Royal Papworth Hospital
NHS Foundation Trust

# Trust Wide Quality and Risk Report Annual Report 2024-2025

**2024/25**

**Deputy Director for Quality and Risk**

**Contents**

## 1.0 PATIENT SAFETY

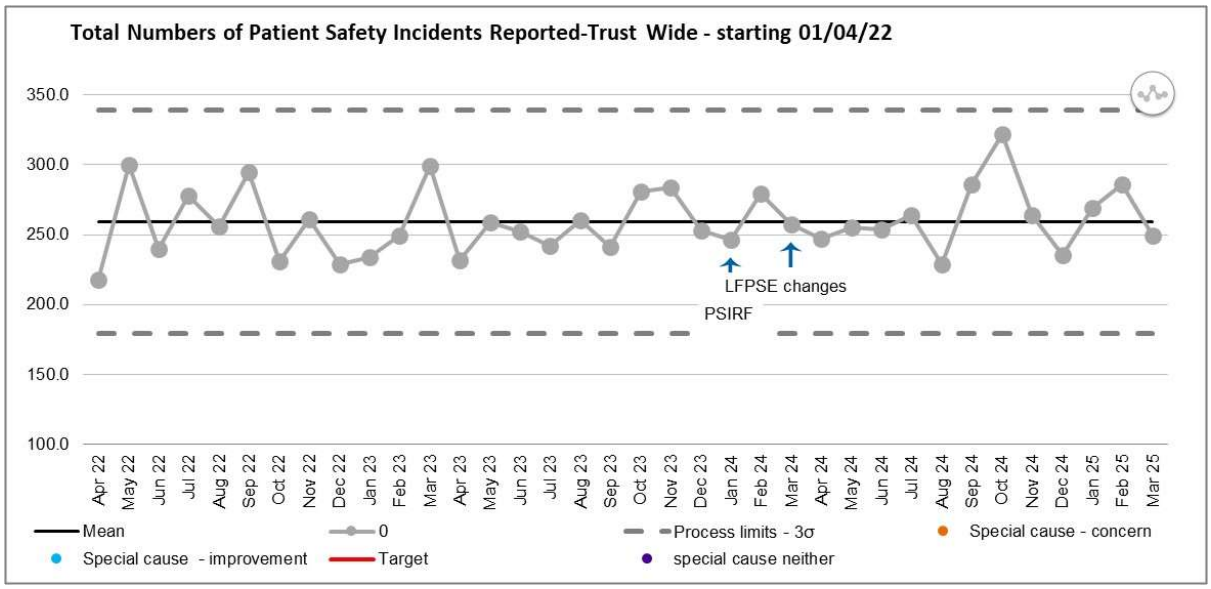
### Summary of incident data

There have been 3160 patient safety incidents reported in the 2024/2025 financial year, in comparison with 3086 in the previous year. In Graph 1 below it shows the variation of number of patient safety incidents reported each month from 01/04/2022 to 31/03/2025.

In January 2024 the Trust implemented the Patient Safety Incident Response Framework and our incident response policy and procedure changing our approach to reporting and investigating patient safety events. Reporting of incidents for the interests of system wide learning and shifting from individual blame has been encouraged. From 20/03/2024, changes were made to the Trust incident management system (Datix), in line with requirements for the national Learning from Patient Safety Event (LFPSE) reporting system. This added additional mandatory fields to the form and allowed us to separate incidents attributable to the Trust. This is important to note as we continued to see consistent reporting levels even excluding non Royal Papworth incidents.

### 1.1 Patient Safety Incident Trends

Graph 1: Number of reported patient safety incidents from April 2022-March 2025




Sourced from Datix 14/04/2025

### 1.2 Patient Safety Incidents by Severity

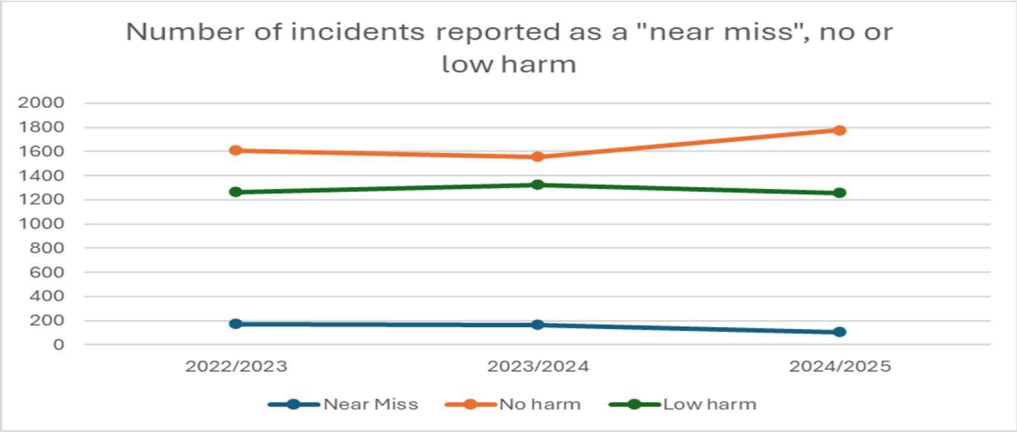
Table 1: Incidents by harm level/severity for 3 financial years starting from April 2022 to March 2025. This is further broken down in graphs one and two.

| Patient incidents by severity | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Near Miss | 172 | 167 | 105 | 444 |
| No harm | 1608 | 1557 | 1775 | 4940 |
| Low harm | 1265 | 1326 | 1257 | 3848 |
| Moderate harm | 27 | 11 | 16 | 54 |
| Severe harm | 2 | 6 | 6 | 14 |
| Fatal - Death caused by the incident | 2 | 1 | 1 | 4 |
| Death UNRELATED to incident (Pre-LFPSE) | 14 | 18 | 0 | 32 |
| Total | 3090 | 3086 | 3160 | 9336 |

Sourced from Datix 14/04/2025

Graph 2 below shows the trend over time of incidents where no/low harm and near miss incidents were reported. Low harm and near miss incidents have reduced and no harm incidents have increased in this financial year (2024/2025) compared to the last one (2023/2024). This indicates a consistent culture of reporting safety events which are responsive and not driven by harm.

Graph 2: Patient safety events by near miss, no or low harm

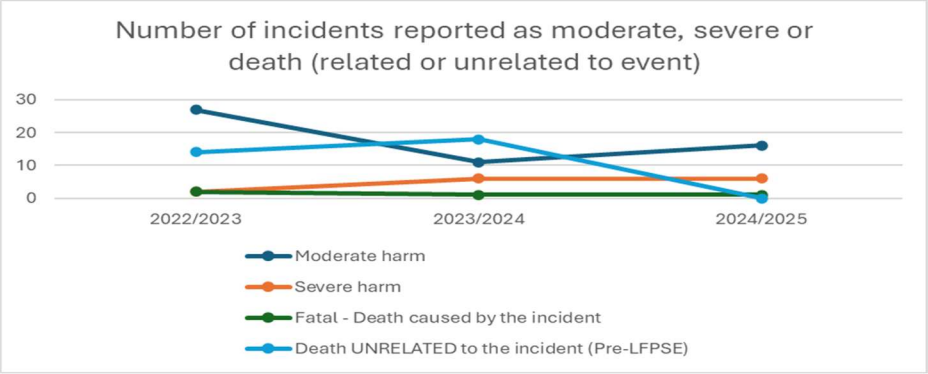



Sourced from Datix: 14/04/2025

Graph 3 below shows the trend over time of incidents where moderate, severe, and death (both related or unrelated to incident) were reported. The number of incidents graded as moderate harm has increased, severe harm and fatal (death caused by the incident) have remained the same compared to last financial year. Changes within LFPSE, removed “death unrelated to incident” as a harm level, this is reflected in the numbers where no incidents are reported against this severity in this financial year (2024/2025). Incidents relating to this harm level are now recorded as no harm as an outcome of treatment or procedure if a patient death was due to clinical condition and not preceded by a related patient safety incident.

Incidents graded as moderate harm or above are reported weekly to the Safety Incident Executive Review Pannel (SIERP) for discussion and to agree next steps. Introduction of PSIRF has initiated learning responses which have replaced previous investigation methodology for moderate harm and above incident reviews. Changes in the approach to safety incidents since PSIRF have enabled us to identify areas where harm may not have been avoidable due to the severity and complexity of a patient condition and there was a recognised, unavoidable outcome of treatment or procedure. LFPSE changes also allow us to capture outcomes of treatment and procedure that have been determined through the Morbidity and Mortality reviews. Again, unless there are elements where avoidable harm has been identified these are reported as low or no harm safety events.

Graph 3: Number of incidents reported as moderate and severe harm




Sourced from Datix: 14/04/2025

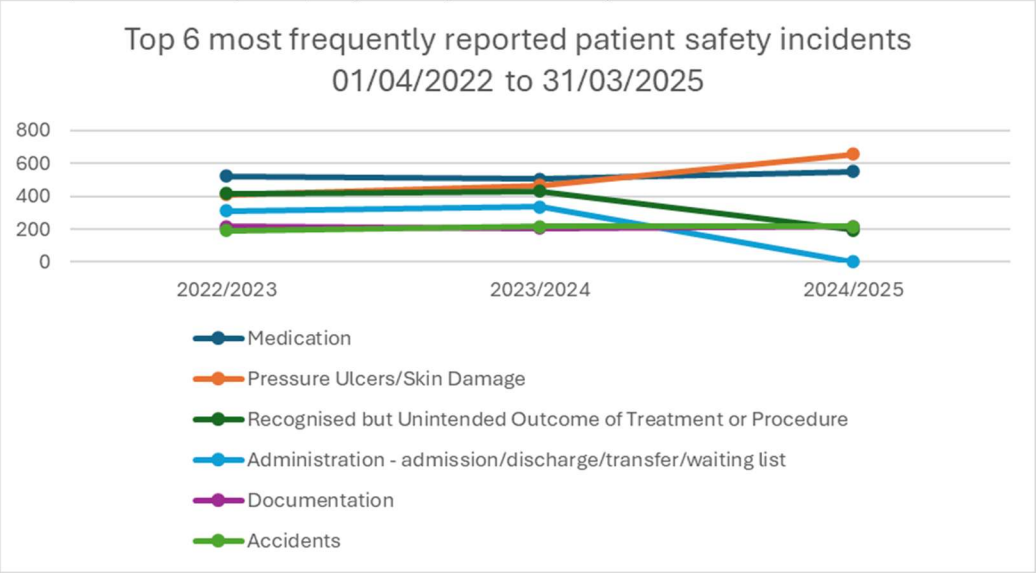
### 1.2.1 Top incident trends and details for financial year 2024-2025

**Most frequently reported patient safety incidents**
Graph 4 below displays the top six most frequently reported patient safety incidents between 01/04/2022 – 31/03/2025.

These were Medication, Pressure Ulcers/Skin Damage, Recognised but Unintended Outcome of Treatment or Procedure, Administration – (admission/discharge/transfer/waiting list), Documentation and Accidents. From 20/03/2024 the incident types on Datix were amended to reflect changes made by the introduction of LFPSE. The "Administration-admission/discharge/transfer/waiting list" type was removed from Datix options which reflects the zero numbers reported for 2024/25. Administration incidents related to patient safety are now captured in the incident type "implementation of care in a patient pathway".

A further breakdown of numbers for the last financial year (2024/2025) is provided in table 2 and a summary for the top 6 incident types provided.

Graph 4: Top 6 Most frequently reported patient safety incidents 01/04/2022 - 31/03/2025




Sourced from Datix: 14/04/2025

Table 2: Top 6 incident trends by type

| Top 6 incident types | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Medication | 522 | 503 | 549 | 1574 |
| Pressure Ulcers/Skin Damage | 410 | 465 | 657 | 1532 |
| Recognised but Unintended Outcome of Treatment or Procedure | 417 | 429 | 195 | 1041 |
| Administration - admission/discharge/transfer/waiting list | 312 | 335 | 0 | 647 |
| Documentation | 215 | 205 | 216 | 636 |
| Accidents | 190 | 216 | 215 | 621 |
| Total | 2066 | 2153 | 1832 | 6051 |

Sourced from Datix: 14/04/2025

**1. Pressure Ulcer (PU and Skin Damage)**
In the last financial year (01/04/2024 to 31/03/2025) the number of incidents reported in relation to pressure ulcer and skin damage have increased. Datix reporting system captures Pressure Ulcer (PU)/ Skin damage incidents which are developed at Royal Papworth as well as incidents developed outside Royal Papworth.

Out of the 657 PU/Skin damage incidents reported during last financial year (2024/2025), 30% were reported as developed outside Royal Papworth. Out of the PU/Skin damage incidents reported as developed at Royal Papworth majority were related to Medical Device Related Pressure Ulcers and Moisture Associated Skin Damage.

Majority of the incidents were graded as no/low harm, one incident was graded as Moderate harm (WEB53519- Category 3 PU developed at RPH). Incident was presented to SIERP with a gap analysis and learning was discussed at Pressure Ulcer Scrutiny panel.

All PU incidents are reviewed by the Tissue Viability Nursing (TVN) team and discussed at the Pressure Ulcer Scrutiny panel. As and when requested by the TVN team the PU incidents which are developed outside Royal Papworth are forwarded to the external trusts for their information and investigation.

Category 2 pressure ulcers or deeper are confirmed where possible, in person, by the TVN team or an experienced TVN link nurse once an incident report has been raised. In keeping with the NHSE and NHSI guidance, all category 2 ulcers or deeper, are subject to a root cause analysis (RCA) of the incident.

Quality improvement initiatives in relation to pressure ulcer and skin damage continues to be monitored by the Harm Free Care Panel and these initiatives are summarised in the Harm Free Care section of the report.

**2 Medication**

The number of medication incidents have slightly increased during last financial year (2024/2025) (n=549) compared to the previous one (2023/2024) (n= 503).

All incidents have been graded and harm levels noted as no/low harm/near miss incidents. Majority of incidents were under the main categories: Administration/supply from a clinical area 53% of the incidents were reported under this and 23% were reported under Prescribing category. Other categories included issues with medication advice, Monitoring or follow-up of medicine use and Preparation of medicine/dispensing in a pharmacy.

Medication incident themes and areas for improvement are summarised in the Pharmacy quarterly report and monitored by the medicine's safety group. In addition, a Trust wide medication safety quality improvement project was started in August 2024. This QI project is focused on incident reporting and culture, Controlled Drugs administration, IV administration and Dopamine administration.

**3 Recognised but unintended outcome of treatment or procedure**

During last financial year (April 2024 to March 2025) the reported numbers of recognised but unintended outcome of treatment or procedure incidents have significantly reduced (n=195) compared to previous financial year (April 2023 to March 2024), (n=429).

In 20/03/2024 the incident types on Datix were amended to reflect changes made by the introduction of LFPSE. The type "Recognised but unintended outcome of treatment or procedure" was introduced, which replaced the original type "Treatment/Procedures" this may have contributed to the reduction in numbers.

All incidents have been graded, the majority with a severity of no/low harm, three graded as moderate harm (WEB51702, WEB52986, WEB53643) and two graded as severe harm (WEB53457, WEB55370). All incidents which have an initial grading of moderate or severe harm are reviewed at the Safety Incident Executive Review Panel (SIERP), as part of the scrutiny, confirmation of grading and type of investigation.

Majority of the incidents (n = 145) were reported under “Treatment and procedure” category these included various cannulation issues, extravasation injury and other issues related to treatment or procedure.

**4 Administration – admission/discharge/transfer/waiting list**
The “Administration- admission/discharge/transfer/waiting list” type was also removed from Datix options during LFPSE changes in 20/03/2024, which reflects the zero numbers reported for 2024/25. Administration incidents related to patient safety are now captured in the incident type “implementation of care in a patient pathway”.

**5 Documentation incidents**
During last financial year (April 2024 to March 2025) there were 216 incidents reported relating to documentation, this is an increase compared to the previous year (n=205). This increase is most likely driven by the removal of the administration field at the end of March 2024. The most common themes reported have been related to electronic medical records “ambiguous/incorrect/incomplete/illegible”, “electronic medical record information misfiled” and ID bands – ambiguous/incorrect/incomplete/illegible.

**6 Accidents**
In the last financial year (April 2024 to March 2025) there were 215 accidents reported on Datix, this is almost similar to the previous year (n= 216). Majority of the incidents were reported under category Slip, Trip or Falls (80%) and the main subcategory being

Unwitnessed falls (74%). All incidents have been graded, the majority with a severity of no/low harm/Near miss, one graded as moderate harm. Falls incidents with a severity of Moderate harm and above are presented to SIERP for review and immediate learning via learning response tools. All falls incidents continue to be reviewed by the Falls Prevention Specialist Nurse who supports learning from a clinical and health and safety perspective. Falls incidents 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 and safety, and to ensure that appropriate actions are undertaken.

With an ongoing focus on Harm Free Care within the Trust, reducing the number of falls sustained by patients and reducing the risk of harm remains a high priority. Monitoring of numbers of falls is achieved through Datix incident reporting system and feeds into the Ward Scorecard and forms a core focus of the Falls Prevention and Management Group and the Falls Prevention Specialist Nurse.

**1.3 Duty of Candour**
During last 12 months (April 2024 to March 2025) 30 patient safety events were initially confirmed as Notifiable Patient Safety Incidents (moderate harm or above) at the Trust Safety Incident Executive Review Panel (SIERP) and where Statutory Duty of Candour was required. Following clinical review, 4 of these safety incidents were re-graded as no or low harm and 6 were excluded from the Trust Duty of Candour compliance based on the exclusion criteria listed below:

- Trust contributing to a joint investigation with another provider- Duty of Candour led by other Trust.
- Patient deceased and no recorded Next of kin given by patient on admission. Contacts located, verbal discussion occurred follow by family meeting and letter. Fell outside of 10 days following harm confirmed. Written outcome of investigation shared with family.
- Clinical judgement on fitness of patient condition to receive written letter due to critical condition. Evidence of family involvement and verbally informed of incident and investigation. Written outcome of investigation shared with family.

- The harm was due to a recognised complication during a life preserving treatment or procedure, a review was undertaken and no shortfall in care was identified. These types of events have been able to be recorded on Learning from Patient Safety Event platform as an Outcome Event. (New category for the Trust since March 2024).

A summary of required duty of candour compliance is presented in the table below.

Table 3: Stage 1 Duty of Candour compliance 2024-2025

| Duty of candour compliance 2024-25 | | | | |
|---|---|---|---|---|
| Q1 | Q2 | Q3 | Q4 | Annual compliance |
| 43.00% | 100.00% | 100.00% | 50.00% | 70% |
| N=3/7 | N=4/4 | N=5/5 | N=2/4 | N=14/20 |

The Trust reports stage 1 duty of candour compliance to the Cambridge and Peterborough Integrated Care System. Whilst the Trust has consistency with keeping patients and families informed verbally following a safety event and good evidence of an open and transparent conversation occurring, it is recognised that further improvements are needed to ensure that patients and families receive written information within the within the 10-working day standard. This remains a priority for improvement in 2025/2026.

**1.4 Incidents/Requests for Patient Safety Feedback from outside Royal Papworth Hospital**

During last financial year (April 2024 to March 2025), the incident team received 40 patient safety events from external organisation for the Trust to review and respond to. 23 of these relate to cardiology and include queries on PPCI referral pathway and ambulance service. 17 were no harm, 5 were low harm and one near miss. This is in keeping with numbers and themes from the previous year. 14 incidents were for STA division and 3 for Thoracic and ambulatory division.

**1.5 Patient incidents with learning responses**

The Patient Safety Incident Response Framework (PSIRF) asks us to review safety events by comparing ‘work as done’ against ‘work as expected’. PSIRF changed the way we approach incident, encourages a proactive approach based on organisational knowledge and horizon scanning for sources of future harm. The Trust launched PSIRF 01/01/2024 and with-it different learning responses and investigation methodology.

We introduced a gap analysis tool at the launch of PSIRF in January 2024. Since 01/04/2024 this tool has been embedded as the 1st line response to determine what happened and if there was a shortfall against what was expected/intended. The changes in approach to commissioning investigations means a basis for strong decision making for the next step investigation and learning response is essential. Since 01/04/2024 to 31/03/2025 54 cases have been discussed at SIERP using the gap analysis tool. In 36 of the incidents, the gap analysis was sufficient and learning was identified to recommend areas for improvement. Using a gap analysis approach has helped with understanding what has fallen short from expected outcomes and standards - even if the safety event was as a result of a recognised complication of treatment or procedure. A gap analysis enables us to identify where further learning and improvement can be made.

An After Action Review (AAR) tool was introduced as a learning response. AARs provide a platform for understanding shared roles and responsibilities and understanding where there is a mismatch in systems and processes between individuals and teams. Since 01/04/2024-31/03/2025 we have used this approach for learning in 6 patient safety cases.

A Round Table (multi professional) Review was introduced as an interactive dynamic problem solving tool. These allowed all parties to explore multi-disciplinary / multi-speciality pathways and roles. It involves key decision makers and steers focus away from individual actions and encourages collaborative improvement ideas. Since 01/04/2024 - 31/03/2025 we have used this approach for learning in 6 patient safety cases.

Patient Safety Incident Investigation (PSII) can be used for system reviews and learning for multiple cases, thematic reviews or single events to obtain information and essential criteria for learning and improvements. It is a multi-source collaborative approach to investigating and uses a safety system analysis tool. Since 01/04/2024 - 31/03/2025 we have used this approach for learning in 4 patient safety cases.

Clinical Safety Review is a tool the Trust uses for high level expert review in specific fields such as infection prevention and control. Since 01/04/2024 - 31/03/2025 we have used this approach for learning in 3 patient safety cases.

The table below shows the type and number of learning responses undertaken in the Trust since PISRF implementation.

