NHS
Royal Papworth Hospital
NHS Foundation Trust




Royal Papworth Hospital NHS Foundation Trust
Quality Report 2019/2020

Contents

Part 1 Statement on quality from the Chief Executive

Providing high-quality, safe and effective care is at the heart of everything we do here at Royal Papworth Hospital. We are extremely proud to have gained an excellent reputation for quality in heart and lung medicine, but we know we must continually work to improve the care we provide to our patients. This Quality Account provides an overview of the quality of services that we have provided to patients during 2019/20 as well as our key priorities for improving quality in the year ahead.

In the last year, our staff and partners have worked extremely hard to maintain our excellent quality standards whilst delivering the move to the biomedical campus in May 2019. In October 2019 we received our 'Outstanding' inspection report and rating from the Care Quality Commission, becoming the first NHS Hospital to achieve an 'Outstanding' rating in all 5 CQC domains, Safe, Caring, Effective, Responsive and Well-Led, and the first NHS Hospital to achieve 'Outstanding' for the Safe domain. As a Trust we will continue to set high standards and strive to meet all of our performance standards, and this means that we still have work to do to achieve this ambition and to identify opportunities to continuously improve.

Through feedback from national and local staff surveys we recognise that we have more work to do to support our staff and create the best possible environment for them to work and develop their careers in. We delivered the first phase of our Compassionate and Collective leadership programme in 2019/20 and are taking this forward in 2020/21 to ensure that we enable our staff to deliver the very best care for their patients. We have included further commentary on these matters through our report.

In the last year our Black and Minority Ethnic (BAME) network has made an incredibly positive contribution to the work and the life of the Trust. It has helped us to celebrate contributions; to challenge behaviours and to consider how we address the issues faced by BAME staff. The Trust has worked hard in this year to listen to the staff BAME community. We have launched a programme of development for our senior leaders on Equality, Diversity and Inclusion and will be taking this forward in 2021.

Our staff told us that they have felt under significant pressure this year following the move to our new Hospital and the process of optimisation of our new facilities. In particular we saw pressures in our critical care unit and put in place remedial actions to support the staff in that area alongside developing plans to deliver a sustainable service model. This work has been overtaken by the steps put in place to respond to the national pandemic. Critical Care remains an area we will continue to support through 2020/21, following the team's incredible response to COVID19 and the support and positive outcomes they and their colleagues across the Hospital provided to our patients from across the East of England and nationally.

We maintained a focused on Diversity, Inclusion and Equality and Staff Health and Wellbeing during the pandemic response. The Trust put in place a range of support to help staff whose emotional and physical wellbeing was affected by the COVID-19 pandemic. This included face-to-face and online resilience sessions and access to an employee assistance programme that provides online and telephone support for staff and their families. We procured coaching for managers on supporting the mental health of their staff, and our chaplain provided tailored support for individuals and teams which has been much appreciated by staff. Our workforce team received more than 2,000 risk assessments for our staff members and conducted 690 individual risk assessments for staff identified as being at greater risk from COVID-19. This work has helped us to identify which staff members can carry on doing their usual work safely, which need modifications in order to do so and, in a few cases, which staff members are not able to carry out their usual role safely. We used the information gained during the risk assessment to change some of our usual processes to mitigate the new risks that COVID-19 presents to our workforce.

The global impact of COVID19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. The response to this threat has been managed at national, regional and local tiers of the public sector (including but not limited to the NHS, Local Government, the Police Force and the Army). The response has included unprecedented steps which have impacted on all economic sectors and have restricted civil liberties. Royal Papworth Hospital (RPH), as a nationally recognised centre of excellence for specialist cardiothoracic health care, has and will continue to play a leading role in the national, regional and local response to this crisis. The Trust has undertaken roles in both an advisory capacity and in our capacity as a direct provider of health care to the population and we are proud of the outcomes that have been achieved for our patients through the care and dedication of our staff.

We have continued to build close links with research organisations and industry on the Campus. The Heart Lung Research Institute (HLRI) was supported through funding from the UK Research Partnership Investment Fund (RPIF) and charitable donations. The building project has progressed well with completion scheduled for February 2022. The Institute will enhance training and career development opportunities for our staff alongside other health and life sciences organisations on the Campus and deliver an array of opportunities to enhance the care that we provide to our patients now and in the future. We are very pleased to be opening the Royal Papworth School which will deliver training for our staff and the wider NHS. This will be launched virtually in 2020/21.

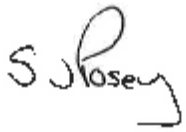
Our Quality Strategy 2019-22 Royal Papworth Hospital embeds and supports Quality Improvement within the organisation. It is important for our staff to recognise and believe that quality is everybody's business, and we need to ensure that staff feel empowered to speak up when they feel that patient care is unsafe or the patient doesn't receive the service they deserve. We want staff at all levels to feel that they are supported by the organisation to act and make a change. We want our staff not only to come to work to do their job, but also to come to work to do their job better.

As a Board we have received regular updates through patient stories and from our staff through use of staff stories and the reports of our Freedom to Speak Up Guardian, a role that has been enhanced over the last year through the development of FTSU Champions across the Trust. We recognise the value of these stories as these allow us to consider and taken action to address issues that are brought to us in this way and this helps us in being a listening organisation.

We recognise the value of continuous clinical quality improvement in supporting clinical effectiveness and in improving patient safety and the patient experience. It is also recognised that, service improvement and cost improvement will benefit from supporting the Quality Improvement agenda. Together with our Board of Directors and Council of Governors, and in consultation with our clinical staff, we have developed a series of quality priorities for 2020/21 that will help us make the most of the opportunities presented by our new hospital. These priorities will be addressed later in the Quality Accounts.

As ever, we rely on the support of all of our stakeholders to continue improving our services and maintain our reputation for care and innovation. I would like to thank all our staff, governors, volunteers and patient support groups and our system partners for helping us to deliver some significant milestones in 2019/20 with the safe and successful move; our Outstanding CQC inspection and the key role delivered by RPH in the response to the COVID19 pandemic where we achieved some of the best outcomes for the patients and the population that we serve.

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



Stephen Posey
Chief Executive
3 December 2020

Information about this Quality Report

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

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

NHS foundation trusts are also required by NHS Improvement (NHSI) to publish a Quality Report as part of the foundation trust's Annual Report and Accounts (although for 2019/20 the requirement was set aside for the 2019/20 report as a result of the national response to COVID19). The Quality Report includes all the requirements of the Quality Account regulations but includes additional requirements as set out by Monitor in its *Annual Reporting Manual* and in the document entitled *Detailed Requirements for Quality Reports*. Foundation Trusts are given the option of either publishing their whole Quality Report as their Quality Accounts or removing the additional NHSI requirements. Royal Papworth publishes its Quality Report in its entirety as its Quality Accounts. References to Quality Report and Quality Account should therefore be treated as the same throughout this document.

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

Further information on the governance and financial position of Royal Papworth Hospital NHS Foundation Trust can be found in the various sections of the Annual Report and Accounts 2019/20.

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

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

2.1 Priorities for improvement

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

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2020/21 and the process that we went through to select this set of priorities.

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

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

Summary of performance on 2019/20 priorities

Our 2018/19 Quality Report set out our quality priorities for 2019/20 under the three quality domains of patient safety, clinical effectiveness and patient experience. *See our 2018/19 Quality Account for further detail: https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports*

The following section summarises the four quality improvement priorities identified for 2019/20 together with the outcomes. The tables below demonstrate achievements against the 2019/20 Goals.

Priority 1: Quality Improvement / Patient Safety
Priority 2: A Safe Hospital Move
Priority 3: Optimise Lorenzo
Priority 4: Leadership & Culture including Recruitment and Retention

Priority 1		Goals 2019/20	Outcomes
1	**Embed an improved safety culture through implementation of the SCORE culture tool across the organisation**	**AIM 2019/20: Implement SCORE Culture Survey in selected clinical areas across the Trust.**	
		Identify five areas to survey and to go live with surveys by July 2019	**Ongoing** Area surveyed: 3 South Aug / Sept 2019 5 North Sept / Oct 2019 5 South Sept/ Oct 2019 All results received and action planning in progress. With the permission of the areas, results will be shared and fed into the Compassionate Leadership programme team to inform and cross reference with findings from this work stream.
2	**Deterioration and Complications**	**AIM 2019/20: To reduce the ward incidents in relation to the recognition, escalation and management of deteriorating patients on the wards.**	
		100% of patients on 5 North ward with a NEWS score of 5 or more will receive the correct actions according to RPH escalation guidelines (DN538) by 2020 Updated to reflect new wards following the move	**Complete** NEWS2 online training available on education intranet site for all new staff Competency achievements recorded on MAPS
		Mindray Monitoring system training prior to hospital move and launch on the 1st May	**Complete** • Study days established and ongoing for all new clinical staff • Training given to all new staff during hospital induction
		Establish deterioration patient study days for band 4, 5 and 6 nurses and junior doctors	This day was originally developed for band 4 nursing associates but has since been implemented into the Preceptorship Programme on day 6 to reach a wider audience. It is now mandatory for all new registered nursing staff to the trust to attend. Subsequent to demand from band 5 & 6 nursing staff it was requested they too had support regarding identification and management of the deteriorating patient. 77 members of staff have since attended these courses.
		Establish competency assessment for	**Complete** • New training programme put in

		completing patient observations for band 2 and 3 HCSW	place in and facilitated by the education team • Training ongoing • 32 HCSW have undergone training at time of writing.
		Improve in timely observations using the electronic Mindray system	**Complete** • Electronic observations not being pulled through into Lorenzo between July and August 2019 • Data missing in patient records /audit results inconclusive • Issue resolved in October. Lorenzo pulling information through from Mindray • Now delivering in line with DN538 guidance
		ALERT team responses to NEWS scores of 5 or more	**Ongoing / Issue not yet resolved** Some of the ALERT team data on responses to NEWS scores stored on hand held devices not accessible for download. Lorenzo team currently has no access to this data. Data can only be downloaded by the software development company (M-IGHTY). Action: • SQL code requested from M-IGHTY to enable Lorenzo/ audit team to download data. Done just prior to the pandemic. No response from M-IGHTY during the pandemic. Have rewritten to them (July 2020). Awaiting response at time of writing
		Improve in the use of SBAR when verbally escalating a patient to the ALERT and Medical teams	**Ongoing** Audit data on data collected between July and September 2019 shows that an improvement is still required on the use of SBAR when escalating concerns. Actions taken: • Copies of SBAR made available at nurses' stations for reference. • SBAR use is being highlighted during the deteriorating patient study days / hospital induction • Plan put in place to add SBAR tool into Lorenzo
		To explore and introduce the practice of out of hours multidisciplinary Safety Huddles for Cardiology and Surgical wards	**Partially achieved / Ongoing** • The DN749 (Recognition of the Deteriorating at night Policy) and safety huddles have been implemented. • First audit on staff's responses carried out. Poor response noted

			mainly from the foundation year doctors. Plan put in place for structured safety huddle. • Due to hospital move and the COVID19 pandemic, audit delayed. • A more structured hospital at night team launched on the 5 August with a mandatory safety huddle occurring every night. • Future audits on the impact of hospital at night/ safety huddles to be carried out.
		Evidence of documentation supporting appropriate escalation of patients with high risk or critical early warning scores.	**Complete** • Ongoing data collection in place • Quarterly reviews by ALERT team and information shared at ALERT/CPR steering group meetings via readmission data
		Use of pulse oximeter probes as per Alert reference number: NHS/PSA/W/2018/009 titled "*Risk of harm from inappropriate placement of pulse oximeter probes"* published on 18th December 2018	**Complete** • All wards/ departments advised to purchase ear probes to prevent risk and these are now available on all wards • Ongoing training at deteriorating patient study days
3	**Falls Risk Reduction**	**AIM for 2019/20: Falls Quality Improvement Project is to reduce falls by 10% per 1000 bed days by April 2020 for Cardiac Surgery patients on 5 North.**	
		To reduce falls by 10% per 1000 bed days by April 2019 for Cardiac Surgery patients on Mallard Ward (New Papworth Hospital - 5 North)	NHSI estimated reported falls rates per 1000 bed days for 2015/16 in Acute Trusts is 6.1. Baseline data for 5 North collected Apr 17- Apr 18 at the old site, shows at Royal Papworth Hospital there was an average of 4.60 falls / 1000 bed days. A 10% reduction from the baseline is 4.14 falls / 1000 bed days. Since the start of the Quality improvement project in April 2018 a number of key changes have taken place which have affected the amount of falls recorded. At the old site from May 2018 to May 2019 there was an average of 4.9 falls /1000 bed days which is a 0.3 falls increase since baseline, this can be attributed to natural variation. In May 2019 the Hospital relocated to

