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Royal Papworth Hospital
NHS Foundation Trust

# Royal Papworth Hospital NHS Foundation Trust

## Quality Report 2022 / 2023

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Royal Papworth Hospital
NHS Foundation Trust

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# Quality Report 2022/23

# Contents

## Part 1 Statement on quality from the Chief Executive

Providing high-quality, safe and effective care is at the heart of everything we do here at Royal Papworth Hospital. We are extremely proud to have gained an excellent reputation for quality in heart and lung medicine, but we know we must continually work to improve the care we provide to our patients. This Quality Account provides an overview of the quality of services that we have provided to patients during 2022/23 as well as our key priorities for improving quality in the year ahead.

The Trust is currently rated 'outstanding' by the Care Quality Commission (CQC), from an inspection carried out in 2019. It became the first hospital Trust in the country to receive the top rating of 'outstanding' in each of the five main domains that the CQC assesses.

As a Trust we will continue to set high standards and strive to meet all our performance targets and identify opportunities to continuously improve performance. We recognise that setting clear standards and measurable outcomes is an important part of quality assurance so that we can assess performance and deliver improvements in patient safety and patient experience.

We are accountable for the quality of care we provide and use quality improvement to drive approaches that improve health outcomes and reduce health inequalities. How we work and the standards that we deliver help to improve outcomes for our patients and our population and contribute to our system. We also recognise that the working environment of the Trust needs be one in which has a just culture which is open, transparent, and open to continuous improvement. We are also an anchor organisation within the system helping to bring local people into the health and care workforce and to build rewarding careers.

We have areas of challenge and have included updates on these areas in our Quality Report. The staffing challenge in terms of vacancy level and the impact of industrial action across various departments has had an effect on our staff, which can be seen through our staff survey results, and on our ability to treat as many patients as we would wish. In some areas in order to maintain patient safety we have had to reduce activity and that has a consequence on our productivity, the number of patients waiting for treatment and the ability to meet our waiting time targets for our patients.

NHS England has set out its expectation for all NHS providers, to work in partnership with their integrated care boards, and embed continuous quality improvement aligned to support increased productivity and enable improved health outcomes. We have invested in more expertise and capacity to be able to take this forward building on our Quality Strategy which we will relaunch in 2023.

We have seen a significant reduction in the number of patients acquiring M.Abscessus with 2 new cases have been identified in 2022/23.

Our surgical site infection (SSI) rates, remain elevated, and we continue to be an outlier for CABG inpatients and readmissions when benchmarked with UK Health Security Agency data. Whilst we recognise our outcomes for cardiac surgery remain very good, we acknowledge the impact of SSIs both on patient experience and extended length of stay. We continue to focus on improvements to reduce the current rates and progress against our improvement plan is under constant review and regularly discussed at the Board of Directors.

Together with our Board of Directors and Council of Governors, and in consultation with our clinical staff, we have developed a series of quality priorities for 2023/24 that will help us develop our services and these are outlined in the Quality Accounts.

As ever, we rely on the support of all of our stakeholders to continue improving our services and maintain our reputation for care and innovation. I would like to thank all our staff, governors, volunteers and patient support groups and our system partners for helping us to deliver safe and high-quality care throughout 2022/23 recognising our ongoing role in response to the COVID19 pandemic and the significant challenges in recovery and maintaining services during a period of significant challenge around service recovery and managing the industrial unrest through which we continue to focus on delivering the best outcomes for the patients and the population that we serve.

The information and data contained within this report have been subject to internal review and, where appropriate, external verification. Therefore, to the best of my knowledge, the information contained within this document reflects a true and accurate picture of the quality performance of the Trust.

Eilish Midlane
Chief Executive
29 June 2023

## Information about this Quality Report

We would like to thank everyone who contributed to our Quality Report.

Every NHS trust, including NHS foundation trusts, must publish a Quality Account each year, as required by the NHS Act 2009, in the terms set out in the *NHS (Quality Accounts) Regulations 2010.*

Part 2.2 Statements of Assurance by the Board includes a series of statements by the Board. The exact form of these statements is specified in the Quality Account regulations. These words are shown in *italics.*

Further information on the governance and financial position of Royal Papworth Hospital NHS Foundation Trust can be found in the various sections of the Annual Report and Accounts 2022/23.

To help readers understand the report, a glossary of abbreviations or specialised terms is included at the end of the document.

# Part 2 Priorities for improvement and statements of assurance from the Board

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## 2.1 Priorities for improvement

Welcome to Part Two of our report. It begins with a summary of our performance during the past twelve months compared to the key quality targets that we set for ourselves in last year's quality report.

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2023/24 and the process that we went through to select this set of priorities.

The mandated section of Part 2, which follows, includes mandated Board assurance statements and supporting information covering areas such as *clinical audit*, research and development, *Commissioning for Quality and Innovation (CQUIN)* and *data quality*.

Part 2 will then conclude with a review of our performance against a set of nationally mandated quality indicators.

### Summary of performance on 2022/23 priorities

Our 2021/22 Quality Report set out our quality priorities for 2022/23 under the quality domains of patient safety, effectiveness, responsiveness and well led. *See our 2021/22 Quality Account for further detail: https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports*

The following section summarises the five quality improvement priorities identified for 2022/23. The tables below demonstrate achievements against the 2022/23 Goals.

Priority 1 Safe: Patient Safety Incident Response Framework to include after action review academy

Priority 2: Effectiveness/Responsive: Health Inequalities – increased action on prevention of health inequalities

Priority 3: Safe: Harm free care – VTE, PU and falls - linked to performance and need for focus on harm free care charting and trends

Priority 4: Safe: Bar code medicines administration

Priority 5: Well Led Compassionate & Collective Leadership (CCL) and good staff engagement

## Quality Account 2022/23 Priority 1

### Aim: Patient Safety Incident Response Framework (National requirement from April 2022)

### To support the NHS to further improve patient safety, a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Quarterly Progress updates |
|---|---|---|---|
| 1. To continue to scope and prepare for the implementation of the new Patient Safety Incident Response Framework (PSIRF) | Two named Patient Safety Specialist (PSS) roles in place for the Trust:<br>• Assistant Director for Quality and Risk<br>• Clinical Governance Manager<br>• Medical lead will be part of the new Associate Clinical Governance role currently being advertised. | To set up an internal working group in Q1 to lead the new PSIRF implementation project working towards the agreed date of implementation of the PSIRF, once released. | The Trust now has three named Patient Safety Specialist (PSS) roles in place:<br>• Assistant Director for Quality and Risk<br>• Clinical Governance Manager<br>• Associate Medical Director for Clinical Governance.<br><br>One of the named PSS attends the local, regional, and national meetings as part of the orientation stage of the Trust wide implementation plan.<br><br>Initial delay with the working group being set up, in Q4 a monthly Trust Implementation meeting was started with the 3 PSS leads and we are at the final stages of working on the first part of the 12 month project. The orientation stage (part 1) we are aiming to complete by end of June. |
| 2. To implement and adopt the new PSIRF and launch in Spring 2022 | The two PSS roles attend the monthly National Training Webinars which updates and supports the education and knowledge requirement for the pending implementation. | Develop an action plan to implement and adopt the PSIRF. This should align to the national programme of suggested implementation which we are awaiting publication, due to be spring 2022. This will be monitored by QRMG. | The PSIRF launch was delayed, and the Trust received the revised framework in August 22. Organisations are expected to transition to PSIRF within 12 months of its publication and complete this by Autumn 2023.<br>Patient Safety Lead commenced 30.01.23 and will lead on supporting the implementation PSIRF plan. Monthly meeting in place and Trust wide action plan developed, and we are on track. |
| 3. To recruit patient partners as required, to be part of the | No patient partners currently recruited. We are awaiting the date | • To scope the role and develop job descriptions in line with the national profile of these roles. | One of the RPH PSS continue to attend the ICS Community of Practice in relation to the PSIRF |

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Quarterly Progress updates |
|---|---|---|---|
| governance structure as part of the PSIRF | of implementation of the PSIRF framework. | • Recruit the required numbers of patient safety partners as per the PSIRF.<br>• To set up a support/supervision system for the new roles. | launch. An approach to recruit system wide patient partners has been agreed.<br><br>For RPH we hope to recruit to these roles in June/July 2023. |
| 4. To scope and implement a Trust wide after action review (AAR) process to support staff with the outcome from incident management | There have been a small number of after actions review held within the year of 21/22. But no formal programme in place. | • Develop a plan to introduce a formal Trust process for AARs.<br>• Scope and commission a training provider to deliver AAR training to 10-15 facilitators.<br>• Roll out a programme of AAR review sessions that provide structured reviews or a de-brief session for relevant staff/patient incidents. Monitor the number implemented and develop mechanisms to capture the feedback from the session for improvement. | We have agreed to trust wide training with the ICS and as part of this we have access to PSIRF training for 20 staff to start the year one implementation and this will include after action review training.<br><br>During Q4 the new patient safety lead started who came to the Trust with AAR training, so we have started to use this for some investigations to support he new way of working. This will be evaluated further in Q1 of 23/24. |

**Executive Lead: Maura Screaton, Chief Nurse**

## Quality Account 2022/23 Priority 2

### Aim: Increased action on prevention of health inequalities

### For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan takes a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Quarterly Progress updates<br>Q4 update |
|---|---|---|---|
| 1. Reduce variation in access to or quality of services | The Trust holds large data base of patient demographics including addresses and post codes. The Trust seeks to understand further information on patient referrals depending on post code deprivation. | Correlate patient distribution from defined services with demographic database information and areas of deprivation. | Collation of data demonstrated that DNA rates of patients living in deprived areas fell significantly when offered the opportunity to undergo diagnostic tests at home.<br><br>Geographical demographic map to show deprivation levels has been built by Business Information Team<br><br>Culmination in 22/23 of a separate focus group formed for the Respiratory Support and Sleep Centre (RSSC) exploring the impact of social deprivation among people referred for investigation of possible sleep apnoea found that changes to appointment processes reduced the DNA rate amongst patients from socially deprived areas. Further projects continue. |
| 2. Support healthy behaviours among individuals | Trust engagement and sign up with treating tobacco dependency national initiative<br><br>Implementation of new tobacco treatment pathways across inpatient and outpatient services | 1) Development of plan to introduce initiative across defined inpatient and outpatient areas<br><br>2) Record number of patients offered tobacco treatment and complete mandatory reporting<br><br>3) Record number of patients who engage with programmes. | The Trust attended system level meetings initiated to implement the ICS Tobacco Dependence Programme and the Trust set up a Treating Tobacco Dependence (TTD) Working Group to support the delivery of programme. Doctor and nursing representation have advised on clinical implementation of the programme.<br><br>The Trust previously recorded patients as smokers vs non-smokers. A base line data of inpatient smokers at RPH was collated and reported to ICS. A digital form to capture data required for national reporting will be implemented in 23/24. |

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Quarterly Progress updates<br>Q4 update |
|---|---|---|---|
| | | | From the working group it was recognised that additional resource was required to implement the programme therefore ICS funding was secured for the Trust to fund staffing and nicotine replacement therapies. A Health Inequalities Specialist will also be recruited in Q1 23/24 and a digital inpatient referral form to the Health Inequalities Specialist has been drafted. A flowchart for an Acute Inpatient Smokefree Pathway has been created.<br><br>Service evaluation will be by data collection against ICS metrics and monitoring of changes in smoking prevalence amongst patients. Digital and Business Intelligence teams are creating an EPR interface for data collection in line with the metrics and templates still currently being provided by the ICS.<br><br>Work on implementing this programme will continue into 23/24.<br><br>In addition the Trust celebrated National No Smoking Day March 2023, engaging with staff, relatives and patients providing advice on stop smoking support. |
| 3. Partnership working and strategy development with local ICS on health inequalities | Trust engaged with local ICS inequalities group.<br><br>Trust leading system cardiovascular care pathway; Inequalities considered as part of this. | Measurement of patient outcomes.<br><br>Linking inequalities to patient safety agenda. | The Medical Director continues to attend regional population health management meeting chaired by Chief Medical Officer for the ICS. The regional focus is currently primary care focused. |

**Executive Lead: Dr I Smith, Medical Director**

## Quality Account 2022/23 Priority 3

### Aim: Harm free care: VTE, PU and falls

| Objectives 2022/23 | Baseline position for April 2022 | Our goals for 2022/23 | Quarterly progress updates |
|---|---|---|---|
| FALLS | | | |
| To introduce and undertake annual falls audits | Constant monitoring of number of falls and levels of harm with mini-RCAs undertaken following fall. Intentional rounding audits undertaken. | Annual audit of falls - aim to implement and complete by end Q2<br><br>Actions and learning from audit to be presented to Quality Risk Management Group (QRMG) in Q3 | There was a delay in the implementation of the audit however this was completed in Q4. Outcomes will be reported in Q1 to QRMG. The outcome of the audit actions will be overseen by the newly refreshed Falls Group. |
| To review all staff groups are receiving the correct falls prevention and trauma information as part of mandatory and local induction to the Trust and areas of work | Falls awareness training is not delivered in a consistent way across all relevant staff groups. | Review content of Trust local induction and essential to job role training for both nursing/AHP and medical | Falls awareness training is delivered consistently at induction as part of manual handling and through annual mandatory training.<br><br>As part of this training we have now added an additional section on what to do after a fall occurs to strengthen awareness around the trauma part of the falls policy. |
| | | Scope and develop an awareness refresher training package for current staff in Q1 and roll out of refresher training in Q2/Q3 | Falls awareness has been disseminated from completed patient safety incident reports throughout the year, highlighting associated learning from the investigations.<br><br>A thematic review of falls was completed in Q2 and shared at QRMG. A Trust wide Message of the Week highlighted the trauma aspect of the policy for the prevention and management of patient falls reminding staff of the procedure if a fracture is suspected following a patient fall.<br><br>Following the thematic review, a Falls Task and Finish Group was established in Q3 to review the following:<br>• Policy for the prevention and management of patient falls<br>• Current imaging capability for patients following a fall<br>• Training requirements for trauma imaging that is currently not carried at the Trust |

| Objectives 2022/23 | Baseline position for April 2022 | Our goals for 2022/23 | Quarterly progress updates |
|---|---|---|---|
| | | | • Potential extra equipment required to undertake scans of trauma patients<br><br>Initial work by the group has undertaken a full review of the Falls Policy, benchmarked against other Trusts. A section on clearer awareness around trauma when a fall occurs has been added to the policy with an additional easy to read flow chart added to the appendix of the policy to aid clear decision making in the event of a fall.<br><br>This policy will be ratified in Q1 of 23/24 with a Trust wide awareness campaign focussing on the key changes and training. |
| | | For new starters, develop and implement Learn Zone (or face to face) falls awareness package for role appropriate staff groups.<br><br>Monitor compliance of falls awareness training for new starters and existing staff receiving refresher training via Learn Zone (or face to face) | Learn Zone was reviewed but the platform was found not suitable to be used for additional awareness training. Extra training for staff has however been provided at induction and attendance is monitored.<br><br>Outside of induction staff can access Falls Training with the Education Team. |

**Executive Lead: Maura Screaton, Chief Nurse**

| Objectives 2022/23 | Baseline position for April 2022 | Our goals for 2022/23 | Progress update |
|---|---|---|---|
| Pressure Ulcers (PUs) | | | |
| A reduction by 20 % in pressure ulcers examined at pressure ulcer scrutiny panel where acts and omissions in care are associated with incomplete documentation found in the pressure ulcer SSKIN care plan document. | There were 11 pressure ulcers in the last reporting year where acts and omission in care were identified and were linked to gaps in documentation.<br><br>The full reporting year 2021/22 found that 38% (11/29) of pressure ulcers that required an RCA and review at scrutiny panel were associated with acts and omission in care with all associated to some extent with incomplete documentation of the SSKIN care bundle. | • Monitor the numbers of incomplete documentation of Lorenzo SSKIN care bundles<br>• Carry out annual PU audit | The pressure ulcers examined at panel are of a depth of category 2 or deeper.<br><br>This reporting year 2022/23 found that 18% (7/38) of pressure ulcers that required an RCA and review at scrutiny panel were associated with acts and omission in care linked to poor documentation. The remaining incidents where there were acts or omission in care were linked with an inadequate plan of care been set or a failure to carry out what was otherwise an adequate plan of care. |
| A reduction by 10% in the number of medical device related pressure ulcers in Critical Care Area patients. (MDRPU) | A CCA QI audit on the subject in 2021/22 found that with 10% reduction in this type of pressure ulcer was achievable when supported with local area, senior leadership and Wounds Care TVN team support.<br><br>There were 56 medical device related pressure ulcers (MDRPU) reported by Critical Care (CCA) in 2021/2022. | • Monitor the numbers of PU associated with medical devices<br>• To include medical device associated PUs in the annual PU audit | 56 MDRPUs in the 2021-2022 reporting year versus 46 in the 2022-2023 reporting year shows a reduction of 18%.<br>There have been several initiatives in this reporting year to date in CCA to raise the awareness of the risk of MDRPU in CCA. The use of many critical types of medical devices including ET tubes and ECMO pipes predisposes patients to this type of pressure injury. |
| Establish 4 teaching sessions a year to be provided for the Wound Care Tissue Viability link nurse group | This programme is new for 2022/23 | • Organise the 4 teaching sessions accessible through MS Teams.<br>• Attendance will be monitored at PU scrutiny panel<br>• Attendance reported in annual audit | A quarterly education update about prevention and management of pressure ulcers and moisture associated skin damage, targeted at registered and non-registered staff caring for patients at risk of pressure ulcer development has been established. |

**Executive Lead: Maura Screaton, Chief Nurse**

| Objectives 2022/23 | Baseline position for April 2022 | Our goals for 2022/23 | Quarterly progress updates Q4 update: |
|---|---|---|---|
| VTE | | | |
| Improve compliance with VTE assessments | National target is 95%.<br>There are an unknown number of VTE link nurses as many have moved around internally or left the Trust during the COVID base. | To continue to carry out monthly audit of compliance to review % of compliance and address areas achieving suboptimal performance.<br><br>Local action plans to be created at divisional level to support improvement in compliance for areas not achieving 95%. Monitored at divisional level and reported into QRMG. To monitor compliance against national target.<br><br>To re-refresh the role of the link nurse per division and increase the number of link nurses and attendance at link nurse meetings.<br><br>To carry out a full scoping exercise Trust wide to review who requires regular education from medical trainees/ relevant Advanced Nurse Practitioners (ANP) re VTE. | A monthly audit was implemented to monitor compliance for VTE assessments on admission. This audit measures % of patients who stayed overnight who had a VTE risk assessment completed within the first 24 hours of their admission, for patients who had a length of stay of greater than 24 hours.<br><br>Compliance with performing VTE risk assessments was 91% in January. This is an improvement from the reported 84.8% in December. This continues to be an area of particular focus and VTE continues to be monitored through monthly Trust quality & risk meetings (QRMG) and divisional performance meetings.<br><br>Digital options for a clinical prompt for outstanding VTE assessments remains very unlikely in short-medium term. Other digital options are being investigated and are under discussion at the clinical decision cell (CDC).<br><br>Work continues with the clinical teams to support improvement with VTE assessment compliance through support from various forums. Leadership support provided from the CDC to provide focus on VTE. Consultant VTE champion roles have been identified across the Trust.<br><br>The role of the VTE link nurse was refreshed and link nurse meetings take place bi-monthly. An opportunity for attendance at national conference and training offered to VTE link nurses in Q4.<br><br>The Trust procedure for VTE risk assessment and prophylaxis reviewed in line with NICE VTE prevention (NG89) guidance. Extra details providing granularity around cohort exemptions, roles, and responsibilities was added. |

| Objectives 2022/23 | Baseline position for April 2022 | Our goals for 2022/23 | Quarterly progress updates Q4 update: |
|---|---|---|---|
| | | | The VTE clinical indicator view (dashboard for patients) within Lorenzo has been optimised to better highlight patients in need of VTE risk assessment before 24h target is breached. Reminders are given to medical staff at safety huddles/handover sheets/Drs job lists.<br><br>We continue to redesign the VTE Datix dashboard and fields, and request VTE champions, matrons to review VTE events that occur and share learning.<br><br>Comms/Education:<br>• Trust wide Message of the Week utilised to highlight VTE clinical indicators in Lorenzo.<br>• Intranet VTE screensaver in place<br>• Patient information video on how to avoid a VTE now available on Trust website<br>• Communication and digital teams have supported plans to deliver a patient video to raise awareness of VTE risk using the patient entertainment system. Awaiting implementation.<br>• Ward based educational sessions taken to all wards |
| Aim for compliance with the Exemplar status | Last Exemplar site approval was carried out in 2017.<br><br>Exemplar renewal date was due 2020 - postponed due to COVID. We are expecting this review in 2022 (no date has been set yet by the governing body) | To carry out a self-assessment within Q1 against last known VTE Exemplar Criteria (to include RAG rating of current compliance).<br><br>Create an action plan from self-assessment to review and work towards achieve revalidation as a VTE Exemplar Trust. | As the Trust was regularly not achieving the national target of 95% the VTE oversight group recommended that the Trust should not apply for revalidation as an exemplary site. It was proposed that a focus on the informatics and engagement, both at a clinical and patient level should be the 23/24 focus, in preparation for re- applying. This recommendation was agreed by the Executive Led Quality & Risk Committee in Q4 22/23. |

**Executive Lead: Maura Screaton, Chief Nurse**

## Quality Account 2022/23 Priority 4

**Aim: Digital enabled care: Barcode medicines administration (BCMA) - BCMA is advocated as a technology that reduces medication errors relating to incorrect patient identity, drug or dose.**

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Progress updates |
|---|---|---|---|
| To implement the scanning of patient wristbands to confirm patient identify prior to the administration of medicines in inpatient areas (excluding CCA) | Patient identify is currently confirmed verbally and by manually checking patient wristbands. | Progress against work package implementation plan.<br><br>% of medicines administration actions where the requirement to scan the patient's wristband is overridden. | This was launched across all ward areas in May 2022 following an awareness implementation and campaign. Clinical floor walkers were deployed to ward areas during and after implementation and assisted staff where necessary. Training continues to be delivered to new starters and refresher training is also available.<br><br>There were no reports of 'wrong patient' medication incidents on DATIX since the implementation which is a reduction compared with previous financial year where 2 incidents were reported.<br><br>Throughout the year this has been monitored on a quarterly basis to review the % of times a patient has been given their medication without their wrist band being scanned.<br><br>Scrutiny of the data in 22/23 shows that 70.39% of drug rounds were performed when wristbands were not scanned and that 41.05% (56,394) of successful scans were free typed, (although this figure is likely to be under-reported).<br><br>Due to complex medication regimes, incorporating patient wristband scanning has increased the time taken to complete a drug round for specific cohort of patients, although familiarising our staff to a scanning workflow has been beneficial as we aspire to implement a full closed loop medicines administration system. It has provided insight to where our medicines administration processes may need to be adapted to |

| Objectives 2022/23 | Baseline position for April 2022 | How will this be measured? | Progress updates |
|---|---|---|---|
| | | | be compatible with a full closed loop medicines administration system.<br><br>The digital team have rolled out a number of new Workstations or Wheels (WOWs) which supports the initiative by ensuring staff have the necessary equipment to utilise this feature reliably and realise the benefits it provides to our patients.<br><br>Formal review of factors adversely affecting compliance remains ongoing however initial findings show this is multifactorial.<br><br>Further work is planned for 23/34 to continue to embed this practice linking with clinical leaders. |
| To investigate the requirements for a full closed-loop medicines administration workflow and create a high level plan for the implement of this workflow. | There is an aspiration for the Trust to implement a complete closed-loop medicines administration workflow, however there is no specific plan to meet this objective. | Evidence of engagement with other organisations who have already implemented this workflow to gather 'lessons learnt'.<br><br>Production and approval of a high level strategic plan for the implementation of Barcode Medicines Administration (BCMA). | Following the decision by our Electronic Patient Record (EPR) supplier, to suspend development of the relevant functionality in our EPR, there is no clear path to a full closed-loop medicines administration workflow at the Trust. The requirement for a closed-loop medicines administration process will be a key consideration in the procurement and implementation of any future EPR or electronic prescribing system. A local DGH has shared a blueprint for closed loop medicines administration, which will inform a future implementation approach with the newly procured EPR system |

**Executive Lead: Maura Screaton, Chief Nurse**

**Implementation Leads:**

- **Chris McCorquodale, Deputy Chief Pharmacist and Chief Pharmaceutical Information Officer**
- **Eamonn Gorman, Deputy Director of Digital and Chief Nurse Information Officer**

## Quality Account 2022/23 Priority 5: Well Led: Quarter 4 update

**Objective:** Compassionate & Collective Leadership (CCL) and good staff engagement

| Objectives | Baseline position at April 2022 | Our goals for 2022/23: | Quarterly progress updates |
|---|---|---|---|
| Deliver three cohorts of the new Line Managers Compassionate and Collective Leadership Programme | Programme launched to the Trust in March 2022 with applications open for the first cohort of 16 which will commence from April 2022.<br><br>Further cohorts planned for Q3&4 2022/23. | Attendee evaluation of the workshop<br><br>Use the quarterly staff survey to assess impact on staff perception and line manager perception of impact on behaviours and introduce a structured survey and assessment of impact<br><br>Improved management of staff experience should see improved Pulse and staff scores related to management and autonomy over work and increased role satisfaction.<br><br>A reduction in sickness absence and numbers of formal disciplinary processes is also anticipated. | Three cohorts are full. Two have been completed and Cohort 3 will complete in April 23. A total of 48 line managers will have completed the programme in 22/23.<br><br>Feedback is good with the peer support this forum provides highlighted as a key positive.<br><br>A further 4 cohorts have been recruited to for 23/24 and the first will commence in April 23.<br><br>A review of the programme has been undertaken and improvements made for example, attendance at the 9 core modules is now mandatory and are requesting that participants attend a minimum of 2 skills workshops in order to be able to graduate from the course.<br><br>Our one-day line manager induction remains popular with it reaching full capacity every month. |
| Continue the delivery of the Values and Behaviours workshops. | 243 staff have attended workshops.<br><br>Team sessions in development<br><br>Home workers delivery of training due to commence May 2022<br><br>V&B session designed for induction and will be offered to all new starters from 9/5/2022. | Achieve 75% workshop attendance of all staff<br><br>V&B session integrated into the corporate induction.<br><br>V&B session delivered as part of the Line Managers Induction | 65% of staff have attended the values and behaviours training and we continue to work towards our target of 90%.<br><br>In Q3 we facilitated 8 sessions with a total of 51 staff attending but it has become more challenging to fill these sessions with the numbers needed to ensure that it is a useful participative event. As we move forward we are changing our approach and are planning bespoke sessions with specific wards and teams and we are planning to work with smaller groups – some of these sessions have already been diarised for the coming months.<br><br>We are considering how we measure the long term impact of these sessions and we are holding short semi structured interviews with staff who have attended in the last 6 months. |

| Objectives | Baseline position at April 2022 | Our goals for 2022/23: | Quarterly progress updates |
|---|---|---|---|
| | | | Values and behaviours training is still a core part of our corporate induction. We are undertaking a review of the materials that we use at our monthly corporate induction to improve the 45-minute V&B session and we have introduced more exercises and opportunities for participants to get to know each other. |
| Implement the Reciprocal Mentoring Programme | Four Reciprocal Mentoring modules planned for 22/23 with module 1 dates agreed for June 2022 commencement.<br>RPH completed four modules of the Diversity and Inclusion (D&I) Partners Programme in March 2022. | Develop a process to monitor the outcome from concepts/projects developed between partners | All modules have been delivered according to the timetable. A review of the programme by an external consultancy was commissioned and scoped in Q3, and was undertaken in Q4.<br><br>A second cohort in 23/24 has been commissioned and recruitment is underway. |
| | | Annual staff survey results (April 23) | The 2022 Staff Survey Results were published on 9 March 2023 and will reviewed at the March Workforce Committee meeting. |
| | | Pulse internal survey results (quarterly) | The Q3 results have been published and were reviewed at the March Workforce Committee. The Q4 results are not available until May 23. |
| | | WRES and WDES annual reports including data on national compliance indicators (March 23) | The 21/22 WRES and WDES data was reviewed at the March Workforce Committee. The action plans will be updated in Q4 in light of the staff survey results. |

**Executive Lead:** Oonagh Monkhouse, Director of Workforce and Organisational Development
**Implementation Leads:**
Larraine Howard-Jones, Deputy Director of Workforce and Organisational Development
Onika Patrick Redhead, Head of Equality Diversity & Inclusion

## Priorities for 2023/24:

Our priorities for 2023/24 reflect the domains of quality: patient safety, clinical effectiveness, well led and patient experience. Our priorities are:

Priority 1: Implement the Patient Safety Incident Response Framework
Priority 2: Increase action on prevention of health inequalities
Priority 3: Harm free care: VTE, PU and falls
Priority 4: Reduce Surgical Site Infections
Priority 5: Improve Resourcing & Retention

To determine its Quality Priorities for the coming year the Trust reviewed clinical performance indicators and identified a long list of improvement proposals that were considered with input from clinical teams, our Patient & Public Involvement Committee and the Quality & Risk Committee before the final priorities were selected.