Table 4 – Learning responses commissioned since 01/04/2024 - 31/03/2025

| Learning Response | Incident Category | Number |
|---|---|---|
| **Gap Analysis** | Recognised but Unintended Outcome of Treatment or Procedure | 13 |
| | Medication Safety | 3 |
| | Patient Fall | 3 |
| | Implementation of care/pathway | 14 |
| | Pressure Ulcer | 2 |
| | Other e.g Infection prevention | 2 |
| **Total 36** | | |
| **After Action Review (AAR)** | Medication Safety | 2 |
| | Recognised but Unintended Outcome of Treatment or Procedure | 2 |
| | Implementation of care/pathway | 2 |
| **Total 6** | | |
| **Patient Safety Incident Investigation (PSII)** | Recognised but Unintended Outcome of Treatment or Procedure | 3 |
| | Implementation of care on a patient pathway (thematic review) | 1 |
| **Total 4** | | |
| **Round Table Review (RTR)** | Recognised but Unintended Outcome of Treatment or Procedure | 1 |
| | Patient Fall | 1 |
| | Medication Safety | 1 |
| | Implementation of care/pathway | 3 |
| **Total 6** | | |
| **Clinical Safety Review** | Patient death on waiting list | 1 |
| | Infection Control | 2 |
| **Total 4** | | |
| **Grand total** | | **56** |

**Learning Responses Completed by Division**
Table 5 shows the distribution by division of learning responses commissioned at SIERP, from 01/04/2024 to 31/03/2025

Table 5 – Learning responses commissioned at SIERP since 01/04/2024 - 31/03/2025

**Cardiology**

| Gap Analysis only | AAR | RTR | Clinical Review | PSII |
|---|---|---|---|---|
| 13 | 2 | 1 | 0 | 2 |

**STA**

| Gap Analysis only | AAR | RTR | Clinical Review | PSII |
|---|---|---|---|---|
| 19 | 4 | 3 | 3 | 2 |

**Thoracic and Ambulatory**

| Gap Analysis only | AAR | RTR | Clinical Review | PSII |
|---|---|---|---|---|
| | 0 | 2 | 0 | 0 |

To note, 1 clinical review and 4 gap analysis were undertaken by other teams that related to the wider organisation such as Clinical Administration and Infection Prevention.

**What have we learnt for moderate harm and above incidents in last 12 months**
The completed learning responses are summarised below in table 6 by the RPH identified PISRF categories, learning themes and actions for improvement.

Table 6 – Learning responses commissioned since 01/04/2024 - 31/03/2025

| PSIRF Category | Learning Themes | Actions |
|---|---|---|
| Recognised but Unintended Outcome of Treatment or Procedure For example, pseudoaneurysm, vascular access misplacement, heart block. | • Improving communication, escalation and processes between teams.<br>• Team dynamic factors and culture influences communication and role congruence.<br>• Influences of external factors such as changes in medical staff roles and experiences | • Using M&M process for learning points involving cross speciality learning.<br>• Clarifying processes across MDT, roles and responsibilities.<br>• Implementation of standards and escalation pathways as a team.<br>• Planning for changes in response to external factors such as medical staff rotation.<br>• Role congruence in teams. |
| Medication Safety For example intravenous medication administration errors and unexpected drug reaction | • Human factors, effect of stress in losing situational awareness<br>• Process of administration of IV medications, human factors, work arounds for multiple steps in medication administration, coping with short supplies of medication and staffing/skill mix | • Observations of medication rounds. Trust wide improvement project.<br>• Diabetes management improvement group.<br>• Reviewing 2 person checking, training, support and education.<br>• Improving communication during Lorenzo downtime and mechanisms to address stresses that affect human factors- such as challenging behaviour from patients. |
| Patient Fall | • Frailty, environment, unwitnessed falls and shared trauma pathway.<br>• Interdependencies with environment, frailty, expectation bias.<br>• Identification benefits of standardised guidance across the Trust. | • Environmental improvements to reduce falls risk factors.<br>• Joint Trauma pathway working group.<br>• 'Clips stop trips' and 'Call don't Fall' campaigns.<br>• Education on MCA<br>• Project to standardise and implement orthostatic blood pressure readings. |

| PSIRF Category | Learning Themes | Actions |
|---|---|---|
| | • Identification of knowledge gap on mental capacity assessment of the clinical staff | |
| Implementation of care/pathway queries For example referral communication/pathway, Management of patient journey. | • Referral information, clarity of pathways and interdependence on systems<br>• Awareness of external pressures and team roles, clarification of shared expectations | • Pathway reviews, improvement work around TAVI, administrative processes and inboxes.<br>• Improvement work and oversight of imaging reporting. |
| Pressure Ulcer | • Communication, equipment provision for specialist cases and documentation | • Revision of handover documents, reaching out to other specialist centres neuro rehab for learning. |

**1.6. Harm Free Care**

The Harm Free Care Panel meets quarterly and aims to triangulate quantitative and qualitative data, review clinical practice and support improvement initiatives to reduce incidences of harm to our patients. The Panel have oversight of clinical quality improvement initiatives relating to the prevention and management of falls, pressure ulcers, venous vein thrombosis (VTE) and diabetes.

The Panel also reviews the ward/department scorecard to facilitate triangulation of data per clinical area and allow for timely measurement of impact of improvement activities.

**Pressure Ulcers (PU) and Skin Damage**

In the last financial year (01/04/2024 to 31/03/2025) the number of incidents reported in relation to pressure ulcer and skin damage have increased. Datix reporting system captures Pressure Ulcer (PU)/ Skin damage incidents which are developed at Royal Papworth as well as incidents developed outside Royal Papworth.

Out of the 657 PU/Skin damage incidents reported during last financial year (2024/2025), 30% were reported as developed outside Royal Papworth. Out of the PU/Skin damage incidents reported as developed at Royal Papworth

Moisture Associated Skin Damage (MASD) continue to remain the highest reported followed by Medical Device Related Pressure Ulcers (MDRPU).

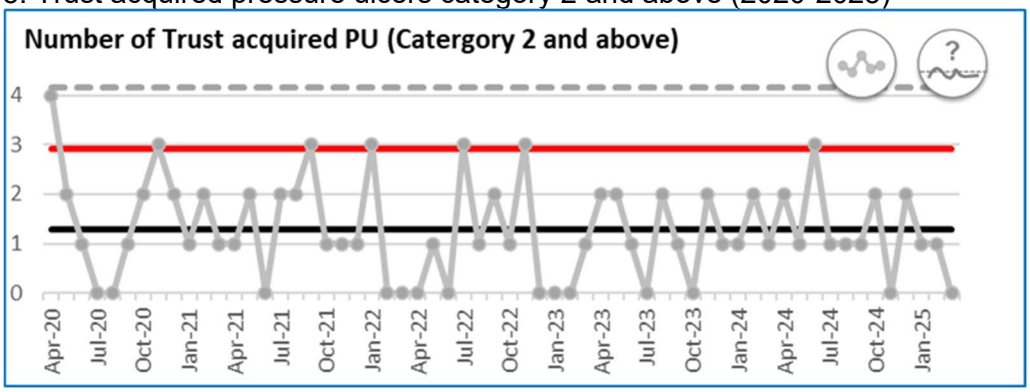
The majority of the incidents were graded as no/low harm, with one incident graded as Moderate harm (WEB53519- Category 3 PU developed at RPH). The incident was presented to SIERP with a gap analysis and learning was discussed at Pressure Ulcer Scrutiny panel.

All PU incidents are reviewed by the TVN team and discussed at the Pressure Ulcer Scrutiny panel. As and when requested by the TVN team the PU incidents which are developed outside Royal Papworth are forwarded to the external trusts for their information and investigation.

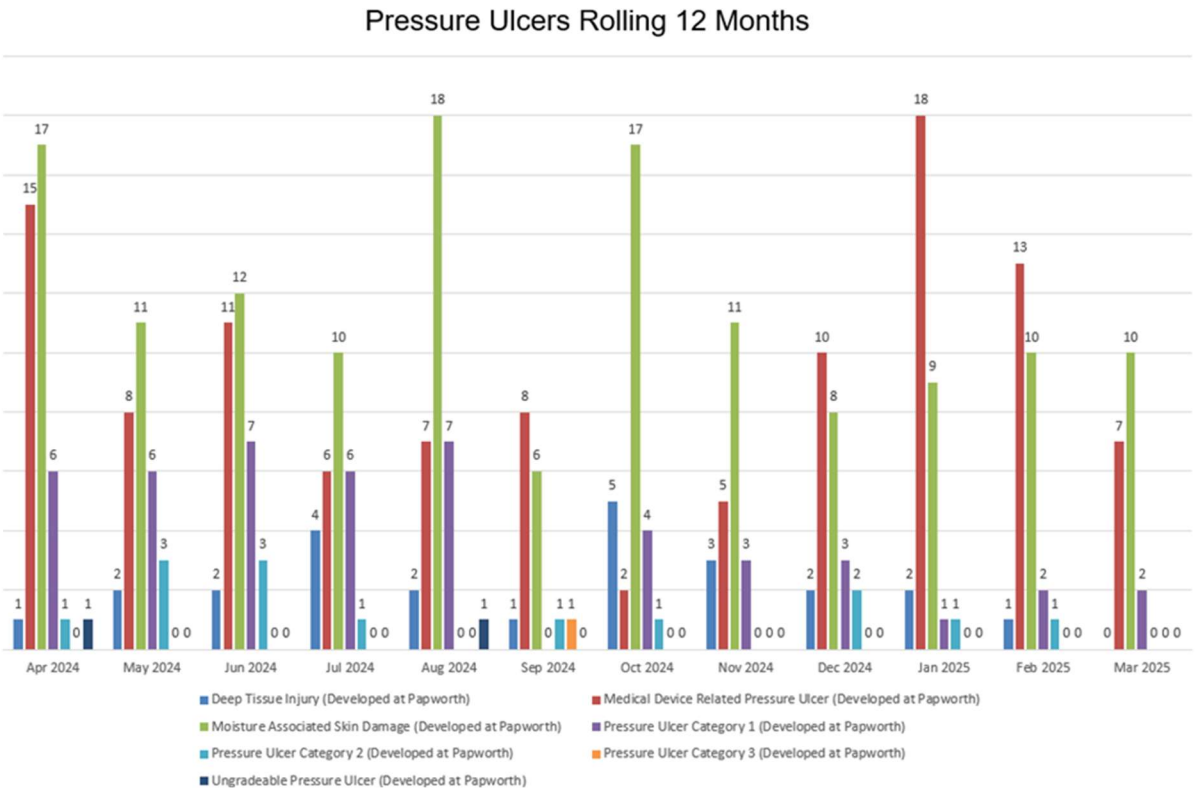
Category 2 pressure ulcers or deeper are confirmed where possible, in person, by the Tissue Viability Nursing (TVN) team or an experienced TVN link nurse once an incident report has been raised. In keeping with the NHSE and NHSI guidance, all category 2 ulcers or deeper, are subject to a root cause analysis (RCA) of the incident.

The Trust continues to have high levels of reporting superficial low harm pressure ulcers and skin injuries and a low rate of deep pressure ulcer development, see graphs 5 and 6 below.

Graph 5: Trust acquired pressure ulcers category 2 and above (2020-2025)




Graph 6: Trust acquired pressure ulcers: rolling 12 months

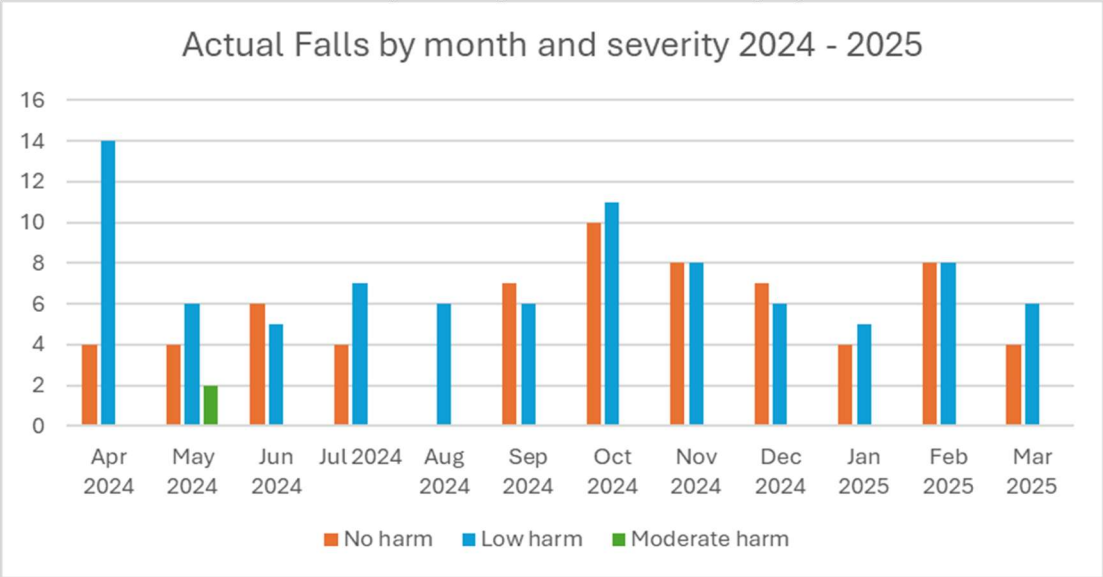



Quality improvements initiatives include a continued focus on education; clinical induction and ongoing educational activities to include MASD identification, reporting and management, assessment on skin integrity on darkly pigmented skin and a focussed campaign within CCA to identify, report and manage ET tube MDRPU. The wound care TVN intranet site has been redesigned to support easy navigation for information. The introduction of the Durapore NG tube fixation system has resulted in almost eliminating NG tube MDRPU.

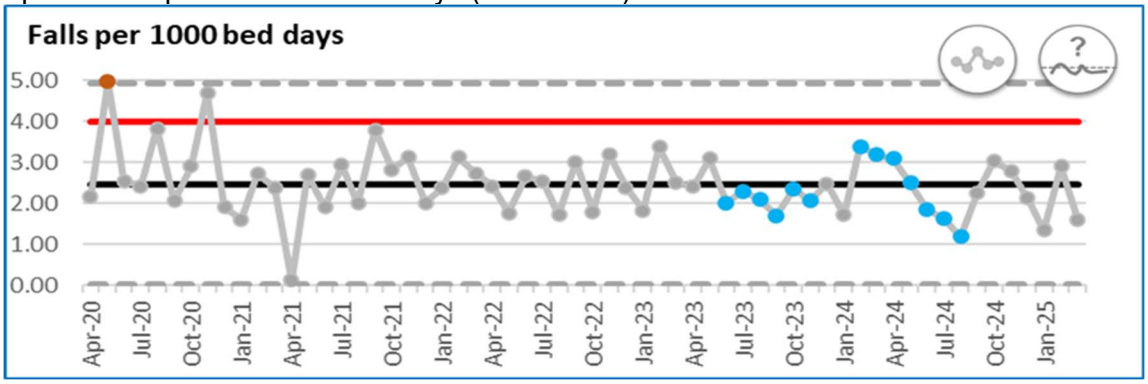
**Falls**

The total number of falls during 2024-2025 was 156, this compares to 151 in 2023-2024. Of these 154 were no or low harm, with two moderate harms occurring during May 2024.

Graph 7: Actual number of falls reported by month and severity April 2024 – March 2025

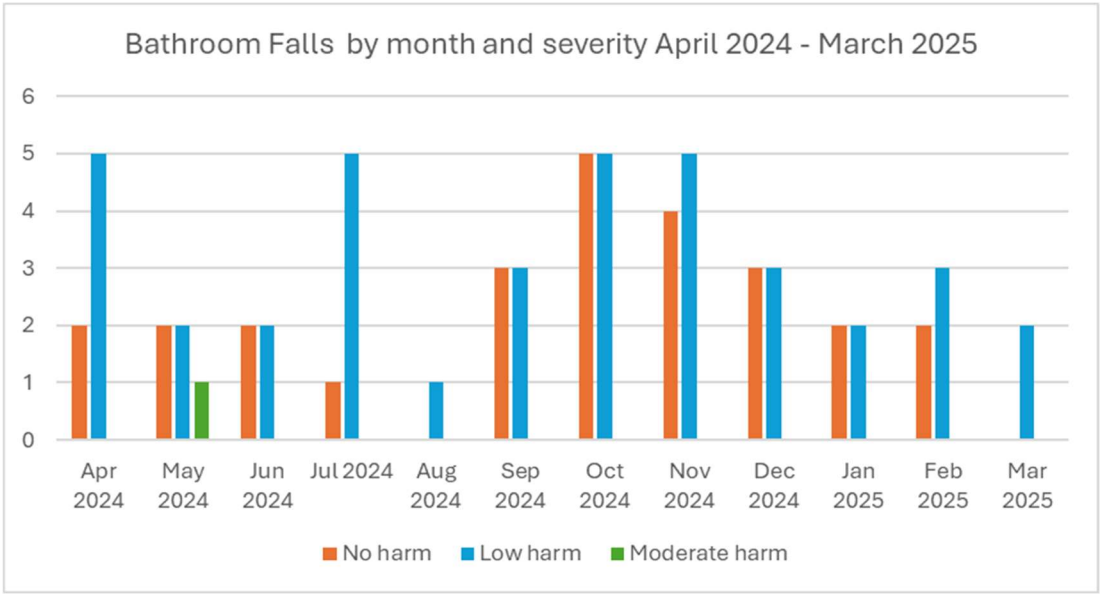



Graph 8: Falls per thousand bed days (2020-2025)



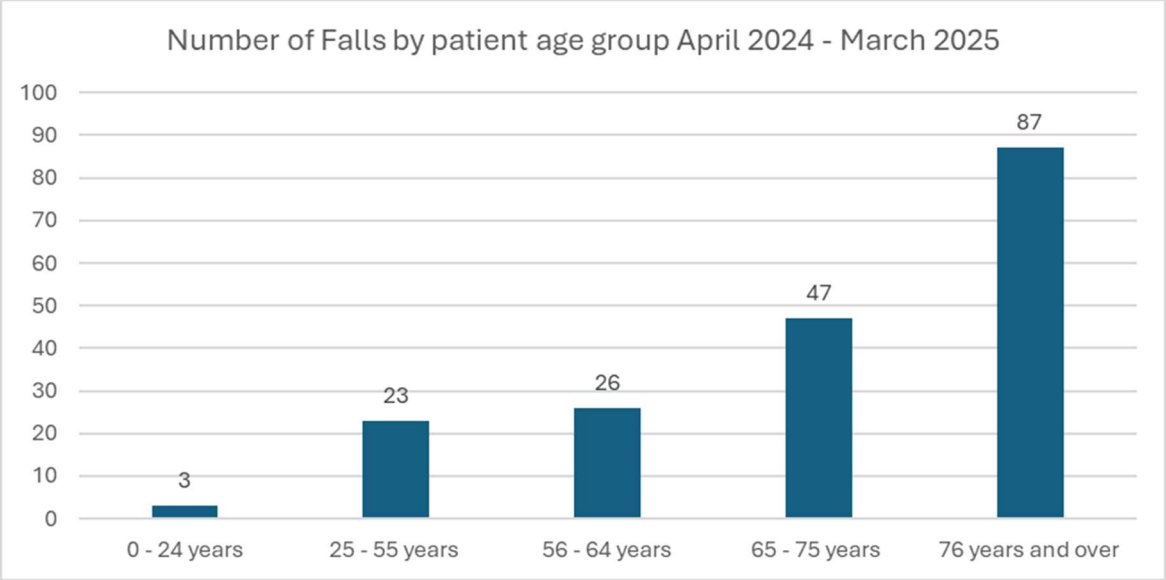

Bathrooms, commodes, toilets and personal hygiene continue to be a theme with the fall's incidents, along with patients mobilising without help, see graph 9 below. The numbers of falls peak around late morning and may be related to medication, independent personal care or following catheter removal. This is thought to be due to the patient not asking for help when they needed it or because the patient needed help urgently. Measures are in place or planned to help mitigate these factors. Bathroom alarms are in place on Cardiology and Surgery to assist staff to detect when a patient has got up without asking for help while using the toilet and there is a plan to remind patients to call for help before getting up.

Graph 9: Bathroom Falls Incidents by month and severity (date reported April 2024 – March 2025)




Falls data demonstrates they are most commonly occurring in the age 75 years and above age group, see graph 10 below. The Falls Prevention Group plan will oversee the implementation of lying and standing blood pressure measurements for patients over 65 or who meet clinical criteria. Assessment of Lying and Standing Blood Pressure can be used to assess orthostatic hypotension, a factor that can be associated with falls.

Graph 10: Number of Falls by patient age group April 2024 – March 2025

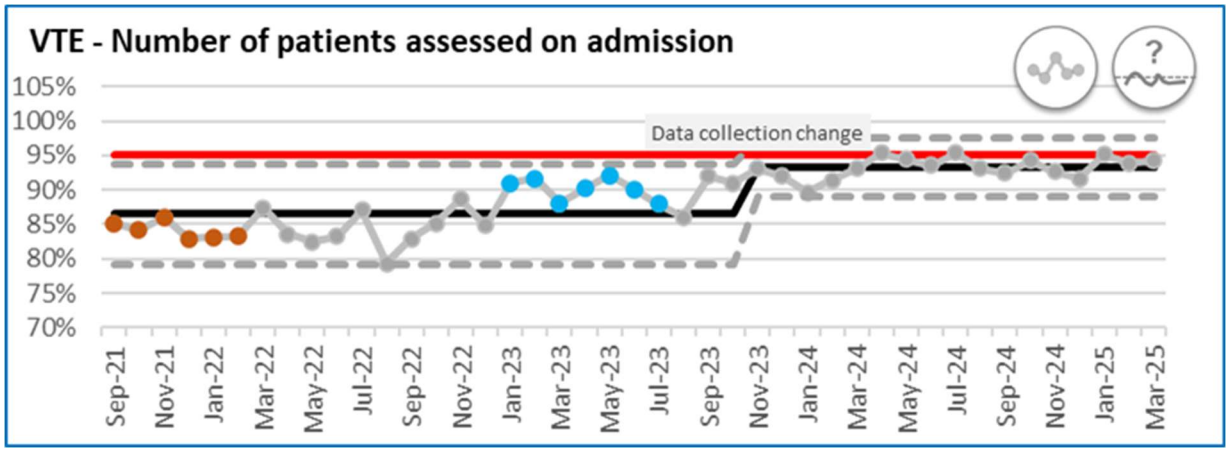



The group held a Falls awareness week in September 2024 which provided displays in the atrium on current innovations and equipment. Staff made pledges to reduce falls and support improvement work and additional improvements ideas were identified.

Educational activities led by the Falls Prevention Specialist continues utilising ‘tea trolley teaching’ on the wards on a regular basis and on away days and the preceptorship programme.