			Cambridge and the patients moved from open wards into single rooms, with this move the Trust anticipated an increase in falls. The data now shows there has been an increase in falls, with an average of 5.48 falls per 1000 bed days from July 2019 to December 2019. As a result of this QI project and an increased awareness in Falls, the reporting process has been streamlined to make it more efficient for reporting falls, this may also have contributed to an increase in the number of reported falls. April 2020 reports 2.2. falls per 1000 bed days and this is reported monthly via the Papworth Integrated Performance Report (PIPR). Audit continues to be necessary to evaluate the improvement measures. This needs to include the use of the bed rails monitoring form and to assess the uptake and staff groups participating in Intentional Rounding.
		Roll out and spread the good practice on Mallard Ward / 5 North	**Complete** The roll out and spread of good practice on Mallard Ward / 5 North has taken place Trust wide.
		Implement multi-disciplinary intentional-rounding forms hospital-wide	**Complete** The implementation of multi-disciplinary intentional-rounding forms hospital-wide has taken place but there is work still to be done on ensuring that all members of the MDT participate. All clinical staff are trained to carry out intentional rounding on Trust Induction.
		Complete a re-audit of the use of bed-rails	**Complete** The FPSN has re-written the Falls Prevention Policy and written a Bed Rails Policy to reflect current guidelines and the needs of the new hospital.
		Audit the use of falls prevention care plans	**Complete** Monitoring of trends continues with appropriate interventions.
		Review the quality and	**Complete**

		completeness of falls risk assessment	A new falls risk assessment and combined care plan have been formulated by the FPSN in order to make the assessment and care planning smoother and easier. This has improved the use of care plans on the wards.
		Use reported Datix incident forms and mini RCA data reported from falls on on 5 North to identify actions to prevent /minimise falls	**Complete** A mini RCA has been devised and added to Datix to improve data collection on the root causes of falls and to enable managers to complete investigations with ease. Bathrooms continue to be a theme in a large proportion of falls.
		Monitor the impact of the new environment of single rooms on 5 North relating to falls prevention and number of falls	**Complete** The data shows that 7 out of the 8 falls reported on 5N which caused harm, (categorised Low Harm and above), since April 2019 are connected with a visit to the bathroom (87.5%)
4	**In House Urgent (IHU) Pathway**	**AIM for 2019/20:** **100% of patients who are referred into the IHU pathway will be assessed appropriately at MDT** **98% of patients on IHU pathway will have their surgery within ten days (start date = when fit for surgery)** **98% of all cancelled surgery will be rescheduled within five days**	
		Develop pathway standards for referral, MDT, Cardiology and Surgery	**Complete** Entire pathway has been reviewed. Pathway standards written and agreed for referral and MDT. Standards for Cardiology and Surgery have been written and all sections except patient ownership (see below) have been agreed.
		Agree ownership of IHU patients between Cardiology, Surgery and ANP	**Ongoing** Discussions ongoing at time of writing.
		ANP to attend twice-weekly bed meeting	**Complete**
		To engage with the Central Bookings team to ensure accurate and equitable allocation of IHU capacity	**Complete**
		Daily monitoring of IHU spreadsheet, referrals and waiting times for IHU surgical slots	**Complete** Data accuracy improved through daily monitoring of IHU spreadsheet Moving into business as usual - Ongoing data collection of key outcome data handed over to data analyst - Escalation pathway through

			ops managers and surgical directorate established
		Operational Manager to assist with the scheduling and rescheduling of IHU patients	**Complete** Cancellations tracked and recorded with any unfit / suboptimal work up cancellations reviewed by IHU team
		Theatre Manager to assist in the allocation of IHU patients and procedure for rescheduling within five days	**Complete**
		Review IHU pathway staffing requirement	**Complete** Business case for additional MDT co-ordinator and additional ANP successful.
		Review the IHU / elective surgical waiting lists	**Complete** Increase in theatre capacity to 15/week since opening of Theatre 6 Regional meeting for local referring centres set up IHU ANP ward round commenced twice weekly Weekly visit to CUH to review patients with a surgical date
		Update the PRIS Referral Form / System	Upgrade to PRIS to Windows 7 complete. Ongoing work to make minimum data set mandatory fields.
5	**Building QI Capability**	**AIM 2019/20: Build and develop QI capability within the QI team and across the organisation.**	
		Develop a QI road map to articulate the direction of travel and in particular how national, mandatory and local clinical audits, other clinical effectiveness assurance and reporting on patient experience outcomes will be prioritised in addition to the Trust's quality improvement priorities	**Ongoing** This is still in progress: and will be carried forward into 2020/21.
		Rebuild the QI team to full establishment, reviewing the team requirements to achieve the ambitions that will be set out in the road map and recruiting into vacant posts	**Complete** The team requirement was reviewed and we have recruited a Clinical Audit and Improvement Manager 1wte. Recruitment into vacant posts will be ongoing.
		Access local and national training to support and develop	We have commissioned master class QI training for the clinical audit/ QI team via EAHSN, This will help build

		the QI capability within the QI support team Develop a QI faculty supported by the leadership team	capacity and capability in the team and support training across the wider organisation. Delivery of the programme is planned in 2020/21.
		Development of QI training tools including access to online QI training, face to face training and development of training materials on individual elements of QI methodology to support staff who are embarking on QI projects	We have introduced the links to the Improvement Academy online Bronze training. Any staff member who would like to be involved in QI is encouraged to undertake this on line introduction training; this is free at no cost to the Trust. We receive regular reports from the Improvement Academy on numbers of Papworth staff who have accessed the training. Fourteen staff have completed the bronze QI training to date, and three have completed the human factors for QI training. Twelve of those that completed the Bronze QI training were senior staff that is, Band 7 or above Nursing/Allied Health Professionals or Medical staff. All three who completed the Human factors training fell into this clinical group. Basic principles of QI are now delivered on the preceptorship training and unregistered nurse training workshops.
		Expand the membership of the QI Steering Group to include the project leads for the three main QI projects, operational engagement and strengthen the links with service improvement	The QISG Terms of reference have been updated during 2019/20 with wider engagement and a wider focus on improvement.
Priority 2		**Goals 2019/20**	**Outcomes**
1	A Safe Hospital Move	To safely move the Royal Papworth Hospital from its existing site in Papworth Everard to the new hospital site on the Cambridge Biomedical Campus, with particular emphasis on preparing the staff for a safe move during the two-week cutover period in April / May 2019.	
		This priority has been fully achieved. The hospital move was conducted over the course of three weeks from 23rd April – 7th May 2019; extensive consultation, planning and exercise testing took place prior to the move to ensure the transition to the new site was efficient for both patients and staff, with safety as the upmost priority for all. A Hospital Cut Over group was established to plan and execute	

		the move, and the cutover plan was shared with stakeholders who included the Emergency Planning and Resilience Forum, Cambridge University Hospitals Operations Team, ambulance service partners, referring hospitals and commissioners (local and specialist). Departmental and operational readiness projects, desk-top exercises, scenario exercises, emergency planning and command and control training were all undertaken prior to the move and a series of comprehensive familiarisation events and workshops provided staff with confidence and assurance in their new place of work. Command and Control was established at the new site and was in place from 26 April to 7th May 2019 (the main cutover period) of the move schedule. Video conferencing was in place through Command and Control to maintain face to face contact with the old site during Command and Control briefings. A set agenda and use of action cards help maintain the efficiency and smooth running of Command and Control. The site move was conducted safely as planned, concluding with the transfer by the East of England Ambulance Service and Amvale of thirty-nine inpatients and nine critical care patients to the new hospital in just one day, rather than the scheduled three. All staff worked incredibly hard and demonstrated upmost professionalism throughout, making the move a complete success and without incident. The first patients were welcomed into the new Royal Papworth Hospital on the 1 May 2019.	
Priority 3		**Goals 2019/20**	**Outcomes**
1	Delivery of the Lorenzo Digital Exemplar Programme	Maximise benefits from the Lorenzo User Group	The User Group has been running monthly; however the group is often not quorate due to competing demands during the year. However, we have been able to influence the DXC roadmap with Personas UI based partly upon RPH feedback and ongoing engagement with DXC and RPH teams.
		Delivery of competency based learning programmes	Competency based programmes of learning have not been delivered; the move to the new site has necessitated these being put on hold for the

			foreseeable future. Real-time bed management incorporating Lorenzo on the wall, project is still in flight seeing early benefits on first ward. Awaiting dates to deploy to other wards, this is due in the next few weeks.
2	Deliver a safer and improved patient experience	Implementation of real-time bed management	Real-time bed management incorporating Lorenzo on the wall, project is still in flight seeing early benefits on first ward. Awaiting dates to deploy to other wards, this is due in the next few weeks.
		Reducing the average length of stay for elective patients	Progress against this goal has been affected by the impact of the COVID19 pandemic.
		Closed loop medication distribution	To be taken forward in 2020/21
		Vein to vein blood administration	Partly delivered and to be taken forward in 2020/21
3	Improve our ability to utilise data for quality assurance, research and audit	Develop a ward and Trust wide dashboard	Trust wide and local dashboards have not commenced due to pull on resources
		Increase the number of Clinical Data Capture forms to enable capture of structured clinical data	Clinical Data Capture form numbers have more than doubled in the last 12 months increasing structured data capture, a number of reports have been created to exploit these new forms increasing both the reuse of data but also the secondary use of data.
Priority 4		**Goals 2019/20**	**Outcomes**
1	To retain, attract and recruit a diverse workforce	**To retain, attract and recruit a diverse workforce who share the values of Royal Papworth Hospital NHS Foundation Trust, providing them with a high-quality recruitment and onboarding process. (Figures in brackets are baseline at March 2019)**	
		Staff Friends and Family score (% strongly agree/agree)	Treatment: 87.5% (88.5%) Recommend to Work: 62.7% (63.3%)
		Turnover of staff (annualised) %	March 2020 14.8% (19.42%)
		Vacancy rate	March 2020: 9.4% (March 2019 11.01%)
		Nurse Vacancy Rate	Qualified staff Registered nursing vacancy rate including pre-registered nurses 8.04% (excluding PRN 9.31%) (March 2019: 4.34% / Excluding PRN

			9.5%) Unqualified staff Unregistered vacancy rate including pre-registered nurses 11.57% (excluding PRN 14.92%) (March 2019: 28.38%) Notes: Our budgeted establishment increased throughout 19/20. Registered nurse establishment increased from 658 in Mar 19 to 711 in Mar 20 which is a 8% increase. Pre-Reg Nurse are qualified nurses who are waiting to gain their registration. They can either be UK trained and waiting for the NMC to confirm registration or overseas nurses undertaking the appropriate training to gain registration.
		Number of Associate/Assistant Practitioners in the organisation	61
		Number of Apprentices in the organisation	20
2	To engage our workforce	**To engage our workforce in defining, developing and owning an organisational culture that embodies high-quality, compassionate care.**	
		BAME staff experience: i. Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion ii. Percentage of staff experiencing discrimination at work from their manager/team leader or other colleague in last 12 months	Staff survey score 2019 vs 2018 i) 55.8% (2018 score: 72.5%) (higher better) ii) 20.5% 2019 (2018: 19.9%) (lower better) The Trust recognises the challenge it faces in making substantive progress to address issues with career progression for staff from a BAME background. Working with our BAME network we have identified that there were a number of actions where progress had been hampered by lack of capacity to implement the actions/schemes and the subsequent onset of the pandemic. The Trust, supported by the Royal Papworth Charity, has increased capacity to make substantive progress with: • Roll out of unconscious bias training

			for all staff and consider cultural awareness training/ information for line managers and staff • Reverse mentoring for senior leaders in the Trust • Roll out of the career coaching programme • Development of those skills and abilities that relate to career development for example, networking and mentoring; communication, presentations, goals, body language, image and reputation. These are key skills which have been shown to increase career progression. • Development programmes that are focused on BAME staff We have focused on Diversity, Inclusion and Equality and Staff Health and Wellbeing during the pandemic response. We restarted our Compassionate and Collective Leadership Programme the programme in September 2020 and will initially focus on refreshing our values, developing a behaviour framework and the development of line managers. .
		Publishing rostering in a timely manner	Percentage compliance with our publication deadline April 2019 – March 2020 18.2% (March 2019: 16%)
		Papworth Discount App	621 Total Active users (March 2019: 619)
		Appraisal Rate	March 2020 84.99% (90.29%) Notes: The Trust paused IPRs in March 2020 as a response to the COVID19 pandemic and needing to focus all staff on the response.
		Appraisals are of a good quality	Staff survey score 2019 vs 2018 2019: 5.6 (2018: 5.4 (higher better))
3	To build leadership capability	To **build leadership capability** at all levels of the organisation through a mixture of high-quality internal and external training interventions.	
		Staff attending internal or external leadership development opportunities (YTD total)	923 staff accessed non-mandatory training in 2019/20 (778 in 2018/19) Source WRES data please note we have not been able to split this out into leadership development and do

			not hold central figures for those on national leadership courses.
		Development and adoption of a formal talent management strategy	Strategy agreed and published by March 2020 We paused progressing this as a standalone strategy. The Compassionate and Collective Leadership Programme identified a programme of work that included talent management/career progression. We will be taking this objective forward as part of this programme.

Priorities for 2020/21

Our priorities for 2020/21 reflect the three domains of quality, patient safety, clinical effectiveness and patient experience. Our priorities are:

Priority	Executive Sponsor	Operational Lead
Priority 1: Safe Quality Improvement/Patient Safety • Building on the QI culture and capabilities across the Trust • Patient Safety Initiatives – to continue to use the SCORE • Improved diabetes management: Making Hospitals Safe for People with Diabetes	Ivan Graham	Carole Buckley Jackie McDermott
Priority 2: Effective/Responsive Services • Same Day Admission/Preadmission and prehabilitation/Frailty • Length of stay/patient flow/use of resources	Eilish Midlane Ivan Graham	Carrie Symington and Amanda Miles Pippa Hales
Priority 3: Well Led • Leadership and Culture programme to continue from 2019/20 • ED led STP system leadership initiative	Oonagh Monkhouse, Eilish Midlane & Roger Hall	Larraine Howard-Jones
Priority 4: Patient Experience: • Communications: To improve our patient experience at Royal Papworth Hospital.	Ivan Graham	Heads of Nursing and Matrons
Priority 5: Digital Quality Improvement • Deliver a more stable user experience, reducing numbers of hours lost to system issues. • Deliver a safer and improved patient experience • Delivering a joined up health record	Andy Raynes	Eamonn Gorman

Details of the goals and aims of each of the programmes are set out below. To determine the priorities for 2020/21, the Trust has reflected on the Quality Strategy refresh and what the Trust needs to achieve this year. These have been considered against the backdrop of the local and national pressures arising from the operational response to COVID19 and likely future surge plans, as well as local system financial pressures and uncertainty around the future financial architecture for specialised services. It is therefore key that the Trust continues to explore more efficient ways of working whilst maintaining and improving safety. With this as a principle, the next section describes the areas in which the Trust feels it must improve or initiatives that need to be completed in order to continue to be a relevant contributor to cardiothoracic treatment and care. We have reviewed clinical indicators, listened to the patients (through PALS concerns, complaints, patient experience feedback, support groups and listening events) who use our services and consulted with staff to ensure that the goals are specific and measurable.