Progress and achievement of goals in relation to our priorities will be reported and monitored by the Quality & Risk Committee (a Committee of the Board of Directors). Reports will also be presented to the PPI Committee and the Council of Governors.

## Quality Account 2023/24 - Priority 1

## Aim: Patient Safety Incident Response Framework

**To support the NHS to further improve patient safety, a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.**

| Objectives 2023/24 | Baseline position for April 2023 | How will this be measured? |
|---|---|---|
| Complete the year one Implementation plan for the Patient Safety Incident Response Framework (PSIRF) | PSIRF Orientation stage (month 1-3) is at final stage of completion. Aiming to finalise in April 2023 | • Completion of the 12-month part of transition plan:<br>• PSIRF Orientation (Months 1-3)<br>• Diagnostic and discovery (Months 4-7)<br>• Governance & quality monitoring (Months 6-9)<br>• Patient safety incident response planning (Months 7-10)<br>• Curation and agreement of the policy and plan (Months 9-12)<br>• Transition (12 months +) |
| Recruit Patient Safety Partners (PSPs) to be part of the governance structure as part of the PSIRF implementation in the Trust. | • No PSPs currently recruited.<br>• In 22/23 we started the implementation plan; this was delayed as we required additional resource to support the implementation.<br>Patient Safey Lead post started in Q4 and project support to start in Q1 23/24. | • Finalisation of role profile for PSPs in line with the national profile and joint ICS approach of these roles.<br>• Recruitment of two PSPs as per the PSIRF.<br>• PSPs to be part of governance and patient safety programmes of work by end 23/24.<br>• Set up of a support and supervision system for the new roles. |
| Implement new patient safety mandatory training for all staff - level 1 and clinical staff and operational leads level 2. | No current training in place. | Implementation of the PSIRF required training:<br>• **Level 1a:** Essentials of patient safety for all staff.<br>• **Level 1b:** Essentials of patient safety for Board and Senior Leadership teams<br>• **Level 2**: Access to Practice for all staff with a registration to practice, and managerial staff who will manage and support patient safety. |

**Executive Lead:** Maura Screaton
**Implementation Leads:**

- Louise Palmer, Assistant Director for Clinical Governance
- Dr David Meek, Consultant Respiratory Physician/ Associate Medical Director for Governance
- Sarah Powell, Clinical Governance Manager
- Clare Steele, Patient Safety Lead

## Quality Account 2023/24 Priority 2

## Aim: Increased action on prevention of health inequalities

For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan takes a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.

| Objectives 2023/24 | Baseline position for April 2023 | How can this be measured? |
|---|---|---|
| To participate in the new reviewed EDS2 for 23/24<br><br>This includes system changes and considers the new system architecture and through collaboration and co-production and taking into account the impact of COVID-19, the EDS has been updated and EDS 2022. | The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The Trust took part in this EDS2 annual review prior to the pandemic. | • Completion of the EDS2 for 23/24 and graded and reported on to board.<br>• Action plan in place for improvement from the annual review |
| We will redesign our inpatient services and increase the support we offer to people who are admitted to or attend Royal Papworth Hospital to help them to stop smoking, to reduce harm from tobacco and be smoke free during an inpatient admission.<br><br>We will provide tobacco treatment advice and support to individuals and groups of people, who want to stop smoking, reduce their harm from tobacco or for temporary abstinence when in hospital. | The NHS Long Term Plan gives a commitment that all patients admitted to hospital that currently smoke cigarettes will be offered NHS-funded tobacco dependence treatment services by the end of 2023/24. This is currently not in place. | • We will embed our new Health Inequalities Specialist role within our services to support this programme of work. Post holder due to start in June 2023.<br>• We will develop the service model, data flows and logistics within the organisation needed to achieve the commitment of all inpatient smokers at RPH being able to access dependency treatment serviced by March 2024.<br>• We will monitor the uptake of the number of patients who engage with the tobacco dependency program. |

**Executive Lead:** Maura Screaton, Chief Nurse and Oonagh Monkhouse, Director of Workforce and Organisational Development

**Implementation Leads:**

- **EDS2;** Onika Patrick-Redhead, Head of Equality Diversity and Inclusion and Louise Palmer, Assistant Director for Quality and Risk
- **Tobacco Dependency Programme:** Pippa Hales, Chief Allied Health Professional

## Quality Account 2023/24 Priority 3

## Aim: Harm free care: VTE, PU and falls - linked to performance and need for focus on harm free care charting and trends

| Harm Free Care Objectives 2023/24 | Baseline position for April 2023 | How can this be measured? |
|---|---|---|
| Launch a Harm Free Care Panel that will have oversight of the Trust Quality Improvements required for Falls, VTE and Pressure Ulcers | • No current panel in place | • Scope and launch a Harm free care panel that reports into QRMG.<br>• Clear Governance Structure to support the Trust wide improvement for these 3 areas of the harm free care. |
| | | |
| **FALLS Objectives 2023/24** | **Baseline position for April 2023** | **How can this be measured?** |
| Re-establish a Falls Prevention group with multi-professional membership to strengthen trust wide learning from patient falls - focus will be on prevention of future harm and improvement. | • Previous prevention group was suspended during the pandemic and remains so.<br>• Falls monitored monthly on PIPR and reported quarterly as part of quality report to QRMG/Q&R | • Group re-established with updated terms of reference and membership agreed and overseen by Harm free care panel and reported into QRMG.<br>• Key Performance Indicators agreed for the year 23/24.<br>• Progress of actions and learning from investigations monitored with quarterly reporting to QRMG |
| Completion of the revision of the review of the existing falls and prevention Policy, with focus on the two main areas:<br>• Prevention of Patient Falls.<br>• Management of a Patient Following a Fall. | • Current review of Falls Policy underway by Falls Task and Finish Group. | • Patient prevention and Falls Policy completed, approved, and launched.<br>• Included in the policy compliance against policy as clear KPI's for the annual Falls audit.<br>• Audit/Actions Plans monitored by Falls Prevention Group.<br>• Clear pathway for all staff to follow if a patient is suspected to have a fracture or trauma requiring acute care (as part of the revised policy. |
| Review trauma Pathway following a patients fall - Options appraisal of the resources and training requirements needed to undertake imaging of trauma patients at Royal Papworth Hospital | • Falls Task and Finish group set up in 22/23 has been reviewing current policy/Trauma process.<br>• Options appraisal currently being scoped | • Options appraisal completed and reported on to QRMG and onwards to Q&R.<br>• As agreed, any new pathways (as required) to be further implemented in 23/24.<br>• To work with our partner Acute hospital on the Biomedical campus (as required) for any new pathways, to support streamlines of care following a fall, with suspected trauma. |
| **VTE Objectives 2023/24** | **Baseline position for April 2023** | **How can this be measured?** |
| Sustained improved compliance with VTE assessments within 24 hours of admission. National target is 95% | • Average monthly compliance rate for period Oct 22- Mar 2023 was 88.22%<br>• Monthly audit of % compliance for VTE assessments on admission implemented.<br>• VTE monitored monthly on PIPR and reported quarterly as part of | • New VTE Medical Lead appointed.<br>• Medical VTE champion roles and responsibilities determined.<br>• VTE oversight committee to be re-established (Quarterly), who will have oversight of performance and action plans, reporting into new Harm free care panel and reported into QRMG.<br>• Medical VTE champion (bi-monthly), led by medical VTE lead, who will review |

| VTE<br>Objectives 2023/24 | Baseline position for April 2023 | How can this be measured? |
|---|---|---|
| | quality report to QRMG/Q&R.<br>• Consultant VTE champions identified across the Trust.<br>• Lorenzo clinical indicator (dashboard) in place to optimise/ highlight patients in need of VTE risk assessments before 24h target breached | ongoing VTE performance and updated ongoing action plans.<br>• Bi-monthly VTE link nurse/AHP meeting led by Head of Nursing Cardiology to be in place. With clear roles and responsibilities set.<br>• Investigation of further digital options to aid compliance of VTE assessment. |
| Preparation for re-application of VTE exemplar status in 2024 | • In 22/23 the Trust was unable to achieve the national target of 95%.<br>• In recognition the Trust decided not to apply for revalidation as an exemplar site.<br>• It was agreed that the focus would be on the informatics and engagement, both at a clinical and patient level in preparation for a re-application in 2024. | • VTE oversight committee to undertake review of this 2022/23 progress for revalidation status.<br>• Benefit and consideration of Exemplar status to reviewed by VTE oversight committee when VTE medical lead in place and details of criteria known.<br>• Facilitate organisation self-assessment against Exemplar criteria when known. |

| PUs<br>Objectives 2023/24 | Baseline position for April 2023 | How can this be measured? |
|---|---|---|
| Promote Equality and Diversity in Pressure Ulcer Management – | • This is not in place at RPH currently. | • There is a growing UK wide evidence base recognising a lack of capability in recognising early onset and depth of pressure ulcer injury in BAME patients which increases the risk of deeper pressure ulcer development due to late recognition of skin injury. Introduce a 'Darkly Pigmented Skin PU Assessment' programme of education |
| Introduce of a Wound Care Tissue Viability education board to each main inpatient department. To include management of pressure ulcer and BAME considerations. | • Currently 3S, 4NW and 5S thoracic surgery have education boards. | • Wound Care Tissue Viability education board – to be in place on:<br>• 5 North cardiac surgery<br>• Thoracic medicine wards<br>• CCA and Theatre area to have a dedicated education board.<br>• All ward/CCA PU boards should highlight PU metrics and education on the specifics of pressure ulcer risk assessment, prevention and management of pressure ulcer and BAME considerations. To be used as dedicated resources to continue to education staff. |
| Integrate the Patient Pressure Ulcer Patient Leaflet into the discharge process to support patients who have become physically deconditioned during the admission, consequently, remain at risk of PU development at home and to promote self- | • In 22/23 there have been documented instances failure to give adequate pressure ulcer advice at discharge.<br>• Lack of information was identified as a contributing factor to the | • Preventing Pressure Ulcers leaflet to be updated.<br>• Preventing Pressure Ulcers leaflet to be given on discharge in addition to verbal advice.<br>• This will be overseen via the pressure ulcer scrutiny panel who engage with ward sisters. |

| PUs Objectives 2023/24 | Baseline position for April 2023 | How can this be measured? |
|---|---|---|
| management of pressure areas post discharge with the support of community teams as necessary. | further deterioration at home. | • Checking patient leaflets are being used - will form part of the annual PU audit to gain assurance the new updated process is in place and implemented. |

**Executive Lead:** Maura Screaton

**Implementation Leads:**

- **Harm Free Care Panel**: Jacqui Wynn, Head of Quality Improvement and Transformation
- **Falls:** Polly Gunsman, Specialist Falls Nurse and Clare Steele, Patient Safety Lead
- **VTE:** Sandra Mulrennan, Nursing Lead for VTE and Dr Webb, Clinical Lead for VTE
- **PUs:** Rob Gannon, Nurse Consultant and Tissue Viability Team

## Quality Account 2023/24 Priority 4

## Aim: Reduced Surgical Site Infections - Implementation of a continued challenge and improvement programme

| Objectives 2023/24 | Baseline position for April 2023 | How will this be measured? |
|---|---|---|
| Continued theatre ventilation assurance work. | • Compliance with national regulations has been confirmed.<br>• Environmental staff concern remains on design of air flow.<br>• Practical changes have been made to practices within theatre to reduce perceived risk (change to area for gowning/gloving). | • Establish regular Ventilation Safety meetings.<br>• Independent specialist review of ventilation |
| Develop assurance on decontamination and sterilisation of sterile instruments. | • Improved oversight on issues with instrument decontamination and sterilisation<br>• All non-conformance events are recorded on Datix and reports are now reviewed.<br>• Instrument replacement programme in place<br>• Decontamination lead appointed | • Regular review of non-conformance reports.<br>• Decreased number of non-conformance incidents reported.<br>• Decontamination assurance report to be presented at monthly IPCC meeting. |
| Embedding of NICE guidelines for prevention of surgical site infections | • Theatre uniform policy reviewed in line with AFPP and NICE guidance.<br>• Trial of antibiotic coated sutures<br>• Trial of antibiotic impregnated dressings and minivac dressings | • Audit of compliance with theatre uniform policy.<br>• Introduce antibiotic coated sutures for all operative cases.<br>• Introduce antibiotic coated dressings for at risk patients<br>• Embed mini-VAC dressings for high-risk patients. |
| Improved theatre environment | • A new theatre schedule was implemented to ensure one theatre a month undergoes a complete deep clean.<br>• A robust deep clean schedule for theatres is in place.<br>• Regular IPC rounds in place including all the patient pathway. | • Decreased footfall in theatres – evidenced through weekly footfall audits.<br>• Theatre audits within target range:<br>➢ Hand hygiene (>94%)<br>➢ ANTT audit (>94%)<br>➢ Cleaning & decontamination (>94%)<br>➢ Cleaning QC (94%)<br>➢ Compliance with administration of prophylactic antibiotics<br>• Monthly deep cleans completed |
| Continued focus on IPC audits | • Programme of IPC audits re-established throughout the year.<br>• Oversight at IPCC and SSI stakeholder group<br>• SSI assurance dashboard in place | • Focus on ANTT training and its implementation in practice to identify areas of non-compliance, and reasons why.<br>• External review of audit process to enable learning and holistic approach to auditing patient pathway |
| External review of practise | • NHSI/E IPC lead advice and guidance<br>• External DIPC review requested | • Consider all recommendations and reviews for learning and improvement through SSI stakeholder group |
| Diabetic management pre and post operatively | • HbA1C preoperatively by GP<br>• Improve education of staff in management of blood glucose | • Audit practice in respect to compliance of completion of |

| Objectives 2023/24 | Baseline position for April 2023 | How will this be measured? |
|---|---|---|
| | | HbA1C and blood glucose management |

**Executive Lead:** Maura Screaton, Chief Nurse

**Implementation Leads:**

- Lisa Steadman, Head of Nursing for Surgery, Transplant and Anaesthetics
- Kathy Randall, Lead Infection Prevention & Control Nurse
- Robert Gannon, Nurse Consultant and Tissue Viability Team

## Quality Account 2023/24 Priority 5

### Aim: To improve resourcing & retention of staff through enhancing line managers skills and improving talent management/career progression.

| Objectives 2023/24 | Baseline position for April 2023 | How will this be measured? |
|---|---|---|
| Develop talented people managers through our Compassionate and Collective Line Managers Development Programme<br>• Run four cohorts of the Programme<br>• Review the impact of the Programme | • Two cohorts have been recruited to and further two are being promoted<br>• Discussions have started on what measures could be used to review the impact of the programme | • 64 line managers to have completed the Line Managers Programme<br>• Positive feedback from participants<br>• Positive feedback from the participants managers<br>• Improvement in the responses to the questions in the Pulse Survey and National Staff Survey about line managers<br>• Report produced, including recommendations for improvement, by the end of 23/24 |
| Effectively manage our talent, supporting development and succession planning across all services.<br>➢ Develop a simple talent management process and supporting training material for line managers<br>➢ Develop a methodology for describing career /development pathways within the organisation and create material that describes an initial six career pathways for key roles | • Revised appraisal policy launched in 22/23 that includes tool for career conversation | • A talent management process developed, piloted and launched for line managers to use as part of the appraisal process.<br>• Monthly training sessions on talent management developed and timetabled<br>• Six career pathways developed and created across a range of professions<br>• Career Pathway material communicated and used in recruitment material |
| • We will develop and implement further leadership development programmes and tools and techniques to support the development of capable, confident, and compassionate leaders at all levels in the organisation. | • Development gap analysis undertaken for the Triumvirate leadership in 22/23. | • Development and delivery of a leadership development programme for the triumvirate leaders that encompasses the accountability framework and team development and coaching.<br>• Develop and deliver sessions on key areas of leadership that are identified as gaps through the Line Managers Programme |

**Executive Lead:** Oonagh Monkhouse, Director of Workforce and Organisational Development

**Implementation Leads:**

- Larraine Howard-Jones, Assistant Director of Workforce and Organisational Development

## 2.2 Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by Royal Papworth Hospital NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare quality accounts for each financial year. NHSE has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports, which incorporate the legal requirements, in the NHS Foundation Trust Annual Reporting Manual.

Indicators relating to the Quality Accounts were agreed following a process which included the input of the Quality and Risk Committee (a Committee of the Board of Directors), Governors, the Patient and Public Involvement Committee of the Council of Governors and clinical staff. Indicators relating to the Quality Accounts are part of the key performance indicators reported to the Board of Directors and to Directorates as part of the monitoring of performance.

Information on these indicators and any implications/risks as regards patient safety, clinical effectiveness and patient experience are reported to the Board of Directors, Governors and Committees as required.

Part 2.2 includes statements and tables required by NHSI and the Department of Health and Social Care in every Quality Account/Report. The following sections contain those mandatory statements, using the required wording, with regard to Royal Papworth Hospital. These statements are *italicised* for the benefit of readers of this account.

*During 2022/23 Royal Papworth Hospital NHS Foundation Trust provided and/or sub-contracted six relevant health services. Royal Papworth Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in six of these relevant health services.*

*The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Royal Papworth Hospital NHS Foundation Trust for 2022/23.*

Full details of our services are available on the Trust web site:
https://royalpapworth.nhs.uk

## Information on participation in clinical audits and national confidential enquiries

National clinical audits and Patient Outcomes Programme are commissioned and manged by the Healthcare Quality Improvement Partnership (HQIP).

Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCEPOD are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG)

In the financial year of 22/23 there were 21 national clinical audits and 1 national confidential enquiry that were relevant to Royal Papworth Hospital NHS Foundation Trust. During 2022/23, Royal Papworth Hospital participated in 19 of the 21 (86%) national audits and 1 of the 1 national confidential enquiries (100%).

The national clinical audits and national confidential enquiries that Royal Papworth Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| National clinical audits relevant to Royal Papworth Hospital<br>Participation rate 22/23 (86%) | | |
|---|---|---|
| **Audit Title** | **Audit Source** | **Compliance with audit terms** |
| Case Mix Programme (CMP) | Intensive Care National Audit and Research Centre (ICNARC) | 100 |
| National Audit of Inpatient Falls[1] | Royal College of Physicians | 100 |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford | 100 |
| Medical and Surgical Clinical Outcome Review Programme | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | See breakdown on next page. |
| National Audit of Cardiac Rehabilitation | University of York | 100 |
| National Audit of Care at the End of Life (NACEL) | NHS Benchmarking Network | 100 |
| National Audit of Pulmonary Hypertension (NAPH) | NHS Digital | 100 |
| National Cardiac Arrest Audit (NCAA) | Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK | 100 |
| National Cardiac Audit Programme: Adult Cardiac Surgery | Barts Health NHS Trust | 100 |
| National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management Devices and Ablation | Barts Health NHS Trust | 100 |
| National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP) | Barts Health NHS Trust | 100 |
| National Cardiac Audit Programme: Coronary Angioplasty (Percutaneous Coronary Interventions) | Barts Health NHS Trust | 100 |
| National Cardiac Audit Programme: National Congenital Heart Disease Audit | Barts Health NHS Trust | 100 |
| National Lung Cancer Audit (NLCA)[2] | Royal College of Physicians | 100 |
| Sentinel Stroke National Audit programme (SSNAP) [3] | King's College London | N/A |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme [4] | Serious Hazards of Transfusion (SHOT) | 100 |
| UK Cystic Fibrosis Registry | Cystic Fibrosis Trust | 100 |
| LeDeR - Learning Disabilities Mortality Review | NHS England and NHS Improvement | 100 |
| National COPD audit | Royal College of Physicians (RCP) | 100 |
| National Comparative Audit of Blood Transfusion | NHS Blood and Transplant | 100 |

*Note 1: Cambridge University Hospitals submits on behalf of RPH as the treatment provider/diagnosing trust for hip fractures as per the audit inclusion criteria.*
*Note 2:The National lung cancer audit records the patients by the hospital in which they were first seen. Since almost no patients are referred directly from their GP to Royal Papworth Hospital, the data which is completed by Hospital counts towards the district general hospitals participation rate.*
*Note 3:The Sentinel Stroke National Audit requires a minimum number of patients to generate a quarterly report. Since the Trust started participation in 2019, we have not had enough stroke patients to meet this requirement and hence withdrew from the audit.*
*Note 4: The Serious Hazards of Transfusion is not a national audit but a haemovigilance scheme. It collects anonymised data on adverse events and reactions in blood transfusion. The blood transfusion department currently reports any adverse events/reactions when they occur and submit the data proforma.*

## National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national confidential enquiry “Transition from Child to adult services” has now ceased as from Oct 2022.

National Audits collect a large volume of data about local service delivery and achievement of compliance with standards, and about attainment of outcomes. They produce national comparative data for individual healthcare professionals and teams to benchmark their practice and performance.

The reports of 10 national clinical audits were reviewed by the provider in 2022/23. Below is a sample of audits discussed at relevant group meetings.

| Audit Title | Report Published |
|---|---|
| Case Mix Programme (CMP) | Y |
| NICOR 2022 Annual Report | Y |
| National Audit of Cardiac Rehabilitation (NACR) | Y |
| National Audit of Pulmonary Hypertension (NAPH) | Y |
| National Cardiac Arrest Audit (NCAA) | Y |
| Myocardial Ischaemia National Audit Project (MINAP) | Y |
| National Adult Cardiac Surgery Audit (NACSA) | Y |
| National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | Y |
| UK Cystic Fibrosis Registry | Y |

The reports of 10 local clinical audits were reviewed for the FY 2022/23 and Royal Papworth Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. A sample of actions is listed below:

**Sepsis Audit**

- There was a decrease in compliance for completion of the Sepsis 6 bundle documentation compared to the last audit – from 97% to 75% in this audit
- Improving documentation of the sepsis 6 care bundle is a focus and part of training at the deteriorating patient study days
- Advanced Nurse Practitioners to continue providing education and support to ward staff when completing the Sepsis 6 bundle

**A re-audit looking at the consistency and appropriateness of Clinical Microbiology results validation**

- It was identified within this audit that validation of results were inconsistent due to the subjectivity of the validation process.
- This has been discussed at the divisional meetings and recommendations made.
- Standard operating procedure (SOP) is to be updated on the guidance on validation process
- Re-audit in April 2023 to evidence whether performance has improved.

**Audit of antibiotics administered in cardiac and thoracic surgery pre and peri-operatively**

- The appropriate antibiotics are given in theatre
- Timings and doses are adequate
- There is appropriate documentation of antibiotic administrations in theatre.
- Cycle 2 noted a general improvement with all standards, excluding documentation.

## Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Papworth Hospital NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 2404. See table below:

| Type of research project | No. of participants recruited per financial year | | | |
|---|---|---|---|---|
| | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
| NIHR portfolio studies | 1,406 | 2246 | 1,061 | 1,192 |
| Non-NIHR portfolio studies | 124 | 186 | 81 | 63 |
| Tissue bank studies | 1,867 | 968 | 1,673 | 1,149 |
| **Total** | **3,397** | **3,400** | **2,815** | **2,404** |

*NIHR = National Institute for Health Research*

By maintaining a high level of participation in clinical research the Trust demonstrates Royal Papworth's commitment to improving the quality of health care. Research conducted by the National Institute for Health Research (NIHR) has shown that research-active hospitals have better health outcomes for patients.

During 2022/23 the Trust recruited to 71 studies of which 60 were portfolio studies (2021/22: 60 studies and 54 portfolio studies).

The Trust has a balanced portfolio of observational and interventional studies across a range of specialities and patient populations including bronchiectasis, atrial fibrillation, cardiac surgery and sleep medicine. The Trust continues to sponsor a number of single and multi-centre studies.

Quality is at the heart of all our research activities and Royal Papworth Hospital was ranked as the top recruiting site in the UK for over 40% of the non-commercial interventional studies we supported and over 50% of the commercial studies we supported.

The Trust remains committed to improving patient outcomes by undertaking clinical research that will lead to better treatments for patients undergoing care in the NHS. We would like to say thank you to all those who participated in our research over the past year.

## Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Royal Papworth Hospital NHS Foundation Trust's income is conditional upon achieving quality improvement and innovation goals agreed between Royal Papworth Hospital NHS Foundation Trust and NHS Commissioners, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Following the suspension of CQUIN during the pandemic, CQUIN schemes were re-established in 2022/23. As in previous years, the Trust has agreed to undertake national CQUIN schemes with both NHSE Specialised Commissioning, and Cambridge and Peterborough ICB (acting for and on behalf of associate ICB commissioners).

In 2022/23, CQUIN achievement was paid in advance through the application of 1.25% to the 2022/23 national tariff and this was reflected in the contract value. Discussion takes place quarterly between the Trust and commissioners on performance against CQUIN metrics and any non-achievement, could be reclaimed by commissioners in line with the national CQUIN guidance. It is not expected that there will be any adjustment to CQUIN payments related to performance in 2022/23.

A summary of the schemes agreed for 2023/24 is provided below:

| CQUIN Ref | CQUIN Name |
|---|---|
| **CQUIN01** | Flu Vaccinations for frontline healthcare workers |
| **CQUIN02** | Supporting patients to drink, eat and mobilise after surgery |
| **CQUIN03** | Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria |
| **CQUIN10** | Treatment of non-small-cell lung cancer (stage I or II ) in line with the national optimal lung cancer pathway |
| **CQUIN11** | Improving the quality of shared decision-making (SDM) conversations |

As in previous years, the Trust has established a CQUIN Review Group. This group ensures that CQUIN schemes are appropriately implemented and monitored.

The Trust reports CQUIN compliance / achievement in year via standard reporting as per the appropriate CQUIN timetable (noting that reporting milestones vary by scheme).

## Care Quality Commission (CQC) registration and reviews

*Royal Papworth Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'. The Care Quality Commission issued enforcement action against Royal Papworth Hospital NHS Foundation Trust during 2022/23 regarding Ionising Radiation (Medical Exposure) Regulations 2017 (further details below).*

Royal Papworth Hospital NHS Foundation Trust is subject to periodic review and was last inspected by the CQC in June & July 2019 when it received an overall rating of Outstanding. It was rated as outstanding because:

- Safe effective, caring, responsive and well-led were rated as outstanding at core service level.
- Medical care, surgery and diagnostic imaging were rated as outstanding overall.
- Critical care and outpatients were rated as good overall.
- The rating reflected the previous inspection for end-of-life care services which was rated as good overall.

The aggregated rating for well-led at core service level was outstanding and the CQC rated well-led at trust-wide level as outstanding. When aggregated with the core services, this gave a rating of outstanding for the overall trust.

The report of this inspection is available on the CQC website at:
https://www.cqc.org.uk/provider/RGM

Following the 2019 inspection the Trust was given six recommendations for improvement. Progress against these was regularly monitored over the intervening time but interrupted by the pandemic when monitoring was paused. During 2022 improvement plans resulting from the recommendations continued to be monitored at a local level as business as usual.