**Venous Thromboembolism (VTE)**

Graph 11: VTE assessment compliance on admission




Overall, there is a continued improvement in VTE assessment compliance, and this has been sustained over the past 12 months. There was 1 VTE recorded incident reported in Q1 and another in Q4.

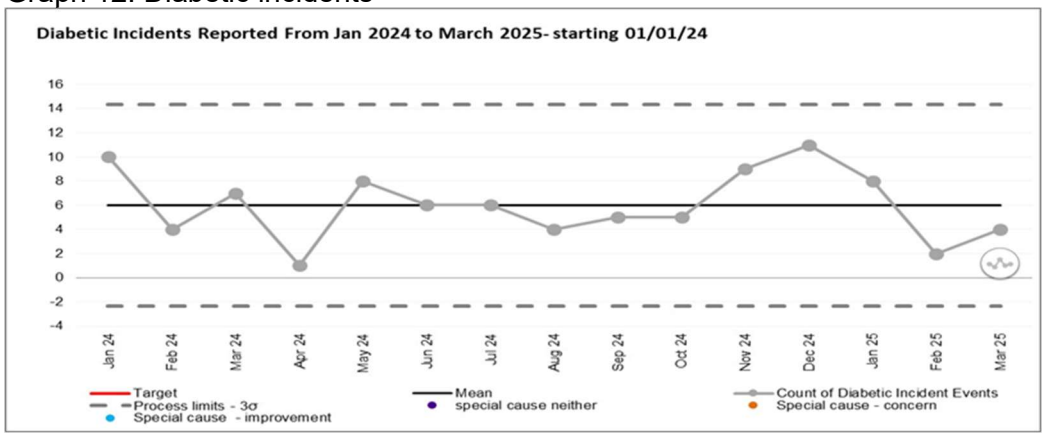
VTE is shared at the Divisional Meetings with ongoing discussion to improve areas of noncompliance. The VTE Oversight Group now has representation from the ALERT team and Resident Doctors. They continue to focus on empowering and increasing patient VTE awareness further as well as educating and training resident doctors. The internal VTE clinical indicator view within the current electronic patient record is reviewed and optimized to highlight patients in need of VTE risk assessment before the 24h target.

Continued quality improvement activities to improve compliance includes ongoing circulation of the non-compliant patients to the VTE champions in each area to review ongoing practice, a trial of weekly breakdowns of VTE assessments to assess whether regularly reviewing events will help identify omissions and Resident Doctor teaching sessions for Foundation Year Doctors.

**Diabetes**

Following successful recruitment to a new position, the Consultant Diabetologist has commenced in post April 2025. Initially shadowing the Diabetes Specialist Nurses, they will support with management of complex patients.

Graph 12: Diabetic incidents



Common themes of diabetes incidents relate to the management of patients with diabetes including insulin medication prescribing and administration, blood glucose monitoring and hypoglycaemia.

The Trust commenced submitting data for the NDISA in 2024/2025. It records the details of any adult who has one of four avoidable complications which can occur in inpatients with diabetes. All NHS providers of inpatient care for patients with diabetes in acute settings are expected to participate. Within this data set, the results for RPH indicate that further understanding of prevention and the management of hypoglycaemia is needed.

The clinical guidelines for management of type 1 and type 2 diabetes, and the management of patients requiring a variable rate intravenous insulin infusion (VRII) was reviewed and concluded with new guidance published and approved at QRMG in August 24. Following this there was a planned campaign of educational activities to support the launch of the new guidelines into practice from September, and subsequently educational activities have focussed on embedding them into practice. There is a plan to audit these guidelines in Q3 2025.

Quality improvements initiatives include regular programmes of diabetes workshops, one covering hypoglycaemia, Type 1 Diabetes and Diabetic Ketoacidosis and the second, oral medications, insulins and VRII, review and updating of the diabetes induction and e-learning, and commencement of procurement of orange hypo boxes. In addition, work with a Patient Safety Partner to develop a patient diabetes satisfaction questionnaire has commenced to better understand the patient experience. The mapping of the resource required to offer pre-optimisation of patients with diabetes waiting for elective surgery has commenced this year and will benefit from the expertise of the new consultant diabetologist.

Diabetes Specialist Nurses are undertaking the Advanced Skills in Clinical Assessment in preparation to become Non-Medical Prescribers, this will support prescribing in our teams alongside medical prescribing.

## 2.0 Incident and Risk Management

### 2.1 Staff Accidents/Incidents

During the past 12 months the total number of incidents that were reported was 554. This demonstrated a reduction when compared to the previous two years.

Table 7 – Number of incidents reported from April 2022 to March 2025

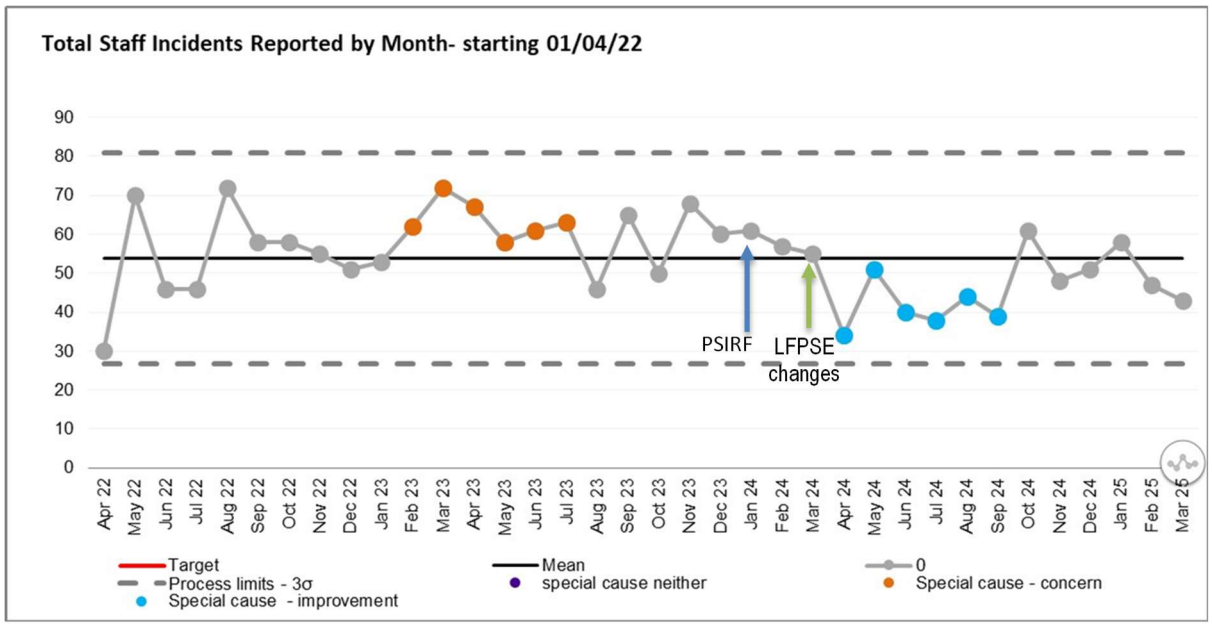
| | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Organisational Issues/Staffing | 142 | 179 | 67 | 388 |
| Behaviour/Violence Aggression** | 100 | 114 | 117 | 331 |
| Accidents | 69 | 70 | 84 | 223 |
| Infection Control | 72 | 74 | 61 | 207 |
| Communication/Consent | 31 | 32 | 53 | 116 |
| Security incidents | 39 | 24 | 41 | 104 |
| Information Technology | 50 | 26 | 22 | 98 |
| Medication | 28 | 33 | 24 | 85 |
| Devices | 31 | 38 | 14 | 83 |
| Buildings or Infrastructure | 23 | 22 | 16 | 61 |
| Data protection | 21 | 18 | 21 | 60 |
| Administration - admission/discharge/transfer/waiting list | 23 | 32 | 0 | 55 |
| Documentation | 12 | 12 | 20 | 44 |

| | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Recognised but Unintended Outcome of Treatment or Procedure | 14 | 15 | 2 | 31 |
| Radiology | 5 | 5 | 0 | 10 |
| Diagnosis Process/Procedures | 5 | 4 | 0 | 9 |
| Fire Incidents | 1 | 3 | 4 | 8 |
| Blood Plasma Products | 3 | 3 | 0 | 6 |
| Anaesthetics | 1 | 3 | 1 | 5 |
| Implementation of Care or treatment Issues | 0 | 0 | 5 | 5 |
| Pressure Ulcers/Skin Damage | 0 | 3 | 2 | 5 |
| Ethnicity Diversity and Inclusion | 3 | 0 | 0 | 3 |
| Nutritional Feeding (Prescribed Feeds) | 0 | 1 | 0 | 1 |
| Total | 673 | 711 | 554 | 1938 |

(Data source: Datix 14/04/2025) As Datix is a live database data is accurate at the time of reporting.

**NB as of April 2024 this category has been renamed as Safeguarding (inc. Behavioural /V&A) but all data is reported under this category for the purposes of this report.

Graph 13: Number of staff incidents from April 2022-March 2025




SPC chart for staff incidents 01/04/2022-31/03/2025

The top 5 categories of incidents reported during the 12 months of 24/25 were:

1. Behaviour / Violence Aggression – 117
2. Accidents – 84
3. Organisational Issues / Staff – 67
4. Infection Control – 61
5. Communication / Consent – 53

These top 5 categories make up 69% of all staff incidents (n=382).

**Behaviour / Violence Aggression**

This category has now become the top reported category in relation to staff incidents with 117 reported incidents. It is however reassuring to note that numbers remain comparable to both 22/23 (n=100) and 23/24 (n=114). Of these incidents: 52 involved patient to staff behaviour with 20 being physical in nature and 21 were verbal. The total numbers of patient to staff incidents remains similar to those reported in 23/24. There was a small increase in

the number of staff-to-staff violence and aggression incidents reported in the second 6 months of 24/25 from 20 to 23, however, the total numbers of these incidents across the year remains comparable to the previous year with one less reported in 24/25 (n=43).

A task and finish group has been set up in response to the revised NHS Violence Reduction Prevention Framework and updated legislation on harassment that is due to commence this year. It is hoped that this work will help to further reduce the numbers of incidents within this category.

**Accidents**
The number of accidents has seen a steady increase across a 3-year period from 69 reported in 22/23 to 84 reported in 24/25. A breakdown of the numbers does not show a significant increase in the numbers of low or moderate harm incidents with the greatest increase being shown across the no harm incidents with the number more than doubling from 11 in the previous 2 years to 23. This suggests an improved reporting culture of accidents across the Trust which is valuable in the identification of hazards prior to a serious incidents occurring.

In addition to this the number of moving and handling incidents involving both patients and other inanimate loads showed a reduction in numbers. This correlates with the reported increased levels of moving and handling training that has been completed by staff across the Trust. Any RIDDOR reportable incidents are discussed further in section 2.3.

**Organisational issues / staffing**
The number of organisational issues / staffing incidents reported has demonstrated a significant reduction in number during the previous 12 months to 67 from 179 reported in 23/24. This is in part due to improved cleansing of data in relation to the person affected by the incident and comes as part of the introduction of Learning From Patient Safety Events (LFPSE) in April 2024.

The category that experienced the greatest reduction in reported numbers was insufficient numbers of healthcare professionals. This was experienced across all directorates with the most significant within theatres, critical care and anaesthesia from 56 incidents in 22/23 and 70 reported in 23/24 to 14 in 24/25. The lack of staffing across this directorate is related to several risks on the corporate risk register. A number of these have already been downgraded (ID3513, ID2442) or are due to be downgraded (ID2704) in the upcoming months due to successful recruitment and retention.

**Infection control**
The number of reported infection control incidents has fallen to 61 during 24/25 when compared to the previous years (22/23 n=72 23/24 n=74). Once again this is due in part to improved incident categorisation upon review by the incidents and risk team with a reduction in the number classified as “other infection control incident” of over a three-year period from 17 in 2022 to 4 in 2025.

There has been an increase in the number of sharps incidents in the year to 39 when compared to 28 in the previous year but this number is the same as those reported 22/23. There has, however, been an increase in the number of RIDDOR reportable sharps injuries. A quality improvement programme for the prevention of sharps and needlestick injuries has been established to look at sharps injuries across the Trust as discussed in section 2.3 below.

**Communication / Consent**
During the past year the number of communication / consent incidents has shown an increase to 53 reported incidents from 31 in 22/23 and 32 in 23/24. This has been most notable with the communications between different teams / staff with an increase of 11

incidents form the previous year. Errors and omissions of facts remain the highest subcategory and occurs most commonly during patient moves between teams.

### 2.2 Organisational Incidents

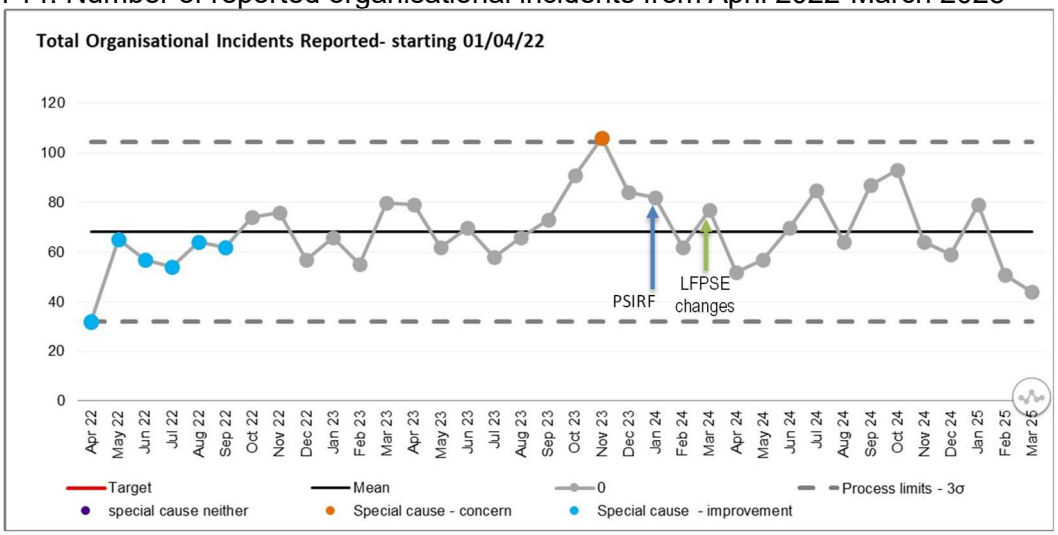
During the 12 months of 24/25 there were 805 incidents reported as organisational. It is worth noting that incidents captured may also relate to multiple parties affected for example organisation and staff or organisation and patient. This means that incidents may have been reported on elsewhere within this report. This is shown in table 8 below.

Table 8 – Number of organisational incidents reported from April 2022 to March 2025

| | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Accidents | 4 | 4 | 3 | 11 |
| Anaesthetics | 0 | 1 | 1 | 2 |
| Blood Plasma Products | 17 | 14 | 14 | 45 |
| Buildings or Infrastructure | 31 | 25 | 27 | 83 |
| Communication/Consent | 33 | 29 | 76 | 138 |
| Data protection | 16 | 20 | 22 | 58 |
| Devices | 99 | 122 | 83 | 304 |
| Diagnosis Process/Procedures | 8 | 6 | 0 | 14 |
| Documentation | 20 | 28 | 38 | 86 |
| Fire Incidents | 7 | 8 | 14 | 29 |
| Implementation of Care or treatment Issues | 0 | 1 | 11 | 12 |
| Infection Control | 56 | 73 | 43 | 172 |
| Information Technology | 44 | 47 | 54 | 145 |
| Medication | 76 | 96 | 88 | 260 |
| Nutritional Feeding (Prescribed Feeds) | 0 | 0 | 2 | 2 |
| Organisational Issues/Staffing | 216 | 310 | 269 | 795 |
| Pressure Ulcers/Skin Damage | 1 | 1 | 0 | 2 |
| Radiology | 3 | 7 | 0 | 10 |
| Recognised but Unintended Outcome of Treatment or Procedure | 15 | 21 | 3 | 39 |
| Safeguarding (inc. Behavioural/V&A) | 0 | 0 | 1 | 1 |
| Security incidents | 32 | 20 | 56 | 108 |
| Administration - admission/discharge/transfer/waiting list | 54 | 61 | 0 | 115 |
| Behaviour/Violence Aggression | 10 | 16 | 0 | 26 |
| Total | 742 | 910 | 805 | 2457 |

(Data source: Datix 15/04/2025) As Datix is a live database data is accurate at the time of reporting.

Graph 14: Number of reported organisational incidents from April 2022-March 2025




SPC chart for organisational incidents 01/04/2022-31/03/2025

The top 5 categories of organisational incidents reported over the previous 12 months were

1. Organisational / Staffing incidents – 269
2. Medication incidents – 88
3. Device related incidents – 83
4. Communication / Consent – 76
5. Security incidents – 56

**Organisational / Staffing**

There were 269 incidents reported in the past year that related to organisational / staffing incidents. “Other” organisational issue was the highest subcategory reported and of this most incidents were reported as low harm, no harm or near miss. This is a very broad category and incidents cover a wide range of topics including non-availability of ward beds for critical care step downs and medical equipment not left ready for use by the previous user.

There was one organisational incident recorded as severe harm, and this was uploaded as an overarching incident for 3 patients that had potential delay in the TAVI treat and return pathway. This formed part of the Patient Safety Incident Investigation (PSII) thematic review.

Insufficient numbers of healthcare professional incidents have reduced this year to 60 when compared to 87 in 22/23 and 147 in 23/24. This is due to successful recruitment in some key areas of the hospital such as theatres and critical care and this is reflected by the closing of key risks discussed in section 2.4.

There was also an increase in the number of food, linen and laundry services when compared to previous years. One area of concern over the previous year has related to the receipt of soiled linen from the external cleaning company. This is being managed externally by OCS and RPH staff are asked to report these incidents for tracking and oversight.

**Medication incidents**

The total number of medication incidents has remained consistent over the previous 3 years with 76 incidents in 22/23, 96 in 23/24 and 88 this year. The categories have also remained consistent with wrong storage and wrong quantity forming 2 of the top 3 subcategories. Of these, all incidents were no harm, low harm or near misses. “Other” medication incidents remained as the second highest reported incident subcategory and included incidents such as Controlled Drug cupboard mismatches. These incidents were fully investigated and a clear explanation as to why the error has occurred, and that no harm has come of it, was established. As confirmed with reports across the year from the Chief Pharmacist there are

no themes for concern of all medication incidents and that the numbers represent good reporting culture across the Trust.

**Device related incidents**
In 23/24 there was a 23% increase in the number of device related incidents across the Trust (n=23) however, during 24/25 this number has reduced back to 22/23 levels with 83 reported incidents.

The number of device malfunction incidents saw reported incidents more than double from 14 in 23/24 to 29 in 24/25. There were three main themes of incidents identified within this subcategory.

- The first of these related to Continuous Veno-venous hemofiltration sets and the identification of holes within the pressure dome of the disposable circuits. There were 6 of these incidents reported across the year. This linked to a related field safety notice (ID664) and staff were asked to report any incidents for tracking with the manufacturer. A risk was also uploaded onto Datix (ID3549) to allow for tracking and oversight of the issue. No further incidents have been reported since August 2024 and an update provided in March 2025 confirms that there is very little affected stock still present within the department having been almost fully replaced with unaffected stock.
- Secondly, there were 3 reported incidents which related to malfunctioning Transoesophageal echocardiogram probes. Irreversible damage was identified as being sustained due to cleaning regimes and subsequent unavailability of the devices was uploaded onto the risk register for both theatres (ID3605) and critical care (ID3612). The purchasing of new equipment and education on staff for the correct cleaning techniques has reduced the risk and should avoid future incidents.
- Finally, a recent trust wide server update on glucometers made the devices inaccessible by many staff as their log in details were deactivated. This was investigated fully by the manufacturer and the RPH digital department and no cause for this error could be established. All devices have been reset and are now working as expected and the situation is to be monitored for reoccurrence.

Further medical device incidents related to a lack of equipment availability, but these levels have remained stable across a 3-year period and relate to different devices over the course of this time. Medical device incidents of concern are raised at the medical devices group on a monthly basis for discussion and escalation where necessary. In addition, this group provides funding for larger medical devices across the year as and when required.

**Communication / Consent**
Communication / consent incidents have now become one of the top 5 organisational incidents reported with 76 incidents reported and shows an increase when compared to 22/23 (n=33) and 23/24 (n=29).

Errors / omissions of facts between different teams was the largest reported subcategory constituting 59% of incidents (n=45) and all were reported as low or no harm or near miss. A lack of suitable handover from referring hospitals to the Cardiology wards was a common theme reported (n=5). This was also noted with patient incidents as 39 additional incidents were reported following insufficient handovers. Work is underway to strengthen this process with the referring hospitals.

**Security Incidents**
The number of security incidents reported has also increased over the previous 3-year period to 56 from 32 in 22/23 and 20 in 23/24. Due to the nature of security incidents across the Trust most were recorded as “other” security incidents with detailed descriptions of the

incident provided. Across 10 separate incidents reported several areas of the hospital, including Ambulatory care day ward, have reported being used incorrectly as a rest area for eating and sleeping. This relates to risk ID3439 reference unauthorised access to day ward where automatic door locks are awaited to prevent further incidents occurring.

A further incident was reported from the CUH team in which a patient had contacted the police claiming to have planted explosives. A full investigation was undertaken and no threat found. Overnight patrols were increased to monitor for further issues.

Due to the use of contractors for building and security management across the Trust it was identified during 24/25 that not all incidents were being reported onto the Datix incident system in a timely manner for Trust oversight. A review with the estates team and Health and Safety Risk Manager highlighted the concern with the contractors and this led to 45% of security incidents being reported within quarter 3 of 24/25 (n=25). Moving forward the estates team will aim to upload all incidents reported via these contractors onto the Datix system as soon as possible.

**2.3 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)**
During the previous 12 months there were a total of thirteen new RIDDOR reportable incidents. This represents an overall increase in numbers when compared to 23/24 (n=9), however, remains comparable with 22/23 (n=11) therefore demonstrating natural variation within the Trust.