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

2020/21 Priority 1: Safe

Objective 1: Building QI Capability - Build and develop QI capability within the QI team and across the organisation.

Royal Papworth Hospital has made a commitment to embed and support Quality Improvement within the organisation. We recognise the value of continuous clinical quality improvement in supporting clinical effectiveness, improving patient safety and the patient experience. Although not the primary focus, supporting Quality Improvement will benefit service improvement and cost improvement.

Aim for 2021/21: This aim will continue for 2020/21 and is in line with the 3 year ambitions outlined in the Trust Quality Strategy.

Goals 2019/20	Goals 2020/21
Develop a QI road map to articulate the direction of travel and in particular how national, mandatory and local clinical audits, other clinical effectiveness assurance and reporting on patient experience outcomes will be prioritised in addition to the Trust's quality improvement priorities	The Quality Strategy outlines the strategic direction for quality improvement. The improvement road map is still in development and will be taken forward by the Clinical Audit and Improvement Manager. Launch the QI road map and priorities going forward at a Trust event during 2020/21
Rebuild the QI team to full establishment, reviewing the team requirements to achieve the ambitions that will be set out in the road map and recruiting into vacant posts	Continue to review the functions and requirements of the clinical audit and improvement team to support the strategic requirements of quality improvement across the Trust
Access local and national training to support and develop the QI capability within the QI support team Develop a QI faculty supported by the leadership team	Develop an in-house QI faculty to deliver local QI training
Development of QI training tools including access to online QI training, face to face training and development of training materials on individual elements of QI methodology to support staff who are embarking on QI projects	This will be progressed following the master class training and be carried forward to 2020/21
Expand the membership of the QI Steering Group to include the project leads for the three main QI projects, operational engagement and strengthen the links with service improvement	This needs to be further developed during 2020/21 being led by the Clinical Governance Manager Clinical Audit and Improvement Manager

Executive Lead: Ivan Graham, Acting Chief Nurse

Implementation Lead: Carole Buckley, Assistant Director for Quality and Risk

2020/21 Priority 1: Safe

Objective 2: Implement SCORE Culture Survey in selected clinical areas across the Trust

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support it. Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes and these measures can be used to monitor change over time. One of the benefits of measuring safety culture is that it provides a tangible indicator of the current status and progress over time of organisations and teams implementing improvements.

The SCORE survey is an anonymous, online tool that teams can use to assess the local safety culture. It provides an overview, but also detail in specific focus areas such as communication and staff burn out. Once the survey has been completed, the results are provided to that team alone for them to start conversations internally about how they would like to improve culture and what they could do to facilitate this. The results are never intended to be used for bench marking or performance management.

This priority is a continuation of the 2019/20 work stream to embed an improved safety culture through implementation of the SCORE culture tool across the organisation.

Aim for 2020/21

The Score Survey tool has been funded by the Eastern Academic health Science Network (EAHSN) and we have been advised in Q3 2019/20 that this funding is being withdrawn from the end of March 2020. The trust will therefore look to source additional funding streams to enable us to continue with this tool. We will liaise directly with the survey provider. In the meantime, the focus for 2020/21 will be on following through the actions identified from the surveys undertaken in 19/20 to support the Quality Improvement programme and continue to improve and embed a safety culture. This will be achieved by the following:

- Review action plans and identify current themes across all areas where projects for improvement can be implemented and measured
- Engage with staff from the areas surveyed to implement actions and improvements
- Link with intelligence from the national staff survey and the compassionate leadership program to ensure a joined up approach to priority of actions

Executive Lead: Ivan Graham, Acting Chief Nurse

Implementation Lead: Carole Buckley, Assistant Director for Quality and Risk

2020/21 Priority 1: Safe

Objective 3: Improved diabetes management: Making Hospitals Safe for People with Diabetes

In October 2018 Diabetes UK published their report “Making Hospitals Safe for People with Diabetes” with 25 recommendations to make all hospitals a safer environment for people with diabetes. We have completed the self-assessment that accompanies the report which has highlighted gaps in diabetes care at Royal Papworth Hospital. We are using the gap analysis to identify areas requiring improvement and have used our action plan to identify our goals to improve patient safety, patient experience and clinical effectiveness. It’s not acceptable that people with diabetes don’t feel safe in hospital.

Goals:
1. All patients with a diagnosis of diabetes are to be identified on admission, using the electronic patient record, and referred to the diabetes inpatient team if appropriate.

2. Every person with diabetes is to be assessed on admission, and a diabetes care plan activated. The assessment should include glycaemic management, insulin/ oral hyperglycaemic agent prescription, and foot assessment

3. All healthcare professionals caring for people with diabetes will have received training on the safe use of insulin, and the main diabetes harms and how they can be prevented

Rationale
Currently one in six hospital beds are occupied by someone with diabetes and by 2030 it is predicted this will rise to one in four. In hospital, people with diabetes have high infection rates, longer lengths of stay – one to three more days than patients without diabetes, and increased mortality (6.4% higher)[1].

The cardiothoracic nature of Royal Papworth Hospital means we are likely to have a higher incidence of all types of diabetes, compared to the national average of a general hospital. The changes to the transplant service with the introduction of DCD transplants has significantly increased the number of patients receiving heart transplants, and at risk of developing steroid induced diabetes.

Corticosteroids are also a regular feature in the treatment plan for patients with COPD, and lung disease, as well as those with Cystic Fibrosis who already have a high risk of Cystic Fibrosis Related Diabetes.

DATIX reporting shows that diabetes care at Royal Papworth Hospital needs improving. We must and can improve diabetes care, including patient satisfaction at RPH by, ensuring all people with diabetes are identified, assessed on admission, and that all staff involved in the care of people with diabetes have received basic diabetes education .

Baseline Performance Data

[1] Holman N, Hillson R, Young RJ. Excess mortality during hospital stays among patients with recorded diabetes compared with those without diabetes. Diabetic Medicine 2013;30:1393-1402
Doi: 10.1111/dme.12282

KPI	Baseline Position at March 2020 Target for 2020/21	Q1 progress
GOAL 1: All patients with a diagnosis of diabetes to be identified on admission, using the electronic patient record, and referred to the diabetes inpatient team if appropriate.		
All patients with diabetes will be identifiable on EPR (90%) • Tick box on Lorenzo admission/discharge form within 12 hours of admission. • If diabetes diagnosis selected, automatically populated as a health problem. Undertake quarterly spot audit to verify data quality	It is currently difficult to identify patients with diabetes as the diagnosis is documented in different sections of the EPR depending on the person completing the documentation.	This has been on hold due to COVID19. For action in next quarter
All patients with any of the following • Glycaemic control out of range 4-12 mmol/l • Requiring diabetes education • Suspected diabetes To be referred to DSN within 24 hours using Lorenzo referral pathway (80%)	Referrals are often informal, phone call, bleep, and verbal request. Late referrals made on day of discharge that prevents optimisation of diabetes management, and on occasion delays discharge	Referrals via Lorenzo have increased with the majority now coming via Lorenzo with the exception of transplant There is a different process in place for new transplant patients who are identified via email at time of transplant.
GOAL 2: Every person with diabetes is assessed on admission, and a diabetes care plan activated. The assessment should include glycaemic management, treatment prescription and foot assessment		
All patients with diabetes are assessed within 24 hours of admission to include all of the following: 1. Glycaemic testing 2. Medication review 3. Foot assessment to be completed and recorded on Lorenzo.	1. Blood Glucose should be tested on admission. We don't currently have data about compliance. 2. Prescriptions often do not accurately reflect patient's current diabetes treatment. 3. Completion of the foot assessment was poor on the last hospital audit	Awaiting audit to be in place .
All Oral hyperglycaemic agents (OHAs)/ Insulins to be prescribed at appropriate times, with meals if indicated.	Insulin and OHAs that should be prescribed with meals are often prescribed post meals or at bedtime.	Dependent on audit

All patients on insulin should be assessed for self-administration of insulin	Patients are encouraged to self-administer insulin if appropriate, but documentation is variable.	Dependent on audit
All patients to have diabetes care plan initiated within 24 hours of admission, and documentation completed throughout patients stay.	The current care plan is an information sheet and is not used consistently for documenting care.	2 new medical and surgical Integrated Care Plans (ICP) are ready to go to the Clinical Professional Advisory Clinic for approval.
All patients with diabetes to have a discharge summary to include all of the following • diabetes treatment • complications • follow up arrangements	Diabetes is not part of the current e-discharge, but we are working to have this added. The DSNs currently write to the GP separately if there have been diabetes issues in hospital that need follow up on discharge	This has been on hold due to COVID19. For action in next quarter
GOAL 3: All healthcare professionals caring for people with diabetes will have training on the safe use of insulin, and the main diabetes harms and how they can be prevented.		
All nurses and HCSWs will receive basic training at induction (90%) on: 1. The safe use of insulin 2. Managing the patient on a VRIII 3. Managing diabetes for people on steroids 4. Managing diabetes for people on artificial nutrition 5. Managing hypos 6. Managing DKA 7. Managing HHS 8. Foot protection and referral to the foot team 9. Perioperative care	Currently 1 hour diabetes education is given to nurses and HCSWs on induction. I hour induction is given to junior doctors 45 minutes diabetes education for preceptorship. Ward based teaching sessions are organised by the diabetes team but attendance is poor. No mandatory diabetes training for staff already in post.	New induction presentation written to incorporate the safe use of insulin, and the main diabetes harms and how they can be prevented. 26/03/2020 Induction with voice over made for junior doctors for when face to face not available/appropriate 29/05/2020 New preceptorship programme written with online questions. Voice over to be recorded 7th September 2020
All staff prescribing or administering insulin will have completed CDEP Safe Use of Insulin module (90%).	CDEP is promoted to nursing staff but is not essential, and the uptake is not audited. CDEP is not currently promoted amongst medical teams.	Proposal was to roll out CDEP module for safe use of insulin but currently unable to get CDEP licences from CCG.

Develop a system to provide annual diabetes refresher training for existing staff involved in diabetes care, and track compliance.	Update training is provided on an ad hoc basis and is currently not well attended	This has been on hold due to COVID19. For action in next quarter

Monitoring & reporting: Diabetes team will be responsible for producing a monthly score card which is reported back to departments to inform their local action plan. Reporting is via Clinical Professional Advisory Committee.

Executive Lead: Ivan Graham, Acting Chief Nurse

Implementation Lead: Jackie McDermott, Diabetes Specialist Nurse

2020/21 Priority 2: Effective/Responsive services

Objective 1: Improving Same Day Admission

Current position

The Coronavirus Disease 2019 (COVID19) pandemic caused by the Severe Acute Respiratory Syndrome Coronavirus-type 2 pathogen (SARS-CoV-2) has led to unprecedented challenges for UK health care. Limitation in access to operating theatres, inpatient and critical care beds, as a direct result of COVID19 has resulted in a significant temporary reduction in the number of surgical procedures undertaken.

This has led to a number of our core activities being placed on hold inclusive of our Same Day Admission (SDA) project.

Below is the finalised performance data for 2019 and Q1 of 2020. Historically performance against this standard has been poor and variable. Limitations in pre-assessment and the need to repeat tests within a 3 week period for an increasing number of long waiting patients have been barriers in our delivery of the SDA Target.

Since the beginning of the pandemic we had seen a steady decline in SDA performance within Cardiac Surgery. Following the reintroduction of P* surgical services in May (for clinically critical patients) this performance has dramatically improved as a result of our adaption of our admissions pathway to support our response to COVID19 and Infection Control guidelines. This however has not been replicated in our Thoracic Cancer patients who have been admitted the day before due to a lack of pre-assessment services.

As we are increasing activity, SDA is becoming more challenging due to the limitation of pre-assessment and levels of ANP ward support to facilitate clerking prior to 8.15am start. Team are currently looking to stagger meeting is being set up to look at, Ward, ANP and Junior Doctors to assist with this process.

SDA Performance data:

		Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Dashboard KPIs	Same Day Admissions –Cardiac (eligible patients)	50%	43.53%	33.80%	40.00%	41.82%	50.00%	52.58%	47.47%	32.10%	46.15%	38.36%	35.11%	30.23%	0.00%	82.35%	68.89%
	Same Day Admissions - Thoracic (eligible patients)	40%	25.93%	38.71%	24.53%	37.93%	36.67%	37.84%	45.45%	40.39%	39.62%	37.50%	16.67%	25.49%	28.07%	29.27%	18.52%

Update on Previous Goals for 20/21 as set out in 19/20 Quality response.

- Increase 1st on list SDA across all Cardiac and Thoracic Surgery lists. By end of quarter 1 20/21: Cases on hold due to response to COVID19 in March and April. All appropriate cases delivered as SDA in May.
- 2. Meet 50% SDA standard in Cardiac Surgery for all elective cases. By end of quarter 2 20/21 Delivered in May and June 20 due to response to COVID19.

- Develop robust documentation that identifies inclusion and exclusion criteria for patients to meet SDA criteria. Delivered -ICP now in place on Lorenzo

Rationale

Admission on the day of surgery for elective cardiac and non-cardiac surgery has been established as a prevalent, critical practice. This approach realises medical, logistical, psychological and fiscal benefits, and its success is predicated on an effective outpatient pre-operative evaluation and preadmission and suitable infrastructure to support this pathway.