## Ionising Radiation (Medical Exposure) Regulations 2017 ('IR(ME)R')

CQC is the enforcing authority for IR(ME)R in England. Its powers of enforcement for IR(ME)R derive from the Health and Safety at Work etc Act 1974 ('HSWA').

In November 2022, the Trust underwent an IR(ME)R inspection. The Trust was issued with an Improvement Notice against 3 of the regulations however it took swift measures to implement actions to address the issues identified. The Trust received notification of the closure of the notice in early March 2023 as the CQC were satisfied actions taken would address the recommendations made with a view to maintaining future compliance with IR(ME)R.

## Heart Lung Research Institute (HLRI)

CQC registration of the HLRI was successfully achieved in September 2022.

All patients attending the unit will be taking part in clinical Trials that have full regulatory approvals and are consented and recruited to in accordance with the approved protocol.

## Data Quality

It is essential that data about patient care is accurate and reliable. How the Trust 'code' a particular operation or illness for example, is important as not only does it impact on income for the care and treatment that the Trust provide, but it also anonymously informs the wider health community about illness or disease trends.

Royal Papworth Hospital NHS Foundation Trust submitted records during 2022/2023 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- *Which included the patient's valid NHS number was 100% (national average 99.6%) for admitted patient care and 100% (national average 99.8%) for outpatient care;*
- *Which included the patient's valid General Medical Practice Code (code of the GP with which the patient is registered) was 100% (national average 99.7%) for admitted patient care and 100% for outpatient care (national average 99.5%).*

## Governance Toolkit Attainment Levels

Good information governance means ensuring that the identifiable information we create, hold, store and share about patients' and staff is done so safely and legally. Data Security and Protection Toolkit is the way that we demonstrate our compliance with information governance standards. All NHS organisations are required to make annual submissions to NHS Digital in order to assess compliance.

*Royal Papworth Hospital NHS Foundation Trust's information governance assessment report is that the* Trust has submitted a Data Security and Protection (DS&P) Toolkit in June 2022, which includes requirements relating to the Statement of Compliance and all assurances were declared as met.

The Information Governance Toolkit is available on the NHS Digital website: https://www.dsptoolkit.nhs.uk/

## Clinical Coding

Royal Papworth Hospital's annual independent clinical coding audit has been carried out by CHKS Ltd, Jane Wonnacott ACC (Dis) TAP accredited Auditor led the audit.

Royal Papworth Hospital achieved the following Information Governance levels in 2022/23:

- Data Quality Assertion Level 1.7 / Information Governance Requirement 14-505: An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months. Attainment Level 3. (Improved from Level 2 in 2021/22).
- Data Quality Assertion Level 3.4 / Information Governance Requirement 14-510: Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards. Attainment level 3. (Maintained the highest level of performance)

Royal Papworth Hospital NHS Foundation Trust will devise an action plan to address the Auditors recommendations for 2022/23. All recommendations for 2021/22 have been actioned.

## Learning from deaths

During April 2022 to March 2023, 203 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 54 in the first quarter; 43 in the second quarter; 46 in the third quarter; 60 in the fourth quarter.

By 17/05/2023, 12 retrospective case record reviews and 10 incident investigations have been carried out in relation to the 203 inpatient deaths. In 0 cases a death was subjected to both a retrospective case record review and an incident investigation. The number of deaths in each quarter for which a retrospective case record review or an incident investigation was carried out was:

0 in the first quarter; 6 in the second quarter; 6 in the third quarter; 10 in the fourth quarter.

One patient death during the reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.

0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 1 representing 1.7% for the fourth quarter.

**Mortality Case Record Review process**

These numbers have been estimated using the Royal College of Physicians' Structured Judgement Review methodology which has been adopted as the agreed method for all case record reviews at Royal Papworth Hospital. Responsibility for case record reviews lies with the Clinical Directors, Clinical Leads and Mortality & Morbidity Leads overseen by the Clinical Governance Manager and Associate Medical Director for Clinical Governance.

The retrospective case record review process sits alongside existing clinical governance processes including Serious Incident investigations and Mortality & Morbidity meeting case discussions. If a patient's death is considered more than 50% likely to have been potentially avoidable following retrospective case record review, it is reported as a patient safety incident triggering an incident investigation process.

Lessons learnt from Retrospective Care Record Reviews:

- 12 retrospective case record reviews have been carried out in relation to 2023 inpatient deaths in 2022-23.
- The Retrospective Case Record Review process is now well established and provides an additional safety net to identify patient safety concerns in the Trust. In 2022-23 the retrospective case record review process did not reveal any patient safety concerns which had not already been reported through the incident reporting system indicating a strong patient safety reporting culture in the Trust.

Lessons learnt from incident investigations:

- 10 incidents investigations have been carried out in relation to the 203 inpatient deaths in 2022-23.
- Of the 10 incidents reported, one has identified the patient's death as potentially avoidable and this incident remains under investigation. This was reported, discussed and graded at the weekly Serious Incident Executive Review Panel (SIERP) as a Serious Incident. The incident investigation is currently in progress and once completed and root cause established, the actions and recommendations will be monitored by the Quality and Risk Management Group. In conjunction with the post mortem report and investigation findings, the grading of the incident will be reviewed.

Impact & Developments in 2022-23

An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

There are now several processes which work in parallel to comprehensively review all deaths in Royal Papworth to identify issues and improve quality and safety for patients. These processes include:

- Medical Examiner Scrutiny Review
- Retrospective Case Record Review
- Morbidity & Mortality Meeting case discussion
- Incident Investigation (grading and level of investigation agreed at SIERP)

In conjunction with the Associate Medical Director for Clinical Governance, Medical Examiner and Clinical Governance and Risk, the procedure (DN682) has been reviewed and is currently being rewritten to reflect current practice and to avoid duplication of mortality scrutiny, giving clearer guidance on the governance process for each death following discussion at SIERP. This will include merging the Trust Medical Examiner Scrutiny Procedure (DN792) with Mortality Case Record Procedure (DN682).

0 case record reviews and 0 investigations were completed after 01/04/2022 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians' Structured Judgement Review methodology.

0 representing 0% of the patient deaths during the previous reporting period 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

## Performance against the national quality indicators

The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing.

Following the merger of NHS Digital and NHS England on 1st February 2023 NHSE are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 was delayed. NHSOF indicators have therefore had a limited update.

The following core set of indicators applicable to Royal Papworth Hospital on data made available to Royal Papworth Hospital by NHSE are required to be included in the Quality Accounts.

| **Indicator**[1] | **2021/22 (or latest reporting period available)** | **2022/23 (or latest reporting period available)** | **Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…** | **Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by…** |
|---|---|---|---|---|
| Statistic: the percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital after admission.[2] | Trust score percentage was 11.3 in 2020/21<br><br>The national average score was 15.9 | Trust score percentage was 11.1 in 2021/22<br><br>The national average score was 14.7 | RPH banding: B1 = Significantly lower than the national average at the 99.8% confidence level.[2] | The Trust recognises the impact of readmissions on patient experience and continues to identify areas for improvement. |
| The trust's responsiveness to personal needs of its patients during the reporting period[3] | Trust Score was 79.8 in the 2019/20 survey.<br><br>National average score was 67.1<br><br>National highest score was 84.2 | Trust Score was 82.5 in the 2020/21 survey.<br><br>National average score was 74.5<br><br>National highest score was 85.4 | This is previously reported data as the annual publication of this dataset has been delayed following the merger of NHS Digital and NHSE. | We will continue to use data from the inpatient survey to identify areas for improvement. |
| The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust | 91.2% of the staff employed by, or under contract to, the trust in the 2021 staff survey would recommend the trust as a provider of care to their family or friends. | 85.7% of the staff employed by, or under contract to, the trust in the 2022 staff survey would recommend the trust as a provider of care to their family or friends. | We have seen high levels of exhaustion and burnout compared to our specialist Trust peers, possibly because the pandemic (being a respiratory virus) | Survey results have been share with Divisions/ Directorates and with staff through our normal communication channels. They are also shared and |

| Indicator[1] | 2021/22 (or latest reporting period available) | 2022/23 (or latest reporting period available) | Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons… | Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by… |
|---|---|---|---|---|
| as a provider of care to their family or friends<br>(Data from National Staff Survey Benchmark report 2021) | Average for acute specialist trusts was 89.8%.<br><br>The Highest scoring specialist trust was 94.0%.<br><br>The Lowest scoring specialist trust was 69.1%. | Average for acute specialist trusts was 86.5%.<br><br>The Highest scoring specialist trust was 95.5%.<br><br>The Lowest scoring specialist trust was 71.6%. | continued to have a much greater impact on us in terms of staff redeployment. We also recognise the impact of high vacancy rates throughout 2022/23 which has had a significant impact on how people are experiencing work, both in terms of feeling overworked but also that they are not able to provide the level of care/service they want to. We have also seen continuing high levels of staff reporting bullying and discrimination from patients and from colleagues and line managers. The results indicate a decrease in kindness, understanding and politeness, which is disheartening to see. | discussed with Staff Networks. They inform the work of the Compassionate and Collective Leadership Programme and the Resourcing and Retention Improvement Programme..<br><br>At the end of 2022/23 we finalised a revised Workforce Strategy which set clear priorities for the next two years.<br><br>See also Annual Report – Staff Report section for other information on the 2022 Staff Survey. |
| Friends and Family Test – In Patient<br><br>NOT STATUTORY REQUIREMENT | In March 2022 99.1% of our inpatients and 97.0% of our outpatients would recommend our services.<br><br>National: 93.8% of inpatients and 92.9% of outpatients. | In March 2023 98.6% of our inpatients and 96.4% of our outpatients would recommend our services.<br><br>National (Feb 23): 94.6% of inpatients and 93.7% of outpatients. | The Trust continues to promote the FFT test. | The Trust will continue to monitor and promote Friends and Family scores.<br><br>Please see our update on a listening organisation for further information. |
| The percentage of patients who were admitted to hospital and were risk | The national VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID19 pandemic. Please see the VTE section for Trust performance figures. | | | |

| Indicator[1] | 2021/22 (or latest reporting period available) | 2022/23 (or latest reporting period available) | Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons… | Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by… |
|---|---|---|---|---|
| assessed for VTE during the reporting period | | | | |
| The rate per 100,000 bed days of cases of C.difficile infection reported within the trust during the reporting period.[4] | Trust rate was 16.0 in 2020/21.<br><br>The national rate for 2020/21 was 22.1. | Trust rate was 21.8 in 2021/22.<br><br>The national rate for 2021/22 was 25.2 | The change in definition of cases attributed to the Trust occurred in 2020/21 this increased the rates reported.[4] | Infection prevention and control is a key priority for the Trust.<br><br>For further information see our update on Healthcare Associated Infections |
| The number and, where applicable,<br>rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.<br><br>i) Number<br><br>*(ii)* Rate per 100 admissions (data unavailable). *Rate per 1000 bed days provided 2020-21.*<br><br>(iii) Number and percentage resulting in severe harm/death<br>Note 4 | (i) Trust number for 2019/20 was 3399.<br>The Acute Specialist Trust highest total was 5861, the lowest was 753 and the average was 3015.<br><br>(ii) Rate per 100 admissions was not available.<br>The highest, lowest and average Acute Specialist Trust rate per 100 admissions was not available.<br><br>(iii) 5 resulted in severe harm/death equal to 0.15% of the number of patient safety incidents.<br>The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 0.78%, the lowest was 0% and the average was 0.13%. | (i) Trust number for 2020/21 was 2439.<br>The Acute Specialist Trust highest total was 5411, the lowest was 761 and the average was 2566.<br><br>(ii) Trust rate per 1000 bed days 48.7 for 2020/21.<br>Acute Specialist Trust rate /1000 bed days 2020/21: highest 185.2, lowest 15.2 and average 71.9.<br><br>(iii) 6 resulted in severe harm/death equal to 0.25% of the number of patient safety incidents.<br>The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 1.95%%, the lowest was 0% and the average was 0.40%. | This is previously reported data as the annual publication of this dataset has been delayed following the merger of NHS Digital and NHSE. | The Trust continues to demonstrate a strong incident reporting culture which is demonstrated by the majority of incidents graded as low or no harm.<br><br>All patient safety incidents are subject to a root cause analysis (RCA). Lessons learnt from incidents, complaints and claims are available on the Trust's intranet for all staff to read.<br><br>For further information please see our update on Patient Safety Incidents. |

Data Source: NHS Digital portal as at 05/06/23 unless otherwise indicated.

Note 1 The coronavirus pandemic began to have an impact on Hospital Episode Statistics (HES) data late in the 2019/20 and continued into the 2020/21 financial year. This means different patterns were seen in the nationally submitted data, for example, fewer patients being admitted to hospital, Statistics which contain data from this period should be interpreted with care..

Note 2 These are experimental statistics. The data set includes indirectly standardised percent with 95% and 99.8% confidence intervals.

Note 3 In 2020-21 survey, changes were made to the survey questions, and scoring regime. As a result, 2020-21 results are not comparable with those of previous years.

Note 4 Data shows annual counts and rates (per 100,000 overnight bed days) of CDI by acute trust. Rate information, using rate calculations as currently defined, is not appropriate for comparison. The counts of infections have not been adjusted to give a standardised rate considering factors such as organisational demographics or case mix. Rate information is of use for comparison of an individual organisation over time https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Note 5 The indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death. A patient safety incident is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare’. The ‘degree of harm’ for patient safety incidents is defined as follows: ‘severe’ – the patient has been permanently harmed as a result of the incident; and ‘death’ – the incident has resulted in the death of the patient. As well as patient safety incidents causing long term/permanent harm being classed as severe, the Trust also reports 'Patient Events that affect a large number of patients' as 'severe' incidents to the NRLS.

# Part 3 Other Information

## Review of quality performance 2022/23

2022/23 has been a very busy year for Royal Papworth Hospital and its staff. We have seen significant challenges relating to our staffing and the continued the impact of COVID19. In the 2022 NHS Staff survey our results demonstrated that we had some of the highest proportions of staff working work with COVID cases and experiencing redeployment in relation to the pandemic as well as high levels of burnout being reported by our staff. This alongside the wide economic and industrial unrest has undoubtably had an impact on morale for many of our staff and we have worked had to recognise and reward their continued efforts that still allow us to deliver excellence in the care that we provide to our patients. We have continued to plan the recovery of our services and undertake some transformational programmes of change to support that recovery and the optimisation of our hospital. We have also seen excellence in innovation and working with our system partners creating a high quality 'nested ward' facility to support winter pressures across our system and maintaining excellent outcomes for our patients. The Hospital has treated 20,797 inpatient/day cases and 103,284 outpatient contacts from across the UK. For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2022/23. We have selected examples from the three domains of quality (clinical safety, patient experience and clinical effectiveness of care). These priorities reflect issues raised by our patients and stakeholders, which also feature highly in the Department of Health and Social Care's agenda. They include information on key priorities for 2022/23 where these are not reported elsewhere.

Pulmonary endarterectomy is included as Royal Papworth is the only centre in the UK to provide this surgery. There is also an update on the Extra Corporeal Membrane Oxygenation (ECMO) service for which Royal Papworth Hospital is one of five centres nationally that provide this service for adults and has played a major part in the response to the COVID19 pandemic.

## Quality Strategy: Providing excellent care and treatment for every patient, every time

Our Quality Strategy was published in 2019 and set our quality ambitions and direction for the three years to 2022 this was extended to March 2023 with the agreement of the Quality and Risk Committee.

Our Quality Strategy is aligned to and takes into account the National Quality Improvement (QI) agenda, current QI research and National QI leadership programmes. The Strategy includes the Trust Board endorsement to implement the Culture and Leadership Programme co-designed by NHS Improvement and the King's Fund, which commenced during 2019 and continues to support the delivery of our Quality Strategy.

We want quality and quality improvement to be our core philosophy and to be at the heart of every decision that we make. Our expertise, reputation and network places us in a

unique position to lead the way in delivering excellence in care through our cardiothoracic, respiratory and transplant services with outstanding:

- Patient experience and engagement; developing and improving our services for and with the patients who need them
- Patient safety; with a focus on eliminating avoidable harm to patients.
- Effectiveness of care; using clear, consistent processes and standards to deliver successful treatment assessed by clinical outcome measures and the patient's experience.

Our Quality Strategy 2019-2023 was underpinned by our three Quality Ambitions with work streams identified as enablers to achieve these. We have reviewed these work streams annually to demonstrate progress and allow flexibility to encompass local, regional, and national changes in the health economy.

Quality Strategy Ambitions:

1. Safe – Provide a safe system of care and thereby reduce avoidable harm
2. Effective and Responsive Care – Achieve excellent patient outcomes and enable a culture of continuous improvement
3. Patient Experience and Engagement - We will further build on our reputation for putting patient care at the heart of everything we do

Since the first wave of the COVID 19 Pandemic we have been challenged and tested as we responded to the huge demands on our specialist services and the subsequent need to recover service delivery. We have demonstrated organisational resilience through our continued ability to provide the specialist care and treatment our patients need. We have maintained a high quality and safe service throughout this difficult time through our ongoing governance and performance monitoring structures and the fantastic commitment and hard work of our staff at all levels of the organisation. We remain vigilant and agile to ensure continuous delivery of safe and effective care for our patients in these challenging times.

A final desktop review was undertaken in April 2023 and has been reported to the Board and we have assessed that we have been able to deliver against 80% of the ambitions that we set.

We are proud of our weekly Serious Incident Executive Review Panel (SIERP) which continues and is well embedded, attended by two executive directors (Chief Nurse and Medical Director). This is now chaired by Assistant Director for Quality and Risk, which was requested by the executive leads to allow time for review of cases, while chairmanship continues alongside.

We have worked with National and local stakeholders to embrace and implement the recommendations from the "Getting it Right First Time" (GIRFT) programme of reviews over the course of the strategy and have undertaken local review where we were not included in dedicated national visits, such as in the Respiratory GIRFT.

Our In-House Urgent pathway is now part of 'BAU' and is continually monitored and reviewed. This pathway remains a challenge for the organisation and remains high on the quality agenda. As part of the GIRFT programme we have implemented a patient feedback form for all patients on the IHU pathway. We focus on building good working relationships with our referring centres and their cardiac specialist nurses and meet quarterly with all the cardiac specialist nurses in the region to enhance communication and education with regards IHU patients.

The expanded Medical Examiner Office is now well embedded and the team has received praise from the Senior Coroner for Cambridgeshire & Peterborough on the success of the ME system which had enabled improved liaison with grieving families. There are now 7

Medical Examiners and 2 Medical Examiner Officers. The Medical Examiner Office provides a rapid independent review of all inpatient deaths at Royal Papworth Hospital. Ongoing steps for the MEO include the community roll out of the ME process, the introduction of national ME database, piloted at Royal Papworth.

Other aspects of our Quality Strategy continue to be enacted through the Quality Account priorities and updates on these areas are included in part 2.

Our ambitions in relation to quality will continue, and evolve further, as we move through to the next full review which will be undertaken in 2023.

## Open and Transparent / Duty of Candour

Openness when things go wrong is fundamental to the partnership between patients and those who provide their care. There is strong evidence to show that when something goes wrong with healthcare, the patients who are harmed, their relatives or carers want to be given information about what has happened and would like an apology. The NHS Standard Contract SC35 Duty of Candour specifically required NHS provider organisations to implement and measure the principles of Being Open under a contractual Duty of Candour which is further underpinned by the CQC Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 20 which places a statutory Duty of Candour on all NHS organisations. The key elements of being open are:

- Providing an apology and explanation of what has happened
- Undertaking a thorough investigation of the incident
- Providing support for the patients involved, their relatives/carers and support for the staff
- Offering feedback on the investigation to the patient and/or carer

A verbal duty of candour conversation will take place with the patient/relative/carer as soon as reasonably practical after an incident is known and to offer an apology. This is followed up in writing, which includes a named family liaison member of staff who is responsible for maintaining contact with the patient and or family throughout the investigation period. Family liaison contact details are provided in the letter. We have a formal procedure and guidance for this role to better support staff undertaking this role (DN791). This has been based on family and patient feedback on their experience of being involved in this process.

For incidents that meet the threshold for duty of candour, this is completed once the investigation and/or clinical review confirm that acts or omissions in the incident resulted in actual harm to the patient. The Trust monitors compliance against our requirements for duty of candour at the Serious Incident Executive Review Panel (SIERP) and the Quality and Risk Management Group (QRMG) reporting by exception to the Quality and Risk Committee of the Board of Directors.

In 2023 the Trust undertook an audit against the requirements of the Being Open and Duty of Candour Policy (DN153) for incidents graded as serious or moderate harm during the period of 2022/23. This demonstrated overall good compliance with the verbal duty of candour conversation happening in a timely way after the incident occurred. One of the areas for improvement is the written duty of candour letter being sent or given to the patient/family/carer. This will be a focus for improvement in 2023/24 for the Trust.

# Patient safety domain

## Safer Staffing Initiatives

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Trust Board corporate accountability for quality and safety.

Developing workforce safeguards (NHS England, 2019) state that effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high-quality care to patients and service users.

At RPH the setting of establishments should triangulate from different sources using evidence-based tools where possible. Establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient needs based information using an acuity and dependency scoring evidence-based tool such as Safer Nursing Care tool (SNCT, 2016).
- Professional judgement
- Activity levels including seasonal variation in service demand
- Service developments and any changes to delivery
- Contract commissioning
- Staff supply and experience issues
- Where Temporary Staff has been required above the set planned establishment
- Patient and staff outcome measures
- Benchmarking with other 'like' organisations

An annual nursing inpatient establishment review for 2023/2024 was undertaken (February 2023) in line with national policy and regulation, with due process followed as detailed in the Trust's Nursing Establishment Setting Policy (2022).

This annual staffing establishment review has considered and analysed the data relating to staffing metrics in line with safer staffing guidance. Triangulation of data was undertaken with acuity and dependency scoring using the Safer Nursing Care Tool and Professional Judgement.

The following conclusions were agreed:

- There are no changes to WTEs in nursing establishments, however there are some changes to skill mix but not overall numbers
- Registered nurses and unregistered nurses are maintained in terms of balance for mix and number of posts

The following recommendations were noted:

- Ward/ unit establishments are to remain the same
- These recommendations have been shared and agreed at the Clinical Practice Advisory Committee and the Workforce Committee (March and April 2023)
- Undertake further SNCT data collections in May and September 2023 and agree % for the side room calculation uplift
- Streamline Rosters ensuring templates match the budgeted and worked WTE for transparency and correct reporting
- Optimise SafeCare Live for daily staffing reviews utilising professional judgement
- Arrange refresher training for SafeCare Acuity tool to the SNCT for consistency and benchmarking
- Utilise the SafeCare system for non-ward based areas such as Theatres which has recently been introduced to capture professional judgements and red flag events Plan to utilise the SafeCare system for Cath Laboratories
- Continue monthly staffing reviews and Roster KPI monitoring

A Safer Staffing Steering Group is currently planned for Quarter 1 (2023/24) to provide advice and direction to nursing teams in the monitoring of SafeCare and ensuring delivery and evaluation of safer staffing for 'ward to board' assurance.

### Visibility inclusive rounds

Weekly inclusive visibility rounds, led by the Chief Nursing Office, were introduced in October 2021. The schedule of these rounds has varied themes across quality, environment, patient safety, safeguarding, staff health and well-being. All staff groups and grades of staff including patient governors and students are invited to attend to shadow and participate in the rounds. These rounds will continue through 2023/24.

Patient Safety Rounds have included: Visibility rounds/ Integrated Care Board rounds/ 15 Steps/ In your shoes/ Fundamentals of Care Board peer reviews.

## Healthcare Associated Infections

Royal Papworth Hospital places infection control and a high standard of hygiene at the heart of good management and clinical practice. The prevention and control of infection was a key priority at Royal Papworth Hospital throughout 2022/23 and remains part of the Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which needs continuous review. The Trust is committed to ensuring that appropriate resources are allocated for effective protection of patients, their relatives, staff and visiting members of the public. In this regard, emphasis is given to the prevention of healthcare-associated infection, the reduction of antibiotic resistance and ensuring excellent levels of cleanliness in the Hospital.

There are a number of important infection prevention and control measures in place to reduce the risk of spread of infection; these include hand hygiene, cleaning, adherence to infection control practices, screening of patients for various organisms and education – all of which were audited continuously in 2022/23 as part of the annual infection prevention and control audit programme, and the compliance figures were monitored through the Infection Control Pre and Peri-operative Care Committee (ICPPC).

### MRSA bacteraemia and C. difficile trajectory infection rates*

During 2022/23 the total number of *Clostridiodies difficile* cases were 8 which was under our national threshold, of 12. We had achieved low cases compared to regionally and nationally which both have seen a dramatic increase last year, and this is something that was recognised by the Integrated Care Board (ICB). There was one case of MRSA bacteraemia for 2022/23 and the ceiling threshold for MRSA bacteraemias remained at zero, which means we were above our threshold for last year. All MRSA bacteraemias and cases of *C. difficile* are reported to our integrated care board (ICB). We perform root cause analysis (RCA)/ post infection reviews (PIR) on each case of C.difficile 2 or more days into admission or MRSA bacteraemia to review the events and enable continuous improvement of practice. Any subsequent lessons learned are shared with the ICB and discussed at scrutiny panels with the clinical teams. All C.diff cases reported 2 or more days into admission are now counted towards Royal Papworth Hospitals annual threshold regardless of any lapses in care.

| Goals 2020/21 | Outcome 2020/21 | Goals 2021/22 | Outcome 2021/22 | Goals 2022/23 | Outcome 2022/23 |
|---|---|---|---|---|---|
| No MRSA bacteraemia | 1 MRSA bacteraemia | No MRSA bacteraemia | No MRSA bacteraemia | No MRSA bacteraemia | 1 MRSA bacteraemia |
| No more than 11 C.difficile | Total for the year = 8 all cases are now counted toward RPH's objective | No more than 11 C.difficile | Total for the year =12 we were one over our yearly target of 11. | No more than 12 C.difficile | Total for the year = 8 C.difficile. below the threshold. |

| | | | | | |
|---|---|---|---|---|---|
| Achieve 100% MRSA screening of patients according to agreed screening risk | 97.5% | Achieve 100% MRSA screening of patients according to the agreed screening risk. | 98.6% | Achieve 100% MRSA screening of patients according to agreed screening risk | 96.7% |

Data Source: Mandatory Enhanced Surveillance System (MESS) and PHE Health Care Associated Infection Data Capture System.
*Please note: The figures reported in the table are the number of C.difficile cases and MRSA bacteraemia attributed to the Trust and added to our trajectory/ yearly threshold.

## Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. Predominantly, they are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. Many countries and regions now have a high reported prevalence of healthcare-associated CPE. The Trust has a robust procedure in place to ensure that screening and isolation of patients in relation to CPE is carried out to minimise the risk of spread. This procedure was produced using the Public Health England (PHE) Acute trust toolkit for the early detection, management, and control of carbapenemase-producing Enterobacteriaceae (2013). This has been recently updated by the UK Health Security Agency (UKHSA) in September 2022 and has been reviewed and our policy has been updated. There have been two cases of CPE but there has not been any ongoing spread of CPE within the Trust in 2022/23.

## Escherichia coli (E.coli)

Data collection for *E.coli, Klebsiella* spp. and *Pseudomonas aeruginosa* BSI has been provided via the PHE Data Capture System. The rates of *E.coli* bacteraemia are available on the PHE Public Health Profile website:
https://fingertips.phe.org.uk/search/ecoli#page/4/gid/1/pat/15/ati/118/are/RGM/iid/92193/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/tre-ao-0
E.coli rates are 8.4 per 100 000 compared with 111.6 in England, therefore, we remain low in comparison. In absolute numbers we had 8 -Ecoli, 15-Klebsiella and 4 -pseudomonas cases last year. The yearly audit will be carried out in due course.

## Mycobacterium Abscessus

In 2019, following some routine testing, we launched an investigation into some cases of *M. abscessus* infection, a rare infection which can cause problems for people with specific underlying respiratory conditions or who are immunosuppressed as a result of their condition.

