Agenda Item: 3.iii

Report to:	**Board of Directors**	**Date: 3 December 2020**
Report from:	**Acting 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/November 2020**
   The Chief Nurse and Medical Director have no matters to escalate to the Board as the information are sufficiently summarised in Chair's Reports.

3. **DIPC Report (BAF 675)**
   In addition to the Chair's reports the Chief Nurse and Medical Director would like to report the following:

   Nosocomial Infections
   There have been no nosocomial infections since April, when restricted visiting was introduced.

   NHSE Key Action for Infection Prevention & Control
   As Part of living with COVID we have followed PHE recommendations and produced a policy: DN799 COVID-19: Infection Control. This is accessed by staff via the intranet. This policy is updated regularly to reflect changing guidance and any changes are shared via communication briefings to the Trust.

   Following publication of '*Key actions: infection prevention and control and testing'* (Appendix 1), issued on 17 November 2020, the DN799 guidance was discussed with IPC team, DIPC and the microbiologist team. It was identified that key actions 4, 7 & 8c were not in current practice.

   The key actions and the mitigation/evidence the IPC team have put in place, or further discussions/actions needed, are summarised at Appendix 2.

4. **Inquests/Investigations:**

   Patient A
   Patient admitted to Accident & Emergency Department at local DGH. Investigations undertaken and patient referred to Royal Papworth Hospital for emergency repair of aortic dissection. Patient arrested and died before transfer.

   Cause of death:
   1a: Ruptured aortic arch aneurysm
   1b: Marfan's Syndrome

Narrative Conclusion: Royal Papworth Hospital not required to attend.

Patient B
Cardiology patient not able to have surgical revascularisation due to co-morbidities. Chronic total occlusion percutaneous coronary intervention (CTO PCI) agreed following MDT discussion, procedure attempted and abandoned due to recognised complication. Patient did not respond to medical management and sadly died.

Cause of death:
1 (a) Acute Cardiac Failure
1 (b) Perforation of Coronary Artery during Percutaneous Coronary Intervention
1 (c) Ischaemic Heart Disease

Coroner's Conclusion: Died from a recognised complication of a necessary elective procedure.

Patient C
Previous tissue aortic valve replacement 11yrs ago. Balloon aortic valvuloplasty (BAV) and redo aortic valve replacement (AVR) carried out in March 2020. Patient required ECMO support. At end of procedure blood pressure dropped significantly resulting ultimately in a team decision to redo the valve replacement. Despite all post-operative support the patient's oxygenation and ventilation continued to be severely compromised and the patient sadly died.

Cause of death:
1a. Multi Organ Failure
1b. Acute Myocardial Infarction
1c. Aortic valve disease, operated on in March 2020 and 2009

Paper Inquest only: No witnesses required

Coroner's Conclusion: Medical misadventure (an unintended outcome of an intended action).

Patient D
Patient underwent balloon valvuloplasty in 2019. Trans apical TAVI performed in 2020 for severe aortic valve stenosis. During the procedure, the patient deteriorated with cardiac tamponade. Repair attempted but patient suffered significant haemorrhage and sadly died.

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

Paper Inquest only: No witnesses required

Coroner's Conclusion: Died from complications of an elective cardiac procedure

Patient E
Patient had elective aortic valve replacement and whilst in Critical Care the patient experienced a cerebral stroke which worsened over several days and the patient sadly died.

Statements provided to Coroner and additional family questions answered.
Investigation closed by Coroner and family satisfied by information provided by RPH

The Trust currently has 59 Coroner's Investigations/Inquests pending with 3 out of area.

Recommendation:

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