The establishment of a highly functional pre-operative clinic with a comprehensive preadmission set-up and efficient logistical pathways is essential to the success of a 'Same Day Admission' programme. Evaluating patients prior to admission for surgery, has the potential additional benefits of reducing unnecessary pre-operative hospital admissions, reducing excess lab tests, unneeded consultations, improved patient experience and ultimately decreasing the cancellations on the day of surgery.

Background and our response to challenge.

In 2018/19, Royal Papworth Cardiac Surgery Service the third highest Same Day Admission across our peer group with Blackpool and Royal Brompton leading for the country. This position has declined in 2019/20 and we currently stand fifth in the country. Restrictions in pre-admission, recent high numbers of cancelled operations, lack of affordable local hotel access and other logistic issues have impacted in our performance over the last 12 months. Those trusts that have seen an improvement have confirmed better access to pre-admission, local hostel and accommodation and better links with health partners who support their pre-admission processes.

In Sept 19, an Organisational Optimisation Group was set up to review patient flow and optimise current practices to improve access for our patients. One of the work streams includes SDA and this feeds into the Pre-admission work stream that is led by the HON for Surgery and the OP Manager.

The SDA work stream is led clinically by the Clinical lead for cardiac surgery, Operations Manager for Outpatients Carrie Symington, HON and lead ANP. The working group also has representation from other stakeholders including booking, pre-admission, anaesthesia and pathology. The working group have identified a number of key areas of improvement that we wish to review and these are outlined in the Aims below.

Aims for 2021/22:

- Develop a robust ICP which fully supports SDA pathway
- Increase pre-assessment including Virtual to ensure all appropriate patients are pre-assessed prior to admission
- Ensure 50% of patients who are clinically appropriate for SDA are listed 1st for theatres.
- Reduce need for overnight stay/bed day saving
- Reduce unnecessary duplicated testing, reducing need for further pre-assessment.
- Ensure all patients have access to pre-admission prior to surgery.

This group was placed on hold due to the COVID19 pandemic, however we are looking to reinvigorate this in the fall (Sept/October) once key staff have returned from shielding and annual leave.

Baseline Performance Data to be collected

KPI	Target for 2021/22 = 50% Cardiac Surgery and Thoracic Surgery
GOAL 1:	All appropriate elective patients are pre-assessed prior to admission.
GOAL 2:	3-4 of all appropriate 1st cases to be SDA per day
GOAL 3:	Monthly 50% SDA target to be met.

Monitoring & reporting: Carrie Symington and Amanda Miles

Executive Lead: Eilish Midlane, Chief Operating Officer

Implementation Leads: Narain Moorjani, Cheryl Riotto, Amanda Miles, Carrie Symington

Priority 2: Effective/Responsive Services

Objective 2: Preadmission

Rationale

Preadmission remains a key part of patient preparation for elective procedures and has an important impact on safety, patient experience and utilisation of capacity.

Progress in 2019/20

During 19/20 additional capacity for preadmission was added to improve access to preadmission, particularly as TAVI numbers increased. A review of booking rules and practices was also carried out to ensure that available slots were booked. This was challenging for Q3 and Q4 10/20 when there was a high number of surgical cancellation and therefore patients were being rebooked and not needing preadmission review.

Pre-COVID19, the proportion of surgical patients attending preadmission clinic was consistently high (85%) and those patients who did not attend were the result of late filling of surgical slots and therefore there was no time available for attendance at preadmission.

Capacity at a face to face preadmission for those patients having cardiology procedures remained limited but all benefited from a preadmission telephone call from the Day Ward the day before their admission. This level of telephone based assessment was agreed to meet the needs of these patient groups.

Plan for 2020/21

Since April 20, preadmission has been delivered virtually with patients being telephoned by a specialist nurse, an anaesthetist and a pharmacist to carry out the assessments. This prevents the patients having to visit the hospital, making it safer for them as well as reducing footfall in the building. A daily clinic has been established to allow preadmission patients to attend for the required blood tests and for COVID19/MRSA swabs in advance of their admission for surgery.

Aims for 20/21:

- Introduce video-consultations for preadmission
- Clinical risk stratification of patients before preadmission
- All specialties to come through the same model
- Collate measures of patient experience on the virtual model
- Develop new metrics to monitor a virtual provision

Baseline Performance Data

KPI	Baseline Position at March 2020	Target
Proportion of patients attending preadmission (all)	34%	50%
Proportion of patients attending preadmission (cardiac surgery)	84%	90%

Monitoring & reporting: Carrie Symington

Executive Lead: Eilish Midlane: Chief Operating Officer

Implementation Leads: Lana Shirley, Fliss Fuller, Amanda Miles, Carrie Symington

2020/21 Priority 2: Effective/Responsive Services

Objective 3: Early identification of care needs and prehabilitation opportunity

Goals
1. Improve the pathway and utilisation of the All About Me booklet.

2. All pre-admission elective cardiac surgery patients with a Clinical Frailty Score of 4 and above, and PTE patients, to be assessed same day by Occupational Therapy team in clinic.

3. IHU patients to be screened pre-operatively on admission by Occupational Therapy.

Rationale
Early Identification of care needs:
The 'All about me' booklet is a self-assessment paper questionnaire detailing the patients current abilities and care requirements. This information assists discharge planning by the Occupational Therapy (OT) and Social Work teams. Delays in the right patient information reaching the right teams at the right time delays discharge.

Elective cardiac surgery patients and patients due to have Pulmonary Endarterectomy (PTE) surgery should be given the 'All About Me' booklet when they attend clinic or their initial out-patient appointment. In-House Urgent (IHU) patients are highlighted at daily board rounds to Occupational Therapy (OT) and Social Work teams after admission. However some booklets get lost, and some patients are not highlighted to the relevant teams until close to discharge. This can cause delays.

A digitally accessible 'All About Me' booklet could be made available prior to patients first out-patient appointment. This can then be completed by patients and/or relatives/carers, ready for review in pre-admission clinic. It could also be made available to IHU patients, especially those who are waiting transfer from a DGH (District General Hospital).

Identifying care needs at preadmission or admission highlights care needs early and improving patient flow and facilitating early discharge. OT in the preadmission clinic/outpatient appointment (or on admission for IHU patients) would support the accuracy of the data collected and its use to assist patient flow through the hospital and wider system.

OT assessing patients at preadmission/admission would not only provide more accurate data collection, but also an opportunity to discuss goals and desired outcomes with the patient and carers. A realistic length of stay and suitable location for discharge can be discussed. This enables patient expectations to be managed from a physical, social and psychological perspective.

Early Identification of prehabilitation opportunity
Evidence shows patients will take longer to recover from cardiac surgery if they are frail pre surgery. By identifying these patients and providing them with appropriate preoperative MDT support and prehabilitation, length of stay can be reduced and patient experience improved.

By working as part of the Frailty team (Frailty priority for 20/21) and OT can identify frail patients and flag the relevant therapy teams to ensure appropriate prehabilitation.

Baseline Performance Data
The Occupational Therapy Team trialled assessing elective cardiac surgery patients in pre-admission clinic, with a clinical frailty score of 4 and above in June 2019. Due to staffing shortages this was a small trial, but showed potential to improve the service as detailed in the previous section.

The Occupational Therapy team is currently trialling assessing PTE patients in clinic. The specialist PTE nursing team have been actively asking for this for some months, due to the complexity and discharge planning needs of their patients. Overall it takes less time for an experienced Occupational Therapist to assess in a clinic and predict functional outcomes.

The team also trialled a very small scale trial of assessing IHU patients on admission. The Occupational Therapist only took 30 minutes to do ward round and in that time, 8 patients were seen, and established 3 that needed raising to the IHU frailty meeting. The problems highlighted by Occupational Therapy were unique individual concerns that were significant in planning and implementing patient's care.

Anecdotally patients have reported that they would be happy to complete a digital 'All About Me' booklet, or they could ask their relatives or friends to help them.

Our neighbours at CUH have developed a successful pre-surgical assessment clinic for older people (PRIME), and other such clinics also run around the country.

KPI	Baseline Position at March 2020 Target for 2020/21
GOAL 1: 100% of all elective cardiac surgery, PTE patients and IHU patients to have the option of completing a digital 'All About Me' booklet. *Completion of this likely to be delayed due to impact of the COVID19 pandemic.*	
GOAL 2: 90% of pre-admission elective cardiac surgery patients (with clinical frailty score of 4 and above) and pre-admission PTE patients, to be assessed on the same day by Occupational Therapy team in clinic. *We are aiming to run a pilot frailty clinic for 3 months for cardiac surgery patients only, so will be a small percentage of this patient cohort only.*	
GOAL 3: 90% of IHU patients to be screened by Occupational Therapy on admission. *Completion of this likely to be delayed due to impact of the COVID19 pandemic.*	

Monitoring & reporting: Pippa Hales, Head of Allied Health Professions
Executive Lead: Ivan Graham, Acting Chief Nurse
Implementation Leads: Team Lead Occupational Therapist

Priority 3 Well Led

Objective 1: Collective and Compassionate Leadership programme goals for 2020/21

During the first phase of the project, more than 200 staff members were interviewed as part of 36 focus groups. They were asked questions about a number of themes, including vision and values, teamwork, learning and innovation and compassion, to help us assess our organisation culture.

Following an in-depth diagnostic phase, we have identified eight priority areas to address:

- **Valuing difference –** We will embed processes and behaviours that will set a standard of equal opportunities for all, building an equal, inclusive and diverse environment in which to work.
- **Personal responsibility and empowerment –** We will create an environment where staff can feel a sense of personal responsibility for their behaviour and feel empowered to make decisions in our new environment.
- **Compassion** – We will treat each other the way we would like to be treated, with respect, kindness and compassion. We will build a culture where uncompassionate behaviour can be called out.
- **Professional and personal development** - We will view development from a wider perspective, creating a transparent framework that ensures equality of access.
- **Values and behaviours –** We will review and reset our values, developing and embedding a behaviour framework throughout the Trust that sets clear expectations for all staff.
- **Health and wellbeing -** We will ensure that the physical and mental health of all staff are respected; introducing and promoting policies and services that support the health and wellbeing of staff.
- **Developing and supporting line managers -** We will give line managers the support and structure they need to become competent and confident; leaders who are visible and able to effectively support their teams.
- **Teamwork** We will enable the building of strong, inclusive teams with positive relationships between teams.

- Since completing the Diagnostic phase and forming our priorities, we have been conducting a gap analysis and considering the order in which we need to tackle the work. It is clear that some priorities need to be addressed first, and underpin everything else we do, thus the Values and Behaviours priority comes first.
- We are now entering the next phase, the Design phase, where we will confirm resource and design interventions to deliver on these priorities.
- We have already identified areas in which we can make an immediate difference and have gone ahead and affected change accordingly:
  - Introduction of career coaching
  - Training to support managers to develop coaching cultures and coaching conversations in their teams
  - The establishment of a staff experience committee with formal reporting lines to the Board to provide a more focused arena for staff experience topics.
  - Mental health support. The introduction of a support line for staff to use and access to a psychological wellbeing service with free cognitive behaviour therapies.

    - Weekly Briefing emphasis on the need to treat our colleagues with compassion and respect.
- This is just the start to a phase where we will continue to identify and adopt early interventions to address our priorities. At the same time we will be designing more in depth and inter-related interventions that will affect real change in our organisation, empowering staff to embed a compassionate and collective leadership culture across the organisation
- This programme is a huge opportunity to re-assess who we want to be as an organisation and how we want to do things, and it will play a crucial role in realising our ambition of offering the best staff experience in the NHS.

We have identified the following Key Performance Indicators (KPIs) for 2020/21:

- Over 90% of Pulse Survey respondents to have an awareness of the Trust values by the Q4 2020/21 pulse survey
- In the 2020 Staff Survey more than 45% (up from 30% in 2020) (Q19e) of respondents state that organisational values are discussed in the their appraisal
- We will improve our staff engagement score as measured in the national staff survey to the top quartile for our peer group.
- We will improve our Friends and Family Reponses in the staff survey in both categories to the top quartile for our peer group.
- We will reduce the % of staff reporting experiencing bullying to the top quartile for our peer group.

Executive Lead: Oonagh Monkhouse, Director of Workforce & Organisational Development

Implementation Leads: Larraine Howard-Jones, Deputy Director of Workforce & Organisational Development

Priority 3 Well Led

Objective 2: ED led STP system leadership initiative

Provide the system and Region with Critical Care Surge Capacity and support the National ECMO surge requirements.

During the first wave of the COVID19 Pandemic, Royal Papworth Hospital surged to 67 Critical Care Beds with 21 ECMO beds. We achieved some of the best outcomes for patients. During subsequent waves we will provide 54 Critical Care Beds internally by reducing services with a possibility of capacity up to 167 Critical Care Beds with system support. The Clinical Decision Cell that was set up at Bronze level in the Trust will support the region with clinical advice for patients. The Trust also provided a transfer service during the surge, and if required to do so will do the same in the event of a second wave.

Key performance indicators

- Develop a surge plan to deliver Critical Care Capacity for the region, including the lessons learned from the first surge.
- Develop a network of hospitals that will provide mutual aid in the event of a second surge.
- Engage the system and region in the Clinical Decision Cell to ensure best possible outcomes for patients through advice and support to clinical teams.
- Develop and communicate a health and well-being package for staff to ensure resilience and support during a second wave.

Executive Lead: Eilish Midlane, Chief Operating Officer & Roger Hall, Medical Director

Implementation Leads: Clinical Directors and Heads of Nursing

Priority 4: Patient Experience

Objective 1: Communications: To improve our patient experience at Royal Papworth Hospital.