Immediate safety measures were put in place and regular review of these were implemented. Since implementing our stringent and additional water safety measures, we have significantly reduced the number of patients acquiring M.Abscessus at the Trust. In 2022/23, 2 new cases have been identified with 0 classed as moderate harm.

## Influenza

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for “frontline” staff 2022/23 was 59.7% and 70% Trust wide.

In 2022/23, the Trust continued to admit flu related ECMO patients into the Critical Care Unit. However, the Trust noticed a significant decrease in ECMO admissions relating to flu throughout 2022/23.

## COVID-19

The Trust has continued to respond to the COVID-19. There was a small increase in COVID-19 positive patients admitted in April, July and October but less needing critical care support. There were nosocomial cases in 2022/23 with 2 cases in July, 1 in August, 2 in October and 2 in

January and February and 1 in March 2022/23. All these were fully investigated and learning shared trust-wide.

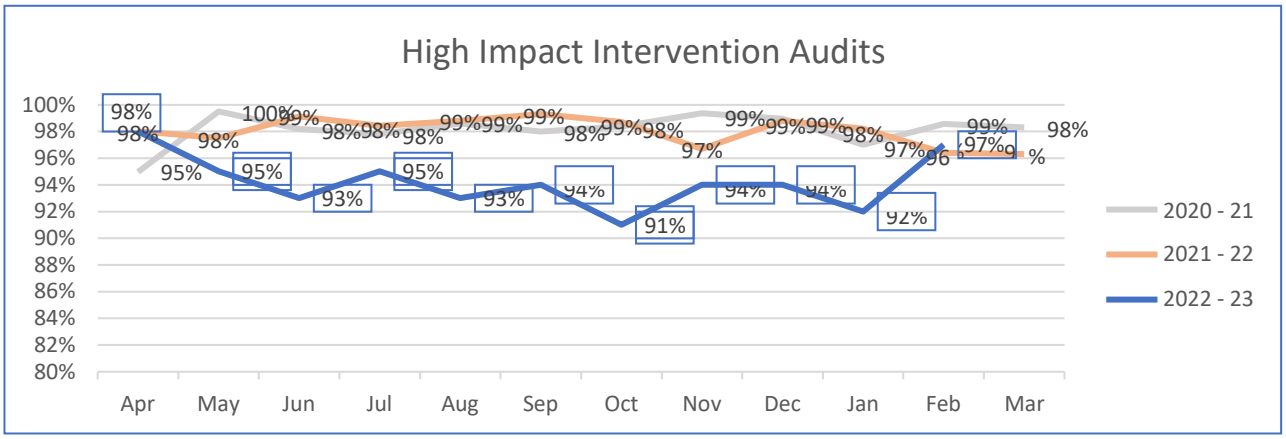
**Table of COVID-19 Figures for 2022-23:**

| Month | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | Year Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New positive patient | 37 | 5 | 7 | 12 | 6 | 6 | 13 | 3 | 6 | 9 | 6 | 6 | 116 |
| Nosocomial 8+ days | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 1 | 0 | 1 | 5 |
| Nosocomial 14+ days | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 5 |
| Total new nosocomial | 0 | 0 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 2 | 2 | 1 | 10 |

We achieved the following staff uptake of COVID-19 vaccinations booster programme for staff which was a total of 54% for frontline start and 67.6% trust-wide.

COVID-19 pandemic was managed as per Emergency Preparedness, Resilience and Response (EPRR) guidance with frequency of meetings tailored as necessary. This has now been stood down and is managed by the Infection Prevention & Control team through the Infection Control, Pre and Peri-operative Care Committee (ICPPCC).

## Trust Hand hygiene compliance figures 2022-23 (April-Mar)




## Surgical Site Surveillance

### Surgical Site Infections

Surgical Site Surveillance at Royal Papworth Hospital (RPH) consists of identifying coronary artery bypass graft (CABG) and valve surgery patients that develop a surgical wound infection. To be classified as having a surgical site infection (SSI) they must meet the SSI criteria set by the UK Health Security Agency (UKHSA). At Royal Papworth we report our CABG infection rates to UKHSA quarterly. We do not submit our valve infection rates – these are for internal monitoring only.

As part of CABG reporting, these SSI patients are grouped in terms of how they are identified:

- Inpatient (during current surgical admission) or readmission due to wound infection
- Other post discharge follow up e.g., outpatients/ community team
- Or patient self-reported

From this data we can compare our hospital rates to all hospitals that submit their CABG SSI rates by gaining a benchmark figure. However, this benchmark figure consists only of those identified as an inpatient/readmission. As per the UKHSA, "the Benchmark comprises inpatient and readmission data only, as it is mandatory for all hospitals to use these two detection methods. Not all hospitals have the resources to undertake other forms of post discharge surveillance; hence we currently use inpatient and readmission

data only for benchmarking". However, at Royal Papworth we do identify patients via the other methods, so it is still important that these are recorded and taken into consideration for internal monitoring.

Surgical Site Surveillance monitors patients for one year post surgery. This means that identification of SSIs can still occur quite some time after the original operation. Due to this, figures that are reported are subject to change. The data in this report is current as of 30th March 2023.

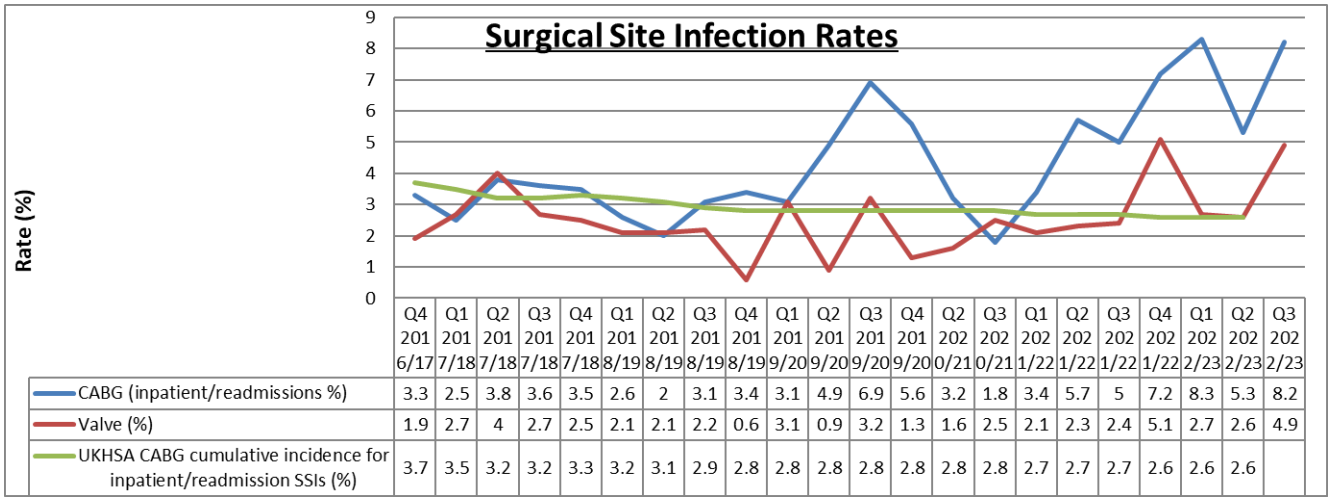
## Surgical Sites Infection rates 2022-2023

Since moving to the Cambridge Biomedical Campus in May 2019, RPH has seen a significant rise in SSI rates. Surveillance was paused during Covid, however once recommenced in 2021, rates have continued to be on the incline. This is being reflected in the number of patients requiring specialist management of deep and organ space wounds by the Wound Care Tissue Viability and Surgical teams.

Annual SSI figures for CABG and valve surgeries are currently still in progress but Q1-Q3 2022-2023 have shown consistently high rates above the national benchmark.

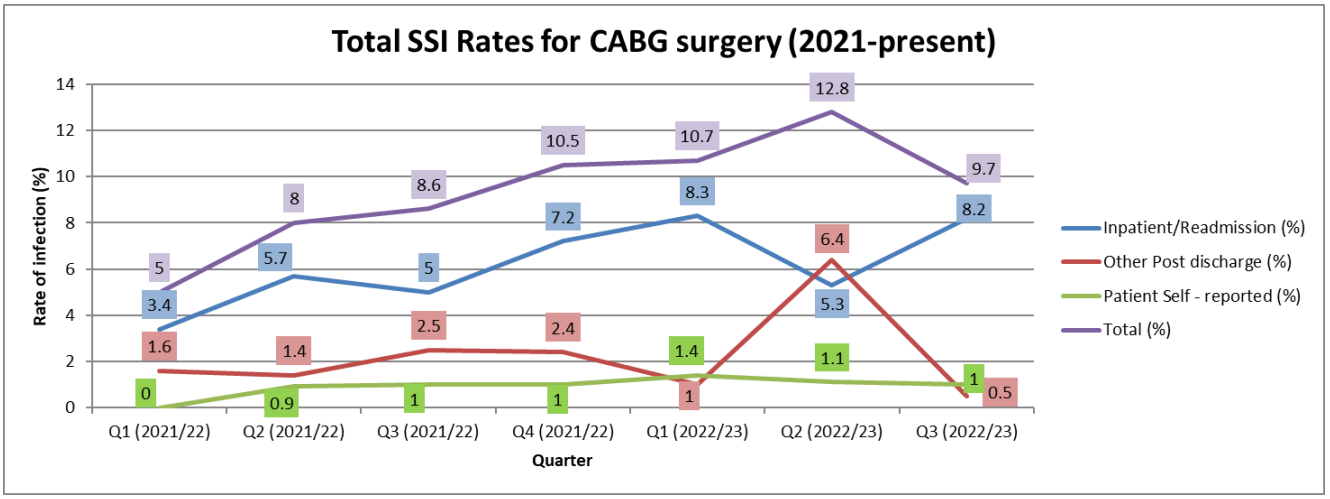
Our inpatient/readmission CABG infection rate has reached a rate of 8.3% this year, the highest rate we have seen since SSI surveillance began at Royal Papworth. The annual national benchmark has remained at 2.6%. The following run chart represents the inpatient/readmission CABG rates from 2016 to 2022/2023 with UKHSA benchmarks.

Note that the benchmark figure for Q3 (2022/23) is not yet available until this data is reconciled and a report is produced by UKHSA after March 2023. This run chart also shows valve infection rates for the same period. Valve infection rates have historically remained around 2 – 3%, with occasional spikes, however, in quarter 4 2021/22 we saw an incline to 5.1% and in Q3 2022/2023 the rate was recorded as 4.9%. Again, these are the highest valve rates we have seen since SSI surveillance in 2016. There is no national wound surveillance of patients who underwent valve replacements, therefore, infections in this patient group are for internal reporting only.

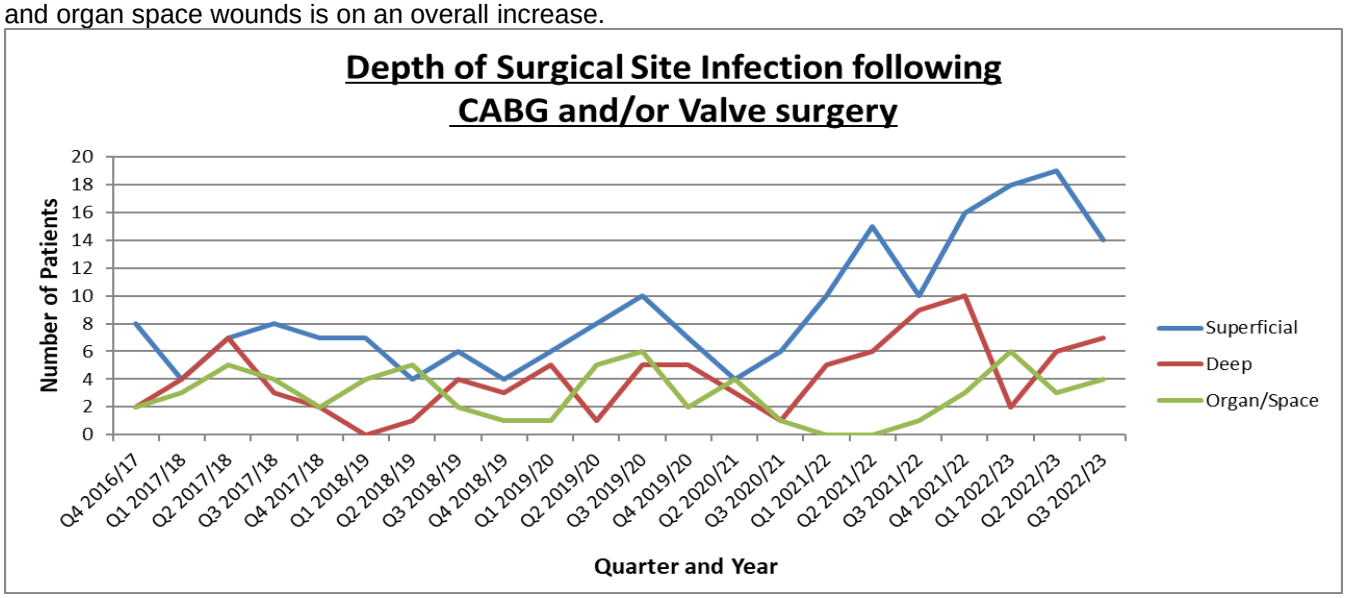



| | Q4 2016/17 | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Q1 2018/19 | Q2 2018/19 | Q3 2018/19 | Q4 2018/19 | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Q2 2020/21 | Q3 2020/21 | Q1 2021/22 | Q2 2021/22 | Q3 2021/22 | Q4 2021/22 | Q1 2022/23 | Q2 2022/23 | Q3 2022/23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CABG (inpatient/readmissions %) | 3.3 | 2.5 | 3.8 | 3.6 | 3.5 | 2.6 | 2 | 3.1 | 3.4 | 3.1 | 4.9 | 6.9 | 5.6 | 3.2 | 1.8 | 3.4 | 5.7 | 5 | 7.2 | 8.3 | 5.3 | 8.2 |
| Valve (%) | 1.9 | 2.7 | 4 | 2.7 | 2.5 | 2.1 | 2.1 | 2.2 | 0.6 | 3.1 | 0.9 | 3.2 | 1.3 | 1.6 | 2.5 | 2.1 | 2.3 | 2.4 | 5.1 | 2.7 | 2.6 | 4.9 |
| UKHSA CABG cumulative incidence for inpatient/readmission SSIs (%) | 3.7 | 3.5 | 3.2 | 3.2 | 3.3 | 3.2 | 3.1 | 2.9 | 2.8 | 2.8 | 2.8 | 2.8 | 2.8 | 2.8 | 2.8 | 2.7 | 2.7 | 2.7 | 2.6 | 2.6 | 2.6 | |

The following graph shows the total infection rate for CABG surgery including all identification groups. 2022/2023 has seen the total rate reach 12.8%.




The depth of infection has remained predominantly superficial, however the number of patients with deep and organ space wounds is on an overall increase.




## Surgical Site Infection Stakeholder Group

The SSI stakeholder group was established in 2019 following the increase in SSI's rates following the move to new Royal Papworth Hospital. The stakeholder group has representation from the multi-disciplinary team involved in the patient's surgical pathway.
Following year end 2021/2022 the Trust reported a serious incident in respect to surgical site infections due to the continued increased incidence especially in deep wound infections. This was to ensure transparency to internal and external stakeholders and allow further scrutiny and learning to improve performance.

Stakeholder meetings have continued to be frequent throughout the year to address actions and review learning. No one cause has been identified for the increase in infection rates however we continue to closely monitor and assess any potential contributing factors. We are engaging with our regulators e.g., CCG, UKHSA and the CQC keeping them informed of actions taken.

Reducing the incidence of SSI's is a priority for the clinical decision cell and the group are supporting implementation of appropriate recommendations including inviting external stakeholders to perform a peer review.

## Sepsis

Sepsis in patients is potentially life-threatening and can prove fatal without treatment. Unfortunately, care failings seem to occur mainly in the first few hours when rapid diagnosis and simple treatment can be critical to the chances of survival. The **Sepsis Six** bundle was developed by the UK Sepsis Trust founders in 2005 as an operational solution to a set of

complex yet robust guidelines developed by the International Surviving Sepsis Campaign. It was revised in 2019 to reflect the latest evidence in the management of Sepsis and ensure that antimicrobials are used effectively and efficiently. The bundle aims to provide a safe, standardised approach to assessing patients with potential sepsis and their subsequent management within the ward setting. It is also envisaged that by using the sepsis bundle, the medical and nursing teams will have the knowledge and understanding to recognise and promptly initiate patient treatment and reduce the complications associated with severe sepsis.

As a recommendation of the NICE guideline (NG51) on Sepsis: Recognition, Diagnosis and Early Management updated in 2017, sepsis should be monitored nationally. From April 2019, this was a new indicator on PIPR. However, RPH had already been monitoring the sepsis management before this. As we have no Emergency Department, our numbers of patients with Sepsis are few. Therefore, while the national quality requirement is 'based on a standard of 50 service users each quarter', we report on every patient confirmed with sepsis. This report covers data for patients admitted in ward areas (Q1-Q4) and critical care area (Q3-Q4) as validated by the Nurse Consultant for the ALERT/ surgical ward ANP teams and CCA matron.

**Standards**

| | **Aspect to be measured** | **Expected standard** |
|---|---|---|
| 1 | Sepsis screening required | 100% |
| 2 | Screening completed | 100% |
| 3 | Sepsis 6 care bundle documentation completed | 100% |
| 4 | IV antibiotics are given within 1 hour (excluding pts already on antibiotics) | 100% |

**Sepsis audit analysis data**
A detailed breakdown of the Q1-Q4 data of patients who were suspected and diagnosed with sepsis and their management as per Sepsis 6 guidelines is shown in the tables below.

Please note that CCA data was captured in Q3 and Q4, as the sepsis 6 bundle had yet to be uploaded to Metavision (electronic patient information system) in its current format.

**Q1 22/23:**

April – June: 45 patients had the Sepsis 6 bundle in their clinical notes. Of these 45 patients, only 3 patients met the criteria for screening. The sepsis bundle was completed for the 3 patients and antibiotics were given appropriately, achieving 100% in all standards.

| | **Sample Size** | **Required Sepsis screening** | **Screening Completed** | **IV antibiotics given within 1 hour (excluding pts already on antibiotics)** | **Total should have been given IV antibiotics within 1 hour** |
|---|---|---|---|---|---|
| April | 12 | 1 | 1 | Already on antibiotics | N/A |

| | | | | | |
|---|---|---|---|---|---|
| May | 16 | 1 | 1 | Already on antibiotics | N/A |
| June | 17 | 1 | 1 | 1 | 1 |
| Quarter 1 (total) | 45 | 3 | 3 | 1 | 1 |
| Compliance | | 100% | (3/3) | 100% | 1/1 |

Data for CCA was not captured in Q1.

**Q2 22/23:**

**July – Sept**: 43 patients had the Sepsis 6 bundle in their clinical notes. Of those 43 patients, only 1 patient met the criteria for screening. However, the sepsis bundle was not fully completed for this patient and antibiotics were not given within the 1 hour, failing to achieve the expected standard.

| | **Sample Size** | **Required Sepsis screening** | **Screening Completed** | **IV antibiotics given within 1 hour (excluding pts already on antibiotics)** | **Total should have been given IV antibiotics within 1 hour** |
|---|---|---|---|---|---|
| July | 15 | 0 | N/A | N/A | N/A |
| August | 11 | 1 | 1 | N | 1 |
| September | 16 | 0 | N/A | N/A | N/A |
| Quarter 2 (total) | 43 | 1 | 1 | 0 | 1 |
| Compliance | | 0% | (0/1) | 0% | 0/1 |

Data for CCA was not captured in Q2.

**Q3 22/23:**

**Ward and CCA combined.**

**Oct-December**: There was a total of 46 patients who had a Sepsis 6 bundle in their clinical notes. Of those 46 patients, 22 patients were identified from their presenting clinical signs and symptoms as requiring sepsis screening. However, only 82% (18/22) had a sepsis bundle fully completed. Of these 22 patients, 21 who met the criteria for antibiotics received IV antibiotics within 1 hour, achieving 100% compliance.

| | **Sample Size** | **Required Sepsis screening** | **Screening Completed** | **IV antibiotics given within 1 hour (excluding pts already** | **Total should have been given IV antibiotics within 1 hour** |
|---|---|---|---|---|---|

| | | | | **on antibiotics)** | |
|---|---|---|---|---|---|
| October | 18 | 8 | 8 | 7 | 7 |
| November | 16 | 11 | 11 | 11 | 11 |
| December | 12 | 3 | 3 | 3 | 3 |
| Quarter 3 | 46 | 22 | 22 | 21 | 21 |
| Compliance | | 82% | 18/22 | 100% | 21/21 |

**Q4 22/23:**

**Ward and CCA combined.**

**Jan - March:** In this quarter, there was a total of 37 patients with a sepsis 6 bundle in their clinical notes. Of the 37 patients, 16 met the criteria for screening. However, only 81.25% (13/16) had a sepsis bundle fully completed. Despite the bundle not being fully completed for 3 of the patients, all the patients who had met the criteria for screening received antibiotics within 1 hour, achieving 100% compliance.

| | **Sample Size** | **Required Sepsis screening** | **Screening Completed** | **IV antibiotics given within 1 hour (excluding pts already on antibiotics)** | **Total should have been given IV antibiotics within 1 hour** |
|---|---|---|---|---|---|
| January | 7 | 2 | 2 | 2 | 2 |
| February | 14 | 8 | 6 | 8 | 8 |
| March | 16 | 6 | 5 | 6 | 6 |
| Quarter 3 | 37 | 16 | 13 | 16 | 16 |
| Compliance | | 81.25% | 13/16 | 100% | 16/16 |

**Actions ongoing:**

The following actions are in place and led by the ALERT/ward-based ANPS / CCA education team and the CCA matron

- sepsis recognition and management training during preceptorship and deteriorating patient study days
- Ad hoc sepsis recognition and training for all staff using the tea trolley concept.

## Acute Kidney Injury (AKI)

Acute kidney injury (AKI) is a common complication in hospitalised patients and is associated with increased risk of morbidity and mortality. Early detection and intervention to correct reversible causes is pivotal to patient safety. The number of patients who develop acute kidney injury continues to fluctuate as the incidence can depend on patient acuity & planned procedures. This report covers data for patients admitted to Royal Papworth Hospital who have had an acute kidney injury. Data has been validated by the Lead Nurse for ALERT and Surgical Ward ANP teams.

It is imperative patients with or at risk of developing AKI is recognised at the earliest opportunity following hospital admission and early management is directed at minimising further injury in line with NICE guidance - Acute kidney injury: prevention, detection and management (2019). Acute Kidney Injury Guidance (DN622) is available on the intranet for the recognition & management of AKI in line with the aforementioned national standard.

Encompassed in this, is the AKI bundle on Lorenzo to ensure a safe, standardised approach to the assessment & management of patients with AKI within the ward setting. This includes staging of AKI, evidence of medicines review & daily creatinine level, fluid balance & daily weight. It is also envisaged that by using the AKI bundle, the medical and nursing teams will have the knowledge and understanding to recognise and promptly initiate treatment to patients and therefore reduce the complications associated with AKI. Our ward based advanced nurse practitioners play a pivotal role in supporting this process. Moreover they ensure any incidence of AKI is communicated to GPs via electronic discharge letter with recommendations for further surveillance.

In April 2021, the detection and management of AKI featured in the trust's 'Message of the Week'. This was primarily to underpin the expected standard of care in line with local and national guidance. Included in this was a guide to accessing and completing the AKI bundle on Lorenzo.

### 1.1 Aims and Objectives

- To identify the total number of patients who develop AKI while at RPH.
- To ensure that the care bundle is used until symptoms are resolved

### 1.2 Methodology

This audit focuses on the accurate use of the AKI care bundle which is recorded in the Patient electronic notes system (Lorenzo), for all retrospective patients who were identified as having AKI during the period April 2022 – March 2023

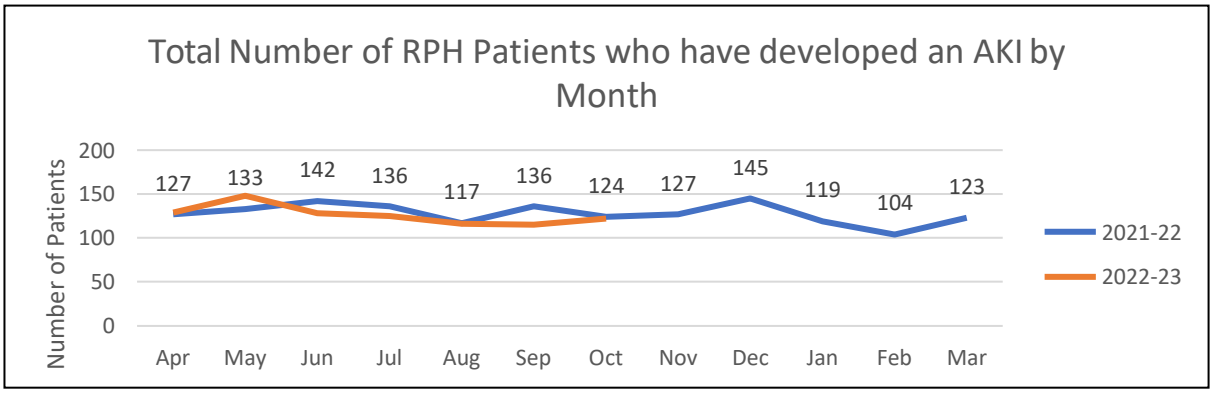
### 1.5 Sample

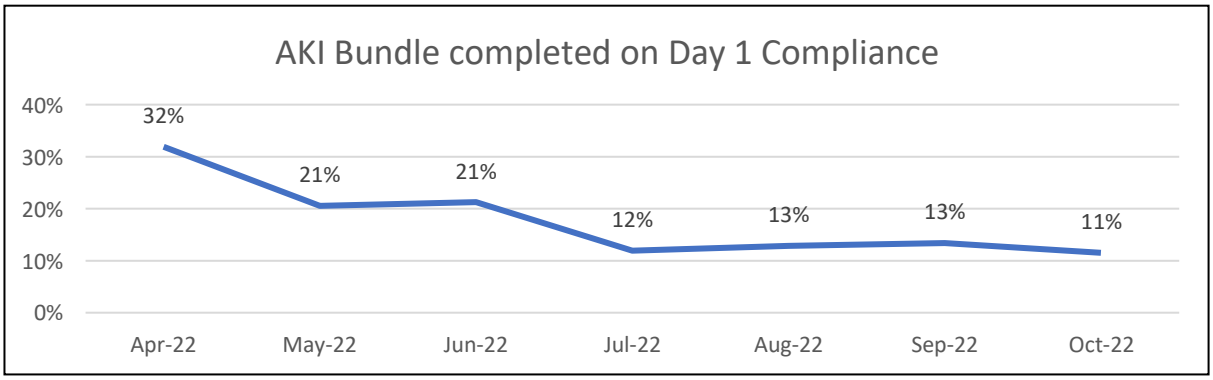
A total of 795 electronic notes for patients identified with AKI, were eligible to be included in this audit.

Criteria for assessing compliance with the AKI bundle:

| | |
|---|---|
| **Completed** | AKI bundle is fully completed for every day of AKI |
| **Partially started** | AKI bundle is fully completed for 50% of total amount of days with AKI |
| **Not started** | No AKI pathway/ less than 50% of total amount of days fully completed |
| **Excluded** | CCA |

**2.0 Results:**




**3.0 Conclusion:**

The current guidance from NICE - Acute kidney injury: prevention, detection and management (2019) highlight the importance of early detection and management of AKI. The result of this audit highlights poor compliance of documented evidence of the AKI bundle.