RIDDOR reporting is subdivided into the reporting of injuries, the reporting of occupational diseases and the reporting of dangerous occurrences. It is worth noting that three of the incidents reported within 24/25 were reported as dangerous occurrences as needlestick injuries with the source having a known blood borne virus (BBV) (WEB55018, WEB55595, WEB54655). This links in with the piece of work discussed in section 2.1 relating to the formation of a quality improvement programme for the prevention of sharps and needlestick injuries. This group is supporting the review of previous safer sharps risk assessments, considering the categories of sharps that can be reported onto Datix and exploring areas for improvement across the Trust.

There has been a reduction in the number of moving and handling incidents reported from staff over the previous 3 years and the number of related RIDDOR reportable injuries has also shown a 50% reduction when compared to last year.

Slip, trip or fall reportable injuries have increased over the past 12 months to six when compared to 22/23 (n=2) and 23/24 (n=3). The six incidents took place across five separate departments and there were no common themes and trends associated.

Gap analyses were conducted and attached to Datix for all work-related injuries reported and investigations captured through the Datix system. Staff are referred to the Occupational Health (OH) Department for further support during the individual's recovery. All RIDDOR reportable staff incidents are discussed at a quarterly meeting with the Health and Safety Risk Manager, OH nurse and the head of workforce to ensure that they are correctly captured on the e-roster.

Table 9 – Number of RIDDOR incidents reported from April 2022 to March 2025

| Category | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Collision/Impact with object (not vehicle) | 0 | 0 | 1 | 1 |
| Inappropriate behaviour by a Pt to staff | 2 | 0 | 0 | 2 |
| Medical device | 1 | 0 | 0 | 1 |
| Moving and handling | 6 | 6 | 3 | 15 |
| Sharps | 0 | 0 | 3 | 3 |
| Slip, Trip or Fall | 2 | 3 | 6 | 11 |
| Total | 11 | 9 | 13 | 33 |

(Data source: Datix 15/04/2025) As Datix is a live database data is accurate at the time of reporting.

**2.4 Risk Register**

As of 10/04/2025 there were 431 total finally approved live corporate risks captured on the Datix Risk Module. This represents an increase in total number of risks of almost 45% (n=133) when compared to the number of finally approved live corporate risks on 29/04/2024. Improved engagement with departments trust wide in the registering and management of their risks via the Datix system is a significant reason for this increase. In addition to this, a review of the Health and Safety Risk Register is underway as it has been identified that some of these risks are corporate clinical risks. A process of reallocating these risks to the appropriate areas of Datix is underway and has resulted in a further increase in the total numbers of open, finally approved live corporate risks.

The top 6 categories with the highest numbers of risks as of 10/04/2025 are listed below:

Table 10 – Top 6 categories by risk severity as at 10/04/2025

| | | Low Risk | Moderate Risk | High Risk | Extreme Risk | Total |
|---|---|---|---|---|---|---|
| 1. | Clinical | 20 | 49 | 60 | 7 | 136 |
| 2. | Staffing | 4 | 16 | 23 | 2 | 45 |
| 3. | Projects | 1 | 11 | 25 | 5 | 42 |
| 4. | Information Technology | 3 | 19 | 15 | 2 | 39 |
| 5. | Financial | 1 | 13 | 15 | 1 | 30 |
| | Medical Devices | 2 | 16 | 11 | 1 | 30 |
| | Total | 31 | 124 | 148 | 19 | 322 |

(Data source: Datix 10/04/2025) As Datix is a live database data is accurate at the time of reporting.

- **Clinical risks** remain the largest category and have increased by 28% to 136 when compared to the previous year (n=106, increase of 30). This is represented across low, moderate and high risks with extreme risks numbers not changing. Despite this number not altering this does not suggest that these risks are the same as April 2024 and of the 7 risks currently open 5 of these were opened within the last 12 months with 5 others being closed.

  Of the 7 current extreme risks three of these relate to delayed access to treatment though referral pathways (ID3628), a lack of sufficient vascular access (ID3580) and the TAVI service treatment delays (ID3350). A further two risks relate to a backlog of patients requiring specialist appointments and testing in RSSC (ID3692, ID3690). All of these risks have a relationship to staffing levels and capacity within the hospital and this links in with numerous other risks that sit within other categories and at other risk rating levels.

- **Staffing** has increased from the fourth largest risk in 23/24 (n=27) to being the second largest increasing by over 66% (n=18). Risk ID2702 has been live since 2020 and has represented a gradual increase from a moderate risk (rating 6) when first uploaded to being extreme (rating 16) currently. However, updates provided show that this should reduce in June with the qualification of new staff. The second currently open extreme risk (rating 16) in this category relates to the CT reporting backlog departmental risk. This risk is part of a larger risk in relation to imaging backlogs and links to two further moderate risks related to the digital system (ID3362) and the patients directly (ID3433).This risk is being managed within the department wherever possible with regular outsourcing of reporting.

  Out of the 45 live risks relating to staffing 18 of these have been opened within the previous 12 months. A further two, that are not captured within this report, were opened within the year but these were also closed due to the successful appointment of new staff.

- **Project risks** are now the third largest category of open finally approved live corporate risk and these were not within the top 5 risks as of April 2024. Of the 42 risks, the Electronic Patient Record (EPR) programme forms the majority at 88% (n=37). Although 11 risks relating to EPR were closed during 24/25, 38 were opened in the first 6 months with a further 4 opened in the last 6 months. Opening and closing of risks related to the EPR is expected to continue until the launch of the new system which is currently expected in 2027. Of the non-EPR risks two relate to the blood transfusion service. ID 3371 is an extreme risk and relates to the proposed moving of blood transfusion services to CUH from its current location at RPH.

- **Information Technology** remains within the top 5 category's, however, has dropped from the 2nd highest in 23/24 to the fourth largest category. There are currently 39 open risks represented by 15 new records added with 7 closed within the past 12 months.

  There are currently two open extreme risks. The Alerting system M-ighty is an extreme risk (ID3470) with the risk level increasing throughout the year due to the concern of non-escalation of deteriorating patients. The digital service is exploring alternative IT solutions to allow for mitigation against this risk. A new extreme risk in the last 6 months relates to the RSSC database (ID3638). Currently the database is not fit for purpose and equipment cannot be accurately tracked with which patients it has been used on. This issue was highlighted during a recent coroner's case and upon receipt of a field safety notice when patient specific device information was unavailable. Work with digital is underway to establish if the current system could be upgraded to meet the business needs.

- **Medical devices** remain within the top 5 categories this year with numbers remaining the same at 30. In the previous annual report, no extreme medical devices risks were reported. ID3668 is a new extreme risk (rating 15) relating to a lack of clinical engineering personnel on call. There have been several occasions over the previous twelve months where a member of the team has been called outside of normal working hours to assist the clinical teams. Information of these incidents is being collated to submit a business case. Five new risks were uploaded in the past 6 months from the Clinical Engineering department due to concern over a variety of their functions as a department.

  Across the course of the year further extreme risks were reported in relation to a lack of sufficient numbers of pacing boxes and Echo machines across the trust. Purchasing and implementation of a new fleet of pacing boxes has reduced a previous extreme risk (ID 3553) as there is now sufficient devices across the Trust

and following a period of use this risk will be closed if appropriate. Similarly, the purchasing of further Echo machines has reduced the extreme risk due to sufficient availability of equipment (ID 3612).

New or concerning medical device risks continue to be discussed at the medical devices group on a monthly basis by the Health and Safety Risk Manager.

- **Financial risks** have increased 58% within the past 12 months when compared to 23/24 remaining in the top 5 with the same number as medical device risks (n=30). There has been a notable increase in the high risks and the upload of an extreme risk. The inability to identify and deliver efficiency schemes represents the new extreme risk (ID3729) and this covers both in year delivery and medium term financial stability. In addition to being a significant project risk the EPR programme also constitutes a third of all financial risks (n=10)

**2.5 Safety Alerts**

In the last 12 months there have been 62 safety notices issued to RPH. Of these 49 were Field Safety Notices, 11 were National Patient Safety Alerts and there were 2 communication alerts. This represented a decrease in the total number of alerts received when compared to 22/23 (n=100) and 23/24 (n=91). This decrease was mostly noted with the reduction in the number of Central Alerting System (CAS) helpdesk transmissions and Communication Alerts since 22/23 from 31 to 2.

Safety alerts are assessed for relevance to the Trust by the appropriate department by assigning handlers for the area in which the item is used. All alerts have been allocated to handlers who are responsible to complete the actions if the safety alert is relevant to the Trust. In addition, new field safety notices that relate to medical devices are highlighted at the medical devices group on a monthly basis.

Of these alerts received, 37 were found to be relevant to the Trust with 21 having all actions completed at the time of reporting. Evidence of this is uploaded onto the Datix document. There were 15 that were not relevant or did not require any action and 9 are still having relevance checked. Work is ongoing with clinical engineering and the head of procurement to establish a robust process for the management of safety alerts across the Trust. Actions are expected to be completed within 14 days of uploading onto the Datix system and there are currently 28 that are overdue for completion. These are tracked monthly at the Quality & Risk Management group by reviewing updates to action plans.

Of the 11 National Patient Safety Alerts opened during 24/25 seven of these were relevant to the Trust. Drugs were the focus of six of these alerts with the seventh related to risk assessment of Transfusion Associated Circulatory Overload. There is only one relevant NatPSA received in year that has not had all actions completed and been closed. Significant progress was also made with a previous NatPSA that was received in 2023 and related to patient bed rails (ID398). The completion of all actions in relation to this notice is expected to be completed within the first 6 months of 25/26.

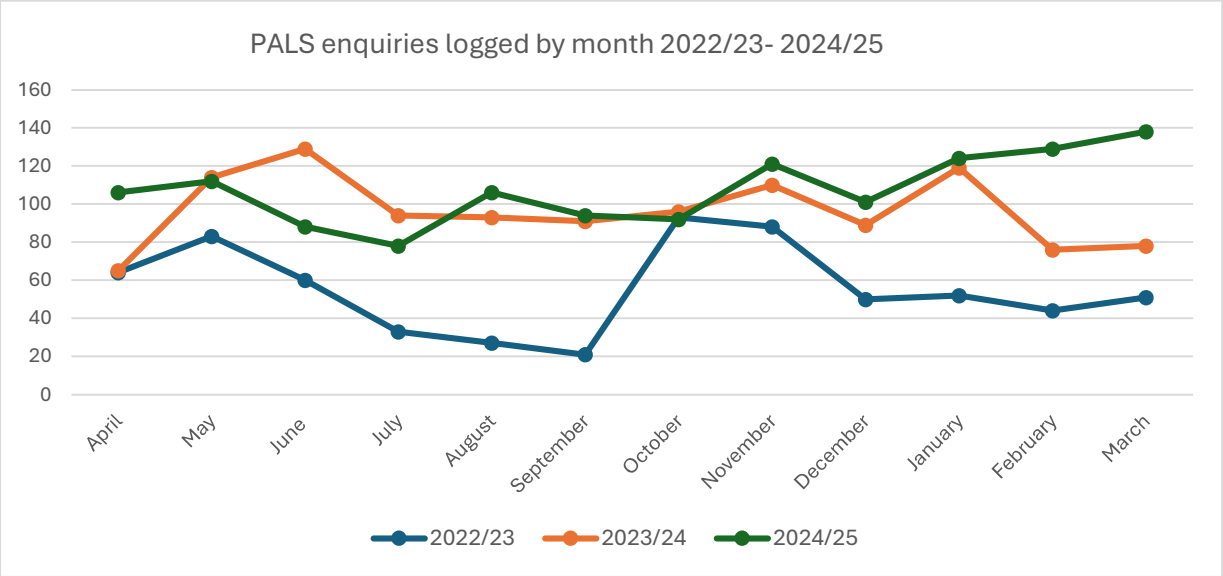
As previously reported an issue had been identified whereby medication alerts had not been received by the incidents and risks team via the MHRA central system since January 2024. These alerts had still been received and actioned where relevant by the pharmacy team. As a result, all 66 medication alerts were uploaded onto Datix between October 2024 and March 2025. These alerts are forwarded to the Chief Pharmacist for checking of relevance. Of these alerts only one was relevant to the Trust (ID822) but due to a lack of current evidence there is no action currently required in relation to this. Moving forward the incidents and risk team are preforming a manual search on a weekly basis to identify and upload medication alerts.

## 3.0 Patient Advice and Liaison Service (PALS)

### 3.1 PALS Summary

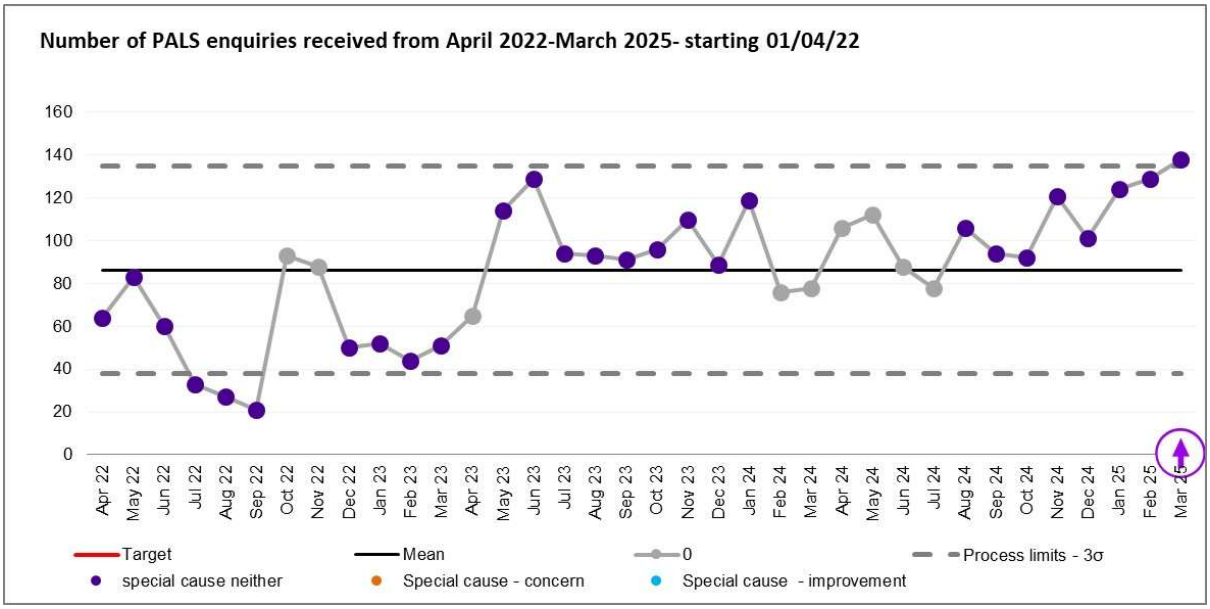
PALS enquiries are logged onto DATIX and typically require either signposting or support from other departments within the Trust. In 2024/25, the PALS team recorded 1289 enquiries. This is an increase of 12% on the previous year, 2023/24. Enquiries categorised as 'immediate resolutions', such as verbal signposting are not included in these figures. The two charts below show the number of PALS enquiries logged by month for the past 3 financial years and shows the fluctuations in activity.

Graph 15: Number of PALS enquiries received from April 2022-March 2025



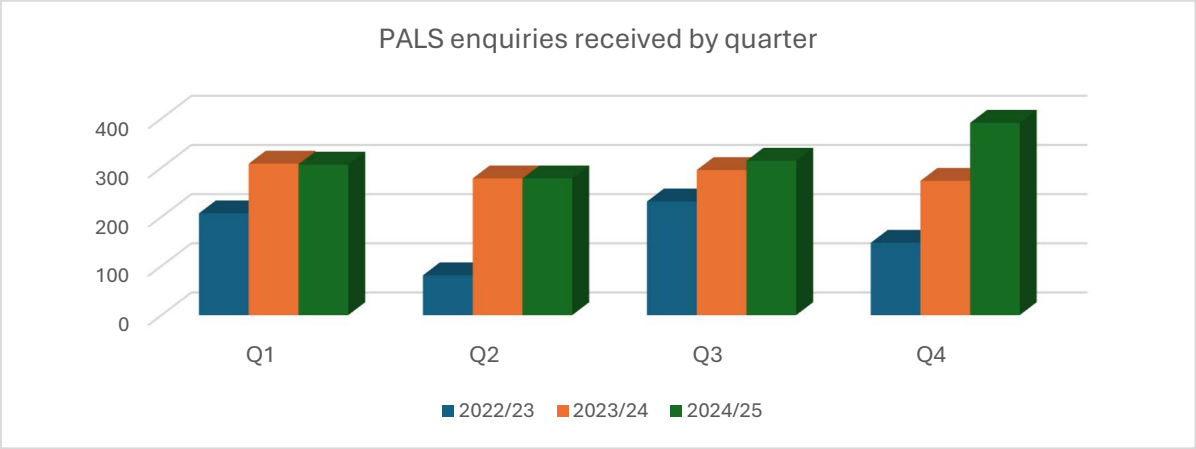

PALS enquiries received. (Source Datix 01/05/2025)

Graph 16: Number of PALS enquiries received from April 2022-March 2025




The chart below (graph 17) shows the same data by quarter and shows that for the past 2 years Q1 and Q2 have had similar activity, however for the last two quarters have shown an increase in the volume of PALS enquiries logged. This upward trend will be monitored for determining whether this is because of more robust administrative recording, or whether this in in line with the increase in demand experienced by other NHS PALS activity.

Graph 17: Number of PALS enquiries received by quarter from April 2022-March 2025

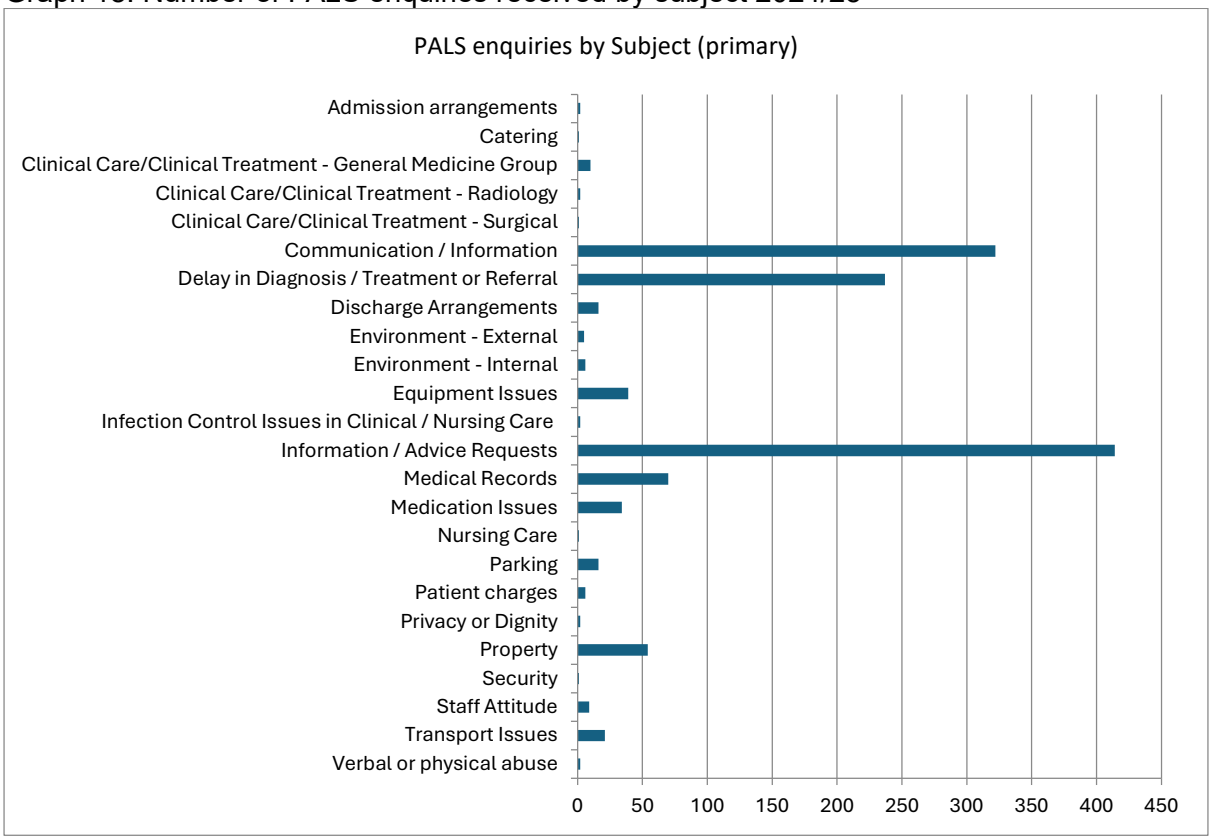



PALS enquiries received. (Source Datix 01/05/2025)

During 2024/25, the main subjects for the PALS enquiries received by the team were: Information/Advice' (34%), Communication/Information (28%), and 'Delay in diagnosis/treatment or referral' (19%).

Information/Advice enquiries tend to be the more general enquiries received, for example appointment details, or information on services or referrals. Communication/Information requests include clarification of medical letters, or issues with contacting other services and teams. Delays include admissions, procedures, or appointments.

Graph 18: Number of PALS enquiries received by subject 2024/25




Primary subjects for PALS enquiries in 2024/25 (Source Datix 01/05/2025)

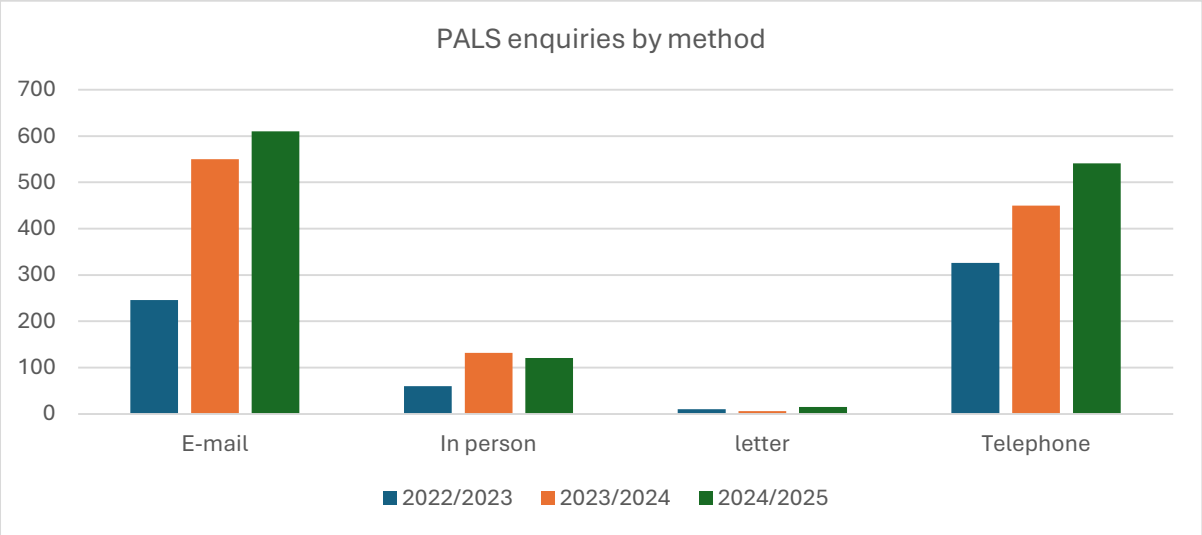
It is important to highlight that, compared with the previous year, 2024/25 saw an increase in PALS Enquiries regarding Communication/Information; Enquiries relating to Delays in Diagnosis/Treatment or Referral also increased.

