Agenda item: 3.ii

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| Report to: | Board of Directors | Date: 03/07/25 |
| 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<br>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) and M abscessus

The surgical site infection rate for May was 4.7% which is an increase from the previous month (3.9%). There has been a slight decrease in some compliance measures in May which are being addressed with oversight from the infection prevention and control team. There has been 2 confirmed cases of M abscesses identified from January and April of 2025. Delayed reporting is a consequence of time taken for genomic sequencing to be carried out. Full root cause analysis and review of all care activities with actions and oversight being provided by the M abscessus steering group.

## 3. Martha's Rule

Royal Papworth Hospital are included in Phase 2 of organisations for implementation of Martha's Rule. An implementation group has been set up oversee the introduction of the three components: 24/7 access to rapid patient review, structured approach to gathering patient and family insights through the use of patient wellness questionnaire and clear communication about the rule itself. Support for the implementation is being provided by Health Innovation East which includes learning from Phase 1 implementation sites.

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## 4. Inquests/Pre-Inquest Review Hearings – April 2025

Two inquests were heard in April 2025 (see concluded inquest details). Both of these required attendance by RPH staff. Three clinicians from the Trust were called to give evidence at these inquests.

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

*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 six new inquest/coroner's investigations in April 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

There are currently 73 Coroner's investigations/inquests outstanding (as at 30/04/25).

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

**Background**:
Patient died in June 2019 at Royal Papworth Hospital. They had been diagnosed in October 2010 with idiopathic pulmonary fibrosis and was given a poor prognosis at that time. In April 2019 they had a bilateral lung transplantation for end stage pulmonary fibrosis at Royal Papworth Hospital. They developed early complications postoperatively, primary graft dysfunction, massive bleeding with pleural and mediastinal clots, and was put on VA ECMO machine. They were treated with lung transplant prophylaxis for the prevention or fungal and bacterial infection and placed on antibiotics postoperatively. They were moved uneventfully from the old Papworth hospital to the new Royal Papworth Hospital in May 2019. Following transfer, they were weaned from ECMO requiring ongoing ventilator support. At the end of May, they had a routine X-ray which unexpectedly demonstrated air under the diaphragm and a CT confirmed a pneumoperitoneum. They took the decision to undergo a laparotomy for a bowel resection and ileostomy.

Histopathology postoperatively identified invasive mucor infection. In June 2019, the stoma was noted to have prolapsed, a discussion with the general surgical team did not advise intervention as they were critically unwell. Extensive discussions took place between the transplant and critical care multidisciplinary team who were in agreement that the condition was irrecoverable and that organ support should not be escalated as this would be futile. The family agreed that do not attempt resuscitation order be put into place.

**Medical Cause of death:**
1a) Disseminated Mucormycosis
1b) Lung transplantation for idiopathic pulmonary fibrosis (25/04/2019)

**Coroner's Conclusion:**
Narrative conclusion:
Died following bilateral lung transplant. Patient suffered a number of post operative complications including primary graft dysfunction from an unknown cause. They underwent a laparotomy to treat bowel perforation and histopathology results post operatively identified mucormycosis a serious fungal infection usually seen in people who are immuno-suppressed. Patient was necessarily immuno-suppressed following their lung transplantation. There is no evidence that earlier detection of mucormycosis was possible and on diagnosis it was recognised that his condition was irrecoverable.

**Patient B (Suffolk Coroner) - RPH required to give evidence**

**Background:**
Patient admitted to their DGH with worsening heart failure with poor prognosis (previous AVR surgery). In house urgent transfer to RPH and underwent high risk re-do sternotomy, aortic root enlargement, tissue aortic valve replacement, tricuspid valve repair and PFO closure. Had extended length of stay in critical care and on ward (8 weeks) with rehabilitation. Discharged March 2024 and suffered stroke on day of discharge. Admitted as emergency to DGH for treatment of stroke (anticoagulant reversal) and suspected infective endocarditis. Patient experienced decompensated heart failure and died.

**Medical Cause of death:**
1a) Acute left ventricular failure

1b) Cardiac valvular disease (recently operated)

**Coroner's Conclusion:**
Narrative conclusion:
Patient died of congestive cardiac failure on the background of cardiac valvular disease.

**Inquests/Pre-Inquest Review Hearings – May 2025**

One inquest was heard in May 2025 Patient C but RPH staff were not required to attend (see concluded inquest details).

The Trust attended one Pre-Inquest Review Hearing (PIRH) in May 2025 and this inquest is due to be listed later this year or early 2026.
*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 ten new inquests/coroner's investigations in May 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

There are currently 82 Coroner's investigations/inquests outstanding (as at 31/05/25).

**Patient C (Cambridgeshire & Peterborough Coroner) – Documentary Inquest, RPH not required to give evidence**

**Background**:
Patient had a longstanding history of pulmonary hypertension and thromboembolic disease which had left them breathless and severely limited their activities of daily living, requiring home oxygen therapy. They were referred to the Royal Papworth Hospital in October 2024 and assessed to undergo a pulmonary thromboendarterectomy (PTE) as a means of improving their symptoms and quality of life. Patient was advised of the significant risks of the surgery but consented to the procedure, despite their co-morbidities rendering them four times more vulnerable to death than normal. They were admitted to hospital on 19 December 2024 and underwent the PTE the following day, seemingly without complication. When patient was being rewarmed on the heart lung machine, an airway bleed became apparent and they were placed onto ECMO support to provide oxygenation before being transferred to critical care unit. After six days, the bleeding stopped and patient was successfully weaned from the full ECMO onto lung support only. Two days later, they became unstable with hypoxia and placed back onto the full ECMO from which they were subsequently unable to be removed. Patient developed multi-organ failure and died.

**Medical Cause of death:**
1a) Multi-organ failure
1b) Airway Haemorrhage
1c) Chronic thromboembolic pulmonary hypertension (operated on)

**Coroner's Conclusion:**
Died from recognised but unavoidable complications of necessary but complex and high-risk surgery (where the deceased's underlying conditions will have depleted their physiological reserves).

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