**4.0 Recommendation and action plan**

- Improve documentation and compliance with the AKI bundle
- Re-audit compliance with AKI bundle in June 2023 following implementation of action plan

## Pressure Ulcer Report: April 2022-23

**Summary:**

There were 288 pressure ulcers reported that were developed at Royal Papworth Hospital this reporting year (table 1 and 2). This is an increase from 236 last year. Of this number, there was one deep category 3 ulcer observed and no category 4 very deep pressure ulcers developed in inpatients. Of 24 deep tissue injuries reported, none would deteriorate to a category 3 pressure ulcer while an inpatient. We are aware of a further 3 incidents of moisture associated skin damage (MASD) that happened while admitted that went on to develop into a category 3 pressure ulcer following either discharge or repatriation to a local DGH.
The overall rise in pressure ulcer incidents was very likely due to three projects this year that focused on raising awareness of medical device related pressure ulcers (MDRPU) in CCA patients, MASD in ward patients and the simplification of reporting standards outlined in the Pressure Ulcer Reporting Procedure (DN522). The rise is linked to an increase in awareness of MDRPU following the introduction of the 'Two Birds Campaign' to raise awareness of endotracheal tube MDRPUs which is regarded as largely underreported (Gannon et.al., 2021, Fletcher 2018, Smith et. al., 2017). The second project - Simple Safety for Skin (S.S.S) - was extended outside of CCA to the wards in September to focus on reporting of all pressure ulcer categories with a particular focus on MASD and described to the ward a simplified prevention and

management strategy to prevent and/or treat such skin injury. This project is associated thereafter with a sustained reduction in the number of category 2 pressure ulcers and DTIs in the last 6 months of the reporting year (table 1). The third project involved updating the Pressure Ulcer Reporting Procedure (DN522) to include the reporting of category 1 pressure ulcers as historically this category was not reported.
In addition, the rate of pressure ulcer development noted on biannual prevalence audit where we inspect the skin of all in patients on two set dates remained low (table 3 & 4).

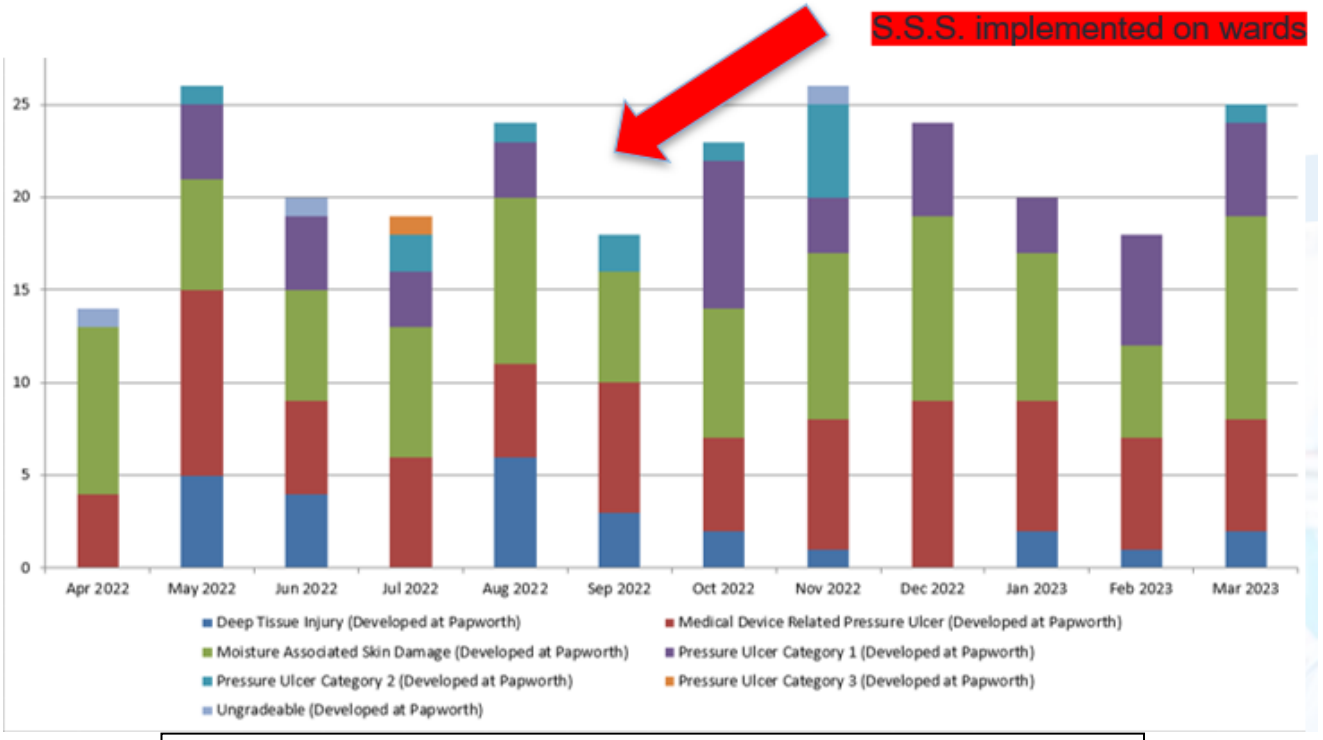



**Table 1: Pressure ulcers, MDRPU and MASD by month**

**Background and standards:**

Pressure ulcers have been defined as ulcers of the skin due to the effect of prolonged pressure in combination with a number of other variables including: patient co-morbidities and external factors such as shear and skin moisture (NPUAP, 2016).
In their detailing of how trusts should report pressure ulcers, NHSE and NHSI (2018, appendix 1) describe eight main pressure ulcer categories, ranging from category 1 to 4, deep tissue injury (DTI), an unstageable category and medical device related skin pressure ulcers (MDRPU) along with moisture associated skin damage (MASD). The paper details that all pressure ulcers with the exception of category 1 ulcers and all MASDs will be reported on through a local reporting system. For the purposes of simplicity and greater situational awareness, we report all categories of pressure ulcers and MASD.
Category 2 ulcers or deeper, are confirmed where possible in person by the TVN team or an experienced TVN link nurse following an incident report. All category 2 ulcers or deeper, in keeping with the NHSE and NHSI guidance are subject to a root cause analysis (RCA) of the incident. The RCA will be reviewed at the Pressure Ulcer Scrutiny Panel who meets quarterly. The panel, made up of trust wide nursing representation, reviews the RCAs and concludes whether all care was in place and the ulcer could not be prevented or if there were acts and/or omissions in care that may have contribute to ulcer formation.

**How we monitor pressure ulcers:**

NHSE and NHSI (2018) guidance directs trusts to validate rates of pressure ulcers using multimodal monitoring strategies.
This is because it is recognised that no single system of pressure ulcer monitoring is infallible in representing rates of pressure ulcers experienced by patients (Gannon et. al., 2021, Fletcher

2018, Smith et. al., 2017). For example, Datix which is our primary reporting system is reliant on the clinician recognising the correct category of ulcer and then reporting it appropriately following training in how to use the system. Prevalence audits demonstrate the numbers of pressure ulcers on a set date and are useful in validating trends identified through Datix but are only a snapshot and must be carried out regularly in order to establish reliable and valid trends. Audit of electronic patient records play an important role in identifying trends. However, they too are reliant on clinicians categorising the ulcer correctly and completing the relevant documentation accurately. A strong clinical presence by the Wound Care TVN team is also a key part of our monitoring strategy as visibility and availability plays an invaluable role in the correct grading of pressure ulcers. This expert clinical presence supports NHSE and NHSI standards around confirming the category of deep ulcers before they are reported to commissioning groups.
The combination of these differing methodologies helps ensure if one monitoring system does not pick up a trend, another monitoring system will. In this reporting year, we reported the patient's experience of pressure ulcers through all these differing methodologies to gain reliable and valid data in support of patient care and to inform us where to direct our resources towards.
The pressure ulcer defined as Deep Tissue Injury (DTI), on resolution, usually are found to be not deep in nature. The National Wound Care Strategy (Department of Health) is currently reviewing this definition as it is largely thought to misrepresent the true depth of skin injury. An update is expected in 2023/24.

**Pressure Ulcer Rates and Outcomes**

**Datix incident reporting system:**

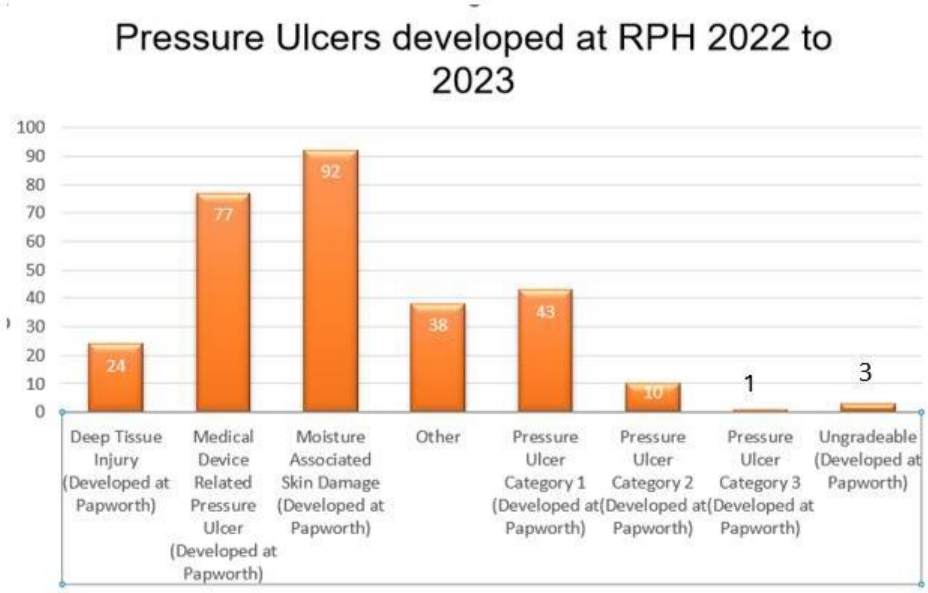



**Table 2: Pressure Ulcers developed at Royal Papworth Hospital by category**

**Pressure ulcers developed at RPH:**
288 pressure ulcer incidents were reported. This is an increase from 236 last year. This increase is thought largely due to change in reporting standards outlined in the Pressure Ulcer Reporting Procedure (DN 522). To avoid confusion in reporting on the clinical floor, reporting of category 1 pressure ulcers was commenced as the national guidance does not include these to be reported via Datix. Before this change, the reporting of category 1 ulcers was not mandated in the trust. The rise is also linked to an increase in reporting of MDRPU following the introduction of the 'Two Birds Campaign' to raise awareness of endotracheal tube MDRPU which is regarded as largely underreported (Gannon et.al., 2021, Fletcher 2018, Smith et. al., 2017). There was no appreciable rise in deep pressure ulcers -DTI, category 3, category 4 and unstageable with 28 reported in this reporting year versus 24 in the previous year.

**Prevalence audit results:**
This audit is a visible check of the skin of every admitted patient in the hospital on a set date. The audit's role is to validate Datix reports and get a true picture of skin injury in this respect. The

biannual prevalence audit findings were consistent with Datix finding very low levels of deep pressure ulcers category DTI, 3, 4

**Pressure Ulcer Scrutiny Panel Outcomes:**
Each pressure ulcer of cataegory 2, 3, 4, DTI and ungradeable are subject to an RCA that is presented at quarterly Pressure Ulcer Scrutiny Panel.

| | Cat 2 | Cat 3 | Cat 4 | DTI | Unstageable | Total |
|---|---|---|---|---|---|---|
| **2022/23** | **3** | **1** | **0** | **11** | **0** | **15** |
| **2021/22** | **5** | **1** | **0** | **5** | **0** | **11** |
| **2020/21** | **6** | **1** | **0** | **5** | **0** | **12** |
| **2019/20** | **3** | **1** | **0** | **8** | **2** | **14** |

**Table 5: Pressure ulcers associated with acts or ommissions in care**

The number of pressure ulcers that scrutiny panel concluded there were acts in ommissions in care has remained broadly consistent since 2019. The number of DTIs associated with acts and/or ommssions in care was greater than last year in this respect with one category 3 pressure ulcer and no category 4 ulcers associated with acts or ommissions in care. 5 of the 11 DTIs were linked to the standard of documentation in the Lorenzo EPR and the patients may have had the care needed but this was not documented. The SSKIN care bundle form on Lorenzo where presssure area care is documented has been simplified and consolidated this year but remains a significantly more difficult document to populate compared to the Metavison EPR system used in CCA as it is a slower system to populate and not as intuitive. Nonetheless, table 1 confirms that the rate of DTI occurance in general in on a downward trend in the last 2 quarters of the reporting year.

**Innovation:**

**Simple Safety for Skin:** This reporting year saw the extending out of the Simple Safety in Skin project beyond the Critical Care Area (CCA) to ward areas. During the COVID-19 CCA surges, the introduction of this simplified system led to a very large reduction in MASD which our data points towards been the most common skin injury in this respect. This project simplified the steps to support achieving the best possible care for our patients. The protocol launched in September on the wards simplifies down pressure ulcer and MASD hygiene to one single type of skin friendly wash, one long-acting skin protectant (Cavilon Advanced) and a focus on repositioning schedules and use of the dynamic mattress system for high-risk patients.
This system was accepted for publication in the journal Wounds UK in 2021, is currently the subject of a national industry supported education roadshow and was presented as a plenary talk at the 2023 Tissue Viability Society conference before been presented to a pan-European expert panel in June of this year.

**Actions:**
Many of the pressure ulcers associated with acts and/or omissions in care reached this conclusion due to gaps in documentation. Medical device related pressure ulcers (MDRPU) and moisture associate skin damage (MASD) remain a challenge.

**Action1: Supporting documentation standards:** In response to this challenge, the SSKIN care bundle pressure area care plan in ward areas which consisted of four different documents that clinical staff persistently fed back was complex to complete and involved filling out many individual documents. This approach to documentation was very different to the style of SSKIN care bundle used on CCA where there were less acts and/or omissions in care associated with documentation efforts. These documents have now been replaced with a single consolidated document similar to the version used on CCA and there is now a common SSKIN care bundle across the hospital.
**Action 2: Continued support for the MDRPU reduction project in CCA: Two Birds Campaign (CCA, 2021)**

**Action 3: Ongoing support for the 'Simple Safety for Skin' project: Simple Safety for Skin protocol**
**Action 4: Engaging with corporate trainers to support education**
**Action 5: Introduction of a Nimbus managed mattress trial**

**2023/24 Quality account targets:**

- Promoting Equality and Diversity in Pressure Ulcer Management. Introduction of a 'Darkly Pigmented Skin PU Assessment' programme of education as there is a growing UK wide evidence base recognising a lack of capability in recognising early onset and depth of pressure ulcer injury in BAME patients which increases the risk of deeper pressure ulcer development due to late recognition of skin injury.

- Capture skin injury caused by poor perfusion that is currently inaccurately described as '**pressure ulcer other'** on a new tab in Datix. This should see the number of 'pressure ulcer – other' category this year reduce from 39 incidents. Target reduction is 25%.

- Introduction of a Wound Care Tissue Viability information board to each main inpatient department. The board will highlight PU metrics and educate on the specifics of pressure ulcer risk assessment, prevention and management of pressure ulcer and BAME considerations.

- Integrate the Patient Pressure Ulcer Information Leaflet into the discharge process to support patients who have become physically deconditioned during the admission, remain at risk of PU development at home consequently and to promote self-management of pressure areas post discharge with the support of community teams as necessary.

**Conclusion**:

- There is a strong and robust reporting culture in place to record pressure ulcers using a multi-modal monitoring strategy. This was demonstrated in incident reported rates of pressure ulcer formation consistent with prevalence inspection rates.
- There are high reporting rates of pressure ulcers in the trust and low rates of deep and very deep pressure ulcers.
- MASD and MDRPU remain a principal challenge in respect to prevention.
- The architecture of the Lorenzo EPR remains non-conducive to supporting efficient documentation practices despite support from our IT team to simplify the relevant forms.
- The appointment of a Wound Care TVN nurse educator (currently 1 day per week) represents a good trust investment in preventative care going forward. However, this is set against sustained rates of trust wide surgical site infection (SSI) which continues to disproportionately consume clinical time and analysis time that otherwise would be dedicated to supporting wider pressure ulcer prevention initiatives.

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## Patient Safety Incidents – Severity

| Incidents by Severity | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023* | Total |
|---|---|---|---|---|---|
| Near Miss | 511 | 375 | 305 | 153 | 1344 |
| No harm | 2349 | 1500 | 1722 | 1553 | 7124 |
| Low harm | 724 | 704 | 916 | 1261 | 3605 |
| Moderate harm | 11 | 21 | 24 | 28 | 84 |
| Severe harm | 5 | 7 | 3 | 3 | 18 |
| Death caused by the incident | 1 | 0 | 0 | 1 | 2 |
| Death UNRELATED to the incident | 11 | 11 | 11 | 13 | 46 |
| Total | 3612 | 2618 | 2981 | 3012 | 12223 |

Patient Safety Incidents by Severity (Data source: DATIX 20/04/23)
*Correct at the time of production. Some incidents may be downgraded in severity following investigation.

Over 3000 patient safety incidents and near misses have consistently been reported during the financial year. There is a healthy safety culture within the Trust and an understanding of the importance of learning from incidents and the CQC requirements to report under the Key Lines of Enquiry (KLOE).

Those graded as near miss, no/low harm over the last 12 months (99%) demonstrates a continuous readiness to report and learn from all types of incidents. The Trust culture ensures staff report incidents in order to demonstrate an open and fair culture of learning. This process also captures the clinical consideration given to all types of incidents.

The level of investigation carried out after a patient safety incident is determined by the level of severity, with moderate harm incidents and above being reviewed at the Trust's Serious Incident Executive Review Panel (SIERP). All moderate harm incidents and above have investigations and associated action plans which are managed by the relevant divisions and monitored by the Quality & Risk Management Group (QRMG). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and supported by the Clinical Governance and Risk Team.

The (*) signifies that not all incidents have been finally approved and grading confirmed as at 22/03/2023. Lessons learnt are shared across the organisation and with associated stakeholders, presentations and local dissemination via Divisions and specialist meetings.

### Never Events

Learning from what goes wrong in healthcare is crucial to preventing future harm; it requires a culture of openness and honesty to ensure staff, patients, families and carers feel supported to raise a concern and speak up in a constructive way.

Never Events are patient safety incidents that are wholly preventable and where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. As with all serious incidents, these events need prompt reporting and detailed investigation to understand what went wrong and what actions need to be taken to prevent the incident from happening again.

The Trust reported no Never Events during 2022/23.

### Reducing falls and reducing harm from falls

Falls prevention remains a top priority for the Trust and is part of Harm Free Care. Falls are monitored through incident reporting, by clinical staff, Clinical Governance and the Falls Prevention Specialist Nurse. Under the Management of Health and Safety at Work Regulations and CQC Regulation 17, the Trust has a responsibility to protect all patients from harm and "so

far as is reasonably practicable" carry out "suitable and sufficient" patient and health & safety risk assessments to that ensure they remain safe.

Harm Free Care is listening to patients, carers and staff and learning from what they say when things go wrong and take action to improve patients' safety. Falls Prevention is a key area and focus for the Trust.

Since moving into the new hospital premises in 2019, all falls are reviewed to ascertain if the patient fell due to a medical condition or because of failure to meet best practice in the management of building premises health & safety, and to ensure that appropriate action is undertaken. All falls are reviewed by the Falls Prevention Lead.

In 2022-2023 a total of 146 falls were reported. This is compared to 150 the previous year. It is notable that patients being admitted to our services are more frail than previous. Throughout the year there have been regular occurrences of, patients being lowered to the ground, no and low harm falls and moderate harm falls. Falls resulting in moderate injury have Root Cause Analysis (RCA) performed and falls resulting in severe harm have a full Serious Incident (SI) investigation. All RCA for falls are reviewed at QRMG and at the Band 7 ward sister and charge nurses meetings.

There were no serious incidents from falls in the financial year 2022-2023. There were 5 moderate harm incidents.

Themes arising from falls overall, were patient frailty, trailing ECG cables and association with mobilising to bathrooms. Delirium/ confusion was noted in 6 falls. 94 of the 156 falls were unwitnessed.

Concerning the moderate harm falls and continuing from previous work, several actions have been put in place:

- Introduction of alarm units for bathrooms across Level 5 Surgery to alert staff to patient movement
- Further emphasis on training provided for all clinical staff on falls prevention
- Promotion of frailty scoring to highlight patients at risk of falls.
- Link Nurse Roles generally have been harder to promote due to low staffing levels. Ward Managers are raising falls issues at the ward meetings.
- Promotion of the use of clips to help prevent cables trailing and causing trip hazards.
- Review and promote use of falls alarms when appropriate, including when patients are stepped down from one-to-one care.
- Telemetry to be introduced where necessary to avoid the hazard of trailing cables.
- Investigate how lessons and themes are being shared to ensure change in practise and learning
- Bed Rail documentation has been improved by changing the flat form to a drop-down format, making it simpler to use.

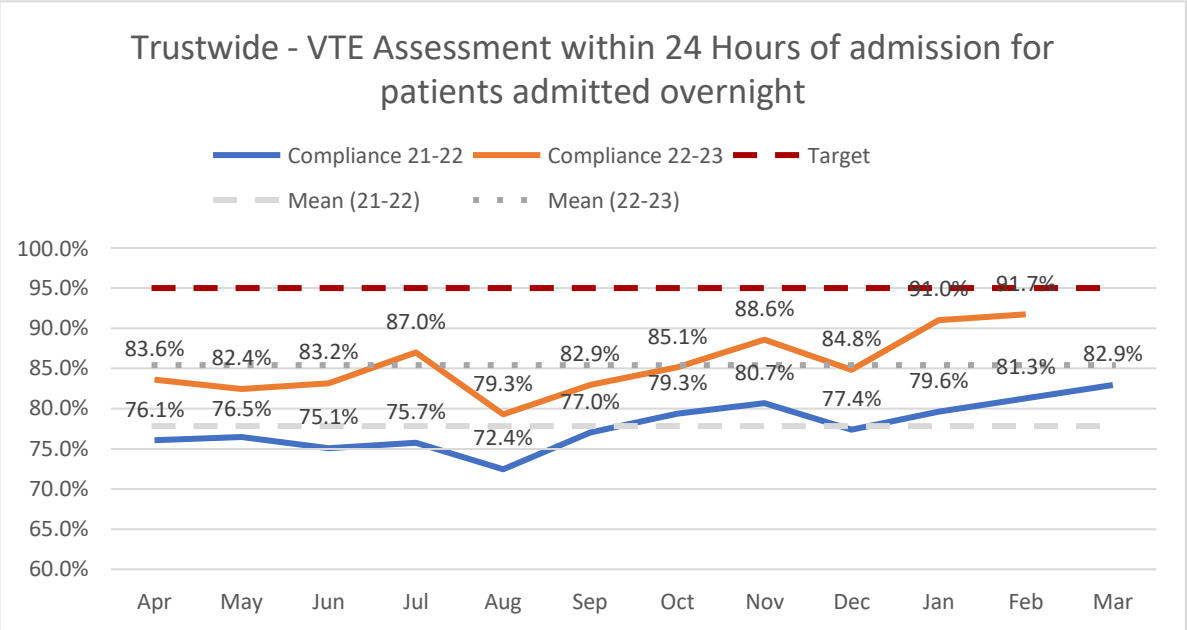
The table below demonstrates the number of actual falls per quarter across the year. The learning from falls incidents is shared at QRMG and among various clinical and nursing forums.

| Financial Year | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| 2019/2020 | 31 | 25 | 44 | 37 | 137 |
| 2020/2021 | 25 | 39 | 53 | 28 | 145 |
| 2021/2022 | 29 | 45 | 34 | 42 | 150 |
| 2022/2023 | 35 | 38 | 38 | 35 | 146 |
| Total | 120 | 147 | 169 | 142 | 578 |

Source DATIX 20.04.2023

## Prevention of venous thromboembolism (VTE)

Venous Thromboembolism (VTE) Assessment on Admission is mandated by Trust procedure for all overnight admissions at RPH. VTE Trust procedure utilises national guidance from NICE and the DoH as its foundation. The criteria for the VTE Assessment on Admission Monthly audit are the % of patients, who stayed overnight, who had a VTE risk assessment completed within the first 24 hours of their admission, for patients who had a length of stay of greater than 24 hours. The trend over the last rolling 12 months of compliance can be seen below in the graph, the target is 95%.




VTE remains an area of particular focus and continues to be monitored through monthly Trust quality & risk meetings and divisional performance meetings.

We continue to work with the clinical teams to support improvement with VTE assessment compliance. Consultant VTE champion roles have been identified and VTE link nurses meet bi-monthly. Educational sessions via a ‘tea trolley’ approach have been rolled to all ward areas.

A communication strategy has been implemented with the support of digital teams, to deliver new initiatives to raise awareness of VTE risk amongst clinical staff and patients.

Digital options for a clinical prompt for outstanding VTE assessments remain very unlikely in short-medium term however other digital options are under investigation. In the meantime the VTE clinical indicator view (dashboard for patients) within the electronic patient record has been optimised to better highlight patients in need of VTE risk assessment before the 24h target is breached

The Trust has not regularly been achieving the national target of 95% therefore it was agreed we would not apply for revalidation as an exemplary site. A continued focus on the informatics and engagement, both at a clinical and patient level for the next year is planned in preparation for re- applying in 2024.

There were no solely hospital attributable thrombosis events and no harms occurred from incidents reported.

# Patient experience domain

## Patient Stories

Patient stories continued to form an integral element of capturing the patient experience throughout 2022/23. Members of staff representing a variety of professions have presented at the Board of Directors and at professional meetings such as the Clinical Professional Advisory Committee, Band 7 meeting, Management Executive and the Patient Experience and Safeguarding groups. Patient stories are also included in monthly Matron reports for the Clinical Divisions which provide a valuable opportunity for discussion directly with the senior multidisciplinary team and reports are circulated to teams for further learning. This practice has continued during 2022/23. Quarterly divisional quality reports to the Quality and Risk Management Group now include examples of patient stories, if available, for sharing of learning.

### Learning from patient stories

Royal Papworth Hospital recognise that patient stories are another important contribution to improving the quality of the services we provide. Patient stories offer a fantastic opportunity to obtain detailed feedback from individuals on the care they receive. It is therefore important that the individual sharing their story understands the process for capturing patient stories and how their story will be used.

In 2022/23 the Patient Experience Manager working in collaboration with staff from across the organisation (Matrons, Allied Health Professionals and Support Staff) undertook a review of the current process for collecting patient stories and developed a consent form and patient information leaflet. The consent form will be used to obtain a patient's consent to use their story to understand more about the health and care services we provide to our patients, their families, and carers. These documents are the initial phase of developing an agreed process for obtaining and sharing patient stories. In 2023/24, we will be developing a range of methods to support staff in capturing patient stories and for presenting these stories at Board Level, whilst ensuring this feedback is used for instigating positive change and improvements.

The Board have heard stories patients that bring the experience of our patients to life with reports from across the organisation that share the challenges, successes and learning from each individual story. We heard stories covering:

- The transplant patient journey. and how they have been supported by different members of the team from diabetes specialist nurses who shared an experience of delirium during a patient's stay on the critical care unit and on the ward. This story was used to provide feedback on delirium training to our critical care team.
- Our Transplant nurses shared the journey of a patient who had been referred in 2018 when he was not suitable for a heart transplant and who's treatment was focused on optimising his condition. The patient was fitted with a left ventricular assist device (LVAD) in 2021 which allows a more normal output from the heart and reduces pressure which meant that he could be listed for a transplant. He received a transplant in June 2022 having waited 55 days on the urgent transplant list. The patient wanted to thank everyone from his first transfer into the hospital, to the LVAD and to the transplant for the rest of his life. The Board were keen to understand what we were doing to support patients at other hospitals and heard how we look at all heart failure referrals working with local hospitals to optimise care through education and patient reviews.
- The Alert team who told the board about a patient with ischaemic heart disease with a complex medical and surgical history who had developed sepsis. He was concerned that the information from the doctors and nurses was given in 'dribs and drabs' and that sometimes during ward rounds, staff spoke amongst themselves and not to him. The Alert team knew that this may not the experience of most of our patients but felt one experience

like this was too many and learning was shared with the surgical ward team and the sisters and matrons' meetings to share how our actions make such a difference to each patient's experience. The surgical ward team put a plan in place to improve continuity of care in terms of senior surgical registrars meaning more patients are looked after by the same doctor.