Of the subjects displayed, the following patterns and themes have emerged:

- Communication remains a concern for hospital users. We have found this comes in tandem with delays. Often people are provided with an expected timeframe for which to expect a procedure or follow-up appointment for instance, but with the increased delays across the NHS, when this time comes and passes, the lack of update can leave them confused and/or apprehensive.
- The parking situation remains a concern for users of the hospital, particularly high costs. Whilst we are limited in what we can do to rectify this, as the car parks are privately owned, PALS continues to support patients, carers, and long-term visitors with discounted parking as set out in the Trust's agreement with the private car parking provider.
- Delays in diagnosis/treatment or referral have increased. This could be related to previous industrial action experienced particularly in the first quarter of last year and the subsequent impact.
- The number of enquiries relating to equipment has shown a downward trend this year. The move of the team to the new dedicated CPAP hub on the ground floor has no doubt had a positive influence on this.

**Methods of Contacting PALS**
The majority of enquiries to PALS are via email and telephone. Of the 1289 enquiries PALS received this year: 46% of enquiries were received via email, 42% via telephone and 9% in person.

Graph 19: Number of PALS enquiries received by method from April 2022-March 2025




In recognition of the in-person enquiries reducing in favour of email and telephone contact, and to support the timely processing of these methods, the PALS office implemented reduced hours during which visitors could walk-in without appointment.

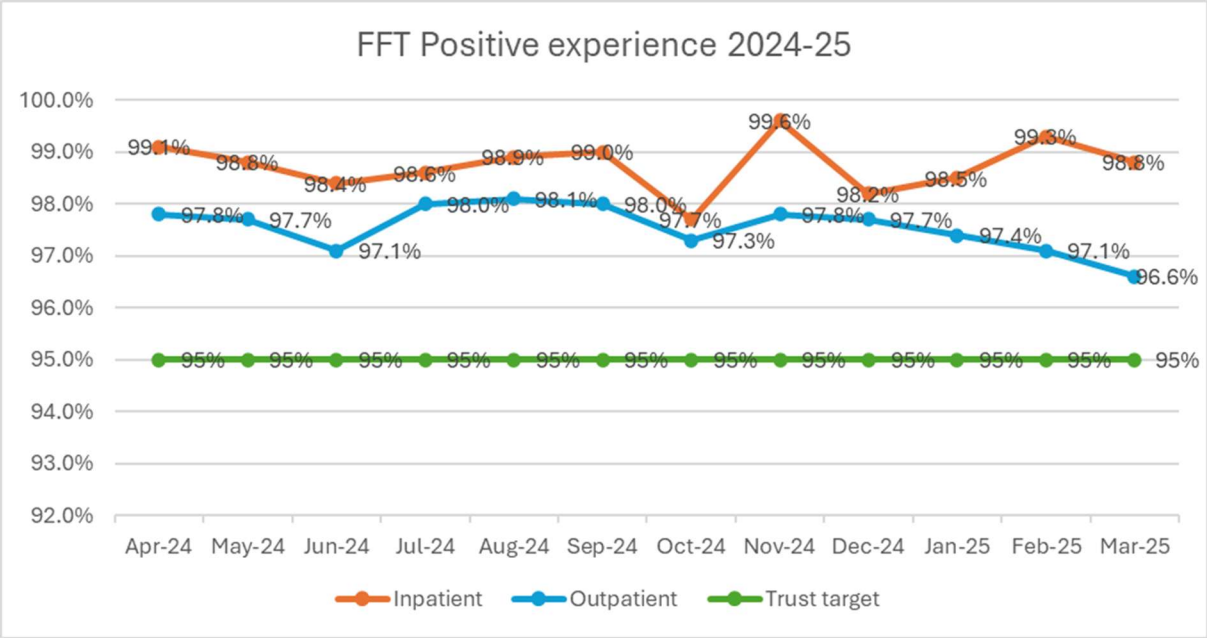
**3.2 NHS "Friends and Family" test (FFT) to improve patient experience and care in hospital**
Patient experience is the core to what we do as a Trust. We strive to achieve excellent patient care; it is even one of the Trust's values. Patient feedback is a vital resource for measuring where we stand. It forms information on what we do well and, more importantly, identifies areas in which we could improve our service. The Friends and Family test is a significant method of receiving patient feedback. We invite all patients of the hospital to participate voluntarily and anonymously in completing this survey, allowing the information to be regularly evaluated and utilized for improvement.

Since December 2020, all information has been captured via digital format. This allows all service-users (inpatients, outpatients, private patients, and day cases) to share what went right and what could have been better. The forms are easily accessible, with links on the website and QR codes provided at different junctures for inpatients, including the recent additional promotion of the QR code being displayed across the patient calling screens in the atrium and Outpatients waiting area, as well as in the CPAP hub and discharge lounge. Outpatients should expect to receive communication from the hospital via text message following their stay asking for their participation in the survey.

The responses to the FFT surveys are collated into a monthly report, allowing for more easily analysed information. The positive scores for each ward area and department are calculated and all free text responses are provided to Matrons, senior ward staff, and directorate management. The themes on areas for improvement are then highlighted and also shared with staff, allowing the possibility for improvements to be made. These are commonly shared with patients via the 'You said - We did' display boards on the wards, emphasising improvements made and the value placed on feedback received.

**Friends and Family inpatient results 2024/25**
Throughout the last year from April 2024 to March 2025, we have continued to be well above the Trust target of 95% recommendation score for our inpatient and outpatient scores collected from r FFT surveys. Scores from the Friends and Family inpatient survey for 2024/25 are shown in the figure below.

Graph 20: FFT Positive experience from April 2024-March 2025




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

**3.3 Compliments from patients and families**
Compliments are made/shared in a multitude of methods, yet they are collected in two different ways. The FFT surveys provide an opportunity to capture compliments for staff members and wards and these are logged on the compliments register. Compliments can also come directly to staff or through the PALs team in methods such as letters, cards, emails, and telephone calls. The different departments tend to collect these compliments and share with the PALS team, again they are then recorded on the compliments register.

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 893 compliments across the Trust received through the PALS team from letters, cards and emails during 2024/25 and a total of 19,429 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. All feedback is shared with our teams for ongoing service feedback and improvement.

One example of a compliment received from a patient who spent some time in our hospital: 'Everyone was kind and personable, and very helpful! The facilities were immaculate and I was provided clear and concise instructions as to how my appointment would work and where to go when. My doctor and technician were phenomenal; my doctor not only listened to my current problem but also asked clarifying questions. They were patient and kind and thorough in making sure that they obtained all necessary information to ensure that we were on the same page.'

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.

**Examples of Compliment Feedback received in 2024/25**

- A note to say a big thank you for your skill, professionalism but most of all your kindness. It made me always feel in safe hands.
- I want to thank the physios, who showed great patience in getting me moving again.
- Thank you all, especially PALS team always very supportive towards patients, families and staff at RPH.
- Thank you so much to the surgical team that took such care of me when I put my life in your hands. I will be forever grateful.
- I specifically want to mention the anaesthetists because I was very nervous about the general anaesthetic, but they made me feel completely safe and reassured.
- It's been a year since my transplant and leaving you in critical care. I will never forget the kindness and care you showed me during my long stay, everyone will be in my heart forever.
- Thank you all you have done for me. You are appreciated. Just wanted to say thank you for going above and beyond just being nurses/doctors. You complete your jobs with the utmost care which makes the difference.

**3.4 Valuing Volunteers**

The contribution of the Volunteers to Royal Papworth hospital is invaluable. Their involvement brings such a positive influence on both our patients and staff ensuring we continue to focus on the very best in patient care as a Trust.

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.

Through the valuable support of the charity team, this year has seen funding secured to allow continued employment of a volunteer's co-ordinator. In addition to supporting the PALS team, this has allowed a dedicated member of staff to focus on what has been a significant recruitment drive over the last year and beyond. The number in the team means that the hours volunteered each month is now achieving on par with pre-pandemic levels.

Our volunteers support a range of roles across the Trust such as Ward Visiting, Meet and Greet, Chaplaincy support, Research Ambassador, Pharmacy Support, Reading Panel, Charity Ambassador, and being part of our Quality Peer Review Assurance process on our wards. New roles have this year been introduced, specifically targeting areas that are seeking support. This includes working with the Treating Tobacco Dependency Programme, as well as an aimed focus on assisting the wards with the patient FFT survey participation.

**Pets as Therapy (PAT)**
The Pets as Therapy (PAT) initiative is being finalised and onboarding of three volunteers and their dogs has begun. There are also another three volunteers going through the recruitment process and will be ready to start visiting patients and staff very soon. Collaborative working between the volunteer co-ordinators at Royal Royal Papworth and Cambridge University Hospital has ensured that a streamlined recruitment process is available for volunteers that wish to volunteer across both sites, this is very positive and has encouraged PAT dog volunteers to support both Trusts.

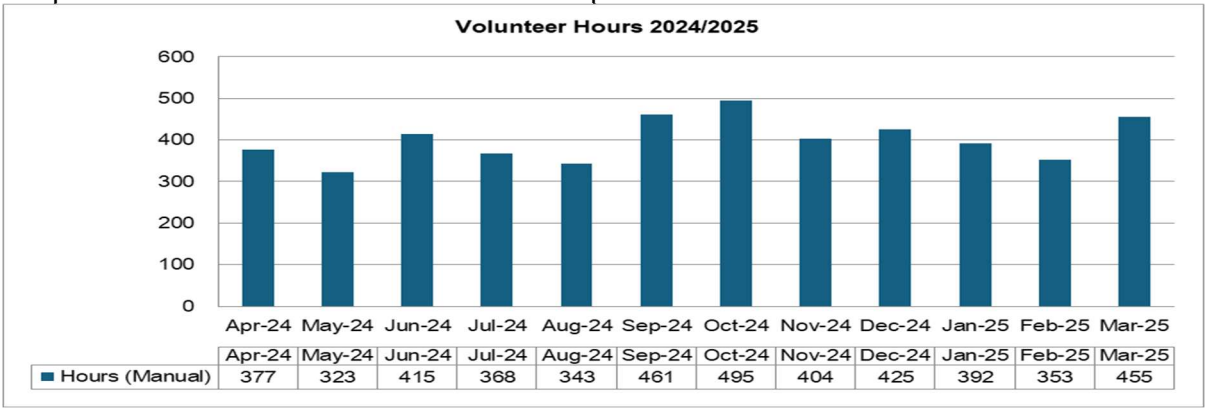
Visits by specially trained pets to a healthcare setting have been shown to have a beneficial outcome to the emotional, physical and social wellbeing of patients and employees. PAT dogs provide additional social interaction for the patient which will help to reduce anxiety, stress and improve the overall mental wellbeing of the patient - research has proven this concept brings a huge benefit to patients through much needed social interaction, in turn reducing stress and anxiety.

In June we celebrated National Volunteers week. This was an opportunity for us to show our appreciation to the team by providing 'Thank you' packages, including certificates, gifts, and a voucher for their use in the restaurant.

Between April 2024 and March 2025, our amazing volunteers contributed a total of 4,811 hours in supporting our staff make a real difference to our patients, their families, friends, and relatives. This compares to 3,609 hours in 2023/24, and 2,220 hours in 2022/23. That is more than a 33% increase in hours volunteered in a year, and a huge 117% increase in 2 years.

The figure below shows the total number of Volunteer hours for each month in 2024/25.

Graph 21: Number of Volunteer Hours from April 2024-March 2025




| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hours (Manual) | 377 | 323 | 415 | 368 | 343 | 461 | 495 | 404 | 425 | 392 | 353 | 455 |

The volunteer coordinator continues 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, including the Volunteers handbook.

The use of the 'Better Impact' database has been advanced this year, with a move to fully utilise this in terms of the volunteers signing in and out for duty. The features of the database continue to be used to our advantage, and it is a source of valuable information, providing

data on such things as the number of patients seen by the team during their volunteered hours for example. This is a powerful tool and will become even more useful as we explore its full capabilities further.

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

**3.5 Bereavement and Bereavement follow-up services**

The PALS service continues to provide a bereavement service for our families. PALS support and provide information regarding bereavement, bereavement follow up, the coroners process and the Medical Examiner process to families and staff across the Trust. This is in the aftermath of a bereavement, offering support and guidance through the process and assisting families in what is a tremendously confusing, challenging, and difficult time.

As of 09 September 2024, the Medical Examiners process became statutory nationwide. Royal Papworth were already operating under these arrangements, however the national implementation brought with it a few changes. The most notable of these were changes to the Medical Certificate of Cause of Death (MCCD) and the expansion of detail required, in addition to the abolition of the CF4 Cremation form. Our continued collaboration with the Medical Examiner Officer team has meant the transition has been seamless and disruption has been minimal.

The PALS team continue to work closely with our ward clerks, medical examiners, medical examiner officers and in addition the mortuary team at CUH. As of November 2024, there was a creation of a hybrid role and the “PALS Advisor” is now the “Bereavement and PALS Advisor”. This has increased the collaboration between the PALS team and the medical examiner’s office, allowing for smoother working on RPH bereavement cases. Whilst still in its infancy, this way of working has shown positive early indications.

Below are some statistics and information based on PALS and their involvement with Bereavement in 2024/25:

- 194 patients passed away at RPH.
- 81 referrals were made to the coroner.
- The PALS team continued to support the mortuary team at CUH with chasing outstanding paperwork and completion of the bereavement process, as well as seeking Funeral Director details.
- In this period the team contacted 149 families via the Bereavement follow-up process. Each family of a hospital bereavement is sent a letter between 6-8 weeks after the date of bereavement offering them an opportunity to discuss their loved-one’s care and death with the medical team. This offers the chance to understand their loved one’s medical journey, often providing them with better understanding and providing the opportunity to have any questions they have answered by the care team involved. This can be a hugely important part of the grieving process and helps the families at such a difficult time. During this period, the PALS team co-ordinated and attended 40 such meetings.

## 4.0 Patient Experience

### 4.1 Formal and Informal complaints

Listening to the patient experience and taking action following investigation of concerns and complaints is an important part of our Quality Improvement framework and provides an opportunity for the Trust to learn from valuable patient feedback to improve the services we provide.

The patient experience team set some local goals to be achieved during the period 2024/25.

The first was to build resilience within the Patient Experience Team by improving cross-cover to ensure no loss of service during periods of staff annual leave and sickness. We have been successful in securing funding to recruit a part-time Volunteer Coordinator, and the team have some cross-cover of roles to cover core-functions of PALS, Complaints, Friends and Family testing (FFT) and Volunteer Services.

The second goal was to continue to proactively engage with service users to resolve PALS enquiries at point of contact and to provide assurance that issues are dealt with appropriately. This has been achieved with 1289 PALS enquiries being received and addressed in 2024/25 compared to 1151 enquiries recorded in 2023/24.

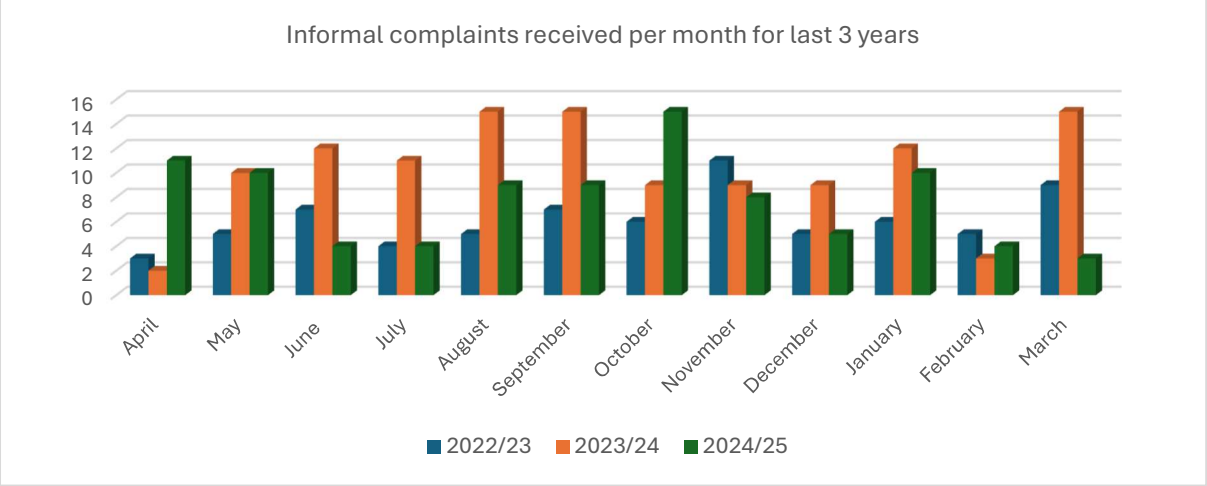
A third goal achieved this year was that since November 2024, our Patient Advice & Liaison Service (PALS) have been collaboratively working with the Medical Examiner's Office to ensure a seamless and more joined-up service for our bereaved families, to better support and guide them through the process following the death of their loved-one.

**Informal Complaints**

95 informal complaints were dealt with and resolved at a local level in in 2024/25, compared to 127 in the previous year 2023/24. Informal complaints are issues that the complaint has agreed that they would like to resolve through local resolution, without a formal complaint process being followed. The resolution process is a more of a personalised approach to gain resolution to the concerns raised and this is often resolved with our clinical team being involved or through our Patient Advice & Liaison Service support.

The graph below shows informal complaints by month over the last 3 years.

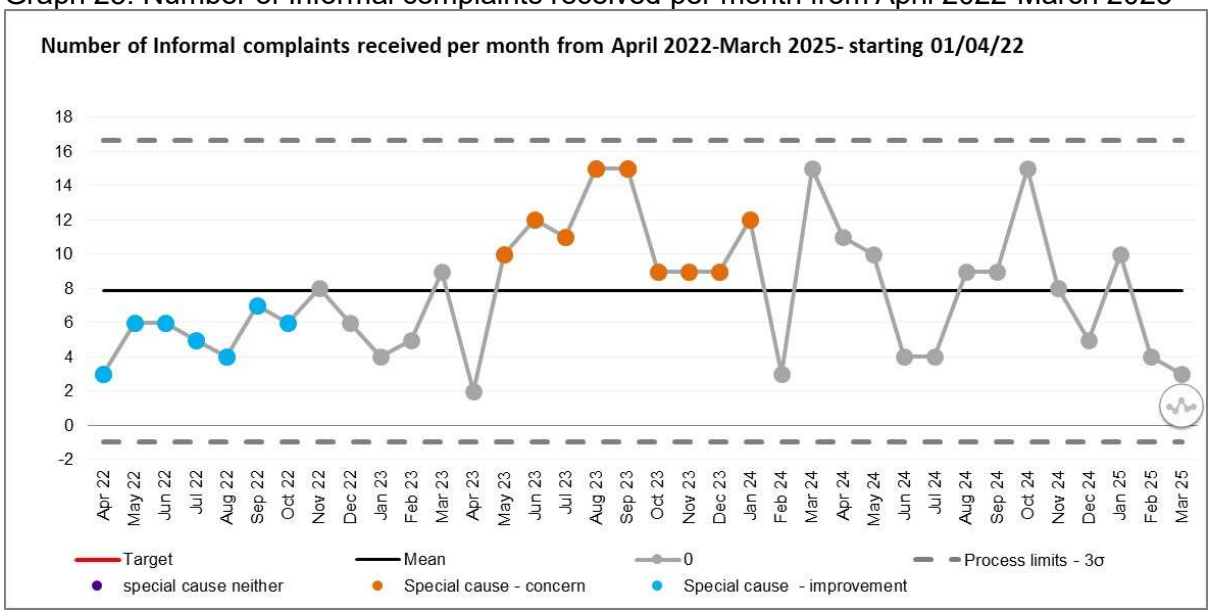
Graph 22: Number of Informal complaints received per month from April 2022-March 2025




Source Datix 29/04/2024

Graph 23 below shows the same data but presented as a timeline which, when compared to the PALS enquiries logged for the same period, indicates which the PALS enquiries are increasing the volumes of Informal complaints logged by PALS staff are tailing off. This downward trend will be monitored in line with the increased PALS enquiries activity to check for inconsistencies in processing.

