Agenda Item: 3.iii

Report to:	**Board of Directors**	**Date: 6 August 2020**
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 June 2020

The Chief Nurse and Medical Director have no matters to escalate to the Board as the information is sufficiently summarised in Chair's Report.

3. DIPC Report (BAF 675)

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

The national NHSE / I team have developed an Infection Prevention and Control Board Assurance Framework. Attached is version 2 of this document as Appendix 1. The Chief Nurse attended a BAF scrutiny session with the CQC on the 11th July 2020. There were no further actions identified by the CQC at this time a brief report (attached Appendix 2) was provided.

The Trust is on track to minimise the risks associated with living with COVID-19 and developing COVID secure areas. Through the Living with COVID Steering group and the IPC team, departments are ensuring they meet the required standards as they re-open services. This element is slightly behind plan, as some services have yet to submit their plans.

4. Annual reports

The following reports are attached for information and were reviewed by the Quality and Risk Committee on the 30/7/2020:

- End of Life Care (Appendix 3)
- Director of Infection and Prevention (Appendix 4)

5 Inquests/Investigations:

Patient A

Patient underwent a transapical transaortic valve implantation (TA-TAVI) under general anaesthetic. The procedure went smoothly and on completion, the left ventricular apex puncture site was closed by tying off the pre-placed sutures. Haemostasis was achieved and no additional stiches were required. Due to post-operative blood pressure drifting down and central venous pressure rising, a transthoracic echocardiogram was performed which suggested a large pericardial collection with right ventricular compression. The clinical picture was suggestive of cardiac tamponade. The previous left

anterior thoracotomy incision was reopened and 400mls of blood was found in the pericardial space and this was evacuated. There appeared on inspection, to be a tear in the myocardium inferior to the site at the left ventricular apical access site from the TA-TAVI. There was an attempt at repair this but the laceration propagated more proximally towards the base of the ventricle. Two long strips of Teflon felt were applied together with sutures and this appeared to provide haemostasis. The patient was initially stable on the intensive care unit but then became haemodynamically unstable with signs of haemorrhage and so was returned to theatre for further re-exploration. On reopening the previous myocardial tear which had been repaired had extended further upwards towards the base of the heart. Further repair was undertaken. Profound coagulopathy developed and despite further interventions the patient sadly died.

Medical cause of death:

1a Haemorrhage and myocardial infarction
1b Transapical aortic valve replacement for aortic stenosis
II Decompensated cardiac failure

Inquest Conclusion:

Died from complications of an elective cardiac procedure.
No concerns raised by the family or Coroner.

Patient B

Patient referred to the Chronic Total Occlusion (CTO) PCI Service and was noted to have disabling angina despite optimal medical therapy with two chronic total occlusions of both the right coronary artery and LAD. PMH; left sided breast cancer with lung metastasis and follicular lymphoma which was being treated by immunotherapy. An echocardiogram had confirmed good LV systolic function. Discussed at CTO MDT and agreed to offer a palliative CTO PCI to the RCA +/- LAD.

On placing the wire in the right coronary artery retrograde injections confirmed that the wall of this vessel had been breached and this attempt was abandoned. On table echo confirmed no pericardial effusion. Procedure continued and attempts to open the LAD CTO were again unsuccessful at opening this vessel. On return to the ward, the patient deteriorated and pericardial tamponade with atrial collapse was diagnosed. A pericardial drain was attempted but failed. Surgical opinion was sought. Patient recovered haemodynamically possibly due to pericardial fenestration from the drain attempts and spontaneous drainage. There was further deterioration with symptoms consistent with acute heart failure secondary to atrial fibrillation with a fast ventricular response. The impression was that of acute decompensated heart failure due to atrial fibrillation and a fast ventricular response. Unfortunately the patient failed to respond to medical management and developed multi-organ failure and sadly died.

Inquest Conclusion:

Died from a recognised complication of a necessary elective procedure.
No concerns raised by the family or Coroner.

The Trust currently has 52 Inquest Investigations/ Inquests ongoing, the oldest going back to October 2016. Three cases are with out of area Coroner's.

To Note:

On 23 June 2020 an informal approach was received from the Cambridge and Peterborough Coroner following concerns raised by the Pathologist at Peterborough City Hospital (PCH). They have noticed a trend of deaths where infection post cardiac surgery is noted at post mortem. These patients have been transferred from Royal Papworth Hospital. We are aware that we have had an increase in Surgical Site Infection Rates in the last 12 months. No one source/cause was identified, however a robust action plan was put in place to mitigate the multifactorial contributory factors which may have influenced the increase. The Coroner was unable to give any details about numbers or which patients the PCH Pathologist is referring to and we await this information. Once received a review of each case will be undertaken.

The above was discussed at Q&R yesterday and the Assistant Director for Quality & Risk will be contacting PCH for details of the patients referred to.

Recommendation:

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