- Ward 5 South nurses shared a story about a patient admitted from outpatients. He wished that he had not had to stay in hospital for two weeks as this had come as a surprise, but he had an excellent experience in theatre and on the critical care ward and on the ward itself. He felt the treatment was impressive and that he was treated with dignity and respect. He also appreciated the environment and noted that his room and the ensuite provision was very nice. He was impressed with the housekeeping service and later in his stay he was able to enjoy the meals that were on offer and felt these were better than he had experienced elsewhere.
- We heard from our AHP teams about the patient's experience of therapies in critical care where our physiotherapy team were fair but firm and supporting patients to do far more than they had believed. Also, the speech and language therapy team who supported patients moving them from being able to take a teaspoon of liquid, onto soft food, and then to a normal diet.
- The Respiratory Sleep Centre brought a story from one of their long-term patients who comes in for a tracheostomy tube change & review for management of his Obstructive Sleep Apnoea (OSA). He had recurrent chest infections since March 2022 and as these had not resolved he was admitted for intravenous antibiotics. He was then supported by the team to that he could continue his IV antibiotics at home, and he was provided information on how to manage this treatment independently. He went home after 2 days after completing the home IV assessment returning to the ward as a day case after completion of his IV antibiotics where his IV line was taken out. This patient had felt respected and valued as he was involved in decision making on how to manage his own IV antibiotics treatment at home. He reported that the information and training were invaluable in helping him make the right decision and his reflection on his experience was that his needs were well covered.
- The impact of delays in very complex cancer patient journeys

## Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning.

There are many different causes of dementia and many different types. People often get confused about the difference between Alzheimer's disease and dementia. Alzheimer's disease is a type of dementia and, together with vascular dementia, makes up the majority of cases. Dementia symptoms may include problems with:

- Memory loss
- Thinking speed
- Mental sharpness and quickness
- Language, such as using works incorrectly, or trouble speaking
- Understanding
- Judgement
- Mood
- Movement
- Difficulties doing daily activities

People with dementia can lose interest in their usual activities and may have problems managing their behaviour or emotions. They may also find social situations difficult and lose interest in relationships and socialising. Aspects of their personality may change and they may lose empathy (understanding and compassion). A person with dementia may see or hear things that other people do not (hallucinations).

Because people with dementia may lose the ability to remember events, or not fully understand their environment or situations, it can seem as if they are not telling the truth or are wilfully ignoring problems. As dementia affects a person's mental abilities, they may find planning and organising difficult.

Maintaining their independence may also become a problem. A person with dementia will usually need help from friends or relatives, including help with making decisions. The symptoms of dementia usually become worse over time. In the late stage of dementia, people will not be able to take care of themselves and may lose their ability to communicate.

NHS Dementia Guide (2020)

People who are living with dementia are entitled to be free from abuse and neglect and where abuse is experienced, and action should be taken to stop and prevent it. The Care Act (2014) provides Local Authorities with a duty to safeguard adults.

Going into hospital for a person with Dementia can be a difficult and distressing time. Someone with dementia may have to go into hospital for a planned procedure such as an operation, during a serious illness or if they have an accident or fall. This can be disorientating and frightening and may make them more confused than usual. Hospitals can be loud and unfamiliar, and the person may not understand where they are or why they are there.

We seek to offer our patients and their carers with dementia safe individualised care, and to be treated with respect, and well informed whilst in our care.

The first Royal Papworth Hospital Dementia strategy was created in 2015 to enhance the experience of patients and carers living with Dementia. Work has commenced to create a combined strategy for vulnerable patients which will encompass those with learning disabilities, autism, acute mental health problems as well as dementia.

Patients who are vulnerable and those who require reasonable adjustments are identified daily in the Site Safety Briefing and during the Daily Board Rounds and reasonable adjustments as required are put into practice.

# Learning Disabilities and Autism

## Definitions

Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities.

Learning disability is defined by Mencap as *'a reduced intellectual ability and difficulty with everyday activities, for example household tasks, socialising or managing money which affects someone for their whole life.'*

Autism is defined by the National Autistic Society a*s 'a lifelong developmental disability which affects how people communicate and interact with the world. More than one in 100 people are on the autism spectrum and there are around 700, 000 autistic adults and children in the UK.'*

## Statutory and regulatory requirements

The Equality Act (2010) imposes a duty to make 'reasonable adjustments' for disabled persons. Reasonable adjustments are defined as 'changes to practice and processes which are implemented to prevent any disabled persons from being at a disadvantage, whether by virtue of a physical feature of the premises or a process that places people with a disability at a disadvantage.'

The Health and Care Act (2022) introduced a requirement that all regulated health and social care service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role.

The Government Mandate (2022-23) to NHS England focused on improving services for people with learning disabilities and on supporting them in the community to reduce reliance on mental health inpatient care. This was felt to be particularly important given the impact of COVID-19 on access to NHS services.

The Disability Rights Commission (DRC) have one key goal 'a society where all disabled people can participate fully as equal citizens (2022). People with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable, and therefore unjust and unfair. The health inequalities faced by people with learning disabilities in the UK start early in life, and result to an extent, from barriers they face in accessing timely, appropriate, and effective health care. People with a learning disability are four times more likely to die of something which could have been prevented than the general population (DRC, 2022).

The NHS Long Term Plan published in 2019 pledged that over the next five years, the national learning disability improvement standards will be implemented by all services funded by the NHS to ensure people with learning disabilities and/or autistic people can receive high quality, personalised and safe care when they use the NHS. The plan aims to improve people's health by making sure they receive timely and appropriate health checks, while improving the level of awareness and understanding across the NHS of how best to support them as patients.

## Performance against the learning disability improvement standards

The four improvement standards against which NHS Trust performance is measured cover:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce
4. Specialist learning and disability services

The first three ‘universal standards’ apply to all NHS Trusts and the fourth ‘specialist standard’ applies specifically to Trusts that provide services commissioned exclusively for people with a learning disability and/or autistic people.

A Trust’s compliance with these standards demonstrates it has the right structures, processes, workforce, and skills to deliver the outcomes that people with a learning disability, autistic people, their families, and carers expect and deserve as well as commitment to sustainable quality improvement.

Royal Papworth Hospital participated for the fifth year running (November 2022) in the NHSEI Learning Disability Improvement Standards self-assessment to better understand the experience of our patients. The results will be published later in 2023 for Year 5.

## Progress reported (2021-22) to improve the experience for patients with learning disabilities and/or autism

Progress against the findings from the Year 4 National Benchmarking exercise 2020/21 is detailed below in relation to the improvement standards

1. **Respecting and protecting rights**

- Royal Papworth Hospital published the Care of Patients with Learning Disability and Autism Policy in 2020 which is due for review in July 2023.
- The Trust has established a system to monitor incidents reported through Datix affecting people with Learning Disabilities. Lessons and themes from this are reported through the Joint Safeguarding Committee.
- At Royal Papworth Hospital, it is important to ensure that patients who are vulnerable have their rights protected and respected. This is undertaken in a variety of way through consistent and responsive individualised care planning. Patients who are learning disabled and/or autistic are supported through this process by ensuring staff recognise and respond to the patients’ individual requirements on admission to its services. This will include providing adjustments by working closely with the patient and their nominated carer/guardian/significant other to enable the person to feel safe and empowered to make decisions about their care wherever possible. Not in all cases can we assure the use of hospital passports, however, good communication between the patient, significant other (where deemed appropriate and consented for) with care staff can ensure care arrangements are in place to protect and respect the rights of our patients.

2. **Inclusion and engagement**

- We have developed some communication resources for patients with Learning Disabilities which are available for staff use: https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/5-good-comms-standards-easy-read.pdf
- The Trust recognises that a low stimulus area for patients with learning disabilities and/or autism is recommended however it has been challenging to identify a dedicated space whilst remaining sensitive to requirements versus the availability of suitable space. The Trust can support individuals on a case-by-case basis if patients’ needs are identified earlier in the patient pathway.

3. **Workforce**

- Two staff members are trained as LeDeR (Learning from Deaths Review).
- RPH is compliant with the training requirements for patients with learning disabilities.
- The Oliver McGowan Mandatory Training on Learning Disability and Autism has been co-produced, trialled, independently evaluated, and will be co-delivered by trainers with lived experience of learning disability and autism. This programme is designed to further enhance awareness and skills for staff working and caring for people with learning disabilities thereby improving outcomes.
- The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the Government's preferred

and recommended training for health and social care staff to undertake. It is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the only training with permission to include Paula McGowan OBE, telling Oliver's story and explaining why the training is taking place.

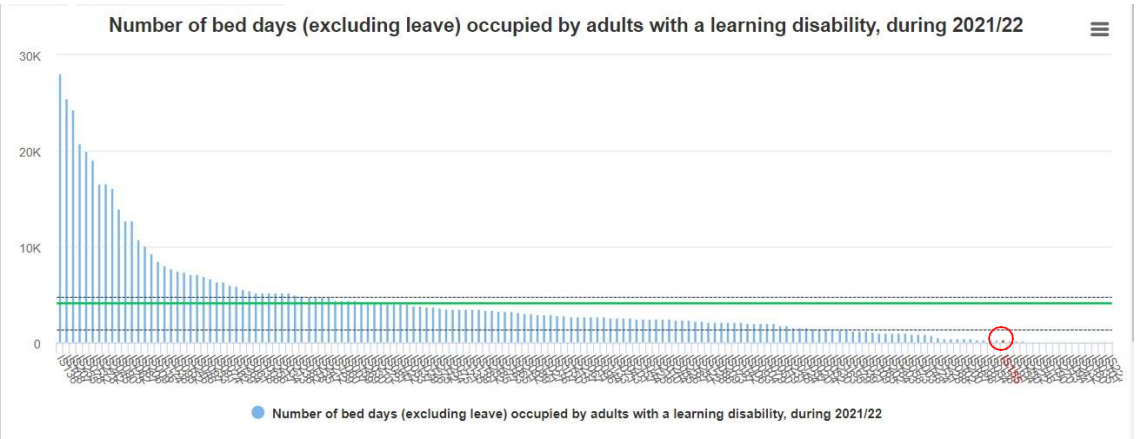
- An eLearning package is the first part of both Tier 1 and Tier 2 of the Oliver McGowan Mandatory Training and is now live. Everyone will need to do the eLearning no matter where they work and what tier they need to complete. The next part is either a live one hour online interactive session for those needing Tier 1, or, a 1-day face to face training for people who require Tier 2.
- HEE is working with partners to arrange trainers' training that will prepare people with a learning disability and autistic people to co-deliver the online interactive and face to face sessions of The Oliver McGowan Mandatory Training on Learning Disability and Autism. Each Integrated Care Board (ICB) is being supported to develop training capacity. Those sessions are expected to be available in 2023. We are waiting for the Integrated Care Board (ICB) to co-ordinate this training across hospitals within the East of England.

## 2021-22 Data for patients with learning disabilities and autism

The numbers of patients attending RPH with Learning Disabilities and Autism are low. Data submission for the NHS England Learning Disability Improvement Standards collection occurred in Jan 2023 for the reporting year 2021/22 (which is the most recent reporting year).

**Chart 1** below shows the 'Total number of bed days (excluding leave) occupied by patients with a learning disability during 2021/22' (there were 161 national responses from NHS Trusts). Royal Papworth Hospital is close to the far right of the chart (highlighted by small red circle; the green line represents sample mean).

**Chart 1 –Total number of bed days (excluding leave) occupied by patients with a learning disability during 2021/22**




**Sample Information**

| | Lower Quartile | Mean | Median | Upper Quartile |
|---|---|---|---|---|
| All Organisations | 1,317.5 | 4,128.3 | 2,730.0 | 4,794.0 |

Total number of responses: **161**

**Your Response**

| Submission | Response |
|---|---|
| Royal Papworth Hospital NHS Foundation Trust | 297.0 |

## Future planning for patients with learning disabilities and autism

- A proposal has been put forward to the Trust Mandatory Training Group to consider the training needs of RPH staff in the delivery of Oliver Mc Gowan training. Staff training will be progressed this year in collaboration with the ICB.
- We are committed to hear the voice of our patients with learning disabilities and/or autism through patient stories. There is clear need for a continued proactive approach to make accessible these stories and to embed that learning across the Trust.
- We monitor patients with a learning disability and autism on a waiting list 'Access Plan' to our services and report quarterly to the Joint Safeguarding Committee. There is however a need to review the patient referral pathway to ensure patients with a learning disability and/or autism are identified *as standard* to allow for the adequate provision of appropriate support on admission, e.g. allocation of low stimulus area.
- Suggestions for autism awareness icons on the electronic patient record (Lorenzo) for learning disability and/or autism patients are being investigated with the system provider. In the event this is not possible the construction of a dashboard to allow increased visibility of these vulnerable patients will be considered.
- Advance the use of hospital passports to help patients with a learning disability and/or autism become familiar with hospital prior to admission by developing a virtual tour information/easy read "getting ready for hospital".
- A virtual hospital tour is already available on the public facing website, however the Communication Team are supporting plans to develop a virtual tour for patients with learning disabilities and/or autism on the website (* will also apply to dementia) to support a positive patient experience when attending and/or visiting the hospital.
- The Trust will consider the contribution of patients with a learning disability and/or autism to the Patient Experience Strategy which is currently being reviewed.

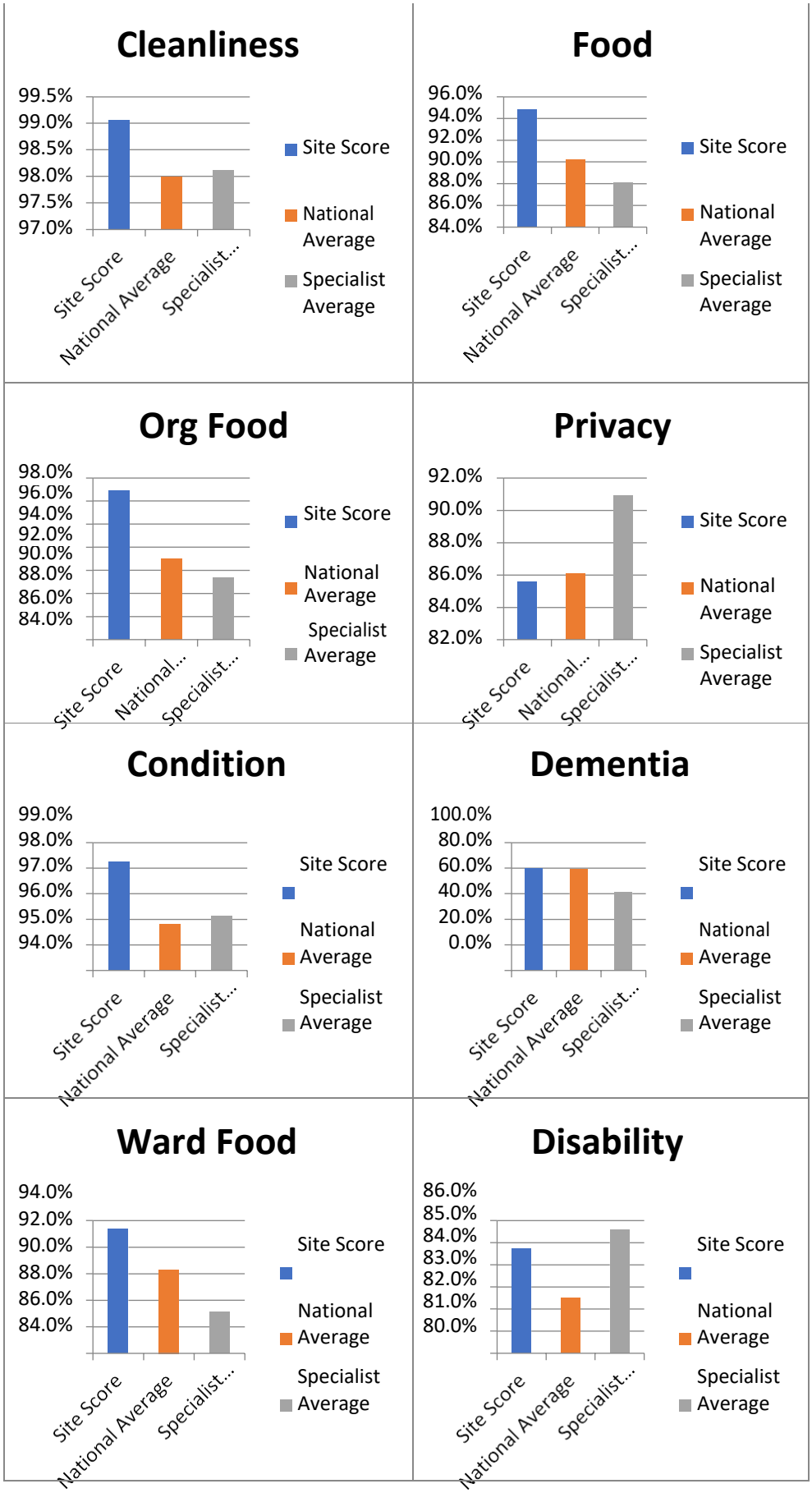
## Patient Led Assessments of the Care Environment (PLACE) Programme 2022

All healthcare providers are required to take part in the national Patient-Led Assessment of the Care Environment (PLACE) annual inspections. PLACE is a national self-assessment tool designed to measure standards of;

- Cleanliness,
- Food comprising Organisation Food and Ward Food
- Privacy, Dignity & Wellbeing,
- Building Condition, appearance & maintenance,
- Dementia friendly environment
- Disability friendly environment

The Health & Social Care Information Centre (HSCIC) provide comprehensive guidance on the organisation and conduct of assessments and separate guidance documents for staff assessors and patient assessors. PLACE assessments are carried out by internal and external assessors within inpatient facilities and the surrounding patients assessed environment. Assessors include Governors, Volunteers, Trust members and representatives from the Trust's facilities contractors. Staff areas and clinical treatments are excluded from this assessment.

The tables below demonstrate the Trust performance against the national average. The Trust has scored above the national average in the following areas: cleanliness; food including organisation food and ward food; condition, maintenance and appearance, dementia and disability, demonstrating that the new site is of an exceptional standard.


Cleanliness
99.5%
99.0%
98.5%
98.0%
97.5%
97.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average
Food
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average
Org Food
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
Site Score
National...
Specialist...
Site Score
National Average
Specialist Average
Privacy
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
Site Score
National...
Specialist...
Site Score
National Average
Specialist Average
Condition
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average
Dementia
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average
Ward Food
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average
Disability
86.0%
85.0%
84.0%
83.0%
82.0%
81.0%
80.0%
Site Score
National Average
Specialist...
Site Score
National Average
Specialist Average

| Area | 2022/23 Site Scores | 2022/23 National Average | Comments |
|---|---|---|---|
| Cleanliness | **99.1%** | 98.0% | The Trust's cleaning service OCS are continuing to uphold high levels of site management. They have maintained staff numbers throughout the year. The audit results show cleaning has this year scored above the national average. |
| Food (comprising Organisation and Ward Food) | **94.8%** | 90.2% | Food scores are high for this year following a high level of input between Trust and OCS teams to ensure patient food quality is of a high level. In efforts to improve the training/education/ management of the Housekeepers, the Trust has employed a Patient Catering Manager. The role of the Manager aims to assist with development of housekeeping staff skills such as presentation, allergen understanding and service times to maintain an effective housekeeping relationship, which in turn will allow us to deliver a more efficient food service to our patients. |
| Organisation Food | 96.9% | 91.0% | |
| Ward Food | 93.38% | 90.3% | |
| Privacy, Dignity & Wellbeing | **85.6%** | 86.1% | The score for this year is slightly below national average – this is largely due to the site not scoring in some categories where services don't exist, such as Children's Services. The introduction of single en-suite rooms, enhanced patient entertainment systems and a more patient focused care environment has however improved on scoring from the previous Royal Papworth site. . |
| Condition, Appearance & Maintenance | 98.3% | 95.8% | The Trust continues to focus in this area with PFI partners to maintain the condition and maintenance of the site, particularly focusing on clinical areas. It is essential and remains a priority for the Estate and Facilities team that we continue to deliver a safe and well-maintained environment for our patients and visitors. |
| Dementia | 79.8% | 79.2% | The Trust has maintained similar scores to national average in the Dementia-friendly element, and works with advisors to review and improve where opportunity exists. |
| Disability | 84.7% | 82.5% | |

**Action Plan**

A few minor issues relating to cleaning and maintenance were brought up in the feedback session. Due to the regular Patient Environmental rounds the issues identified during the PLACE audit were successfully captured and completed.

**Summary**

This is the seventh year the PLACE assessment programme that has run nationally, following a two-year gap due to the Covid-19 pandemic, allowing us to benchmark against the national averages. We will continued to carry out the assessments with a greater number of smaller teams over the forthcoming years.

We're grateful for the continuing support of Governors, volunteers and past patients who have participated in the assessments.

Once again the outcome shows that while we have a diverse spread of inpatient environments, the quality of the cleanliness and condition, appearance and maintenance remains at a high standard across the whole Trust. This is reflected in the Trust score being above the national average in these categories.

**Patient Assessors Feedback**

The Governors and staff assessors who spoke to patients reiterated the excellent standards to which the Hospital is being maintained, as this is the first PLACE assessment following the move to the Cambridge Biomedical Campus.

## Listening to Patient Experience and Complaints

Listening to the patient experience and taking action following investigation of complaints is an important part of our Quality Improvement framework. In 2022/23 Royal Papworth Hospital received 58 formal complaints from patients and or their families. Of the 58 complaints reported (28 inpatient and 30 outpatient complaints) 59 were relating to NHS provided services with 2 complaints related to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has increased in the numbers received during the previous year when 40 complaints were received (an 45% increase from 2021/22).

In line with the Trust's complaint policy, all concerns should be resolved at the earliest opportunity without necessarily escalating to the formal complaint process. In 2022/23 we recategorised enquiries to informal complaints to ensure concerns that have been resolved through local resolution are accurately recorded and reported. We have continued to embed this process in Q4 of 2022/23 and from 2023/24 we will be reporting on themes for both informal and formal complaints within our quality reporting to support our service improvement from our patient/carer feedback gained through the complaints process.

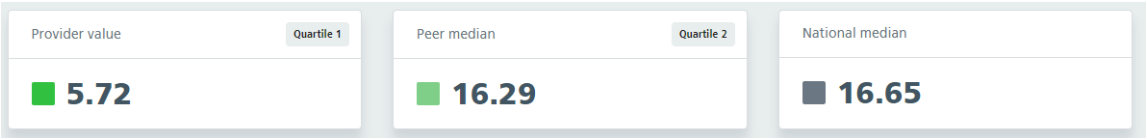
This has resulted in a significant increase in the number of informal complaints in comparison to the previous year (35 in 2021/22). The Trust received 74 informal complaints in 2022/23.

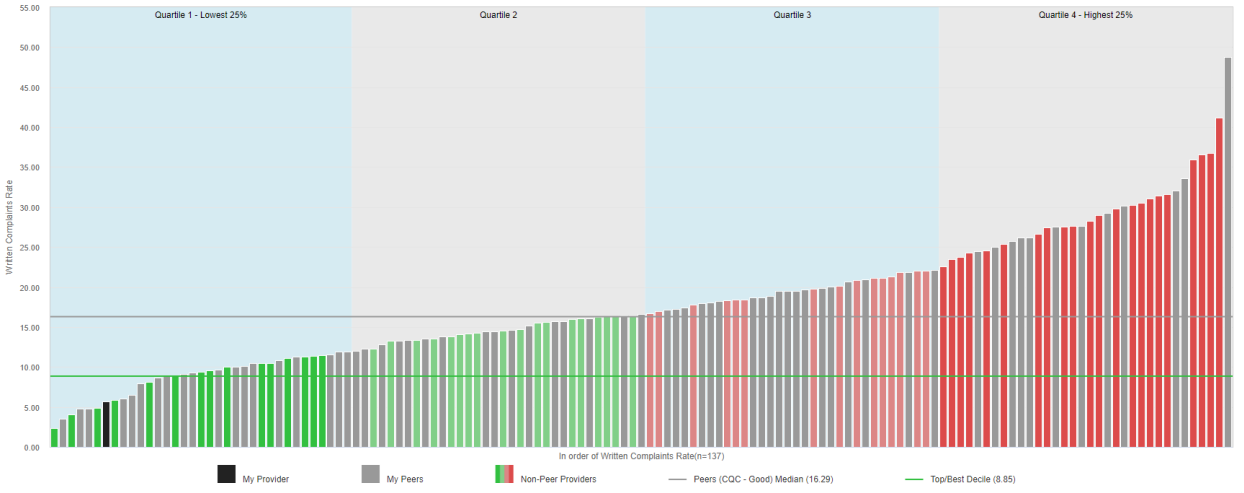
All concerns are fully investigated through a robust process intended to provide complainants with a quick, amicable, and satisfactory resolution to their concerns. The response is provided to the complainant either via email or telephone, this will also include providing details of any actions identified as a result of raising their concern. All informal complaints are now responded to within 15 working days.

**National benchmarking** - The Trust uses the Model Hospital Metric to bench mark the numbers of formal complaints. This is calculated by the number of written complaints made by or on behalf of patients about an organisation per 1000 staff (WTEs). This is reported monthly as part of the Papworth integrated Performance Report (PIPR) as a rolling 3-month average of the number of written complaints per 1000 WTE.

| April 2022 | May 2022 | June 2022 | July 2022 | Aug 2022 | Sept 2022 | Oct 2022 | Nov 2022 | Dec 2022 | Jan 2023 | Feb 2023 | March 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1 | 10.7 | 14.3 | 13.4 | 9.2 | 5.1 | 6.1 | 6.2 | 5.7 | 5.2 | 5.1 | 4.8 |

The overall Trust value remains well below the peer and national median and the latest data from Model Hospital demonstrates that we are in the lowest quartile from National comparison.




