Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.ii

Report to:	**Board of Directors**	**Date: 7th November 2024**
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, 742**	
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:

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. Carbapenemase-producing Enterobacterales (CPE):

The Trust formally closed the CPE outbreak on October 2nd. In total, 31 patients were identified as part of the outbreak however no harm occurred to them as a consequence. Strict controls and mitigations brought the outbreak under control very quickly. Our screening criteria for CPE has been reviewed and enhanced as a consequence of the outbreak.

3. Surgical Site Infections (SSI)

Our surgical site infection rate continues to be higher than the UKHSA average however, the confirmed rate for Q1 shows some improvement, 5.4% (UKHSA average 2.3%).

4. National AHP Day

On October 14th we celebrated national AHP day. The day began with presentation of awards to AHP's who were nominated for providing exceptional care and leadership. Throughout the day there were stands in the atrium with each speciality proudly presenting the fantastic improvement work they are undertaking with their teams.

5. Inquests

One inquest was heard in August 2024 – complex 4 day inquest with the Trust legally represented and staff giving evidence in person. Due to the complexity, the final hearing for the Coroner to summarise findings and conclusion was scheduled for September and is outlined below.

Patient A (August/September – 4 day inquest)
Patient died in 2020 at Royal Papworth Hospital having undergone an elective Minimally Invasive Mitral Valve Surgery (MIMVS) to address severe mitral valve regurgitation. Pre-

operative screening was carried out and did not identify coronary artery disease which would have precluded the patient from a MIMVS. During the MIMVS, the perfusionist identified poor venous drainage and notified the anaesthetist and surgeon, who took action to address the issues raised. The patient suffered further intra operative complications which required additional cross clamp time and time on cardiopulmonary bypass. A bleed was identified in the right atrium which required a median sternotomy to be performed to allow identification of the bleed site and repair. At the conclusion of the procedure, the patient's right ventricular function was poor and they were transferred to ICU where ongoing treatment proved unsuccessful.

Medical Cause of Death:

1a) Multiple organ failure
1b) Chronic degenerative mitral valvar disease (repaired). Multi-vessel atherosclerotic coronary artery disease.
11) Lower limb compartment syndrome/gangrene (operated). Subacute infective endocarditis. Acute pancreatitis. Ischaemic enteropathy.

Coroner's Conclusion:

The surgical team did not take the opportunity to discuss the possibility of a conversion of the patient's surgery from MIMVS to a median sternotomy and whether this step would allow for the ongoing venous drainage issues identified by the Perfusion Team to be fully addressed. It is not possible to say on the balance of probabilities whether a conversion to median sternotomy from MIMVS would have resulted in a different outcome for the patient given the post mortem findings of undiagnosed coronary artery disease. Had coronary artery disease been diagnosed before the surgery, the patient would not have satisfied the criteria for undergoing MIMVS.

<u>Patient B</u> (September)

Patient presented to the Emergency Department at their DGH in 2022 reporting a 4-6 week history of intermittent chest pain. They were at high risk of coronary artery disease due to past medical history. Initial tests did not reveal a cardiac cause for the chest pain but based on the risk factors, further tests would have been appropriate. The patient was discharged the following day without any further tests being caried out. Such tests would have identified that they were suffering with coronary artery disease prompting further treatment with medication and/or surgery.

The patient re-presented to their DGH later in 2022 having experienced increasing shortness of breath. Investigations subsequently revealed they had suffered a myocardial infarction due to severe coronary artery disease. They were transferred to Royal Papworth Hospital but despite ongoing care the patient died two weeks later.

Medical Cause of Death:

1a) Myocardial infarction
1b) Coronary artery disease
1c) Type 1 diabetes

Coroner's Conclusion:

Died from a heart attack which would have been avoided if appropriate investigations to identify coronary artery disease had been carried out during a hospital admission some 4 months earlier.

Natural causes with a contribution from an accident (fall).

There are currently 77 Coroner's investigations/inquests outstanding.

The Inquest team has also been notified in August 2024 of 8 Coroners' investigations which have been closed during the past two years and a further 2 closed in September 2024. These are summarised below.

Inquest Reference	Coroner	RPH Assistance provided to HM Coroner	Conclusion / Outcome
INQ2223-22	Suffolk	Histopathology report and statement from clinician	Coroner's conclusion: Industrial Disease
INQ2324-19	Lincolnshire	Medical records and statement from clinician	Coroner's conclusion: Died as a result of known complications of necessary medical intervention and procedure to treat a natural disease process.
INQ1617-12	Cambridgeshire & Peterborough	Medical records and statements from clinicians	Coroner's conclusion: Died from a spontaneous intracerebral haemorrhage. A contributory factor in the causative sequence of events was an iatrogenic tracheal injury that arose as a complication of a tracheostomy tube insertion that subsequently became displaced and required emergency over-inflation of the cuff of an endotracheal tube so as to prevent migration and further leaks of air.
INQ1920-12	Cambridgeshire & Peterborough	Medical records and statements from clinicians	Coroner's conclusion: Died from complications of necessary surgical interventions
INQ2021-20	Cambridgeshire & Peterborough	Medical records and statement from clinician	Coroner's conclusion: Natural causes
INQ2122-36	Cambridgeshire & Peterborough	Radiology reports and imaging	Coroner's conclusion: Natural Causes
INQ2223-48	Cambridgeshire & Peterborough	Statement from clinician	No inquest heard – closed
INQ2223-52	Cambridgeshire & Peterborough	Statement from clinician	Coroner's conclusion: Natural Causes

Inquest Reference	Coroner	RPH Assistance provided to HM Coroner	Conclusion / Outcome
IINQ2324-47	Norfolk	Medical records	Coroner's conclusion - Narrative: Natural causes contributed to by the effects of having received infected blood products in the past.
INQ2122-06	Lincolnshire	Medical records and statement from clinician	Coroner's Conclusion: Died as a result of a known complication of a necessary medical procedure

6. Recommendation

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