Agenda item: 3.ii

Report to:	Board of Directors	Date: 01/05/25
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	
Regulatory Requirement:	CQC Regulation 12 Safe care and treatment NQB: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care	
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)

SSI rate for March was 3.8% for patients following coronary artery bypass grafts (inpatients and readmissions). Whilst rates remain higher than the UKHSA benchmark (2.6%) there has been a noticeable improvement over the last 6 months. Compliance with infection prevention and control measures and standards are also showing signs of sustained improvement.

3. Inquests/Pre-Inquest Review Hearings – February 2025

Two inquests were heard in February 2025 (see concluded inquest details). Only one required attendance by RPH staff (Patient A). This was a 4 day inquest at which RPH were legally represented and involved 3 clinicians from the Trust attending to give evidence. It was one of our oldest investigations, which we were first notified about in February 2020.

The Trust was required to attend one Pre-Inquest Review Hearing (PIRH) in February 2025 and statements from clinicians were provided to the West London Coroner. The purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest.

The Trust was notified of 4 new inquests/coroner's investigations in February 2025 and statements and clinical records have been requested.

There are currently 80 Coroner's investigations/inquests outstanding (as at 28.02.2025).

Patient A (Cambridgeshire & Peterborough Coroner) – RPH required to give evidence

Background:
Patient suffered from hoarse voice in and seen by specialists and had scans over a seven-week period. Had an endobronchial ultrasound procedure privately to try and exclude possibility of cancer. Two weeks later suffered episode of haemoptysis and admitted to their DGH. Condition was stabilised before discharged home to await a cardiology appointment. Review cardiologist at DGH and admitted to undergo a CT scan of aorta to try and identify the cause of an aortic abnormality or lesion. Case discussed with cardiothoracic experts at RPH who advised that as condition had again stabilised, patient should undergo a respiratory review and be discharged to await out-patient appointment at Papworth, which was then scheduled for beginning of November 2019.

Patient readmitted to DGH in meantime with a further episode of haemoptysis, case was again discussed with experts at Papworth. They sought further confirmation of the nature of the abnormality and suggested that the plan should remain unchanged and await a rescheduled out-patient appointment.

Patient admitted to DGH with a third episode of haemoptysis and it was recognised that condition had deteriorated with increasing breathlessness and chest pain. Follow-up CT scans had not showed significant change but it was agreed with Papworth specialists that patient should remain in hospital until could be transferred for out-patient appointment the following week.

Patient continued to deteriorate further and became so unstable that was transferred to RPH as an emergency, where they were intubated and placed on veno-venous ECMO. Scans taken and showed that the aortic abnormality had increased in size and was decompressing the left main bronchus, such that their airway was virtually blocked and patient required mechanical ventilation. It was agreed that a series of surgical procedures was required to definitively confirm the nature of the abnormality and assess the requirement for aortic surgery and patient was prepared for theatre. Upon inserting the transoesophageal echocardiographic probe, patient suffered a massive bleed from their airway and emergency efforts were deployed to stop the bleeding and stabilise condition. Surgeons assessed only option as to undergo an aortic arch repair, and this operation was performed without significant incident. Patient's condition did not improve and they developed sepsis which did not respond to treatment and a head CT scan showed signs of hypoxic brain injury and cerebral infarcts. Patient continued to deteriorate and it was agreed that active treatment should be withdrawn and sadly passed away.

Medical Cause of death:
1a) Acute lung injury and multi-organ failure
1b) Aortic arch replacement for expanding haematoma
1c) Aortic dissection

Coroner's Conclusion:
Narrative conclusion: The deceased died following emergency surgical intervention to repair the aortic arch that had been impaired by a pseudoaneurysm, which also caused substantial occlusion of the airway and became life-threatening. Difficulties in reaching a definitive diagnosis meant that the deceased did not undergo aortic surgery until their condition had deteriorated substantially, and they suffered recognised complications from the high-risk surgery, from which they could not recover. On the balance of probabilities, it is not possible to say that earlier surgical intervention would have resulted in a different outcome.

Patient B – (Cambridgeshire & Peterborough Coroner) - No attendance required

Background
Patient was found unresponsive at home on the morning of 30.03.23. Paramedics were called and death was confirmed at 10.44hrs. Patient had been diagnosed with chronic obstructive pulmonary disease in 2014 and had been reliant on Non Invasive Ventilation via a NIPPY machine since that time. The NIPPY machine was not working properly prior to their death although it does not appear that the patient had reported this to those professionals who monitored their condition and the extent to which this may have contributed to their death cannot be established on the available evidence.

Post mortem examination confirmed that patient died as a consequence of their serious long term lung disease contributed to by significant heart disease.

Medical Cause of death:
1a) Chronic Obstructive Pulmonary Disease (Emphysema)
1b) Ischaemic heart disease

Coroner's Conclusion:
Natural causes

Inquests/Pre-Inquest Review Hearings – March 2025
Two inquests were heard in March 2025 (see concluded inquest details). Only one required attendance by RPH staff (Patient C). RPH were legally represented and one clinician from the Trust attended to give evidence.

The Trust was not required to attend any Pre-Inquest Review Hearings (PIRH) in March 2025.

The Trust was notified of one new inquest/coroner's investigation in March 2025 and clinical records have been provided There are currently 71 Coroner's investigations/inquest outstanding (as at 31.03.25).

Patient C (Cambridgeshire & Peterborough Coroner) - RPH required to give evidence

Background:
Patient was found deceased at home. CPR attempts were unsuccessful and Ambulance Crew declared patient to be deceased. Police determined that there were no suspicious circumstances.

Patient had a past medical history of complex cardiac issues and had undergone a number of surgical interventions as a child. Patient was under the care of Royal Papworth Hospital congenital heart disease services and was first seen in December 2020. Patient was reviewed in February 2022 and in October 2022 following an MRI was advised that their condition was satisfactory at that stage. they were due for an annual review appointment in February 2023 which was delayed until October 2023 which they did not attend.

Post mortem cardiac analysis determined that there was no clinical indication for further intervention or treatment at the time of their death. An incidental finding of chronic hydrocephalus was made on past mortem which on the balance of probabilities contributed to the patient's death.

Medical Cause of death:
1a) Sudden cardiac death with congenital heart disease
2) Chronic hydrocephalus

Coroner's Conclusion:
Natural causes

Patient D (Suffolk Coroner) – No attendance required

Background:
Admitted to their DGH in March 2024 with sepsis. Past medical history included hypertension, diverticular disease, osteoarthritis, and irritable bowel syndrome. They had previously been seen at Royal Papworth Hospital in May 2018 for a pacemaker lead insertion (ventricular lead) as they had a dual chamber pacemaker implanted originally in 1999.

On admission it was confirmed that the patient was suffering from severe endocarditis related to infected pacemaker wires. They were treated for the infection however; they became severely anaemic. Subsequently, the patient acquired Covid-19 infection and then developed a chest infection. A planned surgical procedure to replace the infected pacemaker wires was delayed due to anaemia and COVID-19 infection.

Sadly, the patient continued to deteriorate, and following discussion with family, palliative management was started and they died three months after being admitted.

Medical Cause of death:
1a) Multi-Organ Failure
1b) Infective endocarditis: (Pacemaker inserted in 1999)
2) CoVID-19 Pneumonia

Coroner's Conclusion:
Died due to a recognised complication of a previous necessary, lifesaving surgical procedure

4. Recommendation

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