Royal Papworth Hospital takes all complaints very seriously and we encourage feedback from our service users to enable us to maintain continuous improvement. All formal complaints received are subject to a full investigation, and throughout the year service improvements have been made as a result of analysing and responding to complaints. Not all complaints are upheld following an investigation and the table below shows the number of complaints received and of those, the numbers upheld, or part upheld. Out of the 58 complaints received in 2022/23, 44% were upheld or partly upheld following investigation, an increase of 6% from 2021/22 (38%).

| Quarter | Number of complaints received (including private patients) | Complaints upheld/ Part upheld |
|---|---|---|
| Q1 2022/23 | 28 | 3 |
| Q2 2022/23 | 10 | 13 |
| Q3 2022/23 | 11 (1 Private Patient) | 5 |
| Q4 2022/23 | 9* (1 Private Patient) | 5* |

*Not all complaints for Q4 have been closed

Overall, the primary subject of complaints received at Royal Papworth Hospital remains clinical care and communication, although we have noticed an increase in the number of concerns relating to discharge and follow up care following discharge from RPH. In 2022/23, 38% of complaints received related to clinical care and 28% relate to communication, in comparison to 38% clinical care; 23% communication in 2021/22, these subjects remain the highest cause for complaints. A comparison of complaints raised by primary subject by year is shown below.

| Complaints received by primary subject | 2022/23 | 2021/23 | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|---|---|
| Clinical Administration and Appointments | 1 | 0 | 2 | 3 | 0 |
| Staff attitude | 6 | 3 | 0 | 0 | 1 |
| Clinical Care/Clinical Treatment | 22 | 15 | 13 | 28 | 12 |
| Patient Care (including nutrition and hydration) | 0 | 5 | 5 | 0 | 0 |
| Nursing Care | 4 | 2 | 0 | 1 | 0 |
| Catering | 0 | 0 | 0 | 0 | 1 |
| Patient Charges | 2 | 0 | 0 | 0 | 0 |
| Communication/Information | 16 | 9 | 8 | 27 | 28 |
| Delay in diagnosis/treatment or referral | 1 | 2 | 0 | 7 | 10 |
| Admissions, discharge and transfers | 2 | 2 | 2 | 1 | 1 |
| Consent | 0 | 0 | 1 | 0 | 0 |
| Equipment Issues | 0 | 0 | 0 | 0 | 0 |
| Privacy and Dignity | 0 | 0 | 1 | 1 | 0 |
| Environment - Internal | 1 | 0 | 0 | 3 | 0 |
| Medication issues | 0 | 0 | 0 | 2 | 1 |
| Facilities including Parking and Transport | 0 | 1 | 4 | 1 | 0 |
| Other | 3 | 1 | 1 | 0 | 0 |
| **Totals** | **58*** | **40*** | **37*** | **74*** | **53*** |

Complaints by primary subject (Data source DATIX 20/04/2023

*The total number of complaints includes those related to Royal Papworth Private Care

| Selection of actions taken as a result of upheld and part upheld complaints – 2022/23 |
|---|
| For families who raise concerns regarding patient discharge will be given further time with the relevant clinicians to discuss, plan and elevate these concerns before the patient is discharged. |
| Share the patient experience at our REALM/ Radiology discrepancy meeting to aid any further reflections or any learning that can be taken from the concerns raised. |
| A telephone log was implemented following the patient feedback to ensure all patient telephone enquiries are documented in the relevant patient records and appropriate action can be taken in a timely manner. |
| Staff have been reminded to ensure patients are aware who their allocated nurse is and we continue to raise awareness across the Trust regarding how isolated patients can feel within their bedspaces and look at alternative ways to support patients. |

All Complaints are detailed in the Quarterly Quality and Risk report available on our public website and reviewed at the relevant Business Units and divisional meetings for shared learning. Further information is available in our quarterly Quality and Safety Reports which are on our web site at: **https://royalpapworth.nhs.uk/our-hospital/information-we-publish/clinical-governance**

## Care Quality Commission (CQC) Inspections

The last CQC inspection was undertaken in June & July 2019 (refer to page 35). The CQC looked at all of the Trust's core services (with the exception of end of life care) and its overall assessment was outstanding. The report of this inspection is available on the CQC website at: Download full inspection report for Royal Papworth Hospital NHS Foundation Trust - PDF - (opens in new window)

### CQC Internal Mock Inspections

The last unannounced mock inspection of the End of Life (EoL) Services was undertaken in July 2021, when internal inspectors were joined by colleagues from the Arthur Rank Hospice, Non-Executive Directors and a patient governor. As part of the information gathering and inspection process, the teams had interviewed key staff members and visited inpatient ward areas identified with EoL activity and complex patients. A range of staff were consulted and the process was further enriched by two patients on the EoL pathway consenting to be interviewed on the day of the inspection. In line with the CQC rating process, the service was rated as 'outstanding', however the inspection team made several recommendations that have continued to be developed throughout 2022. The action plan was finally closed at the EoL Steering Group on 14 March 2023.

### Internal reviews of CQC Fundamental Standards

The Trust has continued to develop and implement its schedule of routine self-assessments against the CQC Fundamental Standards in 2022/23. The fundamental standards are the standards below which our care must never fall so these are an integral part of our internal monitoring process. Each review is undertaken by 3-4 multidisciplinary team members and we have included volunteers in our review teams this year for the first time.

We undertake internal peer reviews to:

- ensure a programme of a continuous self- assessment providing assurance of safe and effective patient care
- create an open and transparent programme of self-reflection and self-assessment
- celebrate areas of excellent practice
- identify areas for improvement
- evidence areas of good practice and maintenance of improvement for future CQC inspections
- offer opportunity for individual personal and professional development for members of the peer review team
- develop the Trust governance around quality compliance

Action plans are created as a result of the review's recommendations and are monitored by subject appropriate committees; the Fundamentals of Care Board is responsible for oversight of all reviews.

### Relationship with the CQC

Royal Papworth Hospital has an excellent working relationship with the CQC Relationship Manager with quarterly meetings. Additional queries and requests are attended to as needed.

### Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) Inspection

This took place on 6th November 2022 – further details can be found on page 35 of this report.

## External Well Led Developmental Review

The Trust undertook an external Well Led developmental review which reported to the Board in May 2022. The key themes identified included:

- Continuing to develop leaders to maintain the high-quality leadership of the Trust.
- To develop and strengthen leaders' capabilities in external stakeholder relationship to enable them to drive the system changes that are on the horizon
- To consider how the Board works to address the poor experience of some staff especially those from a BAME background and to produce more granular data about the experience of our BAME staff.
- To review the Board mechanisms to support workforce issues.

The Board agreed an action plan to respond to the recommendations of the review and that the Trust development through 2023/24 and beyond. This included the establishment of a Workforce

Committee that brings together this agenda and reports directly to the Board on matters across: education and training; equality, diversity, and inclusion (EDI); leadership development; resourcing & retention; staff health and well-being; workforce health & safety; and workforce planning.

We also continue our Compassionate and Collective Line Managers Development which was established last year, and was designed to improve the skills and confidence of line managers to be compassionate and inclusive leaders. We have introduced a one-day line managers induction session for all staff moving into a line managers role and we continue to work with system partners on workforce planning, implementation of the Regional Anti-Racism Strategy and leadership development.

# Clinical effectiveness of care domain

## Cardiovascular Outcomes – NICOR 2023 report for 2019-2022

Royal Papworth Hospital is one of the better performing NHS hospitals in the UK for cardiac surgery survival, according to the latest NICOR annual report and our internal audit data. This era included the COVID pandemic and consequently, case volumes nationally were below average and crude mortality was above the previous averages. During this period, Royal Papworth performed 4261 total cardiac procedures, the third largest case volume in the UK, with an actual mortality of 2.54% (CI 2.04-3.11%), significantly better than the EuroSCORE II prediction of 4.24%, and the national average actual mortality of 2.96%.

## Royal Papworth leads in Transplant Survival Rates

Royal Papworth Hospital has some of the UK's best survival rates for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in September 2022.

The report identified that the national 30-day rate of survival following adult DBD heart transplantation (unadjusted) was 91.4%, which ranged from 88.6% to 93.5% across centres (RPH 93.7%; risk adjusted 87.6%). The national 90-day survival rate (unadjusted) was 88.2%, ranging from 85.0% to 90.7% across centres (RPH 91.9%; risk adjusted 85.5%). The national 1-year survival rate was 84.5%, ranging from 81.0% to 87.4% across centres (unadjusted), (RPH 90.1%; 84.2% risk-adjusted). The national 5-year survival rate was 72.3%, ranging from 68.5% to 75.8% across centres (RPH 77.3%; 77.5% risk-adjusted).

RPH survival rates were consistent with the national rate statistically consistent with the national rate of survival.

For lung transplant the 90-day post-transplant RPH had survival rate of 91.6% (91.3% risk adjusted). This was statistically consistent with the national rate of survival which was 90.3%% which ranged from 87.6% to 92.5%. The national risk-adjusted 1-year survival rate was 82.5%, ranging from 79.1% to 85.4% across centres (RPH 83.8%; 84.6% risk adjusted), with no significant outliers. The national 5-year survival rate was 55.4%, ranging from 51.6% to 58.9% across centres. The 5-year survival rate at Papworth was 56.1%; 56.1% risk adjusted.

According to NHSBT’s Annual Report on Cardiothoracic Organ Transplantation, in 2021/22 Royal Papworth Hospital performed more adult lung transplants and adult heart transplants than any other hospital in the UK. It also had the lowest decline rate for donor organs, meaning it accepts a higher proportion of organs offered for donation than any other UK centre.

## Respiratory Extra Corporeal Membrane Oxygenation (ECMO)

Royal Papworth Hospital is one of eight centres in England and Scotland that provide the highly specialised Respiratory Extra-Corporeal Membrane Oxygenation (ECMO) Service, including specialised retrieval of patients from referring hospitals.

ECMO supports patients with severe potentially reversible respiratory failure by oxygenating the blood through an artificial lung machine. The extracorporeal life support is used to replace the function of failing lungs, usually due to severe inflammation or infection. ECMO is used to support patient groups with potentially reversible respiratory failure such as Acute Respiratory Distress Syndrome (ARDS) sometimes seen in patients with community-acquired pneumonia, seasonal flu or COVID19.

The aim of ECMO in respiratory failure is to allow the injured lung to recover whilst avoiding certain recognised complications associated with conventional ventilation. It is high risk and is only used as a matter of last resort. The procedure involves removing blood from the patient, taking steps to avoid clots forming in the blood, adding oxygen to the blood and removing carbon dioxide, then pumping the blood back into the patient.

ECMO is a complex intervention and is only performed by highly trained specialist teams including intensive care consultants, ECMO specialists, perfusionists together with ECMO-trained nurses.

ECMO is a form of support rather than a treatment, and its aim is to maintain physiological homeostasis for as long as it takes to allow the lung injury or infection to heal. In 2021/22 the average length of time on ECMO Support was 20 days.

ECMO support can also be used to support patients presenting with life-threatening conditions referred to a tertiary cardiothoracic centre, such as severe acute heart failure. This sort of ECMO support is not part of the nationally commissioned Respiratory ECMO Service but Royal Papworth Hospital (RPH) has been offering it for a number of years to many patients.

The Hospital is registered with the international Extracorporeal Life Support Organisation (ELSO) and is renowned for its experience using ECMO. This long experience in providing a high-quality ECMO service is recognised in the success of the residential Royal Papworth ECMO course, which attracts national and international delegates, with more than 600 delegates from five continents having attended so far. The multi-professional team has contributed to multiple scientific communications and articles published in the medical literature, and some of RPH ECMO multi-professional team members sit on National and International Committees sharing experiences and knowledge to inform future practice.

From December 2011, the service provided by RPH became part of the national network of services that provide a year-round ECMO service to all hospitals in the country. This includes the retrieval on ECMO of patients from the referring hospital by a dedicated highly specialised team. RPH works very closely with the other ECMO centres and NHS England to ensure that all patients have immediate access, all week long and at any time of the day or night, irrespective of their location. Our Consultant Intensivists also provide specialist advice by phone to referring centres when patients are not deemed suitable for ECMO.

In 2014 the service expanded to include a follow up clinic. All patients are seen six months after discharge from RPH by the ECMO/CCA Consultant Nurse. The aim of the clinic is to provide ongoing support where required, evaluate their respiratory function to ensure that best treatment is offered and measure quality of life after ECMO to allow us to refine how we deliver the service.

In 2022 the National ECMO service was extended to include Bristol. The national centres providing ECMO in England & Scotland meet at least twice a year to review practices and outcomes and have weekly phone conferences to ensure that access to the service is maintained. St Bartholomew's Trust (SBH) in London which had been recruited to support the response to the pandemic has also started to offer ECMO to patients hospitalised in one of their Trust hospitals, often working closely with RPH team.

Whilst difficult to compare due to the multiple conditions treated and the absence of risk stratification, survival rates are in keeping with international figures. The Extra Corporeal Life Support Organisation (ELSO) registry shows in October 2022 a survival of 58% for patients supported with respiratory ECMO. This is remarkable in patients who were referred because of their high likelihood of death.

**Summary of ECMO activity at Hospital since December 2011 - March 2023**

| Year | Referrals | Accepted | Supported with ECMO | ECMO bed days | Survival to discharge* (ECMO) | Survival to discharge* (all accepted) | 30 day survival (ECMO) | 30 day survival (all accepted) |
|---|---|---|---|---|---|---|---|---|
| Dec 2011/12 | 25 | 15 | 10 | 134 | 50% | 66% | 50% | 66% |
| 2012/13 | 111 | 28 | 22 | 443 | 68% | 75% | 64% | 71% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2013/14 | 116 | 35 | 32 | 348 | 75% | 77% | 71% | 71% |
| 2014/15 | 152 | 40 | 37 | 490 | 76% | 75% | 76% | 75% |
| 2015/16 | 202 | 54 | 50 | 736 | 70% | 70% | 68% | 68% |
| 2016/17 | 149 | 36 | 35 | 406 | 86% | 83% | 83% | 80% |
| 2017/18 | 177 | 50 | 46 | 633 | 78% | 78% | 68% | 62% |
| 2018/19 | 201 | 54 | 54 | 959 | 76% | 76% | 76% | 76% |
| 2019/20 | 192 | 42 | 42 | 707 | 71% | 69% | 69% | 69% |
| 2020/21 | 1012 | 106 | 104 | 4063 | 63% | 64% | 62% | 63% |
| 2021/22 | 507 | 46 | 45 | 2162 | 62% | 63% | 62% | 63% |
| 2022/23 | 241 | 37 | 35 | 717 | 63%** | 65%** | 63%** | 65%** |

*discharge from Royal Papworth ** includes 6 inpatients on ECMO

## Pulmonary Endarterectomy

Pulmonary Hypertension is a rare lung disorder in which the arteries called pulmonary arteries that carry blood from the right side of the heart to the lungs become narrowed, making it difficult for blood to flow through the blood vessels. As a result, the blood pressure in these arteries rises far above normal levels. It is a serious disease that leads to right heart failure and premature death. Patients usually present with symptoms of exertional breathlessness and as there are no specific features, the diagnosis is usually made late in the disease process. There is medical treatment available for some forms of Pulmonary Hypertension.

Chronic Thromboembolic Pulmonary Hypertension (CTEPH) is one type of PH and is important to recognise as it is the type of PH that is most treatable. The disease begins with blood clots, usually from the deep veins of the legs or pelvis moving in the circulation and lodging in the pulmonary arteries (this is known as a pulmonary embolism). In most people these blood clots dissolve and cause no further problems. In a small proportion of people the blood clots partially dissolve or do not dissolve at all and leave a permanent blockage/scarring in the pulmonary arteries leading to CTEPH. There are now three treatments for CTEPH and all are available at Royal Papworth: licensed drug therapy for inoperable patients, balloon pulmonary angioplasty for inoperable patients and the guideline recommended treatment, pulmonary endarterectomy surgery. The pulmonary endarterectomy (PEA) operation removes the inner lining of the pulmonary arteries to clear the obstructions and reduce the pulmonary artery pressure back to normal levels. This procedure allows recovery of the right side of the heart with a dramatic improvement in symptoms and prognosis for the patient.

Royal Papworth Hospital has been commissioned to provide this surgery for the UK since 2000, and since 2001 has been designated as one of the seven adult specialist PH medical centres. With better understanding of the disease, CTEPH is increasingly recognised in the UK but still probably remains under diagnosed. Over the last few years there has been a large increase in pulmonary endarterectomy surgery at Royal Papworth and the Hospital has been at the forefront of international developments in this field.

## Seven Day Services

The daily hospital sitrep does not show significant variation in LOS associated with the day of the week when patients are admitted. There is also no significant variation in the number of discharges by day of the week. Job plans for all our acute specialist consultants provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty.

The template below shows the level of compliance with Standard 5 regarding 24/7 access to emergency diagnostic tests:-

| Emergency diagnostic test | Available on site at weekends | Available via network at weekends | Not available |
|---|---|---|---|
| USS | YES | | |
| CT | YES | | |
| MRI | NO [1] | | |
| Endoscopy | YES | | |
| Echocardiography | YES | | |
| Microbiology | YES | | |

[1] No radiographer to provide cardiothoracic MRI at weekends but this is not a service which is clinically necessary. If there is a need for non-cardiothoracic MRI then this can be done at Addenbrooke's Hospital under the existing SLA agreement for emergency services.

The following template outlines the level of compliance with Standard 6 regarding 24/7 access to emergency consultant-led interventions:-

| Emergency intervention | Available on site at weekends | Available via network at weekends | Not available |
|---|---|---|---|
| Intensive care | YES | | |
| Interventional radiology | | YES | |
| Interventional endoscopy | | YES | |
| Surgery | YES | | |
| Renal replacement therapy | YES | | |
| Radiotherapy | | YES | |
| Stroke thrombolysis | | YES | |
| Stroke thrombectomy | | YES | |
| PCI for MI | YES | | |
| Cardiac Pacing | YES | | |

The Trust completed a 7-day service audit during the month of June 2023.

## Freedom to Speak Up/Whistleblowing

It is pleasing to report on the continued promotion of speaking up at Royal Papworth Hospital. Several of the leadership associated programme initiatives proposed in 2021/22 in supporting the development of a just culture have been progressive throughout the year. Speaking up has an established leadership structure which supports speaking up, building on the work developed by the Freedom to Speak Up Guardian (FTSUG) and the Trust's leadership team. More specific speaking up initiatives across the year have been undertaken towards the Trust's corporate endeavour to enable staff to speak up safely and with confidence, assuring a workplace environment which takes raising concerns by staff seriously.

Of notice, in 2022/23, freedom to speak up (FTSU) champions continued to provide guidance, support, and signposting for all workers located on Trust premises. FTSU champions have supported the work of the Freedom to Speak Up Guardian (FTSU G) in helping staff and workers to speak up. Champions have been provided with training and network support which has enabled champions, with the guardian, to:

- continue to maintain the important profile of speaking up on issues of concern
- provide guidance through signposting to workers on speaking up in line with the Trusts speaking up processes and policies
- Work as a network to provide confidential advice and support to workers in relation to patient safety concerns
- contributed to identifying themes of concern against service areas for reporting
- Supported monitoring actions undertaken where staff identify a concern with trust processes.

**Internal and external governance**

The Trust continues to be fully engaged with the National Guardian Office and support the Trust's FTSU Guardians engagement with national, regional, and local network of Guardians. This has provided the opportunity to explore and apply best practice.

Established internal and external governance processes continue to be effective in overseeing the reporting and monitoring of incidents raised through the Trusts FTSU Guardian. Governance process has included:

- Ensuring the Trust board is regularly sighted on the frequency of incidents reported per quarter (numerical and categorical in line with National Guardian Office (NGO) guidance), with thematic narrative as explanatory considerations
- Reporting quarterly to the FTSU National Office and Trust board
- Independent anonymised incident scrutiny of quarterly submission data against national office categories – undertaken by FTSU champions
- Anonymised incident case review forum with FTSU champions for learning and development purposes (6 weekly)
- Quarterly FTSU champion business meetings to provide network support and for planning speaking up initiatives
- Reporting issues of concern as themes into service operational meetings
- Communicating issues of concern as themes to operational and clinical leaders
- Meeting regularly with executive directors and the non-executive director lead for speaking up

**National Guardian Office (NGO) reporting**

Unfortunately, the FTSU national index report was not produced by the national office for 2021/22, thereby removing the opportunity to compare both against benchmarked NHS Trusts and progression indices. However, quarterly, with annual incident reporting provided sufficient

overview to enable the Trust to report that progress is being maintained on its work of making speaking up business as usual.

All Trust quarter and annual reports were submitted to the NGO on time. All submitted Trust reports for this period have contributed to the development of the NGO annual report to parliament in January 2023 by the Parliamentary Under Secretary of State fort Mental Health and Women's Health Strategy.

**Trust FTSU guardian reporting and speaking up initiatives.**
The Trust confirms an uplift of incidents from previous year. The FTSU Guardian reported 105 incidents (2021/22). At time of writing, incidents reported to the national office (up to and including quarter 3 -2022/23) is 104, projecting an increase of incidents for 2022/23 at year end. Of further interest here, as per previous year, is the growing number of staff who would speak up again. Of the 104 incidents, 64 would or are likely to speak up again. Unfortunately, national indicators through NHS survey results suggest workers have a reducing confidence in speaking up.

Strategies in supporting staff through wellbeing initiatives continue to be welcomed by staff. Staff have also valued investments in and access to leadership development training, as well as noting the high uptake of values and behaviours workshops which facilitated both learning and consolidation of the Trust's corporate organisational values. Other initiatives have included continued investment in mental health first aider training, a first cohort of reciprocal mentoring programme and a return to desired continued professional development programmes as the Trust exits post pandemic restriction.

In contributing to several of the noted learning and development initiatives, the FTSU guardian has supported the implicit message of speaking up alongside other initiatives specifically designed to profile speaking up across the Trust.

These included:
- Regular visibility walk-by into clinical and non-clinical areas
- Communication of key speaking up messages through Trust briefing mechanisms
- Periodic drop-in surgeries
- Celebration of NGO speaking up month (October)
- Engagement with network and operational committees
- Staff inductions to profile speaking up (corporate/junior doctor and non-medical students)
- Involvement with senior staff selection and appointment processes

**Actions going forward 2023/24**
Completion of the NGO self-assessment (Freedom to speak up: A reflection and planning tool NGO 2022) was completed during 2022/23, highlighting key organisational developments and actions. Oversight is provided by actions identified for those that fall within 2023/24 and which have been agreed with executive and non-executives leads supporting the FTSU guardian.

Updating of the previously titled Whistle-blowing policy (Raising Issues of Concern). This has commenced and is nearing ratification, retitled as the Speaking Up policy. The updated policy is guided by a NGO template (issued 2022/23). The policy provides guidance to staff and workers on how they may raise any matter of concern. These may be related but not limited to issues of patient safety, staff safety and wellbeing, public safety or where the issue or concern may be detrimental to an individual or to the Trust as a whole.

A key principle of a speaking up culture is to ensure staff and workers know how to speak up and feel safe and encouraged to do so. The FTSU guardian, supported by our champions, will continue to promote the importance of speaking up through established communication initiatives and networks to ensure good access to FTSU guardian and champions are

maintained and communicated. This will include continuing to extend the number of FTSU champions.

We recognise the challenge of addressing the specific concerns of bullying and harassment across successive years within the Trust, also indicative of a national trend across all NHS Trusts. Of equal concern requiring attention is the support for staff and workers from an ethnically diverse background. WRES reporting indicates a concern that this group of staff are less likely to speak in comparison to non-ethnically diverse colleagues. There is a need to support staff and workers to speak up on issues of matters of concern so they may feel safe in doing so. This is an ongoing need which will continue to inform actions for 2023/23 by the FTSU guardian and Trust.

In reviewing and updating actions for 2023/24, to be included is consideration against the roll out of the e-learning modules developed by Health Education England - *Speak Up; Listen Up; Follow Up* as identified through the NGO self-assessment exercise.

The Director of Workforce and Organisational Development is the responsible executive director for raising concerns, and we have an identified Non-Executive Director lead.

## Compassionate and Collective Leadership programme

One of the key aims of our five-year strategy is to improve our staff experience to ensure staff feel supported and motivated to provide excellent patient care.

We implemented a Compassionate and Collective Leadership Programme to embed a culture that enables the delivery of continuously improving, high quality, safe and compassionate care. The program was commenced in July 2019. The project identified eight key priorities to focus on in Phase 2. One of the key priorities was to review the values of RPH to ensure the values reflect the feedback from staff about what is important and the new working environment and to have a set of behaviours that guided staff and managers in embedding the values into the day-to-day experience of staff and patients. The values and behaviours framework is central to all the other changes required to build a compassionate culture.

We launched our revised Trust values in July 2021 which reflect the feedback from staff on what mattered to them, and to our patients. These are:

### Compassion

**Recognises and responds to the needs of patients and colleagues**

### Excellence

**Makes a difference with each small improvement and by being open to new ways of working**

### Collaboration

**We achieve more together**

Our values are underpinned by a behaviour framework that guides staff on how we can ensure that all staff have a positive experience at work. All staff are expected to participate in a Values and Behaviours Workshop which encourages them to reflect on how they role model and promote the values and behaviours and helps them develop practical skills in giving and receiving feedback.

Further information on our Compassionate and Collective programme is included in our update on our Quality Priorities for 2022/23.

## Performance of Trust

Throughout 2022/23 we have continued to measure our quality performance against a number of metrics. The Table below sets out our performance against the national operational metrics identified in Appendix 3 to NHS Improvement's (NHSI's) Single Oversight Framework which are applicable to Royal Papworth Hospital.

Operational performance Metrics

| Indicator | Target pa | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | YTD actual |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 weeks Referral to Treatment (RTT)* | >92% | 78.2% | 79.3% | 78.6% | 77.8% | 75.8% | 74.3% | 74.1% | 74.1% | 70.6% | 72.1% | 72.7% | 71.0% | 71.0% |
| 62 day cancer wait * | >85% | 80.0% | 37.5% | 64.3% | 20.0% | 53.1% | 35.3% | 33.3% | 75.0% | 50.0% | 40.0% | 57.0% | 50.0% | 49.6% |
| 31 day cancer wait | >96% | 100.0% | 100.0% | 100.0% | 88.9% | 90.9% | 82.6% | 78.0% | 87.5% | 89.0% | 95.0% | 100.0% | 100.0% | 92.7% |
| 6 week wait for diagnostic | >99% | 97.0% | 95.0% | 92.7% | 97.2% | 96.9% | 98.3% | 98.8% | 99.2% | 99.3% | 98.2% | 98.7% | 98.4% | 97.5% |
| Monitoring C.Diff (toxin positive) | Less than 10 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | 7 |
| Number of patients assessed for VTE on admission | >95% | 83.6% | 82.4% | 83.2% | 87.0% | 79.3% | 82.9% | 85.1% | 88.6% | 84.8% | 91.0% | 91.7% | 88.3% | 88.3% |

In 2022/23 these indicators have not been subject to independent assurance.
*The definition of this indicator can be found in Annex 3 of this report.

# A listening organisation

## What our patients say about us

## NHS "Friends and Family" test to improve patient experience and care in hospital.

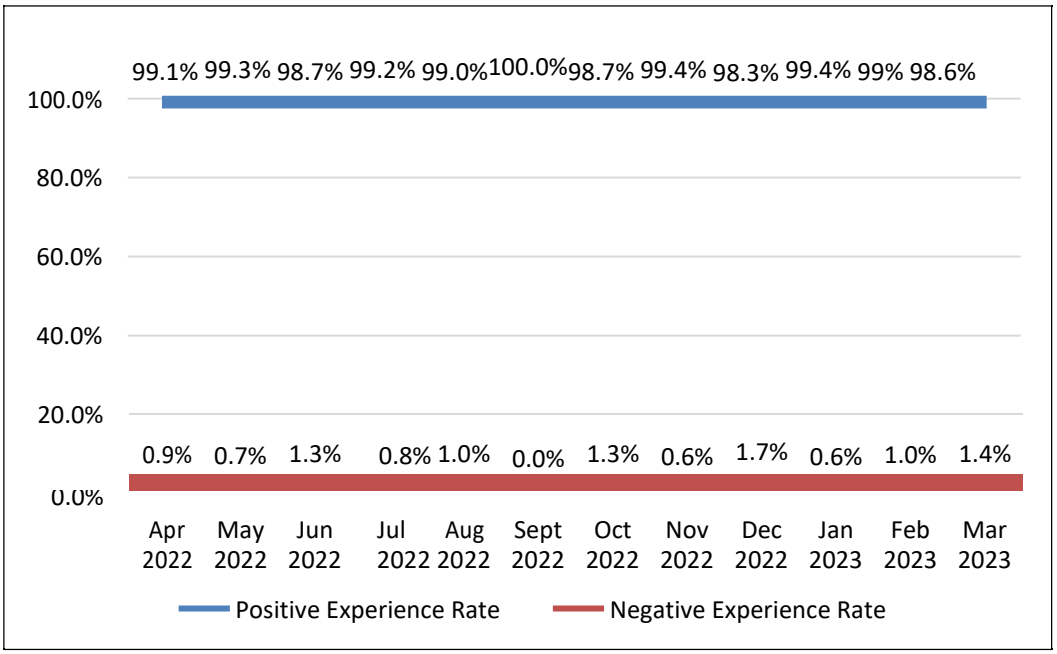
We want our patients to have the best possible experience of our care. The Friends and Family Test is a way of gathering patient feedback so we can learn about our patient's experiences of our services and make improvements wherever possible.

Since December 2020, the Trust has had a digital data collection process which enables all our patients (inpatients, outpatients, and day cases) to complete the survey and let us know about their experience. The survey is accessible and easy to use, utilising digital surveys via tablet onsite and a text messaging service for all outpatients.

Within Royal Papworth Hospital NHS Foundation Trust, the responses are reviewed by the Trusts ward Matrons' who receive a monthly report that details the number of patients who have participated in the survey and the recommendation scores. Alongside this they review all the free text feedback from patients noting and celebrating with their teams the compliments. For any negative comments left these are reviewed and actions and improvement made, using the Wards 'You said - We did' display boards to keep patients updated on how their feedback matters and what improvement have been made.