Rationale
The delivery of outstanding patient care is at the heart of everything we do. We continually strive to consistently offer the best possible patient care and experience to our patients, their families and significant others in a caring environment that engages patients as partners in care, 'no decision about me without me'.

We will continually strive for improvement and in meeting the unprecedented and changing challenges that living with the coronavirus presents, particularly with the restrictions to visiting loved ones and requirement to reduce the hospital footfall in line with infection prevention and control best practice.

Baseline Performance Data

KPI	Baseline Position at March 2020 Target for 2020/21
GOAL 1: To increase the participation rate of Friends and Family by using electronic media	
To increase the inpatient participation rate so that it is consistently greater than 50%.	*Refer to Scorecard Table below for inpatients
To increase the outpatient participation rate so that it is consistently greater than 25%.	*Refer to Scorecard Table below for outpatients
To maintain the recommendation rate of Friends and Family across all clinical areas so that it is consistently greater than 90%.	*Refer to Scorecard Table below for recommendation rates
GOAL 2: To capture electronic virtual 'Attend Anywhere' patient appointments	
Implementation of real-time Friends and Family feedback from attendance at Virtual clinics.	Applicability of new technology in this fast growing 'virtual' clinical field in line with living with the coronavirus (COVID) that requires implementation of infection prevention control and guidance to reduce the footfall in a hospital setting by scheduling virtual consultations in place of face-to- face consultations only if absolutely necessary.
Patient Aide Portal.	Explore the user ability and expansion for gaining patient experience through the Patient Aide Portal which enables patients to see a limited view of their medical record from a portal view, allowing better management of chronic conditions.

GOAL 3: To increase feedback from the patient, family and significant others in support of 'bridging the gap' that 'living with COVID' presents to the patient, their family and significant others such as restricted visiting and social distancing.	
Ensure patient stories are presented at the Quality Risk Management Group, Clinical Practice and Advisory Group and Executive Board.	Patient stories to continue as part of matrons' quality and safety reports. Patient story records to be kept and learning shared across divisional team meetings.
Circulate quarterly Survey Monkey Questionnaires.	Working with divisional triumvirates in the development of standardised Survey Monkey questionnaires and providing feedback at divisional performance meetings.
Partnership working with the Patient Advocacy Liaison Service	To ensure that we continually learn and develop from patient and carer feedback. Communications is a key area to improve patient experience from investigation of enquiries and complaints 2019/20.

Baseline Performance Data

Complaints	0	0	1-3	>3
Friends & Family response rate	>=50%	>=50%	45%-49%	<45%
Friends & Family : % recommended	>=85%	>=85%	77.5%-84%	<77.5%

Current Performance Data (Q1/Q2 - 2020/21 Ward Scorecard)

Complaints

Complaints Trend

Directorate	Ward / Area	LATEST MONTH trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Thoracic	3 North		2	0	0	0	0	0	0							
Cardiology	3 South		0	0	0	3	1	0	0							
Thoracic	4 North & South		1	0	0	1	0	0	0							
Surgery	5 North		1	0	0	0	1	0	2							
Surgery	5 South		0	0	0	0	0	0	0							
Clinical Services	Critical Care		0	1	0	0	1	0	1							
Clinical Services	Day Ward		0	0	0	0	0	0	0							
Clinical Services	Outpatients		3	1	1	0	1	1	2							
Clinical Services	Theatres		0	0	0	0	0	0	0							
Clinical Services	Cath labs		0	0	0	0	0	0	0							
	Total Number		7	2	1	4	4	1	5	0	0	0	0	0	0	0

FFT Response Rate

Friends & Family: Response Rate Trend

Directorate	Ward / Area	LATEST MONTH trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Thoracic	3 North		26.0%	14.0%	NONE	33.0%	28.6%	35.0%	38.7%							
Cardiology	3 South		30.0%	13.0%	17.0%	61.0%	24.2%	28.3%	53.0%							
Thoracic	4 North & South		37.0%	10.0%	38.0%	59.0%	30.8%	49.1%	39.0%							
Surgery	5 North		20.0%	16.0%	28.0%	40.0%	32.4%	33.6%	25.2%							
Surgery	5 South		20.0%	15.0%	23.0%	77.0%	23.6%	27.2%	28.6%							
Clinical Services	Critical Care	NA	NA	NA	NA	NA	NA	NA	NA							
Clinical Services	Day Ward		37.0%	20.0%	36.0%	73.0%	56.5%	44.3%	53.8%							
Clinical Services	Outpatients		4.0%	NA	NA	0.7%	2.4%	36.2%	1.9%							
Clinical Services	Theatres	NA	NA	NA	NA	NA	NA	NA	NA							
Clinical Services	Cath labs		NA	NA	NA	NA	NA	NA	NA							
	Average		**23.8%**	**14.7%**	**28.4%**	**49.1%**	**28.4%**	**36.2%**	**34.3%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

FFT Recommendation %

Friends & Family: % who would recommend us Trend

Directorate	Ward / Area	LATEST MONTH trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Thoracic	3 North		99.0%	100.0%	NONE	91.0%	99.0%	100.0%	99.0%							
Cardiology	3 South		97.0%	100.0%	96.0%	97.0%	97.0%	100.0%	100.0%							
Thoracic	4 North & South		94.0%	100.0%	100.0%	94.0%	98.0%	100.0%	100.0%							
Surgery	5 North		100.0%	100.0%	95.0%	100.0%	95.0%	100.0%	100.0%							
Surgery	5 South		96.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%							
Clinical Services	Critical Care	NA	NA	NA	NA	NA	NA	NA	NA							
Clinical Services	Day Ward		99.0%	100.0%	100.0%	97.0%	100.0%	100.0%	99.0%							
Clinical Services	Outpatients		97.0%	NA	NA	100.0%	97.5%	99.4%	100.0%							
Clinical Services	Theatres	NA	NA	NA	NA	NA	NA	NA	NA							
Clinical Services	Cath labs	NA	NA	NA	NA	NA	NA	NA	NA							
	Average		**97.8%**	**100.0%**	**98.2%**	**97.0%**	**98.1%**	**98.5%**	**99.7%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Monitoring & reporting:

Executive Lead: Ivan Graham, Acting Chief Nurse

Implementation Leads: Heads of Nursing

Programme Delivery Leads: Matrons and Ward Sisters/Charge Nurses

Priority 5: Digital Quality Improvement

Objective to deliver Digital Quality Improvement through:

1. Delivery of a more stable user experience, reducing numbers of hours lost to system issues.

2. Delivery of a safer and improved patient experience

3. Delivery of a joined up health record

Baseline Performance Data

KPI	Baseline Position at March 2020 Target for 2020/21
GOAL 1: Deliver a more stable user experience	
Reduce the number of hours lost to system crashes and slowness.	Identify issues within Lorenzo which are causing system slowness and instability. Monitoring of the 100 most common user activities on Lorenzo and benchmark these as a measure of performance.
Ensure local network is robust and not contributing to system issues.	Independent review of infrastructure to ensure system is robust.
	EPR board
GOAL 2: Deliver a safer and improved patient experience	
Implementation of real-time bed management	Lorenzo on the wall and enabling staff's competence for real-time admission transfer and discharge
Patient Aide portal	Enable patients to see a limited view of their medical record from a portal view, allowing better management of chronic conditions.
Closed loop medication distribution	Reduction in medication related incidents
Vein to vein blood administration	Reducing the risk of transfusion incidents
	EPR board
GOAL 3: Delivering a joined up health record	
Connection with other EPR's and GP systems	Enable clinicians to have increased information available when treating patients, including allergies and medications from the GP practice.
	Working with STP partners towards development of Local Health and Care Record LHCR to enable system wide care.

Monitoring & reporting:
Executive Lead: Andrew Raynes, Chief Information Officer
Implementation Leads: Deputy Director of Digital
Programme Leads: Head of Digital Programmes & Projects

2.2 Statements of assurance from the Board

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

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

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

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

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

During 2019/20 Royal Papworth Hospital NHS Foundation Trust provided and/or sub-contracted six relevant health services. Royal Papworth Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in six of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Royal Papworth Hospital NHS Foundation Trust for 2019/20.

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

Information on participation in clinical audits and national confidential enquiries

National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG)

During 2019/20, 18 national clinical audits and 3 national confidential enquiries covered relevant health services that Royal Papworth Hospital NHS Foundation Trust provides. During 2019/20, Royal Papworth Hospital NHS Foundation Trust participated in 17 of the 18 (95%) national clinical audits and 2 of the 3 (67%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Royal Papworth Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audits relevant to Royal Papworth Hospital Participation rate 17/18 (95%)		
Audit Title	**Audit Source**	**Compliance with audit terms**
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	100
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	100
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	See breakdown
National Audit of Cardiac Rehabilitation	University of York	100
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	100
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	100
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	100
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	100
National Audit of Cardiac Rhythm Management (CRM)	Barts Health NHS Trust	100
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	100
National Adult Cardiac Surgery Audit	Barts Health NHS Trust	100
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	100
National Congenital Heart Disease (CHD)	Barts Health NHS Trust	100
National Lung Cancer Audit (NLCA)*	Royal College of Physicians	100*

Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	100
Sentinel Stroke National Audit programme (SSNAP)**	King's College London	0**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion (SHOT)	100
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	100

** The National lung cancer audit records the patients by the hospital in which they were first seen. Since almost no patients are referred directly from their GP to Royal Papworth Hospital, the data which is completed by Hospital counts towards the district general hospitals participation rate.*

***The Sentinel Stroke National Audit requires a minimum number of patients to generate a quarterly report. Since the Trust started participation in 2019, we have not had enough stroke patients to meet this requirement. The Trust's local stroke group is currently agreeing standards based on national guidance to provide assurance of evidence based care.*

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

A breakdown of the data collection requirement for the national confidential enquiries that Royal Papworth Hospital participated in is presented below:

Title	Cases included	Cases excluded	Clinical Q returned	Case notes returned	Organisational questionnaire returned
Out of Hospital Cardiac Arrests	0	111	0	0	0
Dysphagia in Parkinson's Disease	1	3	In progress	In progress	In progress

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

The reports of 12 national clinical audits were reviewed by the provider in 2019/20 and Royal Papworth Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Example includes:

- Cardiac surgery morbidity measures to be presented over time as a run chart at the surgical mortality and morbidity meeting. This is to ensure complications are in line with expected risk.
- Re-establish working with regional ambulance service to ensure correct ambulance arrival times are recorded on internal clinical systems.

Below is a sample of audits discussed at relevant group meetings.

Audit Title	Report Published
Case Mix Programme (CMP)	Y
National Audit of Cardiac Rehabilitation	Y
National Audit of Care at the End of Life (NACEL)	Y
National Audit of Pulmonary Hypertension (NAPH)	Y
National Cardiac Arrest Audit (NCAA)	Y
National Audit of Pulmonary Hypertension (NAPH)	Y
Myocardial Ischaemia National Audit Project (MINAP)	Y
National Adult Cardiac Surgery Audit	Y
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y
National Lung Cancer Audit (NLCA)*	Y
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y
UK Cystic Fibrosis Registry	Y

The reports of 25 local clinical audits were reviewed by the provider in 2019/20 and Royal Papworth Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. A sample of actions is listed below:

Protected meal times
Actions:

- To ensure patients are not interrupted during mealtimes, it has been agreed non urgent blood tests will not take place.
- The Food and Nutrition group has been reformed to carry out monthly observation checks to ensure patients have protected meal time checks.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Papworth Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee *was* 3,397. See table below:

Type of research project	No. of participants recruited per financial year			
	2016/17	2017/18	2018/19	2019/20
NIHR portfolio studies	1,376	1091	1018	1,406
Non-NIHR portfolio studies	334	243	33	124
Tissue bank studies*	2,369 (2,595)	2,110 (2,290)	1987	1,867
Total	**4,079**	**3,444**	**3,038**	**3,397**

NIHR = National Institute for Health Research
** Tissue bank studies included 2 studies registered on the NIHR portfolio. Total figure given in brackets to avoid double counting as participants are included in NIHR portfolio studies.*

By maintaining a high level of participation in clinical research the Trust demonstrates Royal Papworth's commitment to improving the quality of health care.

During 2019/20 the Trust recruited to 68 studies of which 60 were portfolio studies (2018/19: 63 studies and 58 portfolio studies).

The 2019 CQC Inpatient survey included a question about whether patients had been approached to participate in research. Papworth was in the top 10 Trusts in England for positive responses. Research conducted by the National Institute for Health Research (NIHR) has shown that research-active hospitals have better health outcomes for patients.

The Trust recruits to studies in wide variety of disease groups including cystic fibrosis, lung cancer, motor neurone disease, heart failure, atrial fibrillation, cardiac surgery and idiopathic pulmonary fibrosis. The Trust continues to sponsor a number of single and multi-centre studies and in September 2018 the clinical trials unit gained full accreditation from the UKCRC.

Quality is at the heart of all our research activities and Royal Papworth Hospital ranked as the top recruiting site in the UK for 35% of the interventional studies and in the top 3 highest recruiters for 70% of the interventional multicentre NIHR portfolio studies we supported. The fantastic recruitment figures are in spite of the hospital move period.

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

Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Royal Papworth Hospital NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Royal Papworth Hospital NHS Foundation Trust and NHS Commissioners, through the Commissioning for Quality and Innovation payment framework.

Further details of the 2019/20 national Specialised and non-specialised CQUINs are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Due to the COVID19 pandemic, guidance was issued from NHSE/I that providers would not be required to submit Q4 CQUIN evidence. The guidance further advised that a pragmatic approach be taken to agreement of 2019/20 total achievement. Confirmation has been received that CCG CQUIN has been achieved at 99% and NHSE at 100%.

The amount of income available in 2019/20 conditional on achieving quality improvement and innovation goals was £1,132k. (2018/19: £2,650k). The amount expected to be achieved is £1,127k (2019/20: £2,560k (97%)).

