Royal Papworth Hospital
NHS Foundation Trust

Agenda item: 3.ii

Report to:	Board of Directors	Date: 04/09/25
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. The Trust has observed an increase in falls with harm during Q1 and Q2 2025/26 though there has not been an increase in the number of falls. Following a thematic review a comprehensive workplan has been developed and will be monitored through Harm Free Care Panel and QRMG.

Surgical site infection rates were 5.4% for Q1 2025/26. Whilst the rate is lower that same time period last year it remains above the UKHSA benchmark. Improvement work continues to focus on IPC standards, staff behaviours and environment.

There were no further cases on M abscessus identified in July and August. The M abscessus steering group has good clinical engagement and continues to monitor improvements whilst at the same time supporting patients visitors and staff with up to date communication.

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

- One inquest was heard in June 2025 - patient was in advanced heart failure and required a cardiac transplant. Consultant Cardiologist required to give verbal evidence.

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

There are currently 88 Coroner's investigations/inquests outstanding (as at 04/07/25).

Patient A (Cambridgeshire & Peterborough Coroner)

Background:
Patient presented to University Hospital Bristol in 2022 with a myocardial infarction followed by coronary stenting, and then persistent cardiogenic shock (failure to perfuse main organs due to insufficient cardiac output). Transferred to Royal Papworth Hospital where patient underwent emergency biventricular assist device support and subsequently had a heart transplant. It was recognised that the patient was high risk for transplantation.

Death at post mortem was deemed to relate directly to the myocardial infarction they suffered and despite treatment, patient never seemed to have recovered significantly from this point and they suffered a large number of complex medical complications during their illness both pre and post surgery. Each complication set them further back from recovery, until a point at which recovery became impossible and it was clinically recognised that further active treatment would be futile given their extremely poor prognosis.

Medical Cause of death:
1a) Multi-organ failure following cardiac transplantation
1b) Myocardial infarction
2. Type II diabetes mellitus; stroke; peritonitis due to bowel ischaemia due to band adhesion; pneumonia

Coroner's Conclusion:
Patient died following heart transplantation, after which they had a long and difficult recovery period and suffered a number of significant medical complications.

Inquests/Pre-Inquest Review Hearings – July 2025

- One inquest was heard in July 2025 A Consultant Cardiothoracic Surgeon and a Consultant Cardiologist were both required to give verbal evidence.

- The Trust was not required to attend any Pre-Inquest Review Hearings (PIRH) in July 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 five new inquests/coroner's investigations in July 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

There are currently 81 Coroner's investigations/inquests outstanding (as at 31//07/25).

Patient B (Cambridgeshire & Peterborough Coroner)

Background:
Patient was admitted to DGH in March 2024 following an out of hospital cardiac arrest. Patient was resuscitated and transferred to Royal Papworth Hospital where they were diagnosed with triple vessel disease which required coronary artery bypass graft surgery. Patient suffered with regular episodes of slow heart beat which was medicated whilst they were optimised for surgery. Patient suffered a further cardiac arrest and underwent coronary artery bypass graft surgery. During this the patient was noted to show signs of infection. They also suffered a bleed which required surgical repair the following day. Patient did not recover following surgery and died a day later.

Medical Cause of death:
1a) Cardiogenic shock, Hospital-acquired Pneumonia
1b) Acute coronary syndrome treated with coronary artery bypass grafting (March 2024)

Coroner's Conclusion:
Narrative conclusion: Patient died as a result of complications from necessary surgery to treat a previously undiagnosed heart condition.

3. Recommendation

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