Royal Papworth Hospital
NHS Foundation Trust

Agenda item: **3ii**

Report to:	**Board of Directors**	**Date: 9 January 2025**
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. Surgical Site Infections (SSI)

A review of work undertaken following the surgical site infection (SSI) summit on August 8th has identified improvements made across 3 main workstreams.

An in depth audit of operating theatre ventilation identified a number of areas for optimisation. A task and finish group has enabled prioritisation of these task and seen most through to completion. The remainder are being overseen by the ventilation steering group.

New guidelines for management of patients with type 1 and type 2 diabetes have been completed and introduced into the clinical areas. The aim is with education and support patients' blood glucose will be more tightly controlled. An audit of compliance will be undertaken early in 2025.

There has been an improvement in compliance with infection prevention and control standards across theatres and all aspects of the surgical pathway. It is identified that further improvement is required in the area of theatre footfall.

SSI rates for Q2 have shown improvement 4.2% compared to 5.6% in Q1. Whilst this is seen as positive the rate remains above the benchmarked average of 2.4%.

3. World Antibiotic Awareness Week

As part of World Antibiotic Awareness Week (November 18th - 24th), our region was selected to receive a visit and host David Webb, National Chief Pharmaceutical Officer, Kieran Hand, National Antimicrobial Prescribing Lead. This was a system-wide event which was hosted by RPH on November 19th. The event consisted of presentations from all organisations on quality improvement initiatives in relation to antimicrobial stewardship all of which generated discussion and sharing of best practise. The antimicrobial stewardship team are supporting a quality improvement initiative aimed at early mobilisation following cardiac surgery thereby promoting respiratory function and reducing the risk of post operative respiratory infections.

4. Inquests

Inquests/Pre-Inquest Review Hearings – October 2024

Two inquests were heard in October 2024 (see concluded inquest details).

There was one Pre-Inquest Review Hearing (PIRH) in October which involved Papworth and the Trust was represented at this by the Trust Solicitors. The inquest is expected to be heard early 2025. Medical records and statements from clinicians have been provided to the 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 7 new inquests/coroner's investigations in October 2024 and statements and clinical records have been requested.

Concluded Inquests:

Patient A (Cambridgeshire & Peterborough Coroner) – Not an in-patient, no attendance required

Background:
Patient was admitted to the Emergency Department at their DGH in April 2021 with a ten days history of central chest pain radiating to the back and left arm and numbness in their left hand. Their initial ECG was abnormal and the patient underwent chest X ray and blood tests which indicated rising troponin levels. A diagnosis of acute coronary syndrome (ACS) was made. The patient was reviewed by the cardiac specialist nurse and a general physician. Follow up ECG changes showed dynamic changes and blood tests indicated rising Troponin levels. The severity of the patient's worsening condition was not recognised by the treating clinicians. The patient was treated in the Medical Short Stay Unit and was subject to cardiac monitoring. The patient was not transferred to the Coronary Care Unit for specialist care because of a lack of bed space and was not seen by a Consultant Cardiologist.

The patient's care was not escalated by way of urgent referral to Royal Papworth Hospital. The day after they were admitted they collapsed on the ward and resuscitation attempts were unsuccessful.

On the balance of probabilities had they been recognised as a high risk patient during admission to the DGH and received appropriate urgent treatment they would not have died at this time.

Medical Cause of Death:
1a) Recent myocardial infarction
1b) Coronary Artery Atherosclerosis

Coroner's Conclusion:
Patient was diagnosed with acute coronary syndrome (ACS) on admission to their DGH in April 2021. The severity and seriousness of their condition was not recognised by the treating clinicians. She was not reviewed by a Consultant Cardiologist nor was she managed on Cardiac Care Unit which could have provided her with specialist cardiac care. Patient's' care was not urgently escalated to Royal Papworth Hospital for cardiac care. If these steps had been taken on the balance of probabilities the patient's death may have been prevented.

Patient B (Cambridgeshire & Peterborough Coroner) – Read Only Inquest - no attendance required

Background:
Patient underwent elective mitral valve surgery at Papworth in July 2022. During the course of that surgery, patient was found to have a mass in their right lung which was suspicious for a malignant tumour. Post operatively, patient made slow progress and was considered to be very unwell suffering from amongst other things, a significant post operative lung infection which was treated. Due to their poorly condition there were no treatment options for the cancer. Patient continued to decline and died in August 2022.

