on the Ward Score Cards, mainly due to vacancy rates in both HCSW and registered staff groups.

2.3 The Quality and Risk Committee received the following annual reports which are attached for information:

- **Director of Infection Prevention and Control (DIPC)**
- **Learning from Deaths**
- **Quality and Risk Annual report** - the Board is asked to note:

    - During 2018/19 there were 15 patient safety incidents reported as serious incidents. This compares with 11 in 2017/18.
    - During 2018/19 the Trust gave evidence at 19 Inquests; the coroner's conclusions have been reviewed and there are no trends.
    - In 2018/19 Royal Papworth Hospital received 54 formal complaints from patients, the previous year this was 70 formal complaints.
    - During 2018/19, the PALS Service received 3023 enquiries from patients, families and carers. This was an increase of 509 enquiries on the number recorded in 2017/18, which was 2514
    - The Trust remains fully compliant with responding to Safety Alerts throughout 2018/19

3. DIPC Report (BAF 675)
Bed closures for IPC issues in May 2019:

Ward	Number of bed days in May 2019	Reason
Mallard	4	Loose stools

These bed closures were on the Papworth Everard site and had no impact on care delivery or patient flow as it was during the cutover period when activity had been reduced to accommodate a safe move.

4. Quality Priorities for 2019/2020 - Safe Hospital Move update
One of the quality priorities set this year was to move the hospital safely from the Papworth Everard site to the Cambridge Biomedical Campus. The first stage of this priority has now been completed. Below is an executive summary:

Due to the delays, the move process was moved from September 2018 to April 2019. To ensure a safe transition, annual leave was restricted to ensure adequate staff were available for simultaneously caring for patients, and moving the hospital.

The move process started on the 23rd April 2019, using the natural ramp down period of the Easter break to start the reduction in activity. Command and Control Centre opened successfully on the 26th April 2019 and then opened daily during the cutover period.
The equipment moves went to schedule and the sign off of clinical areas allowed for the opening of the new site to patients as planned on the 1st May 2019. There were slight delays in commencing in the catheter labs and in theatres due to lack of overnight cleaning; this was quickly remedied. The admission and treatment of the first patients was followed quickly with the cutover of emergency activity at 12 noon on the same day. Within 20 minutes of declaring the emergency services cut over the new site saw the first emergency referrals on the Primary PCI service (heart attack service). The site received 2 unexpected patient transfers from a local Trust and accommodated these patients. The new site was up and running.

At the old site cohorting of patients was going slightly slower than planned due to the volume of patients still as inpatients. The planning for patient transfer went as planned on the 2nd May with ambulance staff engagement. It was decided to bring 2 Critical Care patients across to the new site ahead of the schedule due to the nature of their conditions. This was carried out without incident.

By Saturday 4th May, the hospital was almost completely open, and patient transfers commenced at 8 am as planned. The teams worked collaboratively to ensure safe patient moves, and enabled all transfers to take place in 1 day. This was completed with zero patient safety events.

The Papworth Everard site was closed to patient activity on the 4th May 2019.

The opening of the outpatient services on the new site commenced on Tuesday 7th May which was the last piece of the new site to open.

Command and Control Centre closed on 7th May and the hospital moved into the recovery phase. The hospital transition now moves into optimisation.
The Cutover group have had a debrief meeting and the hospital move will now be formally evaluated.

5. Quality Priorities for 2019/2020 - Focus on Falls Quality Improvement update
When designing the new hospital, falls were of significant concern due to the move to almost completely 100% single bedrooms. There has been careful consideration of bedroom design using learning from other Trusts and from our own falls data; however until in the new building it was difficult to predict the impact of the new designs on patient fall incidents. In preparation for the move, the Falls Specialist Nurse increased teaching, highlighting of falls prevention assessment and care planning. The Falls Nurse Link role has been

promoted and the Link Nurses are now involved in teaching staff on the wards and highlighting areas of concern. Intentional Rounding, which is now standard practice throughout the hospital, not only improves falls prevention but also with other patient quality work such as nutrition, pain management. Intentional Rounding has been very successfully implemented on the wards, with nurses reporting that patients call for help less in the bed rooms as their needs are being pre-empted more effectively.

Our figures for May have been unusual in that one patient fell 5 times but all falls so far have been no harm or low harm. Below is a weekly breakdown of falls leading up to and over the move period:

Week commencing	Number of Falls
31/03/2019	2
07/04/2019	3
14/04/2019	1
21/04/2019	5
28/04/2019	5
05/05/2019	1
12/05/2019	4
19/05/2019	4

Overall our falls remain on average lower than the national average and the quality improvement cycles continue with further developments such as the purchasing of special equipment such as single use wrist alarms for patients and the Possum Nurse Call, in response to patient need.

6. CQC Mock Inspection

The Trust undertook an internal CQC Mock inspection on the 22nd May 2019. This was supported by 5 external partners and a patient representative. The Trust self-rated the services as Good overall, with 'outstanding' possibilities across the all areas. Surgery and Theatres received a 'Requires Improvement' for safe due to issues found with arrest trolley, notice clutter and drug cupboard issues; all areas of concern were immediately actioned. Of note, Diagnostics moved from 'Requires Improvement' to 'Good' for well led. The external partners all congratulated the team on transporting the positive safety culture and staff 'can do' attitude from the old site to the new site. All patients spoken to during the inspection reported an excellent experience. A full report will be presented to the Fundamentals of Care Board and to the Quality and Risk Committee.

7. Inquests/Investigations

Patient A

Patient under the care of RSSC and an expert opinion sought from one of our Consultants on the impact of a disconnection from respiratory support at another hospital – this was not a Papworth inquest.

Coroner's Conclusion: Open

Patient B

Patient transferred from Royal Victoria for ECMO and died 2 days later at Papworth. Inquest held in Newcastle – Royal Papworth were not required to attend.

Coroner's Narrative Conclusion – Patient died from the unwanted consequences of surgical procedures. Inquest investigation closed.

Patient C

Dual chamber pacemaker inserted October 2018 – patient repatriated to Hinchingbrooke. Patient re-admitted to Hinchingbrooke Hospital in January 2019 and transferred to Royal Papworth Hospital with an infected pacemaker site. Pacemaker explantation procedure carried out.

Cause of death – multi-organ failure secondary to hypoperfusion and sepsis.

Investigation closed by Coroner on the 2nd May 2019.

Patient D – Pre-Inquest Review Hearing
Patient underwent bilateral lung transplant in Oct 2018 and transferred post-operatively to the Critical Care Unit for on-going care. During this early post-operative time the patient had a sudden cardiac arrest. A one way (valved) T-piece had been used in error to administer nebulised medication. This was investigated as a serious incident SUI-WEB28342.

The family were present at the pre-inquest hearing and were very gracious in the way that they spoke positively about the care provided for the patient. They accept this was a human error. The family have been particularly grateful for the open transparency from the Trust regarding this incident. The main focus of the discussion was around the equipment and the disappointment we all shared that the company have not felt it necessary to take any action regarding additional labelling/change of appearance of the device to prevent any future incidents. The family acknowledged the learning and actions we have taken as a Trust.

The Coroner is minded to send Regulation 28 (Prevention of Future Deaths) Reports to themanufacturer regarding this issue and to NHSI to advocate for a National Safety Alert. The full Inquest will be heard later in the year.

The Trust currently has 30 Coroner's investigations/inquests pending with 7 out of area.

Recommendation:

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