For further information on CQUIN performance for 2019/20 see Part 3 of the Quality Report.
Development of on CQUIN priorities for 2020/21 remains on hold.

Care Quality Commission (CQC) registration and reviews

Royal Papworth Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'. The Care Quality Commission has not taken enforcement action against Royal Papworth Hospital NHS Foundation Trust during 2019/20. Royal Papworth Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Royal Papworth Hospital welcomed the CQC to the new hospital in April 2019 and the CQC the site was registered without conditions.

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

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

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

There were areas identified in which Royal Papworth Hospital could improve and action plans have been put in place to address these.

The report of this inspection is available on the CQC website at
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ4523.pdf

Data Quality

It is essential that we produce accurate and reliable data about patient care. For example, how we 'code' a particular operation or illness is important as that not only allows us to receive the correct income for the care and treatment that we provide, but it also anonymously informs the wider health community about illness or disease trends.

Royal Papworth Hospital NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

• which included the patient's valid NHS number was 100% (national average 99.4%) for admitted patient care and 100% (national average 99.7%) for outpatient care;
• Which included the patient's valid General Medical Practice Code (code of the GP with which the patient is registered) was 100% (national average 99.7%) for admitted patient care and 100% for outpatient care (national average 99.6%).

Governance Toolkit Attainment Levels

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

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

The Information Governance Toolkit is available on the NHS Digital website:
https://www.igt.hscic.gov.uk/

Clinical Coding

Royal Papworth Hospital was not subject to the Payment by Results clinical coding audit during 2019/20.

Royal Papworth Hospital's annual independent clinical coding audit was carried out by Jane Wonnacott Ltd in March 2020.

Royal Papworth Hospital has achieved the following Information Governance levels:

1. Information Governance Requirement 14-505: An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months. Attainment level 1: no change from 2019-20.

2. Information Governance Requirement 14-510: Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards. Attainment level 3: no change from 2019-20.

Royal Papworth Hospital NHS Foundation Trust is currently working on an action plan to address the Auditors recommendations for 2020-21. All recommendations for 2019-20 have been actioned.

Learning From Deaths

During April 2019 to March 2020, 167 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 37 in the first quarter; 46 in the second quarter; 47 in the third quarter; 37 in the fourth quarter.

By 25/06/20, 46 case record reviews and 3 investigations have been carried out in relation to 167 of the deaths. In 2 cases a death was subjected to both a case review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

21 in the first quarter; 5 in the second quarter; 3 in the third quarter; 20 in the fourth quarter.

No patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Mortality Case Record Review process

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

The case record review process sits alongside existing clinical governance processes including Serious Incident investigations and Mortality & Morbidity meeting case discussions. If a patient's death is considered more than 50% likely to have been potentially avoidable following case record review, this is reported as a patient safety incident triggering an investigation process. The local procedure is set out in DN682 Mortality Case Record Review Procedure.

Analysis of number of deaths by Clinical Directorate shows that most deaths in Royal Papworth Hospital occur in Cardiology and Surgery, with smaller numbers in Transplant, Thoracic Medicine and Respiratory ECMO.

Lessons learnt & Actions taken in 2019-20

Actions which Royal Papworth Hospital has taken in the reporting period, and proposes to take following the reporting period, in consequence of what Royal Papworth Hospital has learnt during the reporting period:

Lesson learnt from Medical Examiner Service:

- In 2019-20 the introduction of the Medical Examiner service has provided additional scrutiny for all inpatient deaths and allowed a more selective approach for case record reviews following criteria recommended by the Independent Advisory Group to Royal College of Physicians' National Mortality Case Record Review Programme.
- The Medical Examiner service has provided additional support for bereaved families and has indentified operational difficulties with the Bereavement Service provided for Royal Papworth by a neighbouring organisation.
- The Serious Incident Executive Review Panel set up in 2018 has continued to meet weekly in 2019-20 to discuss deaths in the previous week and now links to ME scrutiny reviews as well as case record reviews and incident investigations.

Lessons learnt from Retrospective Care Record Reviews:

- The Clinical Audit team and Patient Advice & Liaison Service team jointly administer the mortality database and ensure that all patient details are recorded on a weekly basis. Some technical issues have been encountered using the spreadsheet leading the risk of data loss and the need for a comprehensive digital platform has been identified. A review of all mortality processes supported by the Business Intelligence team will help improve data collection and analysis.

- The introduction of the Retrospective Case Record Review process has acted as an additional safety net to identify patient safety concerns in the Trust. In 2019-20 the case record review process did not revealed any patient safety concerns which had not already been reported as an incident indicating a strong patient safety reporting culture in the Trust

Lessons learnt from Mortality & Morbidity Meetings:

- In 2019-20 case discussions at Mortality & Morbidity meetings have improved through the additional collective judgement of the overall quality of care using the NCEPOD grading tool in Surgery, Cardiology, Critical Care and ECMO M&M meetings.
- Patients who die deaths after transfer from Royal Papworth to another hospital are not easily captured using our existing processes. We will work with other organisations in the region to improves our ability to learn lessons from patients who die in other hospitals.

Impact & Developments in 2019-20

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

- The Patient Advice and Liaison Service (PALS) will provide a bereavement follow up service for all in-hospital deaths from April 2020.

- The Bereavement Service has been reviewed with a plan to deliver the service directly by Royal Papworth Hospital from September 2020.

- The risk of data loss for the Retrospective Care Record Reviews has been added to the Trust's risk register with actions is place to mitigate the risk.

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

- Medical Examiner Scrutiny Review
- Retrospective Case Record Review
- Morbidity & Mortality Meeting case discussion
- Serious Incident Investigation

1 case record reviews and 0 investigations were completed after 01/04/2020 which related to deaths which took place before the start of the reporting period.

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

2 representing 0.6% of the patient deaths during the previous reporting period 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Performance against the national quality indicators

Publication of data against a number of national indicators has been suspended during the pandemic and this is highlighted where appropriate within the table.

The following core set of indicators applicable to Royal Papworth Hospital on data made available to Royal Papworth Hospital by the Health and Social Care Information centre are required to be included in the Quality Accounts.

Indicator	2018/19 (or latest reporting period available)	2019/20 (or latest reporting period available)	Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…	Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by…
The percentage of patients aged 16 or over readmitted to the hospital within 28 days of discharge from the hospital Note1 [this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review]	Trust rate was 9.01% for 2011/12 placing the Trust in Band B1. National average was 11.45%. Highest rate for an acute specialist trust was 14.09%. Lowest rate for an acute specialist trust was 0.00%.	Trust rate was 9.01% for 2011/12 placing the Trust in Band B1. National average was 11.45%. Highest rate for an acute specialist trust was 14.09%. Lowest rate for an acute specialist trust was 0.00%.	Readmission rates are low due to the quality of care provided.	We will continue to monitor. Percentages could be distorted by readmissions following an inpatient stay for investigations in which there was no treatment intended for the underlying condition.
The trust's responsiveness to personal needs of its patients during the reporting period [Data from National Inpatient Survey]	Trust score was 78.4 in the 2017/18 survey. National average score was 68.6. National highest score was 85. National lowest score was 60.5.	Trust Score was 82.7 in the 2018/19 survey. National average score was 76.2 National highest score was 88.4	Our staff pride themselves on providing patients with safe, high-quality, and well-coordinated care treating our patients with respect and dignity. This level of care is reflected in the Trust achieving results in the top 10% of trusts in the inpatient survey.	We will continue to use data from the inpatient survey to identify areas for improvement.

		The next publication of the Overall Patient Experience Scores for the 2019 Adult Inpatient Survey update has been suspended due to COVID19 work pressures		
Indicator	**2018/19 (or latest reporting period available)**	**2019/20 (or latest reporting period available)**	**Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…**	**Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by…**
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends [Data from National Staff Survey]	88.5% of the staff employed by, or under contract to, the trust in the 2018 staff survey would recommend the trust as a provider of care to their family or friends. Average for acute specialist trusts was 90.1%. The Highest scoring specialist trust was 94.8%. The Lowest scoring specialist trust was 77.5%.	87.5% of the staff employed by, or under contract to, the trust in the 2019 staff survey would recommend the trust as a provider of care to their family or friends. Average for acute specialist trusts was 90.0%. The Highest scoring specialist trust was 94.8%. The Lowest scoring specialist trust was 80.9%.	This rating has remained broadly static; the change is not statistically significant. In 19/20 the Trust experienced the most significant organisational change in its history with the relocation of the hospital to the Cambridge Biomedical Campus. This affected every individual and every team. Long established ways of working, team configurations, travel to work and staff facilities all changed. This had a significant impact on staff engagement.	The Compassionate and Collective Leadership Programme identified eight priorities areas we will focus on to build a high quality care culture were staff feel valued and recognized for their contribution. The implementation of this programme commenced in June 19 following the relocation. Phase 1 was completed in February 2020. The COVID19 emergency has delayed progression to Phase 2. We restarted the programme in September 2020 and will initially focus on refreshing our values, developing a behaviour framework and the development of line managers. We have also focused on Diversity, Inclusion and Equality and Staff Health and Wellbeing during the pandemic response. We have secured support from the Trust

				Charity to increase the resources and support for staff in these areas. See Annual Report – Staff Report section for other information on the 2019 Staff Survey.
Friends and Family Test – Patient NOT STATUTORY REQUIREMENT	In 2018/19 96.4% of our patients would recommend our service.	In 2019/20 97.4% of our patients would recommend our service. *(Data published to February 2020 Data submission and publication for the Friends and Family Test will restart for acute and community providers from December 2020, following the pause during the response to COVID19. A score of 97.6% was achieved for March 2020 Source: PIPR))*	The Trust achieved a response rate of 33.3% in 2019/20 and continues to promote the FFT test. Responses are reviewed at the weekly Matrons meeting, and actions are monitored. Improvements made as a result of patient feedback are displayed on our 'you said we did boards'.	The Trust will continue to monitor Friends and Family scores. There are actions in place to improve the Friends and Family response rates for both inpatients and outpatients.
Indicator	**2018/19 (or latest reporting period available)**	**2019/20 (or latest reporting period available)**	**Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…**	**Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by…**
The percentage of patients who were admitted to hospital and were risk assessed for VTE during the reporting period [Since April 2015 data published quarterly not monthly]	Trust achieved 92.64% for 2018/19. RPH: Q1 94.33% Q2 93.44% Q3 90.56% Q4 92.22% Acute Trust average was: Q1 95.62% Q2 95.44% Q3 95.60%	Trust achieved 95.33% for 2019/20. RPH: Q1 93.46% Q2 93.53% Q3 97.33% Q4 97.00% 2020/21 Q1 96.63% Acute Trust average was: Q1 95.56% Q2 N/A	Concerns were identified following the previously falling level of compliance with the VTE standard. Trust wide education had continued to ensure VTE documentation on admission and reassessment during admission was complete. Auditing compliance since the introduction of Lorenzo has been time consuming.	Following review of VTE and falling compliance against 95% target of VTE risk assessment on admission a local action plan was put in place. This involves key staff within the organisation to affect change and optimisation of Lorenzo and Metavision to capture data for audit. NHS Improvement is also working with us to monitor compliance and the

	Q1 to Q3 95.55% 2018/19. Highest acute provider 100%. (Q1-3) Lowest acute provider Q1 75.84 % Q2 68.67% Q3 54.86%	Q3 N/A Q1 to Q3 N/A Highest acute provider N/A. (Q1) 100% Lowest acute provider Q1 % Q2 N/A% Q3 N/A% *The national VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID19 pandemic.*		improvement of risk assessment on admission. This is monitored through QRMG and shared with the Quality and Risk Committee. We have seen sustained improvement in late 2019/20 shown below with increased compliance above 95% in three consecutive quarters.
The rate per 100,000 bed days of cases of C.difficile infection reported within the trust during the reporting period Note 2	Trust rate was 3.9 in 2018/19 for Trust attributed patients aged 2 years and over (2 cases). Total cases 10 with two attributed to RPH	Trust rate was 1.67 in 2019/20 for Trust attributed patients aged 2 years and over (1 case). Total cases 11 with one attributed to RPH	The Trust rate is based on the one cases attributed to the Trust in 2019/20. Infection prevention and control is a key priority for the Trust.	See Part 3 of report – Other Information.
Indicator	**2018/19 (or latest reporting period available)**	**2019/20 (or latest reporting period available)**	**Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…**	**Royal Papworth Hospital NHS Foundation Trust intends to take/has taken the following actions to improve this score or rate and so the quality of its services, by…**
The number and, where applicable, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	(i) Trust number for Month 1 to Month 6 in 2018/19 was 1374. The Acute Specialist Trust highest total was 3812, the lowest was 262 and the average was 1493. (ii) Rate per 100 admissions	(i) Trust number for Month 6 to Month 12 in 2019/20 was 1596. The Acute Specialist Trust highest total was 2491, the lowest was 366 and the average was 1393. (ii) Rate per 100 admissions	Data is submitted to the National Reporting and Learning System in accordance with national reporting requirements.	The Trust continues to demonstrate a strong incident reporting culture which is demonstrated by the majority of incidents graded as low or no harm. All patient safety incidents are subject to a root cause analysis (RCA). Lessons

(i) Number (ii) Rate per 100 admissions (iii) Number and percentage resulting in severe harm/death Note 3	was not available. The highest, lowest and average Acute Specialist Trust rate per 100 admissions was not available. (iii) 5 resulted in severe harm/death equal to 0.36% of the number of patient safety incidents. The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 0.38%, the lowest was 0% and the average was 0.12%.	was not available. The highest, lowest and average Acute Specialist Trust rate per 100 admissions was not available. (iii) 3 resulted in severe harm/death equal to 0.19% of the number of patient safety incidents. The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 1.26%, the lowest was 0% and the average was 0.12%.		learnt from incidents, complaints and claims are available on the Trust's intranet for all staff to read.