Graph 23: Number of Informal complaints received per month from April 2022-March 2025

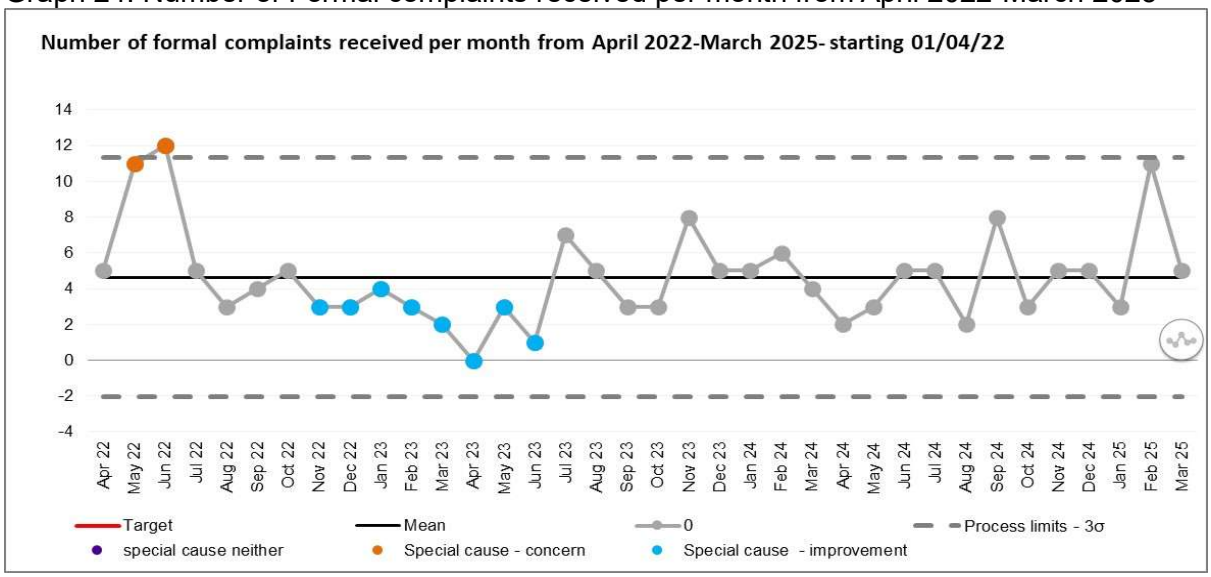



**Formal Complaints**

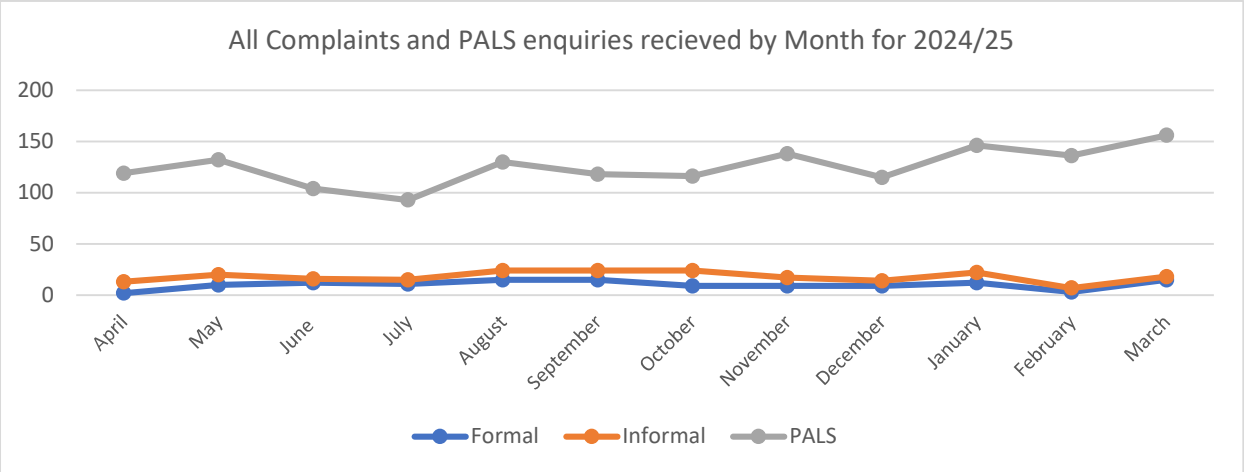
Every year the trust must make a statement under the NHS Health & Social care Act 2009 about how many complaints it has received, their subject, the issues they raise, whether they were well founded, and any actions taken. During the year we received 57 complaints in the period 2024/25. This compares to 52 complaints in the previous year 2023/24.

Graph 24 shows the formal complaints received over the last 3 consecutive years and shows that although monthly volume received have fluctuated, overall, the total per year have remained fairly static (57 in 2024/25; 50 in 2023/24; 58 in 2022/23)

Graph 24: Number of Formal complaints received per month from April 2022-March 2025



Graph 25 shows All Complaints (Informal and formal) and PALS enquires received per month from April 2024-March 2025




Source Datix 29/04/2024.

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.

**Subjects of complaints**
The most frequently occurring themes from Formal and Informal complaints were communication/Information (46%), delay in diagnosis/treatment or referral (26%) and clinical care/clinical treatment (24%)

**Sub subjects of complaints**
The five most frequently occurring sub subjects, specific issues raised within complaints about communication/information, delay in diagnosis/treatment or referral, or clinical care/clinical treatment were: lack of information for patients, waiting time for operation, and dissatisfied with medical care/treatment/diagnosis outcome.

**How many formal complaints were well founded?**
In the language of the complaint's services, the terminology used states whether the complaints are upheld. Just over half of all complaints closed (60%) were concluded as being fully upheld or partially upheld. By this we mean that at least one of the concerns raised by the complainant required concerted action on the part of the hospital to address the issue. Of the 52 closed there were 26 that were recorded as partially upheld, 5 classed as upheld and 21 that were agreed to be not upheld of those closed by the end of the financial year.

A breakdown of the number of complaints upheld per month in 2023/24 is shown below:

Table 11 – Number of complaints upheld per month from April 2023 to March 2024

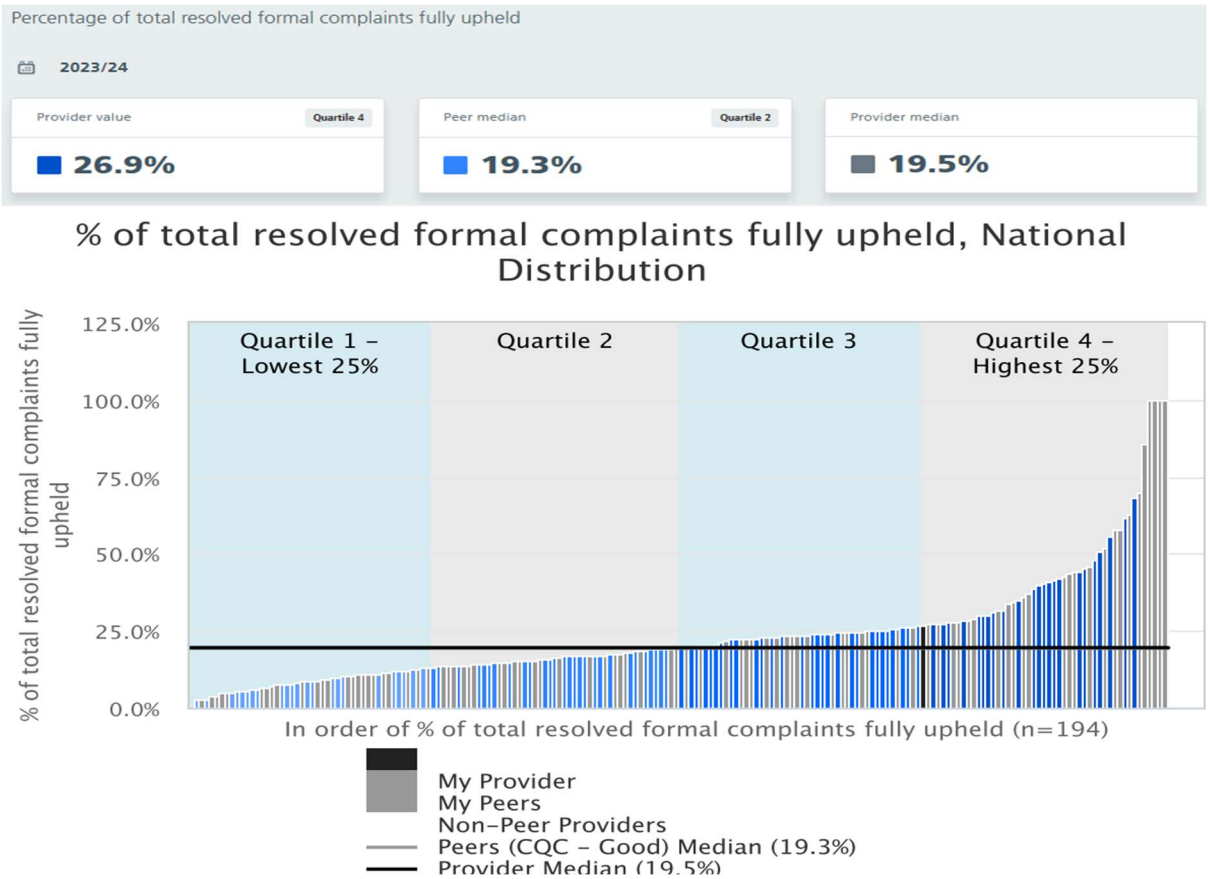
| April 2023 | May 2023 | June 2023 | July 2023 | Aug 2023 | Sept 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | March 2024 | Total upheld |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 5 |

**National benchmarking**
The Trust uses the Model Hospital Metric to benchmark the number of formal complaints we receive against the total number upheld. Model Hospital reports the percentage of formal complaints upheld and provides a common basis for comparing the rate of

upholding complaints, between organisations. This is monitored monthly as part of the Royal Papworth Integrated Performance Report (PIPR) and quality and risk reporting. Of the 52 formal complaints closed in 2024/25, 5 (10%) were fully upheld.

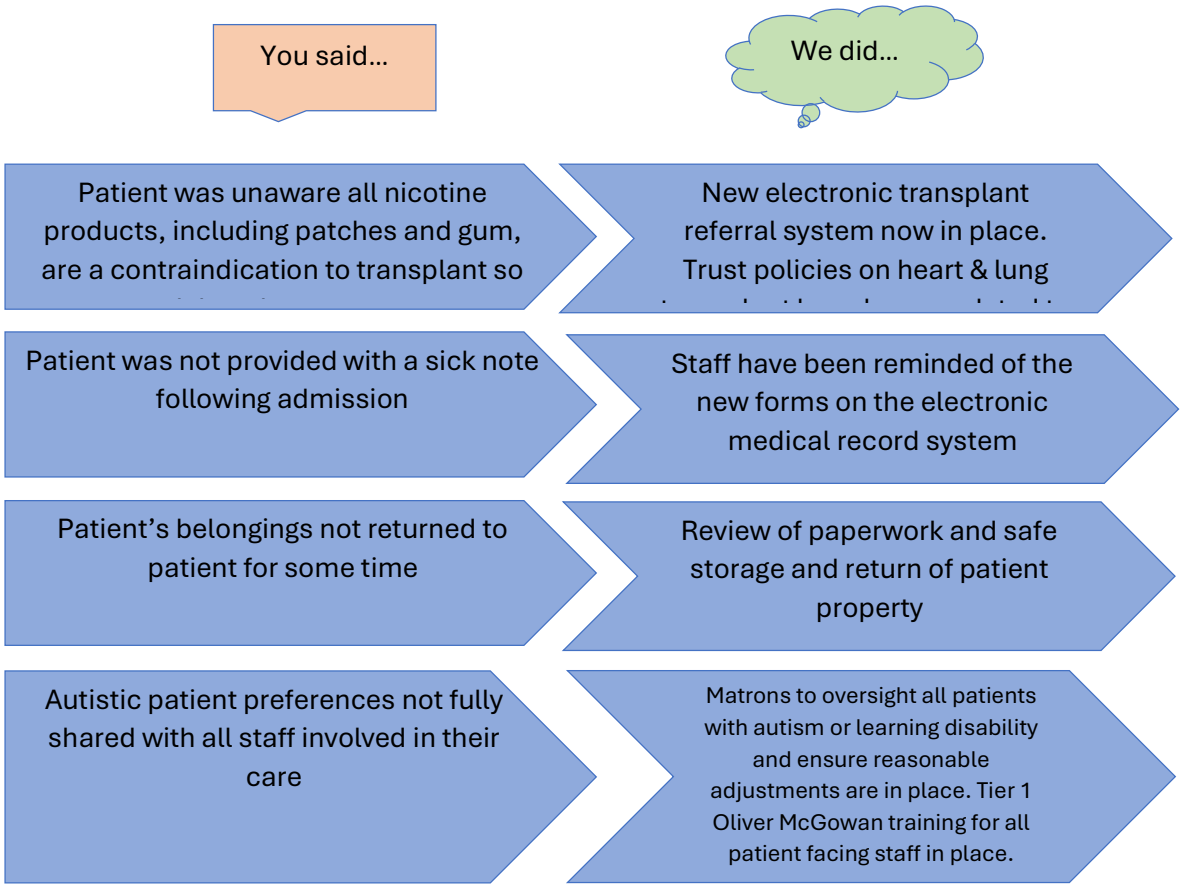
The below graph shows the data from 2023/24 when 26.9% (14/45) of the total number of resolved formal complaints were fully upheld. Comparing this to 2022/23 data we have moved into the fourth quartile for the number of complaints upheld (as seen in graph below where the peer median was 19.3%) and 7.4% above the national provider median (19.5%), based on the national comparative data. The shift in our provider value could be attributed to the change in personnel within the hospital complaints services from September 2023 and the subjective nature of whether a complaint is partly or fully upheld. The model hospital data will be updated again in October 2025 following the KO41A submissions from all Trusts, so we will be able to compare this year's annual figure further at this point.

Graph 26: % of total resolved formal complaints fully upheld 2023/24




Source Model NHS UK 30/04/2024.

**Learning from Complaints**
Actions are taken over the year and should demonstrate a clear connection from the concern raised to the change the organisation has made. Below are some of the quality improvements to our services we have made from the actions agreed and implemented from the complaint received in year:




## 5.0 EFFECTIVENESS OF CARE

### 5.1 Clinical Audit

**National Clinical Audits 2024/25 Summary**

In 2024/25 there were 19 National clinical audits and 1 National Confidential Enquiry projects that were relevant to Royal Papworth Hospital NHS Foundation Trust. During 2024/25, Royal Papworth Hospital participated in 100% of National Clinical Audits and both 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 submitted during 2024/25, are listed below.

Table 12 – National Clinical Audits in 2024/25 relevant to RPH

| National clinical audits relevant to Royal Royal Papworth Hospital<br>Participation rate 19/19 (100%) | |
|---|---|
| **Audit Title** | **Audit Source** |
| Case Mix Programme (CMP) | Intensive Care National Audit and Research Centre (ICNARC) |
| National Audit of Inpatient Falls<br>Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF) | Royal College of Physicians |
| Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) | NHS England |

| National clinical audits relevant to Royal Royal Papworth Hospital<br>Participation rate 19/19 (100%) | |
|---|---|
| Maternal, Newborn and Infant Clinical Outcome Review Programme | MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford |
| Medical and Surgical Clinical Outcome Review Programme | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) |
| National Audit of Cardiac Rehabilitation | University of York |
| National Audit of Care at the End of Life (NACEL) | NHS Benchmarking Network |
| National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA) | Royal College of Surgeons of England (RCS) |
| National Cardiac Arrest Audit (NCAA) | Intensive Care National Audit & Research Centre (ICNARC) |
| National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA) | National Institute for Cardiovascular Outcomes Research (NICOR) |
| National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA) | National Institute for Cardiovascular Outcomes Research (NICOR) |
| National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM) | National Institute for Cardiovascular Outcomes Research (NICOR) |
| National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP) | National Institute for Cardiovascular Outcomes Research (NICOR) |
| National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI) | National Institute for Cardiovascular Outcomes Research (NICOR) |
| National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138 | NHS Blood and Transplant |
| National Pulmonary Hypertension Audit | NHS England (formerly NHS Digital) |
| UK Cystic Fibrosis Registry | Cystic Fibrosis Trust |
| UK Renal Registry National Acute Kidney Injury Audit | UK Kidney Association |
| National Diabetes Inpatient Safety Audit (NDISA) | NHS England (formerly NHS Digital) |

In 2024/25, 13 national audit reports were published that were relevant to RPH. Between October 2024 – March 2025, 5 national audit reports were published that were relevant to RPH. A summary is provided in table 13 below.

Table 13 – Published National Clinical Audit Reports in 2024/25 relevant to RPH

| National Audit | Date Published | Divisional / Department Ownership |
|---|---|---|
| **Falls and Fragility Fractures Audit Programme (FFFAP)** – the 2024 National Audit of Inpatient Falls (NAIF) report presents a new approach to risk factor assessment that focuses on promoting activity to ensure each patient is fit to move as safely as possible. | October 2024 | Nursing |
| **National Clinical Audit and Patient Outcomes Programme (NCAPOP) Impact Report** - the report provides a summary of some of the key impacts the NCAPOP projects have had. | October 2024 | Trust-Wide |
| **End of life care – Planning for the End (NCEPOD)** – the report presents a review of the quality of care provided to adult patients with a diagnosis of dementia, heart failure, lung cancer and liver disease towards the end of life. | November 2024 | Nursing<br>Supportive and Palliative Care |
| **National Audit of Dementia (NAD)** – the report on Care in General Hospitals 2023-2024, underscores the need for a continued strong focus on governance, monitoring and oversight of dementia care. | December 2024 | Nursing |
| **National Cardiac Audit Programme (NCAP) Annual Report 2025 – t**he report looks at the performance of cardiovascular services, shows the positives but illustrates where there are opportunities for improvements. It is accompanied by supporting interactive reports from 10 sub-specialties covered by the audit programme and a dedicated Annual Report for Patients, Carers and the Public. | March 2025 | Cardiology/STA |

Source HQIP website 15/04/2025

Trust Wide Annual Report 2024/25 - external publication

A copy of these reports and relevant links to key findings and recommendations have been circulated to relevant clinical audit leads and their divisions for dissemination and discussion of the specific recommendations contained within each report. Any actions and improvements resulting from these national audits will be shared with QRMG via the Clinical Audit Team.

### 5.2 Progress against Clinical Audit Annual programme

There were 34 agreed Trust-wide and local clinical audits on the clinical audit annual programme for 2024/25 *(excluding the 20 National Clinical Audits),* see Appendix 1. One audit was cancelled, leaving 33 to be completed in 2024/25. A total of 23 audits were completed (70%), 4 (12%) were on placed on hold by the project lead or not completed within the designated timeframe and 6 (18%) were carried forward to 2025/26. The clinical audit programme is reviewed regularly at the Quality & Risk Management Group. Table 14 below shows a breakdown of progress against the clinical audit annual programme for 2024/25 by division.

Table 14 – Progress per division against clinical audit annual plan

| Division | Number of audits | | | |
|---|---|---|---|---|
| | Due to be completed in 2024/25 | Completed in 2024/25 | Cancelled or Not Completed in 2024/25 | Awaiting update |
| Surgery, Transplant & Anaesthetics | 3 | 2 | 0 | 1 |
| Cardiology | 2 | 1 | 0 | 1 |
| Thoracic & Ambulatory Care | 4 | 0 | 1 | 3 |
| Nursing | 12 | 11 | 0 | 1 |
| Trust-Wide | 13 | 9 | 3 | 1 |
| **TOTALS** | **34** | **23** | **4** | **7** |

Source Clinical Audit Management Tracker 15/04/2025

### 5.3 Local/Divisional Audits

**Completed Clinical Audit and Improvement Projects in 2024-25**

In addition to the clinical audit projects detailed on the clinical audit annual programme, 142 local/divisional audits were registered for completion in 2024/25. These projects were aimed at improving the quality of local patient care and clinical outcomes through reviews of practice against evidence-based standards and included clinical audits, service evaluations, quality improvement and patient satisfaction/experience projects. A breakdown of these projects by division is shown in table 15 and a summary of the 20 local audits completed between October 2024 – March 2025 can be found in Appendix 2.

Table 15 – Projects by division in 2024/25

| Division | Number of Projects Registered | Number Completed in 2024/25 | Number cancelled or not completed in 2024/25 | Number carried forward to 2025/26 |
|---|---|---|---|---|
| Surgery, Transplant & Anaesthetics | 75 | 29 | 2 | 44 |
| Cardiology | 25 | 17 | 2 | 6 |
| Thoracic/Ambulatory care | 19 | 13 | 1 | 5 |
| Nursing | 23 | 10 | 0 | 13 |
| **Total** | **142** | **69** | **5** | **68** |

Reports detailing the current Local/Divisional audit activity and progress against the clinical audit annual programme is presented by the relevant Clinical Audit and Improvement Coordinator for the division. Regular reporting at relevant business unit, working group or

steering group meetings ensure that progress is monitored and any areas for escalation i.e. those projects which have yet to commence are identified.

### 5.4 NICE Guidance

In 2024/25 there were 152 NICE Guidance publications disseminated. Of these, 97 were technology appraisals which have been reviewed by DTC, 46 were deemed as not relevant to Royal Papworth Hospital, 2 were circulated for information only and 7 were disseminated to the relevant clinical leads for review and confirmation of relevance. A detailed breakdown of all published NICE guidance documents is reported at QRMG each month.

A summary of the 4 relevant publications which were disseminated between October 2024 – March 2025 is provided in table 16 below.

Table 16 – Relevant NICE guidance published between October 2024 – March 2025

| Publication date | Reference | NICE Guidance Title |
|---|---|---|
| 24/10/2024 | DG61 | Heart failure algorithms for remote monitoring in people with cardiac implantable electronic devices |
| 19/12/2024 | HTE19 | Digital technologies to support self-management of COPD: early value assessment |
| 04/02/2025 | NG209 | Tobacco: preventing uptake, promoting quitting and treating dependence. |
| 05/02/2025 | IPG802 | Intravascular lithotripsy to treat calcified coronary arteries during percutaneous coronary intervention |

**Reviews in Progress**

In addition to these new publications, between October 2024 – March 2025 the Trust is currently responding to 3 publications which are relevant to RPH which are either undergoing baseline assessment or awaiting approval of an action plan, the progress of which is shown in table 17.

Table 17 – Relevant publications under review October 2024 – March 2025

| Ref No. | Title | Publication Date |
|---|---|---|
| NG197 | Shared decision making | 17/06/2021 |
| NG128 | Stroke and transient ischaemic attack in over 16s: diagnosis and initial management | 13/04/2022 |
| NG236 | Stroke rehabilitation in adults | 18/10/2023 |

**Outstanding Actions**

There are currently 6 publications with an action plan in progress following completion of a baseline assessment. A summary of the progress to date is provided in the table below.

