Royal Papworth Hospital
NHS Foundation Trust

Agenda Item: 3iii

Report to:	Board of Directors	Date: 7 November 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 October 2019

In addition to the Chair's report, the Chief Nurse and Medical Director would like to escalate the following to the Board:

- **Lung Cancer Pathway Performance**
  Concerns have been raised about delays in our lung cancer pathway which have been exacerbated by difficulties in accessing staging PET scanning and poor turnaround times in final histopathological reporting. The Medical Director has met with Dr Hugo Ford, Divisional Director, Division B at CUH who oversees cancer and laboratory services there. He reassured the Trust that he expected improvements in waiting times for PET scanning in the next few weeks. Pathology turnaround times have been consistently worse than those achieved at the old site initially because of the out sourced processing solution that had unavoidable delays because of logistics. These times have not improved significantly with the CUH based service largely because of unwanted variation in tumour molecular testing pathways; these times will improve as our consultant pathologists become more familiar with the CUH laboratory. To date there have been no instances of patient harm caused by these delays although patient experience has not met our normal high standard.

- **Intensive Care National Audit & Research Centre (ICNARC) Potential Outlier Notification**
  The Trust received notification that they were an outlier for readmissions to Critical Care following discharge (attached). The Clinical Lead for Critical Care, Nicola Jones (NJ), queried some of the data and the Trust then received notification of re-categorisation as 'less of an outlier'. '*Following the checking work you completed and fed back to us, we have made the data corrections and re-run the analyses and I can confirm that the Royal Papworth Hospital - Critical Care Unit remains an outlier for Unplanned readmissions within 48 hours. The data updates have however reduced the value from three standard deviations to two standard deviations on or above the comparator. As the unit was also two standard deviations on or above the comparator for this indicator in 2017/18, the unit now fall into the "at least two standard deviations above or below the expected comparator value in two consecutive periods" category. National Clinical Audit Manager'.*

  Now we have the correct data NJ will complete a review and this will be reported to Quality & Risk and escalated to the Board if required. Readmissions are discussed at the Critical Care multidisciplinary meeting.

3. CQC Inspection Outcome

Following the inspection visits from the CQC in June and July 2019 the final report has now been received. The Trust is really pleased to announce that we have attained outstanding in each domain.

Ratings	
Overall rating for this trust	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

The following table demonstrates the outcome for each service area.

Ratings for Royal Papworth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Outstanding ↑↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Surgery	Good →← Oct 2019	Outstanding →← Oct 2019	Outstanding →← Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019
Critical care	Good →← Oct 2019	Good ↓ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients	Outstanding Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Diagnostic imaging	Good Oct 2019	Not rated	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019
Overall*	Outstanding ↑ Oct 2019	Outstanding →← Oct 2019	Outstanding →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019

The Trust has seven 'should do' actions as listed below, and an action plan has been developed and work is underway to address these areas of concern.

- Medical care (including older people's care): The service should continue to address mandatory training compliance.
- Critical Care: The service should continue to work to reduce the number of cancelled operations due to critical care beds not being available.
- The service should continue to audit the response times for the Alert team to evidence the service is meeting its targets.
- The service should audit patient outcomes for patients treated for suspected sepsis on the critical care unit.
- Diagnostic Imaging:

- The service should continue to address recruitment to ensure a permanent workforce of radiographers.
- The service should continue to address mandatory training compliance for allied health professionals and medical staff.
    - The service should review the way it collects patient feedback to reflect the views of patients using the diagnostic imaging department.

The full report and the evidence report are available at: https://www.cqc.org.uk/provider/RGM/reports

4. DIPC Report (BAF 675)

- **M. Abscessus outbreak:**
  A serious incident has been reported as we have had three patients contract M.abscessus post lung transplant. This mycobacterium is very difficult to treat and one of the patients has developed a M.abscessus bacteraemia. In one water sample we have M.abscessus present, and as a result have taken precautionary measures of fitting point of use filters on outlets on rooms where immunocompromised patients are currently inpatients. We are awaiting further test results and have good engagement from all the MDT to tackle the issues. A full investigation is taking place as to the root cause of the outbreak.

- **2019 Flu Campaign**
  A second delivery of flu vaccines has been received and staff in patient-facing roles have continued to be been vaccinated.

Staff Group	Total number of staff vaccinated since September 2019	% Vaccine update
Medical	115	48.9
Nurses	377	55.7
Other professionally qualified	153	58.8
Support	228	41.2
Total	**873**	**50.6**

A further delivery of vaccine is expected in early November.

- **Bed closures**
  There were no bed closures for IPC issues in October 2019.

5. Inquests/Investigations:

Patient A

Pre-Inquest Review Hearing – dual chamber pacemaker patient repatriated to Hinchingbrooke Hospital in October 2018. Patient re-admitted to Hinchingbrooke early in 2019 and transferred to RPH with infected pacemaker site. Pacemaker explanted with subsequent multi organ failure secondary to hypo-perfusion and sepsis.

Coroner and family satisfied with the information provided and RPH will not be required to attend the full inquest when listed.

Patient B

Patient underwent right pneumonectomy and returned to theatre the same day for re-exploration for bleeding and subsequently admitted to Critical Care. Patient arrested the next day, re-explored in Critical Care and found to have a tear around the inferior pulmonary vein. CPR discontinued.

Coroner's Conclusion:
Died from a rare post-operative complication of a necessary surgical procedure.

Trust has been notified that 2 inquests have been closed since our last Board report and RPH was not required to attend to give evidence at either:-

Patient C
Patient underwent coronary artery bypass graft and valve replacement surgery in November 2016 and subsequently transferred to Peterborough City Hospital in December but sadly died.

Coroner's Conclusion: Natural causes

Patient D
Patient underwent coronary artery bypass graft and mitral valve repair surgery. Readmitted in June 2017 with enterococcal endocarditis.

Coroner's Conclusion: Patient died at RPH from complications from complex, high risk cardiac surgery – a second mitral valve operation had been carried out. Whilst there were delays in referral for surgery it is not possible to say on the balance of probabilities whether this altered the outcome. This is due to the underlying endocarditis mandating a second valve operation and the patient died from complications associated with the second surgery.

The Trust currently has 31 inquests/investigations pending with 5 out of area.

Recommendation:

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