Throughout the last year from April 2022 to March 2023, we have continued to be well above our Trust target of 95% recommendation score for our inpatient and outpatient scores collected from our FFT surveys. Our scores from the Friends and Family inpatient survey for 2022/23 are shown in the figure below.

**Friends and Family inpatient results 2022/23**




The Chief Nurse and Deputy Chief Nurse monitor the patent feedback through the Trusts Papworth Integrated Performance Report (PIPR) and these are reported to every meeting of the Board.

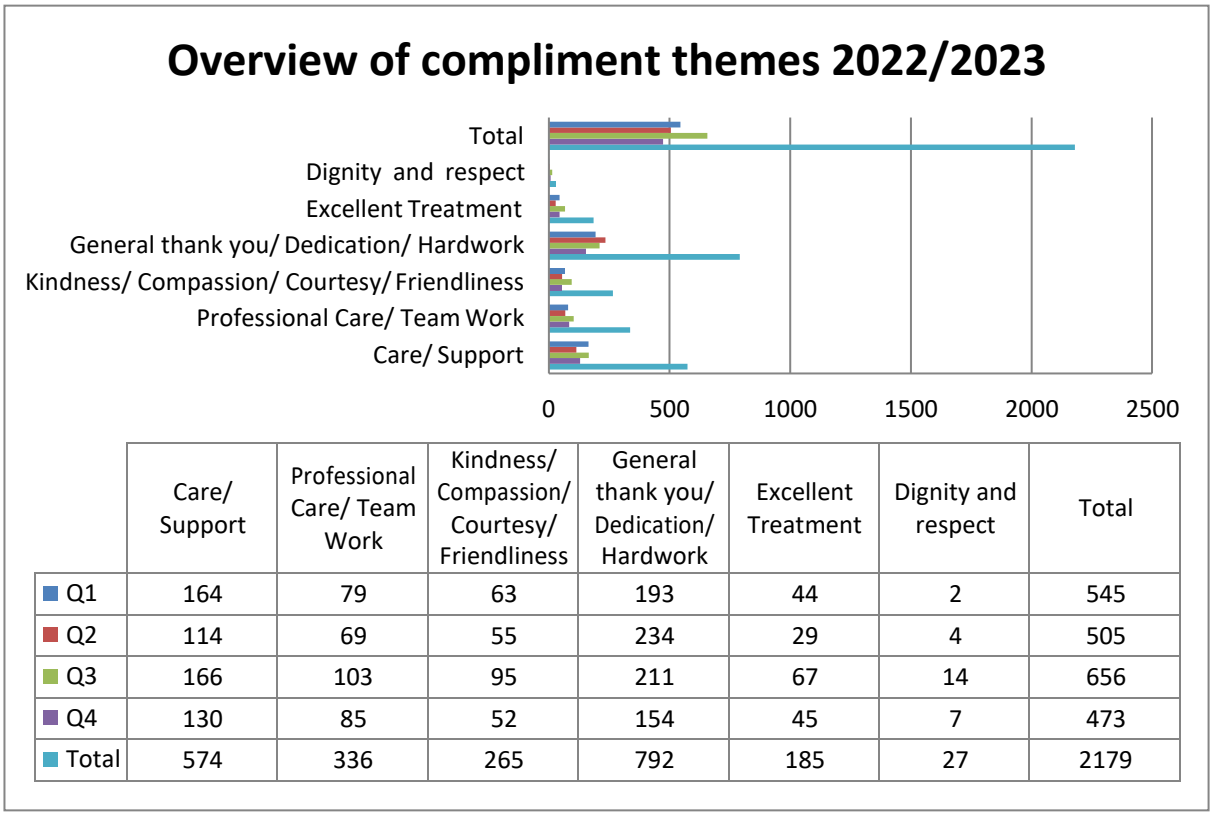
## Compliments from patients and families

Compliments are received in two ways, through our Friends and Family Test (FFT) surveys and through verbal feedback, letters, thank you cards, and e-mail correspondence received via our Patient Advice and Liaison service (PALS). PALS record on a monthly basis the number of compliments received by our patients and their families relating to their experience at Royal Papworth Hospital NHS Foundation Trust.

There were 2179 compliments across the Trust received through the PALS team during 2022/23 and a total of 17,112 recorded through the Friends and Family surveys. Each quarter we review the compliments that have been captured from all feedback from our patients and from their families/carers through either our FFT surveys or feedback received via PALS. We are currently unable to theme our FFT surveys as this is captured through an electronic form and there is no ability to filter or theme the feedback left, due to the high numbers of surveys. However, all feedback is shared with our teams for ongoing service feedback and improvement.

The compliments were analysed for key themes and the top three themes for the year were:

- General thank you, hard work of staff
- Care and support provided
- Professional care provided and teamwork of staff across the Trust.




| | Care/ Support | Professional Care/ Team Work | Kindness/ Compassion/ Courtesy/ Friendliness | General thank you/ Dedication/ Hardwork | Excellent Treatment | Dignity and respect | Total |
|---|---|---|---|---|---|---|---|
| Q1 | 164 | 79 | 63 | 193 | 44 | 2 | 545 |
| Q2 | 114 | 69 | 55 | 234 | 29 | 4 | 505 |
| Q3 | 166 | 103 | 95 | 211 | 67 | 14 | 656 |
| Q4 | 130 | 85 | 52 | 154 | 45 | 7 | 473 |
| Total | 574 | 336 | 265 | 792 | 185 | 27 | 2179 |

## Patient Support Groups

Our website provides links to these and a wide range of independent organisations and groups offering advice and support to patients, families and carers. Details of these are available at: Patient support groups :: Royal Papworth Hospital

## Staff Survey 2022

NHSI's requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2022 and these were included in the Staff Report section of the Annual Report.

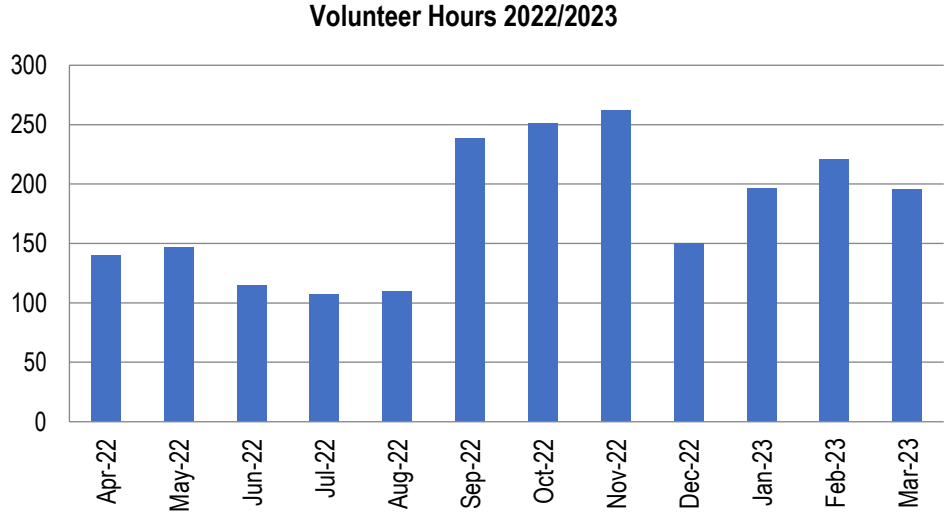
## Valuing Volunteers

Royal Papworth Hospital NHS Foundation Trust recognises the contribution of volunteers is invaluable. The Trust believes volunteering is integral to delivering and supporting a diverse range of services and activities that enrich the organisation.

Our volunteer policy demonstrates the Trust's commitment to the development of a volunteer service that improves patient experience by making a difference to service delivery or by being an advocate for positive change. That promotes and gives opportunities for people to volunteer and develops partnership and networking with national, charitable and third sector organisations including volunteer support groups.

In 2021/22 following a successful bid through the NHS England and Improvement Volunteering Services Fund we were able to employ a volunteer coordinator to support the Trusts volunteer recovery programme. In 2022/23 additional funding has been secured through Charity funding and with this additional role we have been able to support the Patient Advice and Liaison Service (PALS) Team in enabling the return of 14 volunteers, 8 existing and 6 new to the organisation from September 2022.

Our volunteers are currently undertaking several roles such as Ward Visitor, Meet and Greet, Pharmacy and Chaplaincy volunteers in several areas across the Trust including Critical Care Area, Day Ward, Levels 3, 4 and 5 and in the main atrium. Since April 2022, our volunteers have contributed a total of 2,135 hours in supporting our staff make a real difference to our patients, their families, friends, and relatives. The figure below shows the total number of Volunteer hours for each month in 2022/23.




| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hours | 140 | 147 | 115 | 107 | 110 | 239 | 251 | 262 | 150 | 197 | 221 | 196 |

The volunteer coordinator is continuing to support the PALS team and our volunteers by providing regular support and feedback whilst ensuring our policies and procedures are up to date and fit for purpose.

The NHS England and Improvement Volunteering Services Fund enabled the Trust to procure the Better Impact database. Throughout the year the volunteer coordinator has been populating and developing this all in-one platform to enable the effective recruitment, screening, onboarding of new volunteers. Going forward the Better Impact database will assist the PALS team in communicating, scheduling and the time logging of all our volunteers whilst enabling the team to report meaningful data regarding our volunteer hours and feedback.

For more information, see the Foundation Trust section of our Annual Report.

## Royal Papworth Staff Awards and Long Service Awards

In October 2022 we held our annual Long Service Awards in the Heart and Lung Research Institute (HLRI), next to our hospital. The event recognised and thanked staff who had given 15, 20, 25, 30 or 35 years of service to our hospital and the NHS, with a light lunch, a presentation ceremony and a celebration of achievements.

After postponing our Staff Awards in September 2022 due to the death of Queen Elizabeth II, our re-arranged event at Homerton College in Cambridge was held just before Christmas.

Around 150 colleagues, volunteers and guests came together for a special evening, starting with a reception before a three-course meal and the awards ceremony.

Comprising 45 nominees across 15 categories – whittled down from more than 300 nominations which was the highest number ever received – the awards evening was hosted by former BBC Look East presenter Stewart White.

New awards included the Green Award, the EDI award and awards aligned to our values of compassion, excellence and collaboration.

Generously sponsored by Philips UK and Ireland, with support from Fysicon, it was a special evening celebrating the remarkable and outstanding achievements of so many people who contribute to the team effort at Royal Papworth Hospital every day.

## Annex 1: What others say about us

# The Royal Papworth Hospital NHS Foundation Trust

# Quality Account 2022/23

# Statement by Cambridgeshire County Council Adults and Health Committee

The Adults and Health Committee received in its scrutiny capacity the draft Quality Account for the Royal Papworth Hospital NHS Foundation Trust on 28th April 2023. A Task and Finish Group was established in order to respond within the required timeframe.
The draft Account was clear and accessible, and we welcomed the Trust's candour in identifying areas of challenge as well as success. Regular liaison meetings take place during the year with the Trust's senior leadership team, and county councillors value this opportunity to discuss current issues and share views. The Trust is currently rated as Outstanding by the Care Quality Commission, following inspection in 2019.

Addressing health inequalities is a key focus for the Adults and Heath Committee, and we welcome the decision to carry forward increased action on the prevention of health inequalities as a priority for 2023/24. The planned recruitment of a Health Inequalities Specialist follows the creation of a Health Inequalities group in 2022/23. This saw a significant reduction in 'did not attend' rates for patients living in deprived areas when they were offered diagnostic tests at home. In future we would be interested to see more information on the challenge of heart disease within the general population and specific population groups, such as older women, as part of the Trust's vision in relation to preventative work. We welcome the planned re-establishment of a multi-disciplinary Falls Prevention Group, which links with work being done by the Public Health team.

The Trust is rightly proud of the high satisfaction levels of its services users and their families. During 2022/3 there were 2179 compliments received through the Patient Advice and Liaison Service (PALS), and a further 17,112 through Friend and Family surveys.

We welcome the Trust's openness in reporting a significant rise in surgical site infection (SSI) rates since its re-location in May 2019, with a serious incident being reported following 2021/22 year end. We note the internal measures planned to address this and welcome the proposed external review of practice. This will be followed up during the year through informal meetings with the Trust's senior management team and may be explored further through a future public scrutiny session.
Royal Papworth has an international reputation and is able to attract staff from the national talent pool and beyond, but it is also an important employer locally. It would be good to see this local link celebrated. We have also discussed workforce development and outreach in relation to apprenticeships during informal contacts. The collaborative relationship which exists with Addenbrookes Hospital on the Cambridge Biomedical Campus is to be commended.
The Adults and Health Committee welcomes the willingness of the Trust's senior leadership team to engage with the health scrutiny process through both formal public meetings and informal contacts. We look forward to maintaining this constructive relationship during the coming year and beyond.

30 May 2023

## Healthwatch Cambridgeshire and Peterborough

## Royal Papworth Hospital Quality Account Statement 2022/23

***Summary and comment on relationship***

Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the Trust's draft Quality Account.

Healthwatch is pleased to have a positive relationship with the Trust. We find the Trust is always responsive to feedback and we welcome the commitment to learning and improving care for patients and staff.

Healthwatch receives mostly very positive feedback from patients and their families regarding treatment at the Royal Papworth Hospital. Where issues are reported we find the response is swift.

Healthwatch welcomes the opportunities to communicate with the Trust through our representation on the Patient and Carer Experience Group and the Patient and Public involvement meetings. We also attend Trust Board meetings.

We support Partnership working and strategy development with local ICS on health inequalities and are pleased to note that RPH clinicians and staff actively participate in, and reporting back to, the various system quality assurance meetings which meet regularly.

We understand the RPH Library service is now run by a separate charity. Whilst substantial in its current delivery, a concern has been raised that it might not be meeting the full range of Web Content Accessibility Guidelines to which the main body of the Royal Papworth has signed up to. We look forward to this being resolved.

## *The coming year*

We welcome the Trust's contributions toward the ongoing development of the Integrated Care System for Cambridgeshire and Peterborough, and to continuing our positive relationship with the Trust over the next year.

Healthwatch will organise a series of patient engagement events at the hospital in the coming year. This will allow Healthwatch staff and trained volunteers to engage with patients and their families and garner feedback about their experiences.

9 June 2023

## Patient and Public Involvement Committee (PPI) Committee and the Council of Governors

For the third year running, the Covid pandemic meant that Governor activities were limited as access to the hospital was still subject to restrictions in the earlier part of the year. Virtual meetings continued but planning for face to face enabled the last two quarterly Council of Governors meetings used a 'hybrid' format.

We welcomed new staff and appointed Governors, and their input has been most appreciated. The excellent NHS Providers Induction programme again provided a valuable introduction to new Governors on their specific roles and especially their relationship to the Board and the NEDs (Non-Executive Directors).

Local Lead Governors held Teams meetings with the ICB Chair, John O'Brien, with the new Integrated Care System going active in July 2022. Quarterly Eastern region Lead Governor meetings have continued via Teams.

It was encouraging that Governor attendance at the monthly Board meetings increased with up to 10 Governors observing the Part I proceedings.

In year Governors re-joined Visibility Rounds led by the Chief Nurse, these included Patient Safety and 15 Steps visits. Governors also joined our PLACE inspection in November 2022 and acted as 'peer reviewers' in the Trust's programme of inspections that reports to the Fundamentals of Care Board.

Governors chaired the PPI (Patient & Public Involvement), Forward Planning, Access and Facilities and Appointments committees. Other Governors sat on these committees and also observed/participated in Q&R (Quality & Risk), Performance, Nominations, Governor's Assurance, Audit, Fundraising, End of Life, Emergency Preparedness, Digital Strategy Board, PCEG (Patient and Carer Experience Group) and the Ethics committee.

All of these activities help governors to gain assurance and allow direct feedback from staff and patients about the quality of the services provided by the Trust.

Dr Richard Hodder
Lead Governor
9 June 2023

## Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru | Welsh Health Specialised Services Committee

Nothing further to add.

**Carole Bell**
**Cyfarwyddwr Nyrsio ac Ansawdd**
**Director of Nursing and Quality Assurance**

31 May 2023

## NHS England - East of England (incorporating feedback from Cambridgeshire and Peterborough ICB)

The Royal Papworth Hospital continues to demonstrate high standards of care for patients within the East of England and as a National Specialised and Highly Specialised centre regularly achieving higher than average outcomes for patients (such as the ECMO survival rate). As an organisation they continue to ensure that patients are at the centre of their purpose with demonstrable openness and duty of candour when incidents occur. Examples of the open and collaborative working across multiple agencies can be found with their management of the M. Abscessus and surgical site infection incidents and creating a forum where NHS England is a member at the executive oversight group to support monitoring and gain assurance.

The established Clinical Quality Review Group Meetings continue to be held quarterly led by NHS England with Cambridgeshire & Peterborough ICB and multi professional attendance, meetings are open and honest about progress against key performance indicators and areas of particular focus. Sharing and learning from patient incidents is a key element to ensure on-going learning and enhanced experiences for the future.

Royal Papworth have demonstrated flexibility in areas of recruitment and a good programme of organisational Development and Leadership Programmes are in place to support the workforce to grow and develop in their careers.

Outside of established meetings the Chief Nurse and Assistant Director for Quality and Risk meet regularly with members of the NHS England Quality team to ensure ongoing communication and support.

NHS England (East of England) is pleased to support the Royal Papworth Quality Accounts.

**Joanne Pope**
**Head of Nursing, Leadership and Quality (Direct Commissioning)**
**NHS England – East of England**

20 June 2023

## Annex 2: Statement of Directors' responsibilities in respect of the Quality Report

*The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.*

*NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.*

*In preparing the Quality Report, directors are required to take steps to satisfy themselves that:*

- *The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance 'Detailed requirements for quality reports 2019/20.'*

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

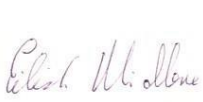
  - Board minutes and papers for the period April 2022 to 1 June 2023
  - Papers relating to quality reported to the Board over the period April 2022 to 1 June 2023
  - Feedback from NHS England - East of England, which incorporates feedback from Cambridgeshire and Peterborough ICB dated 20 June 2023
  - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated 9 June 2023
  - Feedback from Healthwatch Cambridgeshire dated 9 June 2023
  - Feedback from Cambridgeshire Health Committee dated 30 May 2023
  - The Trust's "Quality and Risk Report: Quarter 4 and annual Summary 2022/23"
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2022 National Inpatient Survey
  - The 2022 National Staff Survey
  - The Trust's Annual Governance Statement 2022/23
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated 15 June 2023
  - CQC Inspection Reports published 16 October 2019

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date: 29 June 2023 Chairman



Date: 29 June 2023 Chief Executive

# Annex 3: Mandatory performance indicator definitions

## Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

*Source of indicator definition and detailed guidance*

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

*Detailed descriptor*

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

*Numerator*

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

*Denominator*

The total number of patients on an incomplete pathway at the end of the reporting period

*Accountability*

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

*Indicator format*

Reported as a percentage

## Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

*Detailed descriptor*[1]

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

*Data definition*

All cancer two-month urgent referral to treatment wait

*Numerator*

Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

*Denominator*

Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

*Accountability*

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: /www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

[1] Cancer referral to treatment period start date is the date the acute provider receives an urgent (two week wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment commences if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131880

# ANNEX 4 Glossary

## C

| | |
|---|---|
| CABG | Coronary artery bypass graft |
| Cardiac surgery | Cardiovascular surgery is surgery on the heart or great vessels performed by cardiac surgeons. Frequently, it is done to treat complications of ischemic heart disease (for example, coronary artery bypass grafting), correct congenital heart disease, or treat valvular heart disease from various causes including endocarditis, rheumatic heart disease and atherosclerosis. |
| Care Quality Commission (CQC) | The independent regulator of health and social care in England. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. The CQC publish what it finds, including performance ratings to help people choose care. **www.cqc.org.uk** |
| CCA | Critical Care Area. |
| Clinical audit | A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary. |
| Clostridium difficile (Clostridioides difficile; C. difficile, or C. diff) | Clostridium difficile are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever.<br><br>There are ceiling targets to measure the number of C. difficile infections which occur in hospital. |
| Coding | An internationally-agreed system of analysing clinical notes and assigning clinical classification codes |
| Commissioning for Quality Innovation (CQUIN) | A payment framework that enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of national and local quality improvement goals. |
| CSTF | Core Skills Training Framework |

## D

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|---|---|
| Data Quality | The process of assessing how accurately the information we gather is held. |
| DATIX | Incident reporting system and adverse events reporting. |
| DCD | Donation after circulatory death transplant using a non-beating heart from a circulatory determined dead donor. (Previously referred to as donation after cardiac death or non-heart-beating organ donation). |
| Dementia | Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. |
| Department of Health and Social | The Government department that provides strategic leadership to the NHS and social care organisations in England. |

| | |
|---|---|
| Care (DHSC formerly DH or DoH) | www.dh.gov.uk/ |

## E

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|---|---|
| EDS | Equality Delivery System |
| EPR | Electronic Patient Record |
| Extracorporeal membrane oxygenation (ECMO) | ECMO is a technique that oxygenates blood outside the body (extracorporeal). It can be used in potentially reversible severe respiratory failure when conventional artificial ventilation is unable to oxygenate the blood adequately. The aim of ECMO in respiratory failure is to allow the injured lung to recover whilst avoiding certain recognised complications associated with conventional artificial ventilation. The procedure involves removing blood from the patient, taking steps to avoid clots forming in the blood, adding oxygen to the blood and pumping it artificially to support the lungs. |

## F

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|---|---|
| Foundation Trust (FT) | NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Papworth Hospital became a Foundation Trust on 1 July 2004. |

## G

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|---|---|
| Governors | Foundation trusts have a Council of Governors. For Royal Papworth the Council consists of 18 Public Governors elected by public members, seven Staff Governors elected by the staff membership and four Governors nominated by associated organisations. |

## H

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|---|---|
| Health and Social Care Information Centre | The Health and Social Care Information Centre is a data, information and technology resource for the health and care system. |
| Healthwatch | Healthwatch is the consumer champion for health and social care, gathering knowledge, information and opinion, influencing policy and commissioning decisions, monitoring quality, and reporting problems to inspectors and regulators. |
| Hospital standardised mortality ratio (HSMR) | A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average. Neither it nor the Summary Hospital-level Mortality Indicator (SHMI), are applicable to Royal Papworth Hospital as a specialist Trust due to case mix. |

## I

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| Indicator | A measure that determines whether the goal or an element of the goal has been achieved. |
| Information Governance Toolkit | Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The toolkit provides NHS organisations with a set of standards against which compliance is declared annually. |
| Inpatient survey | An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate. |

## L

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|---|---|
| LearnZone | An internal e-Learning platform for Royal Papworth Hospital staff |
| Local clinical audit | A type of quality improvement project that involves individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team |

## M

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|---|---|
| Methicillin-resistant Staphylococcus aureus (MRSA) | *Staphylococcus aureus (S. aureus)* is a member of the Staphylococcus family of bacteria. It is estimated that one in three healthy people harmlessly carry *S. aureus* on their skin, in their nose or in their mouth, described as colonised or a carrier. Most people who are colonised with *S. aureus* do not go on to develop an infection. However, if the immune system becomes weakened or there is a wound, these bacteria can cause an infection. Infections caused by *S. aureus* bacteria can usually be treated with meticillin-type antibiotics. However, infections caused by MRSA bacteria are resistant to these antibiotics. MRSA is no more infectious than other types of *S. aureus*, but because of its resistance to many types of antibiotics, it is more difficult to treat. |
| MOU | A memorandum of understanding (MOU) is a formal document describing the broad outlines of an agreement that two or more parties have reached through negotiations. |
| Multi-disciplinary team meeting (MDT) | A meeting involving health-care professionals with different areas of expertise to discuss and plan the care and treatment of specific patients. |

## N

| | |
|---|---|
| National clinical audit | A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and Social Care. All NHS trusts are expected to participate in the national audit programme. |
| National Institute for Health and Care Excellence (NICE) | NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health http://www.nice.org.uk/ |
| National Institute for Health Research (NIHR) | The National Institute for Health Research (NIHR) is a UK government body that coordinates and funds research for the National Health Service It supports individuals, facilities and research projects, in order to help deliver government responsibilities in public health and personal social services. It does not fund clinical services. |
| National Institute for Health Research (NIHR) Portfolio research | The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio is a database of high-quality clinical research studies that are eligible for support from the NIHR Clinical Research Network in England. |
| Never events | Never events are serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been implemented. Trusts are required to report if a never event does occur. |

| | |
|---|---|
| NEWS2 | National Early Warning Score (version 2) – a nationally used early warning score designed to help detect and respond to clinical deterioration in adult patients. |
| NHS Improvement (NHSI) | NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHSI offers the support these providers need to give patients consistently safe, high-quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHSI help the NHS to meet its short-term challenges and secure its future. From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together:<br>• Monitor<br>• NHS Trust Development Authority<br>• Patient Safety, including the National Reporting and Learning System<br>• Advancing Change Team<br>• Intensive Support Teams<br><br>NHSI builds on the best of what these organisations did, but with a change of emphasis. Its priority is to offer support to providers and local health systems to help them improve. |
| NHS Safety Thermometer | The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. From July 2012 data collected using the NHS Safety Thermometer is part of the Commissioning for Quality and Innovation (CQUIN) payment programme. |
| NHS number | A 10 digit number that is unique to an individual. It can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care. |
| NMC | Nursing and Midwifery Council |
| NSTEMI | Non-ST-elevation myocardial infarction |
| **P** | |
| PALS | The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. |
| Patient and Public Involvement Committee (PPI) | **A Committee of the Council of Governors that provides oversight and assurance on patient and public involvement.** |
| PEA (formally PTE) | Pulmonary Thromboendarterectomy or Pulmonary Endarterectomy. |
| PHE | Public Health England |
| PLACE | Patient-led assessments of the care environment (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013. |
| Pressure ulcer (PU) | A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. |
| Percutaneous coronary intervention (PCI) | The term percutaneous coronary intervention (sometimes called angioplasty or stenting) describes a range of procedures that treat narrowing or blockages in coronary arteries supplying blood to the heart. |

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| Primary percutaneous coronary intervention (PPCI) | As above, but the procedure is urgent and the patient is admitted to hospital by ambulance as an emergency. |
| Priorities for improvement | There is a national requirement for trusts to select three to five priorities for quality improvement each year. These must reflect the three key areas of patient safety, patient experience and clinical effectiveness. |

## Q

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| Quality Account | A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012. NHS England or Clinical Commissioning Groups (CCGS) cannot make changes to the reporting requirements. |
| QRMG | Quality Risk Management Group |

## R

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| Root Cause Analysis (RCA) | Root Cause Analysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviour, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers. |
| Royal Papworth Hospital or Royal Papworth | **Royal Papworth Hospital NHS Foundation Trust.** |

## S

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| Safeguarding | Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care. |
| SDTIs | Suspected deep tissue injuries |
| Serious incidents (SIs) | There is no definitive list of events/incidents that constitute a serious incident but they are incidents requiring investigation. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf |
| Sign up to Safety | A national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of Sign up to Safety is the philosophy of locally-led, self-directed safety improvement. |
| Systematic Inflammatory Response Syndrome (SIRS) | An inflammatory state affecting the whole body, frequently a response of the immune system to ischemia, inflammation, trauma, infection, or several insults combined. |

## U

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| UNIFY (Now NHS Digital) | NHS England data collection, analysis & reporting system. |

## V

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| VAD | Ventricular Assist Device. |
| Venous thromboembolism (VTE) | VTE is the term used to describe a blood clot that can either be a deep vein thrombus (DVT), which usually occurs in the deep veins of the lower limbs, or a blood clot in the lung known as a pulmonary embolus (PE). There is a national indicator to monitor the number of patients who have been risk assessed for VTE on admission to hospital. |

## W

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| WDES | NHS Workforce Disability Equality Standard |
| WRES | NHS Workforce Race Equality Standard |

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