Data Source: Health and Social Care Information Centre portal as at 10/04 2018 unless otherwise indicated

Note 1
Emergency re-admissions within 28 days of discharge from hospital. Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.

Note 2
The number of *Clostridium difficile* (C. difficile) infections, for patients aged two or over on the date the specimen was taken. A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health and Social Care guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken. Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. Accountability is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one). The Quality Accounts Regulations requires the C. difficile indicator to be expressed as a rate per 100,000 bed days. If C. difficile is selected as one of the mandated indicators to be subject to a limited assurance report, the NHS foundation trust must also disclose the number of cases in the quality report, as it is only this element of the indicator that Monitor intends auditors to subject to testing.

Note 3
The indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death. A patient safety incident is defined as 'any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare'. The 'degree of harm' for patient safety incidents is defined as follows: 'severe' – the patient has been permanently harmed as a result of the incident; and 'death' – the incident has resulted in the death of the patient. As well as patient safety incidents causing long term/permanent harm being classed as severe, the Trust also reports 'Patient Events that affect a large number of patients' as 'severe' incidents to the NRLS.

Part 3 Other Information

Review of quality performance 2019/20

2018/19 has been another busy year for Royal Papworth Hospital and its staff, with the Hospital treating 22,795 inpatient/day cases and 93,852 outpatient episodes from across the UK. For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2019/20. We have selected examples from the three domains of quality (clinical safety, patient experience and clinical effectiveness of care). These are not all the same as in the 2018/19 Quality Accounts but reflect issues raised by our patients and stakeholders, which also feature highly in the Department of Health and Social Care's agenda. They include information on key priorities for 2019/20 where these have not been carried forward as key priorities for 2020/21. Pulmonary endarterectomy is included as Royal Papworth is the only centre in the UK to provide this surgery. There is also an update on the Extra Corporeal Membrane Oxygenator (ECMO) service for which Royal Papworth Hospital is one of five centres nationally that provide this service for adults.

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

The Quality Strategy was reviewed and refreshed in 2018 and sets our quality ambitions and direction for the next three years to 2021. Our Quality Strategy is aligned to and takes into account the National Quality Improvement (QI) agenda, current QI research and National QI leadership programmes. The Strategy includes the Trust Board endorsement to implement the Culture and Leadership Programme co-designed by NHS Improvement and the King's Fund, which commenced during 2019 and supports the delivery of our Quality Strategy.

We want quality and quality improvement to be our core philosophy and to be at the heart of every decision that we make. Our expertise, reputation and network places us in a unique position to lead the way in delivering excellence in care through our cardiothoracic, respiratory and transplant services with outstanding:

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

Our current Quality Strategy is underpinned by our three Quality Ambitions. The work streams that have been identified in the Quality Account are set as enablers to achieve our Quality Account Ambitions. We review these work streams annually to demonstrate progress and allow the flexibility to encompass local, regional and national changes in the health economy.

Quality Strategy Ambitions:

1. Safe – Provide a safe system of care and thereby reduce avoidable harm

2. Effectiveness and Responsive Care – Achieve excellent patient outcomes and enable a culture of continuous improvement

3. Patient Experience and Engagement - We will further build on our reputation for putting patient care at the heart of everything we do

The Quality Strategy continues to be enacted through the Quality Account priorities.

Open and Transparent / Duty of Candour

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

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

We have a named family liaison member of staff who is responsible for sending the initial duty of candour letter and maintaining contact with the patient and or family throughout the investigation period. Family liaison contact details are provided in the letter. In 2019/20 we have developed a formal procedure and guidance for this role to better support staff undertaking this role (DN791). This has been based on family and patient feedback on their experience of being involved in this process. Training on the principles of being open and duty of candour are provided as part of the Investigation Skills workshop training provided by the Trust.

In 2019 the Trust undertook an audit against the requirements of the Being Open and Duty of Candour Policy (DN153) Incidents reported between April 2018 and March 2019 were reviewed which demonstrated an overall improvement on compliance against a previous audit in 2016.

Criteria	Expected Standard	2016 audit	Standard Achieved **SIs**	Standard Achieved **Mod harms**
Patient or their family/carer to be informed of suspected patient safety incident within 10 working days.	100%	93% (25/27) 1 N/A	80% (8/10) 5 N/A	73% (8/11) 2 N/A
Duty of Candour to be written to patient/family/carer	100%	89% (24/27) 1 N/A	92% (11/12) 3 N/A	89% (8/9) 4 N/A
Duty of Candour to include details of the incident	100%	88% (21/24) 3 N/A	100% (11/11) 4 N/A	89% (8/9) 4 N/A
Duty of Candour to include an apology	100%	96% (23/24) 3 N/A	100% (11/11) 3 N/A 1 unknown	89% (8/9) 3 N/A, 1 unknown
Duty of Candour to include a family liaison name	100%	83% (20/24) 3 N/A	100% (11/11) 3 N/A 1 unknown	91% (10/11) 2 N/A
Duty of Candour to include family liaison contact details	100%	71% (17/24) 3 N/A	100% (11/11) 3 N/A 1 unknown	82% (9/11) 2 N/A
Signed and dated copy of Duty of Candour to be attached to Datix	100%	79% (19/24) 3 N/A	83% (10/12) 3 N/A	80% (8/10) 3 N/A
If Serious Incident summary to be attached to Datix	100%	100% (5/5) 23 N/A	100% (15/15)	N/A
Copy of Route Cause Analysis and action plan to be offered to patient/family/carer	100%	81% (22/27) 1 N/A	100%(12/12) 3 N/A	88% (7/8) 5 N/A
If Serious Incident follow up meeting to be offered to patient/family/carer	100%	100% (4/4) 1 N/A	100% (10/10) 3 N/A, 2 unknown	N/A

In 2019/20, the Trust reported 11 serious Incidents and duty of candour was completed in 100% of cases, although not all within the 10 day standard. For incidents reported as Moderate Harm, duty of candour is completed once the investigation and/or clinical review confirm that acts or omissions in the incident resulted in actual harm to the patient. The Trust monitors compliance against our requirements for duty of candour at the Serious Incident Executive Review Panel (SIERP) and the Quality and Risk Management Group (QRMG) reporting by exception to the Quality and Risk Committee of the Board of Directors.

Patient safety domain

Healthcare Associated Infections

Royal Papworth Hospital places infection control and a high standard of hygiene at the heart of good management and clinical practice. The prevention and control of infection was a key priority at Royal Papworth Hospital throughout 2019/20 and remains part of the Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which needs continuous review. The Trust is committed to ensuring that appropriate resources are allocated for effective protection of patients, their relatives, staff and visiting members of the public. In this regard, emphasis is given to the prevention of healthcare-associated infection, the reduction of antibiotic resistance and ensuring excellent levels of cleanliness in the Hospital.

There are a number of important infection prevention and control measures in place to reduce the risk of spread of infection; these include hand hygiene, cleaning, adherence to infection control practices, screening of patients for various organisms and education – all of which were audited continuously in 2019/20 as part of the annual infection prevention and control audit programme, and the compliance figures were monitored through the Infection Control Pre and Peri-operative Care Committee (ICPPC).

During 2019/20 the total number of *Clostridiodies difficile* cases was 11, against an objective of 11. Only one case was attributed to Royal Papworth Hospital. There were no cases of MRSA bacteraemia for 2019/20, the ceiling trajectory remained at zero. All MRSA bacteraemias and cases of *C. difficile* are reported to our Commissioners. We perform root cause analysis (RCA)/ post infection reviews (PIR) on each case of C.difficile or MRSA bacteraemia to review the events and enable continuous improvement of practice. Any subsequent lessons learned are shared with the Commissioners and discussed at scrutiny panels. If the RCA/PIR does not show any avoidable factors, i.e., there were no lapses in the care of the patient, the case will not be counted against the ceiling target.

Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. Predominantly, they are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. Many countries and regions now have a high reported prevalence of healthcare-associated CPE. The Trust has a robust procedure in place to ensure that screening and isolation of patients in relation to CPE is carried out to minimise the risk of spread. This procedure was produced using the Public Health England (PHE) Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (2013). There has not been any ongoing spread of CPE within the Trust in 2019/20.

Escherichia coli (E.coli)

Data collection for *E.coli, Klebsiella* spp. and *Pseudomonas aeruginosa* BSI has been provided via the PHE Data Capture System. The rates of *E.coli* bacteraemia are available on the PHE Public Health Profile website. Please note the latest data in the graph below is from the year 2018/19 as the data for 2019/20 is not yet available:

Period	Papworth Hospital NHS Foundation Trust				England
	Count	Value	Lower CI	Upper CI	
2012/13	8	11.2	-	-	93.8
2013/14	10	14.0	-	-	99.9
2014/15	6	9.2	-	-	102.9
2015/16	11	17.0	-	-	110.6
2016/17	12	18.7	-	-	115.9
2017/18	11	17.9	-	-	118.3*
2018/19	9	14.6	-	-	125.2*

Graph 1.Counts and rates of E.coli bacteraemia over a seven-year period:
It can be seen that RPH E.coli bacteraemia rates remain low in comparison with national rates.

The Trust could not reduce the number of E.coli bacteraemias further in 2019-20. This might be because rates are already low (14.6 vs 125.2 nationally):

	2017/18		2018/19		R*	2019/20		R*
	Trust	England	Trust	England		Trust	England	
Total number of E.coli bacteraemias	11		9		18%	9		0%

R - reduction rate*

Causes of E.coli bacteraemias in 2019/20:

- Urosepsis - 1
- Cannula-related infection - 1
- Deep sternal wound infection – 2
- Chest infection - 1
- Unknown – 4

The area of priority for further reduction of *E.coli* BSI next year is management of surgical site infections – this is the only cause of infections that stands out but only marginally.

Heater- cooler units and M.chimaera infection

There have been no cases of M.chimaera associated with heater coolers. Water that is used for heater coolers is tested regularly as well as water from heater-coolers tanks. All heater-coolers have a closed circuit that prevents aerosols from escaping into operating theatres.

Mycobacterium Abscessus

In December 2018, the water system of the new Hospital had high counts of Legionella and Pseudomonas across the site. The Water System Remedial Action Plan (WSRAP) was implemented, which involved the installation of a hypocholorous dosing system as a secondary control measure, removal of all taps, replacement of all cartridges, and removal of pipework in 55 locations. This was then backed by increased flushing. Having implemented the WSRAP throughout January-April 2019, the Trust successfully achieved a clean water system in line with occupation of the building.

Between July and September results received from 3 patients confirmed positive M.abscessus infections. The Estates and Facilities team worked together with the Infection Control team to implement an action plan, with flushing being increased in high risk areas, and the decision was made to install a hydrogen peroxide dosing system into the top of the fourth and fifth floor risers, as well as continue an extensive sampling programme to include the incoming water sampling, risers, and outlets.

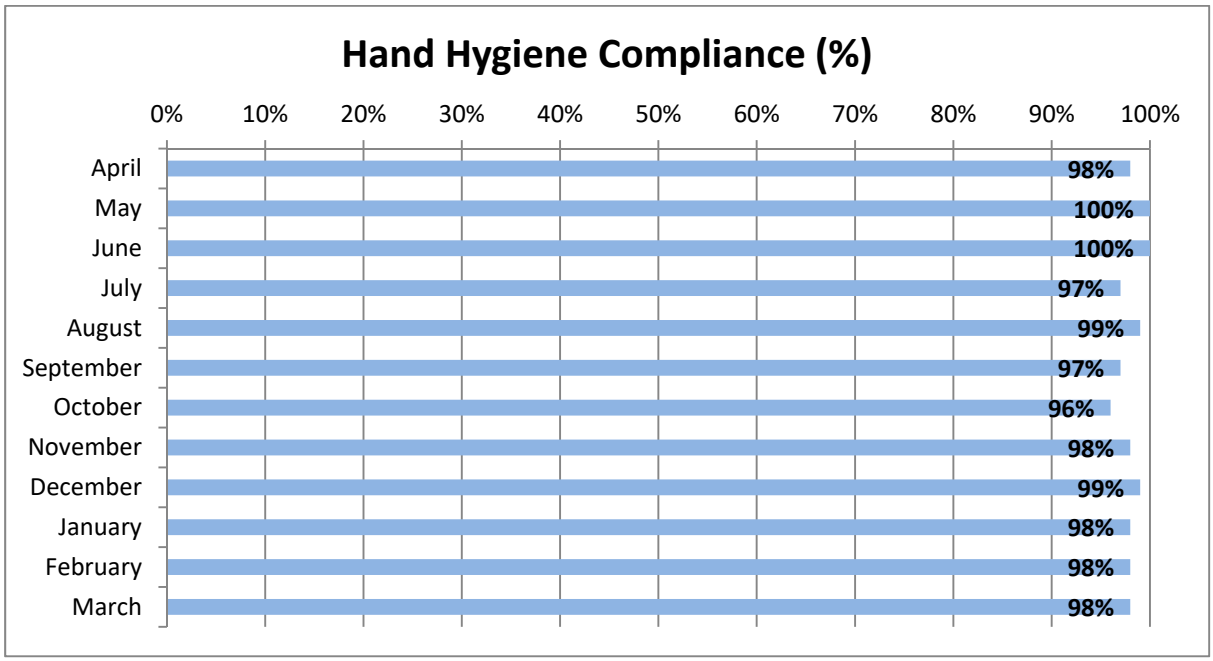
Over the past 6 months a number of water system interventions have taken place, these have had a positive impact on the level of mycobacteria found in the water system.