Medical Cause of Death:
1a) HSV pneumonitis and congestive cardiac failure
1b) Mitral valve replacement July 2022
1c) Severe mitral valve stenosis
11) Squamous cell carcinoma of the right lung, emphysema, chronic kidney disease

Coroner's Conclusion:
Patient died due to post operative illness and complications following elective mitral valve surgery. Surgery revealed a previously undiagnosed cancer which was not causative of patient's death.

Inquests/Pre-Inquest Review Hearings – November 2024

Two inquests were heard in November 2024 (see concluded inquest details). One of these (Inquest D) was a four-day inquest at which the Trust was represented by a barrister and involved attendance by 7 clinical members of staff.

The Trust attended 2 Pre-Inquest Review Hearings (PIRH) in November 2024 and medical records and statements from clinicians were provided to the Cambridgeshire & Peterborough and Suffolk Coroners.

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 November 2024 and statements and clinical records have been requested.

There are currently 84 Coroner's investigations/inquests outstanding (as at 30/11/24).

Concluded Inquests:

Patient C (Cambridgeshire & Peterborough Coroner)

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Background:
The patient was diagnosed with coronary vessel disease and underwent an elective coronary angiography and stent procedure at Royal Papworth Hospital in February 2024. The procedure was technically challenging due to heavy calcification in the left anterior descending coronary artery and it was recognised that a septal branch had become occluded.

Following the procedure, the patient was kept in hospital for observation overnight but was discharged the next day. The day after this, they were found in respiratory distress and taken by ambulance to their DGH before being transferred back to the Royal Papworth Hospital. The patient was due to have a cardiac implant to monitor heart rhythms but suffered chest pain and

then a cardiac arrest, which necessitated the placing of a pacemaker. On follow-up echocardiography, it was identified that the patient had suffered a ventricular septal defect, for which a surgical patch repair represented their only chance of survival. The patient underwent the procedure but the repair failed and the patient died in the operating theatre.

Medical Cause of Death:
1a) Post-infarct ventricular septal defect (operated on)
1b) Septal branch occlusion by stent in false lumen of left anterior descending artery.
1c) Coronary atherosclerosis.

Coroner's Conclusion:
Narrative: Died from an extremely rare complication of an elective coronary stent implantation procedure.

Patient D (Cambridgeshire & Peterborough Coroner) – 4 day inquest

Background:
The patient underwent mitral valve repair, tricuspid valve repair, coronary artery bypass grafting x 3 and atrial appendage exclusion in March 2021 at Royal Papworth Hospital. After a lengthy post operative recovery, they were repatriated to their DGH but following arrival deteriorated rapidly in the early hours of the morning.

Post mortem examination determined the cause of death was a haemothorax which on the balance of probability had started to develop gradually following a removal of their chest drain at Royal Papworth Hospital before transfer to their DGH. Clinical signs of the haemothorax were first identifiable at 1am when a medical assessment detected decreased air entry on their left side following prior examination results which showed equal air entry. Haemothorax did not form part of the differential diagnosis at 1am and the patient continued to be treated for presenting complaints of fast atrial fibrillation, low blood pressure and severe heart failure and possible myocardial ischaemia due to low blood pressure.

A chest X-ray was not considered to be necessary as they were not presenting with a primary lung cause and their respiratory system did not seem particularly affected at that time. It is not possible to say whether a chest X-ray would have identified a haemothorax. It was recognised by the treating clinicians that the patient was very unwell and it was determined they would be unlikely to survive Intensive Care Unit care.

Medical Cause of Death:
1a) Haemothorax
1b) Mitral and Tricuspid Valve Repair and Coronary Artery Bypass Graft
1c) Ischaemic Heart Disease and Mitral Valve Disease

Coroner's Conclusion: Patient died as a result of a known, but extremely rare complication of necessary post operative treatment.

Prevention of Future Deaths(PFD) report – Regulation 28
The Coroner issued a PFD report to the Department of Health and NHS England.

The MATTERS OF CONCERN are as follows:

Hospital Discharge notes are not uniform across Hospital Trusts. This carries the risk of essential patient information not being available to treating clinicians when a patient is received into a new clinical setting, leading to potential delay in providing life saving care and treatment.

Dr Ian Smith, Medical Director is currently assisting NHS England in providing context for the inquest to enable them to respond to the PFD report.

5. Recommendation

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