Table 18 – Publications with an action plan in progress

| Title and reference Number | Lead/Division | Status | Completion Date |
|---|---|---|---|
| Acute coronary syndromes (NG185) | Consultant Cardiologist | 1 action identified from baseline assessment. A clinical audit being undertaken to confirm compliance.<br>Audit ongoing. | Aug 2025 |
| Delirium: prevention, diagnosis and management in hospital and long-term care (CG103) | TBD at Delirium and Dementia Working Group | 1 action identified from baseline assessment – implementation of the delirium care bundle on Lorenzo once the revised policy has been approved and rolled out. Completion date extended whilst policy is ratified. | May 2025 |

| Title and reference Number | Lead/Division | Status | Completion Date |
|---|---|---|---|
| Advocacy services for adults with health and social care needs NICE guideline (NG227) | Safeguarding Lead | Action plan has been agreed by Safeguarding Committee following completion of baseline assessment. 6 actions have been identified and allocated to relevant leads. Progress is being monitored through the Safeguarding Committee. | August 2025 |
| Autism spectrum disorder in adults: diagnosis and management (CG142) | Safeguarding Lead | Action plan has been agreed by Safeguarding Committee following completion of baseline assessment. 6 actions have been identified and allocated to relevant leads. Progress is being monitored through the Safeguarding Committee. | August 2025 |
| Anaphylaxis (QS119) | Lead Resuscitation Officer | 1 action identified through baseline assessment, currently exploring methods of monitoring referrals to specialist services. Progress is being monitored through the ALERT Steering Group. | July 2025 |
| Suspected sepsis: recognition, diagnosis and early management (NG51) | Lead Advanced Nurse Practitioner | Action plan has been agreed by ALERT Steering Group to update the discharge summary to reflect the recommendations within the NICE Guideline. Progress is being monitored through the Alert Steering Group. | July 2025 |

### 5.5 National Confidential Enquiry into Patient outcome and Death (NCEPOD)

Between October 2024 – March 2025 there was one new publication which was relevant to RPH from NCEPOD. The End-of-life care – Planning for the End Report presents a review of the quality of care provided to adult patients with a diagnosis of dementia, heart failure, lung cancer and liver disease towards the end of life. The report and relevant key recommendations were circulated to the Supportive and Palliative Care team and an action plan for the relevant recommendations was developed and progress is monitored through the End-of-Life Steering Group.

During 2024/25, Royal Papworth Hospital participated in two NCEPOD studies a summary of which is provided in table 19 below.

Table 19 – NCEPOD studies participated in by RPH Between October 2024 – March 2025

| Study Title | Update |
|---|---|
| Rehabilitation following Critical Care | All data was submitted within designated timeframes. No outstanding actions. Awaiting publication of final report in Spring 2025. |
| Blood Sodium | Clinician questionnaires and case note records have been submitted. Awaiting completion of the organisational questionnaire.<br>Report due to be published in Winter 2025 |

### 5.6 Quality Improvement

The Clinical Audit team continue to support staff across the Trust in undertaking Quality Improvement Projects. Since, June 2024 the team have developed a variety of resources and dedicated training sessions for staff wishing to undertaking quality improvement projects at Royal Papworth Hospital. The clinical audit team have also developed pages on the intranet to provide staff with key resources to undertake a clinical audit or quality improvement project. Clinical Audit Awareness week in June 2024 was an opportunity to promote and celebrate the benefits and impact of clinical audit and quality improvement work in healthcare. It was an opportunity to showcase examples of quality improvement projects as well as clinical audit and service evaluation projects which have resulted in improvements to service delivery and, or the quality of patient care our teams deliver.

A Medicines Quality Improvement Project was undertaken during Q3 2024 by the Head of Quality Improvement and Transformation, and Chief Pharmacist to review medicines incidents and explore key themes arising. Four focussed areas were identified to form the Terms of Reference for the project: reporting culture, controlled drugs (CD), intravenous (IV) medications and dopamine infusions. It is recognised that the aim of any improvement is not

to reduce the numbers of reported incidents, which evidence a psychologically safe culture but to demonstrate a movement from incidents with harm to patients, near miss incidents or the same type of No harm/low harm incidents re-occurring.

A review of all medicine's incidents reported from April 2021 to August 2024 was undertaken to understand reporting over time and demonstrated that the number of incidents reported, and themes remained largely the same over the data period. The findings guided areas to undertake staff engagement and exploratory discussions with wards/departments leads/staff, meetings, and observations/discussions of practice with the nursing teams. The aim being to further understand through a system lens the challenges posed in practice and potential opportunities to support safe medicines management. The project findings were summarised within the System Engineering Initiative for Patient Safety (SEIPS) model and shared at Medicines Safety Group with group members sharing their reflections on the relevance to their areas of practice. Subsequently the project findings have also been shared via QRMG and the Quality and Risk Committee.

There were some excellent examples of safe and effective medicines management practices observed, and examples where wards had made significant improvements. Wider sharing of their improvement journey and approach to learning was recommended.

The project made several recommendations for opportunities for improvement. The Patient Safety Incident Response Framework plan for 2025/2026 includes medication safety as one of the 3 focussed areas. Improvement work will be taken forward via a specific Medication Administration Task and Finish Group overseen by Medicines Safety Group reporting to Quality and Risk Management Group (QRMG) and the Trust Medication Safety Committee.

A new approach to CQC preparedness was approved through the Fundamentals of Care Board (FoCB) in Q3 2025/25 with implementation overseen by Head of Quality Improvement and Transformation through a two-step approach to quality assurance.

1. Divisional self-assessment against the Single Assessment Framework is in progress. The self-assessment tool is mapped to the CQC single assessment framework and enables ward and department leaders to undertake a baseline assessment against the CQC Single Assessment Framework, to assist with identifying areas for celebration or improvement (where applicable) and future CQC inspections.
2. A Quality Accreditation (QA) assessment pilot undertaken in Cardiology wards in Q4 2024/25. Cardiology were commended for the quality of care observed and their positive enthusiasm to participating in the pilot approach to Ward to Board assurance of the Fundamental Standards (regulations 8 to 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Detailed feedback has been provided to the division to enable them to identify opportunities for improvement to take forward via a locally led improvement plan monitored via their business unit meeting and FoCB. The pilot QA assessment will undergo evaluation to enable learning and revisions before the next QA assessment commences in 2025/2026.

## 6.0 INQUESTS AND CLAIMS

### 6.1 Inquests

There were 26 inquest hearings between 01/04/2024 and 31/03/2025 and the length of inquest ranged from 1 day to 4 days. This is a slight increase on 2023/24 (23) and has remained lower than the peak in 2022/23 (36).

- 15 inquest hearings required representation from Royal Royal Papworth Hospital, and of these five had legal representation.
- 11 inquests RPH submitted documents or statements, and the evidence was read under Rule 23 and no one from the Trust was required to attend.

- The coroner's conclusions have been reviewed and there are no trends. As with previous years the majority of conclusions were narrative to reflect the complexity of the case or the complication experienced.

Any learning points identified at Inquest are discussed at QRMG and a summary of inquests heard in month is presented in the monthly Clinical Governance report.

**Pre-Inquest Review Hearings (PIRH)**
11 Pre-Inquest Review hearings were held in 2024/25 which the Trust attended, this is a decrease compared to 2023/24 (16). The purpose of these is for all interested parties to meet and agree the scope of the future inquest.

**New Inquest notifications**
The Trust has been notified of 48* new inquests/coroner's investigations between 01/04/2024 and 31/03/2025 and statements and clinical records have been requested. The number of cases open with the Trust under the Inquest process as at 31/03/2025 is 71 *(end of previous year was 81).*

In addition to the above, there were 20 additional cases in 2024/25 where the Coroner asked the Trust to provide information from the patients' medical records for their initial investigations (such as biopsy results, Rapid Casenote Reviews, pacemaker information) but RPH had no further involvement.

**One new notification had not been included in the previous 24/25 6 monthly report due to the notification date added as 23/24 when a family bereavement meeting was organised ahead of the official Coroner's investigation process. This has been amended to reflect the date the Trust was first notified of an investigation by the Coroner.*

**Learning from Prevention of Future Deaths (PFD) report – Regulation 28**
The prevention of future death reports are published on the Courts and Tribunals judiciary website. Any relevant reports or themes are forwarded to the relevant clinical leads and presented at QRMG for further dissemination and learning.

The Trust did not directly receive any PFD reports in 2024/25. Following one of the inquest hearings the Trust attended in Q3 2024/25, the Coroner issued a PFD report to the Department of Health and NHS England. This was reported in the Clinical Governance monthly report for November 2024 and highlighted at the QRMG meeting in December 2024.

### 6.2 Clinical and Non-Clinical Negligence Litigation

In 2024/25 the Trust received 17 new requests for disclosure of records for potential claims, 4 formal Letters of Claim and 4 Letters of Notification of potential claims. There were 5 cases closed. Total claims activity for 2024/2025 is shown in Table 20 below.

Table 20: Clinical claims activity between 01/04/2024 and 31/03/2024

| **Total Claims Activity for 2024/25** | | |
|---|---|---|
| Records Disclosure Requests received | 17 | CL599, CL481, CL484, CL488, CL494, CL511, CL517, CL520, CL611, CL612, CL613, CL617 CL622, CL626, CL627, CL629, CL630 |
| Letter of Claim (LOC) received: | 4 | CL489, CL436, CL531, CL600, |
| Letter of Notification (LON) received | 4 | CL452, CL459, CL602, CL599 |
| Closed – LOC / LON Settled | 4 | CL363, CL452, CL403, CL407 |
| Closed - Records Disclosure Requests Closed - No Further Action | 1 | CL358 |

Data Source: NHS Resolution 31/03/25

| Total Inquest Funding Activity | |
|---|---|
| Requests to NHSR for Inquest Funding | 5 |
| No of requests accepted for Inquest funding | 4 |
| No of inquests funded by Trust | 1 |

**Outstanding Clinical negligence claims as at 31/03/2025**
Table 21 below summarises the 31 clinical negligence claims that are currently open and being managed by NHS Resolution on behalf of the Trust as at 31/03/25. These costs represent the total claims cost if all these were accepted as breach of duty. *The Trust contributes to these costs via the Clinical Negligence Scheme for Trusts (CNST).*

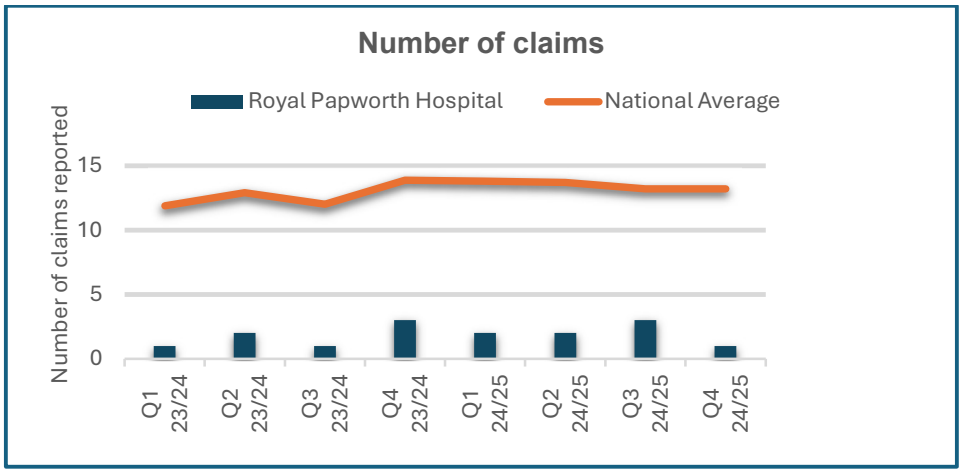
Table 21 The total costs of claims if these were accepted as breach of duty

| No. of claims | Total damages reserve | Total claimant costs reserve | Total defence costs reserve | Total outstanding estimate |
|---|---|---|---|---|
| 31 | £18,112,596 | £2,947,499 | £1,200,818 | £18,459,256 |

Data source: NHS Resolution Q4 2425 (As at 31/03/25)

Graph 27 shows the total number of formal letters of claims and early notification claims that have been uploaded to NHSR over the last 2 years compared to the national average per quarter. For the12 months to 31/03/25 this total was 8 (the same number as reported in 23/24). This included the 4 Letters of Claim and an additional 4 uploaded in relation to claims accepted under the early notification process.

Graph 27: Total number of claims reported to NHSR compared with national numbers per quarter from April 2023-March 2025




Data source: NHS Resolution 31/03/25

**Non-clinical claims**
The Trust had no new non-clinical claims in 2024/25. There were 2 non-clinical claims closed during the year. All non-clinical claims are shared with the local department and Root Cause Analysis reports requested at the time of the incident.

**Appendix 1 – Progress Update Clinical Audit Annual Programme 2024/25**

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| 1 | Cardiology<br><br>Interventional Cardiology | Compliance with NICE Guidelines for Acute Heart Failure<br>(CARD-119) | Audit completed in June 2024 (Q1) and reported to QRMG. | The audit identified areas for improvement in optimising heart failure medications such as SGLT2 inhibitors and MRAs and investigating BNP levels. Actions included educational interventions including ward-based teaching sessions to improve compliance with commencing patients on the correct medication and prompt referral to community heart failure teams. |
| 2 | Cardiology<br><br>Interventional Cardiology | Inter hospital transfer delay for non-ST elevation myocardial infarction patients<br>(CARD-120) | Due to be completed on 30/06/2024. Further request sent on 30/04/2024 for update. | Clinical Audit to be marked as cancelled if no update by 06/05/25. |
| 3 | Surgery, Transplant & Anaesthetics<br><br>Blood Transfusion | National Comparative Audit of NICE Quality Standard QS138<br>(STA-127) | Audit completed in March 2025 (Q4) and reported to HTC and QRMG. | The audit identified good compliance with the standards, but further improvements are required to ensure full compliance. Actions include:<br>• Review of procedures in place for the pre-operative identification and the timely management of iron deficiency anaemia.<br>• Review procedures for providing written and verbal information to patients who may or need transfusion and documenting this.<br>The updated SaBTO guidelines (expected to be available in mid-2025) will provide further guidance and examples of good practice. |
| 4 | Surgery, Transplant & Anaesthetics<br><br>Blood Transfusion | National Comparative Audit of Bedside Transfusion Practice<br>(STA-128) | Audit completed in July 2024 (Q2) and reported to HTC and QRMG. | This national audit has provided a snapshot of bedside transfusion practice across the UK, covering transfusions given in both in-patient and outpatient settings. Results demonstrate compliance with the checking process was high and practice was seen as safe. Actions include:<br>• Dissemination of the audit findings to all staff involved in transfusion<br>• Review current processes for delivering mandatory training and updates ensuring specific learning needs are identified and addressed. |
| 5 | Surgery, Transplant & Anaesthetics<br><br>Radiology | QSI Accreditation Audits | Continuous cycle of ongoing audits monitored through Radiology BU Meeting | Ongoing |
| 6 | Thoracic and Ambulatory care<br><br>Immunology | Typing Turnaround Times for patients seen in the Immunology Clinic | Project to be carried forward to 2025/25 due to capacity within the team. | Carried over to 2025/26 |
| 7 | Thoracic and Ambulatory care Immunology | Times from Referral to Immunology Clinic Review | Project cancelled in September 2024. | Cancelled |
| 8 | Thoracic and Ambulatory care<br><br>Immunology | Home Therapy | Project to be carried forward to 2025/25 due to capacity within the team. | Carried over to 2025/26 |

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| 9 | Thoracic and Ambulatory care Immunology | Patient satisfaction (QPIDS) | Project to be carried forward to 2025/25 due to capacity within the team. | Carried over to 2025/26 |
| 10 | All Divisions Trust-wide | Duty of Candour (TRU-138) | Audit completed in October 2024 (Q3) and reported to QRMG. | The audit results showed good compliance with the standards defined within DN153, but further improvements are required to ensure good compliance with all standards. Actions include:<br>• Training on PSIRF Framework<br>• Ensuring all staff who contact patients have access to Duty of Candour and Being Open Guide.<br>• Documentation on Datix of DOC to be checked by Incident and Risk Admin support, weekly. |
| 11 | All Divisions Trust-wide | Consent Audit (TRU-139) | Audit completed in November 2024 (Q3) and reported to Consent Working Group and QRMG | The audit continues to produce overall positive results. The percentage compliance reflecting completion of the consent form has increased again this year, from 98% to 99%. Several actions were made based on the overall findings and areas for improvement:<br>• Health professionals to ensure that all procedures are written clearly and not abbreviated.<br>• To remind patients when signing a consent form, to print their name and date the form.<br>• To remind staff to ensure that the consent forms are legible when scanning into EMR.<br>• To ensure that the newly introduced consent forms are being used. |
| 12 | All Divisions Trust-wide | Venous Thromboembolism (VTE) (Including Risk Assessment and Prophylaxis) (TRU-140) | Audit completed in April 2025 (Q1) and to be reported to VTE Oversight Group and QRMG in June 2025. | The 2023 audit identified that a structured process for documentation of the use of pharmacological prophylaxis was required to measure compliance with the standards defined in DN500. This audit, the first since the implementation of new forms on Lorenzo, demonstrated areas for improvement, whilst compliance with all patients having a VTE assessment within 24 hours of admission is 92.7%. Actions include:<br>• Continue with educational interventions and clinical speciality monitoring through the VTE oversight group<br>• Fully embed the implementation of the new documentation form in Lorenzo to prompt accurate documentation. |
| 13 | All Divisions Trust-wide | Prevention and Management of Inpatient Falls (TRU-141) | Audit completed in April 2025 (Q1) and to be reported to Falls Prevention and Management Group and QRMG in June 2025. | The results demonstrate overall good compliance for inpatient fall standards but the most significant areas for improvement identified through this re-audit remain the same as those identified in 2023/24.<br>Actions to improve practice are to be discussed and agreed at the Falls Prevention and Management Group in May 2025 as it's agreed a detailed actions are required to improve compliance, including changes in the audit methodology. |

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| 14 | All Divisions Trust-wide | Diabetes Care Management Audit<br>(TRU-142) | Audit completed in November 2024 (Q3) and reported to Harm Free Care Panel and QRMG. | The results show that the Trust is not compliant with requirement to complete a hypoglycaemia patient record note on Lorenzo for all patients with a capillary blood test value of 4 mmol/l or below. The reasons for this non-compliance are not clear but the audit highlights the need for a focused effort to increase the completion of these patient record notes on Lorenzo for all inpatients with a glucose result of <4.0mmol/L. Actions include:<br>• Implementation of ward-based teaching from the Diabetes Team in relation to the importance of completing hypoglycaemia patient record notes.<br>• Raise awareness across the Trust of hypoglycaemia. |
| 15 | All Divisions Trust-wide | Compliance with NICE Guidance Procedure Audit (DN217)<br>(TRU-143) | Audit completed in August 2024 (Q2) and reported to QRMG in October 2024. | Compliance with the audit standards remain consistent when compared to 2023/24 and performance against standard 6, which has not previously been measured, is good. Actions to improve compliance include:<br>• Review the timeframe for which clinical leads can complete baseline assessments and ensure this is reflected accurately in the policy.<br>• Ensure that the publication which was omitted is recorded on Datix and circulated to the relevant clinical leads for assessment.<br>• Continue to ensure all published NICE guidance is recorded on Datix and any actions identified following completion of a baseline assessment are recorded and monitored. |
| 16 | All Divisions Trust-wide | Pressure Ulcer Prevalence Audit<br>(TRU-144) | Second cycle of audit completed in March 2025 (Q4) and reported to QRMG in May 2025. | The rate of deep pressure ulcers remains low. There persists a number of superficial depth MASDs and MDRPUs with the majority found within CCA which is our highest risk area for pressure ulcers. Action identified include:<br>• Continue supporting the project known as 'Simple Safety for Skin' as this project focuses on the identification, prevention and management of MASD which is the most prevalent skin injury noted in the audit.<br>• Relaunch the 'Two Birds' campaign on CCA which is a project that is revisited usually every 6 months to address prevention of MDRPUs.<br>• Continue to support bedside and classroom-based teaching initiatives. |
| 17 | All Divisions Trust-wide | Dementia Audit<br>(TRU – 145) | Delayed start:<br>audit commenced in February 2025 following recruitment of Practice Development Lead | Ongoing – planned completed end of June 2025 (Q1) |
| 18 | All Divisions Trust-wide | Assessment and Management of Delirium<br>(TRU – 146) | Audit on hold, whilst new documentation and assessment tool is implemented following ratification of the Delirium policy. | On hold.<br>To commence in Q2 2025/26 |

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| 19 | All Divisions Trust-wide | Clinical Record Keeping (TRU-147) | Audit completed in April 2025 (Q1) and to be presented to IGSG and QRMG in June 2025. | The audit results demonstrate overall good compliance with the core record keeping standards. In total 8 standards achieved more than 95% compliance and 2 standards over 76% compliance. In response to the audit results the following recommendations have been identified:<br>• Communicate audit results to the Directorates and presented at various meetings, such as QRMG and relevant BU meetings<br>• Raise awareness/education across the Trust regarding the importance of the standards for documentation |
| 20 | All Divisions Trust-wide | Stroke Audit (TRU-148) | Data collection and analysis completed, awaiting input from Clinical Lead to finalise data and report. | Ongoing – planned completed end of June 2025 (Q1) |
| 21 | All Divisions Trust-wide | CQUIN Shared Decision Making (NURS-149) | Audit on hold following confirmed pause of national mandated CQUIN quality incentive scheme for 2024/25. | On hold. |
| 22 | All Divisions Trust-wide | Food and Nutrition Audits (includes Mouth Care and CQUIN DrEaMing (Drinking, eating and mobilising within 24 hours of surgery) (TRU-150) | Audit completed in October 2024 (Q3) and presented to Food and Nutrition Group and QRMG. | Whilst compliance with the standards was low, it was acknowledged that this initial audit, following the implementation of the Trust's Mouth Care Procedure DN731 in early 2024 would identify key areas for improvement as part of the implementation and embedding process. On consideration of the audit results, several recommendations were made:<br>• Add assessment form to the admission/ discharge checklist on Lorenzo to act as a visual prompt for staff<br>• Continue with the established training on mouth care awareness for staff<br>• To undertake a re-audit in 6 months to allow further implementation and time to embed new practices associated with the mouth care assessment tool and supporting documentation |
| 23 | Nursing<br><br>Resuscitation Services | Resuscitation Trolley Annual Audit (NURS-151) | Audit completed in September 2024 and presented to ALERT/CPR Steering Group | Completed – awaiting copy of the report (requested on 30/04/2025). |
| 24 | Nursing<br><br>Resuscitation Services | ReSPECT Process Audit (NURS-152) | Audit completed in January 2025 (Q4) and presented to ReSPECT steering group and QRMG | The audit demonstrated some improvements in compliance with the standards in comparison previous years and whilst improvements were noted further engagement in the ReSPECT process to improve compliance across all standards is needed. In response to the audit results the following recommendations have been identified:<br>• Introduction of ReSPECT Champions to increase audit capture and advocate ReSPECT to clinicians and patients. |

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| | | | | • Encourage further engagement and ongoing learning via forums, mandatory training sessions and Learn Zone with a focus on lower compliance areas.<br>• Identified the need for targeted training to Drs, specially around finding the forms and how to complete them. |
| 25 | Nursing<br><br>ALERT / Surgical ANP | Detection and management of the deteriorating patient (includes NEWS2 Escalations and response times, CCA readmission, scoop and run data) (NURS-153) | Continuous cycle of ongoing audits monitored through ALERT Steering Group and Deteriorating patient task and finish group. | Ongoing |
| 26 | Nursing<br><br>Infection Control | Environment Audit for Theatres, Cath Labs, Bronchoscopy (NURS-154) | Audit completed in June 2024 (Q1) and September (Q2) and presented to the IPCC Committee and QRMG. | The results of this quarterly audit in Theatres showed a reduction in compliance from 99% Q1 and 88% in Q2 and an improvement in Cath Labs from 84% in Q1 and 98% in Q2. Overall compliance resulted 93% for Q1 and 92% for Q2. Findings were disseminated via the infection control committee and individual actions were identified for each clinical area. |
| 27 | Nursing Infection Control | Safe handling and disposal of sharps<br>(NURS-155) | Audit completed in September 2024 (Q2) and presented to IPCC Committee and QRMG. | The audit results highlight 8 of the 12 standards show compliance of 95% and above, standards 9-12 are unchanged from 2023 at 100%. Of the 4 standards that reached less than 95% compliance, 3 are the same as reported in last year's audit (standards 1, 4 and 7). Findings were disseminated via the infection control departmental actions plans and individual actions were identified for each clinical/ward area. |
| 28 | Nursing<br><br>Infection Control | Hand Hygiene Technique (NURS-156) | Audit completed in May 2024 (Q1) and presented to IPCC Committee and QRMG. | The results of this audit show a decrease in 6 criteria, an increase in 2 criteria and 3 criteria remaining the same at 99% (standard 1) and 100% (standards 7 and 11). Findings were disseminated via the infection control departmental actions plans and individual actions were identified for each clinical/ward area. |
| 29 | Nursing<br><br>Infection Control | Environment audit for Wards (NURS-157) | Audit completed in December 2024 (Q3) and presented to IPCC Committee and QRMG. | The overall results from this environment audit shows a significant decrease in compliance from the last audit in Q1, from 97% to Q3 with results of 90%. All areas, consisting of general environment, clinical room/clean store, toilet area and dirty utility have all decreased in compliance. Actions for improvements include:<br>• Actions from this audit have been recorded in individual ward action plans and have been sent to each ward to be implemented.<br>• OCS have been given a copy of the audit report with itemised actions.<br>• Results will be followed up in ongoing IPC Environmental Rounds.<br>• Monthly Environment audits have been introduced for the Wards and CCA from November 2024 and are continuing to be monitored. |

| | Division/ Directorate | Project Title | Current Status | Outcome |
|---|---|---|---|---|
| 30 | Nursing<br><br>Infection Control | Departmental waste handling and disposal (Compliance with DN375)<br>(NURS-158) | Audit completed in December 2024 (Q3) and presented to IPCC Committee and QRMG. | Compliance with the standards was generally good, with 13 standards achieving 100% which is the same as in 2023 - and a further 5 scoring >=95%. There were 9 standards which scored more than 77% (ranging from 78%-94%). Actions from this audit have been recorded in individual ward action plans and have been sent to each ward to be implemented, these include:<br>• Advise housekeeping staff to familiarise themselves with DN375 and ensure waste bags have been sealed and tagged.<br>• Work alongside OCS to improve current practice. |
| 31 | Nursing<br><br>Infection Control | Linen audit (Compliance with DN789)<br>(NURS-159) | Audit completed in March 2025 (Q4) and presented to the IPCC Committee and QRMG. | Compliance has remained high with improvements noted from last year in 8 of the 10 standards. The results have highlighted some potential areas for improvement and actions have been implemented to remedy any identified issues, these include:<br>• Ensuring Linen Stores are tidy and free from inappropriate items.<br>• Used linen to be stored away from clean linen in a linen rounder and not placed on the floor. |
| 32 | Nursing<br><br>Infection Control | Hand Sanitiser Audit<br>(NURS-160) | Audit completed in September 2024 (Q2) and presented to the IPCC Committee and QRMG. | Results of this audit show that hand sanitisers available by the bedspace to be 89%. The lowest number of hand sanitisers in the bedspace areas was for Outpatients at 72%. Day Ward has increased from 29% to 77% this year, and HLRI has increased from 50% to 83%. Findings were disseminated via the infection control departmental actions plans and individual actions were identified for each clinical/ward area. |
| 33 | Nursing<br><br>Infection Control | Skin prep (Evaluation of the use of Chloraprep surgical skin preparation)<br>(NURS-161) | Audit completed in April 2025 (Q1) and presented to the IPCC Committee and QRMG | The results demonstrate good compliance in 9 out of the 13 standards, for which 100% compliance was noted. 2 out of 13 standards both show 0%, standard 4 achieved 40% and standard 14 showed 86% compliance. In response to the audit results the following recommendations have been identified:<br>• Disseminate finalised audit report and action plan.<br>• All newly employed Cath Lab Practitioners to undergo assessment into the Royal Royal Papworth's procedures and protocols regarding prepping and draping before they are exposed to their new theatre environment.<br>• Cath Labs practitioners will be re-assessed annually |
| 34 | Nursing<br><br>Infection Control | Scrubbing and Gowning<br>(NURS-162) | Audit completed in September 2024 (Q2) and presented to the IPCC Committee and QRMG | The results demonstrate overall good compliance with scrubbing and gowning standards. As mentioned above, 8 new or updated criteria have been included in this audit, compared with last year. 10 of the 19 standards achieved 97%-100%. The low compliance from last year has been addressed with education days and training provided on the spot. This year, findings were disseminated via the infection control departmental actions plans and individual actions were identified for each clinical/ward area. |

## Appendix 2 - Completed Local Clinical Audits

Completed Local/Divisional Clinical Audits October 2024 – March 2025

| | Audit Title and Reference Number | Summary of Key Findings/Outcome | Action/Recommendations/Shared Learning |
|---|---|---|---|
| 1. | **Identifying time from collection to receipt in the microbiology laboratory of bronchoalveolar lavage samples with aim to reduce the time between sample collection and culture for bronchoalveolar lavage (BAL) samples performed at Royal Royal Papworth Hospital**<br>(STA-QI-506)<br><br>FY2 doctor with support from Microbiology Consultant | • 79% of samples incubated outside of the required time of 24 hours.<br>• Majority of samples sent from Critical Care Unit (CCU).<br>• Time delay does not vary with location or day of the week and does not appear to vary with time of sample collection.<br>• Majority of samples are culture negative or grow mixed respiratory flora.<br>• The most cultured pathogen is Pseudomonas aeruginosa. | • Increasing staff numbers in the Cat-3 lab, for example on the days when more<br>samples taken: Tue, Wed, Thursday, or at night, to allow for samples to be cultured during night shift.<br>• Ensure that samples that are incubated after 24 hours are stored in the fridge.<br>• Presented audit to the Laboratory Clinical Quality Group. |
| 2. | **VTE Assessment Form (August 2024). Not completed within 24 hours of admission**<br>(CARD-222)<br><br>FY1 doctor | • VTE assessments may have been delayed, considering the timing e.g. shift changes, late hours/nighttime, weekend days.<br>• Team transitions – FY1/2s, IMTs rotating during start of August<br>• Lack of confidence can result in delays while waiting for more specialised team to take over/advise.<br>• Outstanding VTE assessments usually recorded in doctor job list. Often not checked frequently during the day, leading to VTE assessments being delayed to following day. | • Teaching session delivered along with the anticoagulation pharmacist lead to resident doctor's regarding the findings of audit, and on important of VTE risk assessment.<br>• Audit the VTE risk assessment compliance for Oct and Nov.<br>• Create a poster highlighting VTE importance and update handbook.<br>• Suggest to nursing team to bleep non-urgent Resident twice a day with list of patients with outstanding VTE.<br>• Suggest sessions during induction of new resident doctors, starting in December. |
| 3. | **Hand Sanitiser Audit Report**<br>(NURS-160)<br><br>Clinical Nurse Specialist Infection Control and Clinical Audit Co-ordinator | • 97% of hand sanitiser dispensers audited as available at the point of care across the organisation.<br>• 89% of hand sanitisers are available by the bed space.<br>• Improvements were noted on Day Ward (an increased from 29% to 77% this year) and HLRI from 50% to 83%. | • All bedspaces should have a bottle of hand sanitiser to facilitate the five moments of hand hygiene.<br>• Request to OCS for refilling of wall dispensers and request to Estates if dispensers not in good working order.<br>• Results disseminated via the IPC departmental action plans and reported to ICPPCC. |
| 4. | **The Safe Handling and Disposal of Sharps Compliance Report**<br>(NURS-155)<br><br>Clinical Nurse Specialist Infection Control and Clinical Audit Co-ordinator | • 95% compliance was noted with 8 out of 12 standards.<br>• Compliance with 4 out of 12 standards remained unchanged since 2023 at 100%.<br>• Improvements were noted in compliance for 2 of the 12 standards since the last audit in 2023. | • Ward sisters to familiarise staff with DN180 Sharps Policy where it has been identified staff not aware of managing sharps injury procedure.<br>• Ensure all containers are labelled and tagged with date, location and signed.<br>• Results disseminated via the IPC departmental action plans and reported to ICPPCC. |

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| 5. | **Audit of Scrubbing and Gowning in Theatres and Cath Labs 2024-25**<br>(NURS-162)<br><br>Surgical Pathway Infection Prevention Control & Clinical Audit Co-ordinator | • The results demonstrate overall good compliance, 10 out of 19 standards achieving 97%-100% compliance.<br>• A significant improvement was noted in the standard 'If incorrect procedure, challenge and rescrub' from 50% in 2023 to 100% this year.<br>• An increase in compliance was noted in 5 of the 19 standards this year compared to last year.<br>• A decrease in compliance with noted in 3 of the 19 standards when compared within results from 2023. | • Enhanced education on scrubbing procedures, especially on use of nail picks and brushes.<br>• Education on eye protection wearing.<br>• Remind staff to glove surgeons at the table and staff to gown in the scrub area. |
| 6. | **Speech and Language Therapy Notes Audit**<br>(NURS-184)<br><br>Dietetic and Speech and Therapy Assistant Practitioner & Clinical Audit Co-ordinator | • The results demonstrate good compliance with several standards for documentation and areas for improvement.<br>• Standards are divided into three domains: style (82%), content (67%) and recommendations (50%).<br>• Significant improvements in compliance were noted (in Style domain) when compared to results from the last two years. | • An abbreviation list and compliance information will be provided for new staff as a part of their department (local) induction.<br>• Raise importance of documenting IDDSI levels – changes to reword recommendations in assessments discussed with Speech therapists<br>• Discuss with staff at departmental meetings how consent is being documented and discuss how data is collected.<br>• Documentation of recommendations and NBM only required in Dysphagia assessment documentation<br>• Re-audit to be undertaken by registered SALT |
| 7. | **Impact of a novel CRT Optimization Clinic using 12 lead ECG and Heart Failure Questionnaires (HFQ) in clinical response**<br>(CARD-50)<br><br>Highly Specialised Cardiac Physiologist with support from Electrophysiology Consultant | • Significant reduction in QRS duration at post-CRT (compared to pre-implant); Significant increase in LVEF at post CRT (compared to pre-implant).<br>• Great percentage of patients with echo LVEF improvement compared to baseline (80% of patients with delta LVEF more or equal than 5%<br>• Significant number of patients with post CRT LVEF >50%.<br>• Significant increase in patients prescribed the 4 pillars of HF medications, compared to previous CRT and National HF Audits.<br>• 88% of patients with NYHA class improvement of at least one class/no change from implant to visit 1.<br>• Incidence of AF similar to National HF Audit, with no increase of incidence at visit 2; No significant change in QoL, assessed by HF Questionnaire.<br>• 16% of patients had admissions lasting >24hours (all cause admissions), although only 2 admissions coded as HF admissions. | • The CRTOPT clinic is beneficial in achieving reduced QRS duration and improved LVEF post optimised CRT.<br>• Symptoms are difficult to access.<br>• Communication with Regional HF Teams is essential to maximise CRT therapy (results show that a combined medical and device therapy are beneficial to patients, although not able to ascertain the individual impact of each component).<br>Recommendations:<br>• To continue to refer these patients int CRTOPT clinic; Patients who do not report a symptomatic benefit from device implant, can be referred to Echo CRT Optimisation - which is a new service developed in parallel with the Electrical CRT Optimisation Clinic. |
| 8. | **Upgrading to Cardiac resynchronisation therapy (CRT) at the time of Elective Unit Replacement (EUR) (CARD-216)**<br><br>Highly Specialised Cardiac Physiologist with support from Highly Specialised Cardiac Physiologist | • Patients that meet one of the criteria are not being referred (RVp >40%)<br>• Patients that do not meet the criteria (Battery left >18 months) are being referred<br>• Patients with broad QRS, IHD, male are more likely to require upgrade. | • Re-educate the team regarding clinic referral criteria.<br>• To be shared at physiologist meeting and for abstract submission at HRS 2025. |

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| | | • Patients who had upgrade to CRT at the time of EUR had significant clinical improvement. | |
| **9.** | **Long Saphenous Vein Harvesting in surgical coronary revascularisation (STA-27)**<br><br>Theatre Manager, Senior Surgical Care Practitioner & Team Surgical Care Practitioners.<br><br>**Clinical Audit undertaken in 23/24 but results shared in 24/25** | • Endoscopic vein harvesting (EVH) contributed to reduce the harvesting time, surgical incision length, intra- and post-operative bleeding and infection rate when compared to a traditional open vein harvesting surgical approach.<br>• A marginal reduction in the patients' hospital stay and a quicker independent mobilisation were also recorded following EVH. | • Presented at the SSI Clinical Practice Group meeting (12th March 2024).<br>• Presented at the RPH SSI Summit (8th August 2024). |
| **10.** | **Protected Mealtimes Audit 2024 (NURS-85)**<br><br>Dietetic Assistant and Specialist Dietitian | • Many data notes highlighted that interruptions were prior to the protected mealtimes hours, as was highlighted in the 2022 audit.<br>• Compliance with the Protected Mealtimes procedure and the standards outlined in the audit have decreased since the last audit and a number of recommendations have been made to improve practice. | Areas of exceptional and good practice identified; however, compliance with key standards have declined since the last audit. Recommendations include:<br>• Request TV screens highlight when protected hours are active with specific signage displayed 12:30-13:30 and 17:30-18:30.<br>• Remind ward sisters, PSS staff and matrons of procedure expectations<br>• Email reminders to ward sisters and matrons that ward activities (unless urgent) should be stopped during protected mealtime hours<br>• Highlight good practice to catering manager |
| **11.** | **Departmental Waste Handling and Disposal Audit 2024-25 [NURS-158]**<br><br>Clinical Audit Coordinator and Clinical Nurse Specialist Infection Control | • Compliance with the standards was generally good, 13 standards achieving 100% and a further 5 standards scoring >=95%.<br>• Six standards have seen a decrease in compliance from 2023 in standard 17 'glass and aerosols are not used for prescription only medicine bottles' reduced from 100% to 77%, and standard 18 'waste bags are removed at least daily', reduced from 100% to 90%. | • The final report was presented to ICPPCC in February 2025.<br>• Results have been shared with each clinical area and the comments highlighting poor practice or areas for improvement which need to be addressed have been incorporated into practical actions and shared with the relevant clinical areas. |

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| **12.** | **Environment (Wards) [NURS-157].**<br><br>Clinical Audit Coordinator and Clinical Nurse Specialist Infection Control | • Overall, results show a significant decrease from last audit in Q1, 97% compliance to 90%.<br>• All areas have seen a decrease in compliance, with general environment results reducing from 98% in Q1 to 89% in Q3. | • The report including a breakdown of the results per each ward/area was presented to ICPPCC in February 2025.<br>• Specific actions from the audit have been recorded in the individual ward action plans which has been circulated to all wards/areas.<br>• OCS have also been given a copy of the report with itemised actions to take forward to improve compliance.<br>• Actions will also be monitored through ongoing IPC environmental rounds. |
| **13.** | **Evaluation of the Use of Skin Preparation of Patients for Surgery in Theatres [NURS-161]**<br><br>Clinical Audit Coordinator and Surgical Pathway Infection Prevention and Control Nurse | • Overall, the results show a reduction in compliance compared to the last audit in March 2024. 100% compliance was achieved in 11 standards, 96% compliance in 3 standards and less than 75% was achieved in 3 standards.<br>• Compliance with Standards 8, 10 and 17 have had a notable drop in compliance compared to the audit undertake in March 2024. | • The final report and detailed action plan were presented to ICPPCC in February 2025.<br>• In response to the audit results several recommendations have been identified to improve practice. These include:<br>• All newly employed Theatre Scrub Practitioners to undergo assessment into the RPH procedures and protocols regarding prepping and draping before they are exposed to their new theatre environment.<br>• Theatre practitioners will be re-assessed annually.<br>• "Chloraprep Champions" to be identified as being responsible for daily check and challenge on the floor and the escalate of future learning outcomes.<br>• A regular cycle of re-auditing will be implemented to monitor compliance in response to these actions. |
| **14.** | **Evaluation of Rotablation PCI at Royal Royal Papworth Hospital [CARD-61]**<br>CMT, Clinical Fellow & Interventional Cardiologist | • The safety outcomes for patients undergoing rotablation at RPH are acceptable.<br>• Most procedures are led by two operators, with other Consultants, Clinical Fellow and SpR becoming involved.<br>• There was no on the table mortality, and very few complications during the admission or after the procedure. | • The results of this audit have been presented to the Clinical Governance meeting in June 2024 and the Interventional CSG in July 2024. Discussions included:<br>• The continued expansion of operators among the Consultant body.<br>• Transition to ad-hoc procedure as a continuation of index case as a standard (part of update to consent form ongoing).<br>• Transition to one consultant procedure.<br>• Out of hours atherectomy.<br>• Plan to re-audit in 2025. |

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| **15.** | **Audit into the completion of the WHO checklist on patients undergoing Transoesophageal Echocardiology (TOE) (CARD-211)**<br><br>Cardiac Physiologist | • Results show a drop in completion of Standard 7: TOE Care Pathway WHO checklist (80%) since the last audit.<br>• Post-procedure throat test and MDT notes have both declined to 66% and 76%, respectively.<br>• Findings were presented at the ECHO team meeting on 11/03/2025. | • The reduction in compliance needs to be investigated further, the reduction could be exaggerated due to population size and smaller time window.<br>• Contact operators to emphasise importance for completing checklist.<br>• Re-audit in 6 months. |
| **16.** | **Management of cardiovascular risk factor in heart transplant recipients (STA-96)**<br><br>Consultant | • Monitoring compliance is satisfactory, meeting standards in over 90% of cases.<br>• Risk factors control adequate, although improvements could be made in blood pressure and lipid management. | • Efforts to increase the use of novel therapies, particularly in patients with persistently high LDL cholesterol or BMI.<br>• Further studies are needed to determine the exact number of patients who could benefit from additional interventions.<br>• A re-audit to be undertaken in next three to five years<br>• Continue with current monitoring. |
| **17.** | **Primary graft dysfunction after heart transplant at RPH 2023-2024 (STA-93)**<br><br>Consultant Cardiologist | • 38 heart transplants performed in 2023-24.<br>• 100% of patients had PGD grade agreed and recorded.<br>• 34.2% patients had any grade of PGD.<br>• 18.3% patients had PGD that required tMCS. | • Continue to agree PGD grade for every heart transplant.<br>• Automate annual audit using R and Quarto.<br>• Build large, granular PGD database to enable better understanding of risk factors, explore alternative definitions and investigate association between PGD and survival. |
| **18.** | **Trans Radial (TR) Band Audit (CARD-57)**<br><br>Consultant Cardiologist with support from Cardiology IMT | • Timing of TR band removal needs to be more consistently documented.<br>• No obvious trend in the limited data linked to haematoma rates. | • A bedside protocol for TR band removal to be uploaded on discharge.<br>• A presentation to the day ward staff about facilitating discharge and the early management of preventing haematoma.<br>• Re-audit with timings of TR band removal to consider if this can be made more efficient to streamline discharge. |
| **19.** | **Stop Hickman Line Infections: A study of Pulmonary Hypertension Patients with a Hickman Line (THOR-201)**<br><br>SNRs and Thoracic Consultants | • Findings highlight infection rate (39%) among pulmonary hypertension patients with Hickman Lines from 2020-2024 with a recurrence rate of 31% in the overall patient cohort.<br>• Results suggest procedural sterility is adequate and factors like dermatological conditions and wound care practices contributed towards infection risk. | • Implement wound care checklist for Hickman line patients prior to discharge.<br>• Standardise protocols for dressing and line care.<br>• Further tangible data for MRSA decolonisation measures.<br>• Consult with Dermatology for wound care and hypoallergenic dressing advice.<br>• Compare data to previous audit cycles for further improvements and recycle. |

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| **20.** | **Respiratory Support and Sleep Centre Advance Nurse Practitioner Patient and Staff Satisfaction Survey 2024 (THOR-14)**<br><br>Advanced Nurse Practitioners, Sleep Studies | • Highlights significant role of RSSC ANPs in improving patient experience.<br>• While both surveys (patient and staff) show positive aspects of ANPs' contributions, they also indicate areas for further improvements. | • RSSC ANPs continue to enhance their consultation skills to maintain a positive patient experience.<br>• According to staff survey, improving communication and clarifying awareness of RSSC ANP roles could enhance overall effectiveness; including being available to address clinical issues of ward patients and allowing new team members to shadow RSSC ANPs during supernumerary period. |