Our results relating to Mycobacteria have been decreasing in a manner that is pleasing to the trust, these results are to continued to be monitored, for us to carry out the monitoring we propose to introduce a weekly schedule of sampling which will concentrate areas of risk

that have been highlighted, and an additional 50+ ad hoc samples to be carried out each week this will increase our knowledge and coverage of the sites Mycobacteria counts.

All of these results will continue to be shared at the water safety groups on a Bi monthly period to ensure transparency, any trends that the schedule is producing are discussed highlighted and actioned.

Trust Hand hygiene compliance figures 2019-20 (April-Mar)



MRSA bacteraemia and C. difficile trajectory infection rates*

Goals 2017/18	Outcome 2017/18	Goals 2018/19	Outcome 2018/19	Goals 2019/20	Outcome 2019/20
No MRSA bacteraemia	3 MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia
No more than 5 *C. difficile* cases *	Total for the year= 3	No more than 4 C. difficile	Total for the year 2	No more than 11 C.difficile	Total for the year = 11 only one was attributed to Royal Papworth
Achieve 100% MRSA screening of patients according to agreed screening risk assessment	98.7%	Achieve 100% MRSA screening of patients according to agreed screening risk assessment	97% data collected between April 18 – February 19 Q4 data is not currently available	Achieve 100% MRSA screening of patients according to agreed screening risk	95.5%

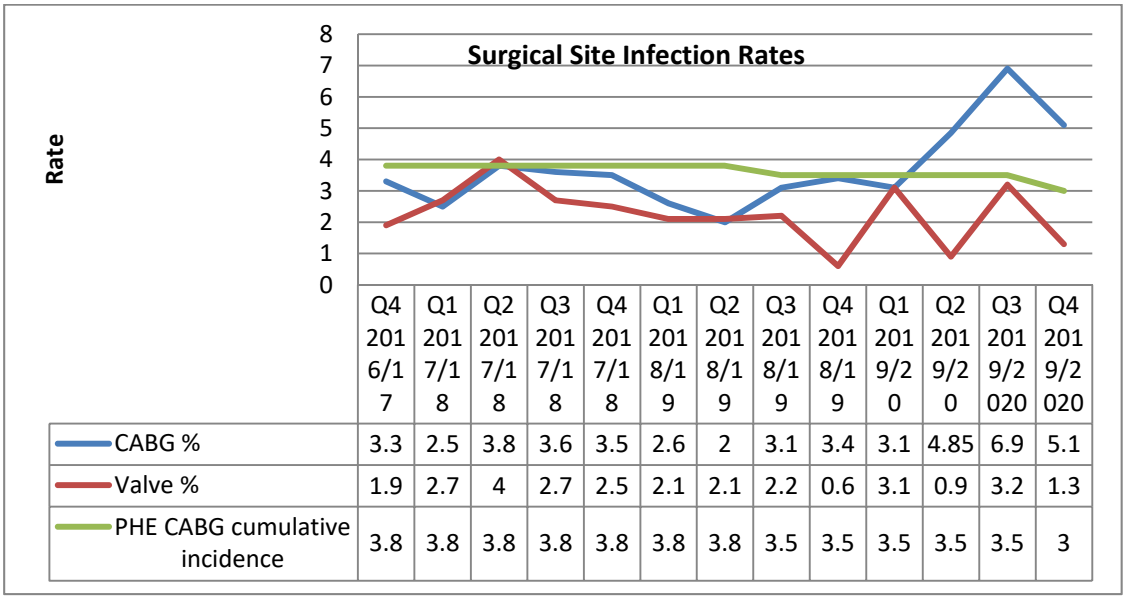
Data Source: Mandatory Enhanced Surveillance System (MESS) and PHE Health Care Associated Infection Data Capture System

***Please note: The figures reported in the table are the number of C.difficile cases and MRSA bacteraemias attributed to the Trust and added to our trajectory ceiling targets.**

Surgical site surveillance

From April 2009, we have undertaken continuous surgical site surveillance of CABG patients to monitor infections post-surgery using the Public Health England (PHE) surveillance protocol. A bundle of interventions in pre-, intra- and post-operative care are carried out in line with NICE guidance CG74 and WHO recommendations These actions have driven down our infection rates from 9.85% in 2009 to 2.7% in 2018/19. The current cumulative national benchmark for inpatient and readmissions for SSI in CABG is 3.0% (PHE 2019). Unfortunately, we have seen a rise in SSI's in inpatient/readmissions in the past 12 months and our yearly total is currently 5% for CABG. This has been highlighted through ICPPC quarterly and fedback to surgical teams via M&M meeting and quarterly rates. An additional SSI stakeholder group was formed to review current practices and discuss any issues found to try and identify causes of this rise. We have gone through a huge organisational change in the last 12 months which may have some bearing on these figures. Audits in monitoring pre-op skin prep, timing of antibiotic prophylaxis, aseptic technique and air testing in theatres have all been carried out and results fed back to relevant teams. Increased education on wards has been carried out on the importance of pre-op decolonisation and rates highlighted to teams. There are regular Tissue Viability ward rounds to support staff and identify and treat wound issues promptly. A spotlight on theatre discipline has also been raised in audit meetings led by theatre staff.
As well as reviewing each case to see if there are lessons to be learned we have submitted our data for Oct-Dec and Jan-Mar to the national PHE SSI surveillance scheme for further analysis.

We will be continuing with surveillance in both CABG and Valve patients in the next financial year and our aim will be to reduce our SSI rates as the safety of our patients is paramount.



	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/2020	Q4 2019/2020
CABG %	3.3	2.5	3.8	3.6	3.5	2.6	2	3.1	3.4	3.1	4.85	6.9	5.1
Valve %	1.9	2.7	4	2.7	2.5	2.1	2.1	2.2	0.6	3.1	0.9	3.2	1.3
PHE CABG cumulative incidence	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.5	3.5	3.5	3.5	3.5	3

Influenza

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for “frontline” staff 2019/20 was 86% Trust wide.

In 2019/20, the Trust continued to receive flu-related ECMO patients into the Critical Care Unit.

COVID19 Pandemic

COVID19 is a new coronavirus disease, which causes respiratory symptoms. It was first identified in December 2019 in China and quickly spread around the world. The COVID19 pandemic was officially declared on the 11th March 2020. During the early stages of the outbreak the Trust put together surge plans to prepare for the expected upturn in demand of patients who would be admitted or transferred to us. During March the Trust put these plans into place and extended the capacity of its Critical Care Unit (CCA) to house COVID19 patients. It also substantially increased its capacity to treat severely ill patients with COVID19, who required Extracorporeal Membrane Oxygenation (ECMO).

Sepsis

Sepsis in patients is a potentially life threatening condition and without treatment can prove fatal. Care failings seem to occur mainly in the first few hours when rapid diagnosis and simple treatment can be critical to the chances of survival. The **Sepsis Six** bundle was developed by founders of the UK Sepsis Trust in 2005 as an operational solution to a set of complex yet robust guidelines developed by the International Surviving Sepsis Campaign. It was revised in 2019 to reflect the latest evidence in the management of Sepsis and ensure that antimicrobials are used effectively and efficiently.The purpose of using the bundle is to ensure a safe, standardised approach to the initial assessment of patients with potential sepsis and their subsequent management within the ward setting. It is also envisaged that by using the sepsis bundle, the medical and nursing teams will have the knowledge and understanding to recognise and promptly initiate treatment to patients and therefore reduce the complications associated with severe sepsis.

As part of the NHS Standard Contract 2019/20 there is a continued monitoring of Sepsis across the country. From April 2019 this was a new indicator on PIPR for 2019/20 (RPH has been monitoring prior to this). As we have no Emergency Department our numbers of patients with Sepsis are less, therefore while the national quality requirement is ‘based on a standard of 50 service users each quarter’; we are reporting on every patient confirmed with Sepsis (as validated by the Lead Nurse ALERT and a Consultant; excluding Critical Care).

Standards

	Aspect to be measured	Expected standard
1	SIRS criteria to be met for all patients referred for Sepsis	100%
2	Sepsis 6 care bundle to be present in patient notes	100%
3	Sepsis 6 care bundle documentation to be complete	100%
4	IV Abx to be commenced within one hour of referral	100%
5	ABG/Lactate measured within one hour of referral	100%
6	Blood cultures to be taken within one hour of referral	100%
7	Fluid challenge administered within one hour of referral	100%
8	High Flow Oxygen administered within one hour of referral	100%
9	FBC/Catheterisation commenced	100%
10	Care bundle used until resolved	100%

Results to date:

Dec 2018 (Q3 2018/19) = 100% (33 patients)
Mar 2019 (Q4, 2018/19) = 83.3% (33 patients)
Jun 2019 (Q1, 2019/20) = 100% (13 patients).
Sep 2019 (Q2, 2019/20) = 67%, reflecting 8 out of 12 patients getting their initial sepsis bundle completed, although 100% received antibiotics as required; only two patients out of the 12 had 'sepsis' when mapped against the national criteria.
Dec 2019 (Q3, 2019/20) = 81.2%, reflecting 13 out of 16 patients getting their initial sepsis bundle completed although 100% received their antibiotics as required within the hour. A detailed breakdown of the Q3 data is shown in the tables to the right. The top table gives a breakdown of patients who required screening for sepsis and if they were screened (yes or no). The second table shows that 100% of patients who required antibiotics, received them.

Sepsis audit analysis data (Q3 2019/20):

Data Submission PIPR. Quarter 3 19/20

Month	Patient ID	Required screening for Sepsi	Screening completed?
October	1	Yes	No
October	2	Yes	Yes
October	3	Yes	Yes
October	4	Yes	Yes
October	5	Yes	Yes
October	6	Yes	Yes
November	7	Yes	Yes
November	8	Yes	Yes
November	9	Yes	Yes
November	10	Yes	Yes
November	11	Yes	Yes
November	12	Yes	No
December	13	Yes	Yes
December	14	Yes	No
December	15	Yes	Yes
December	16	Yes	Yes
Totals	**16**	**16**	**16**
Compliance			**81.2% (13/16)**

	Sample size	Required Sepsis Screening?	Screening completed?	IV antibiotics given within 1 hour (excluding pts already on antibiotics)
October	6	6	5	3
November	6	6	5	3
December	4	4	3	3
Quarter 3	**16**	**16**	**13**	**9**
Compliance		**100% (16/16))**	**81% (13/16)**	**100% (9/9)**

Actions ongoing:

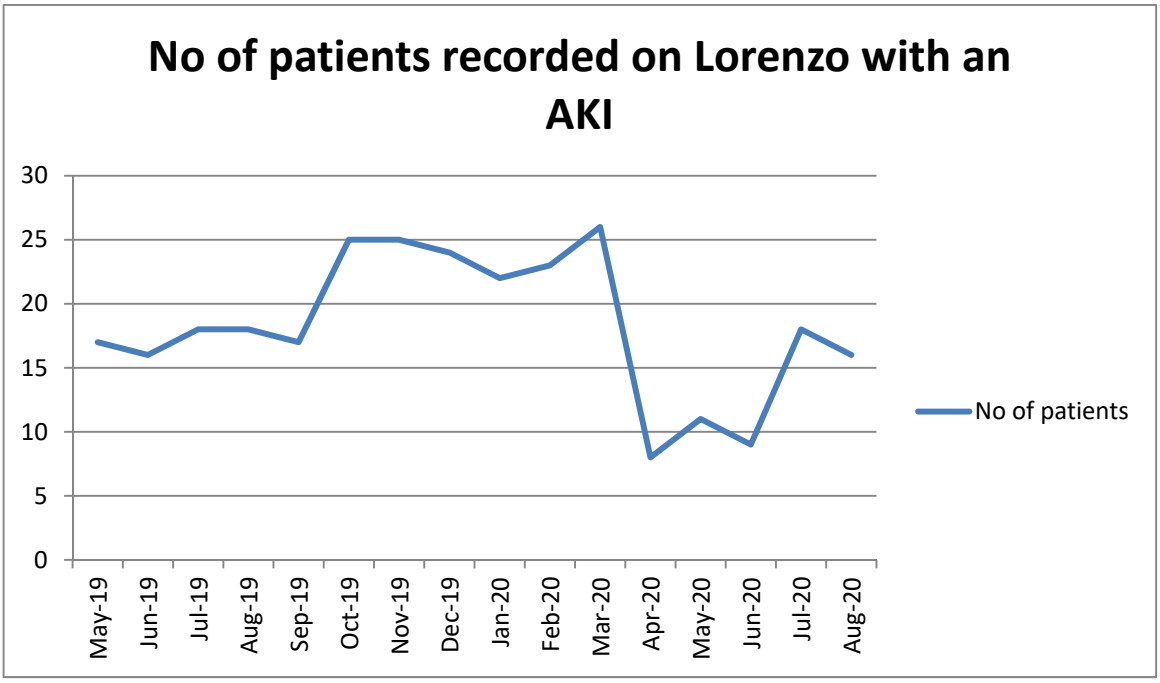
Follow up actions are in place led by the Lead Nurse ALERT, including reminding staff regards better compliance with completing the initial sepsis care bundle; appropriate use of the term ‘sepsis’; introduction of Sepsis bundle and audit into Critical Care.

Acute Kidney Injury (AKI)

Acute Kidney injury remains on the agenda at Royal Papworth Hospital. The numbers of patients who develop an Acute Kidney injury continues to fluctuate as one would expect as the incidence can be dependent of the acuity of the patient and also the type of procedure the patient is admitted for. We still see more patients developing stage 1 Acute Kidney injury. Guidelines remain in place for the management of Acute Kidney injury and Fluid management for patients in hospital and follow the up to date recommendations from NICE. The most recent inclusion to the guidelines is in relation to paediatric patients. Whilst Royal Papworth does not have many young children, we occasionally admit them for specific procedures. Both these guidelines have been updated and approved. They can be found on the hospital intranet.

We provide quarterly reports of our incidence of AKI to the National Renal Registry

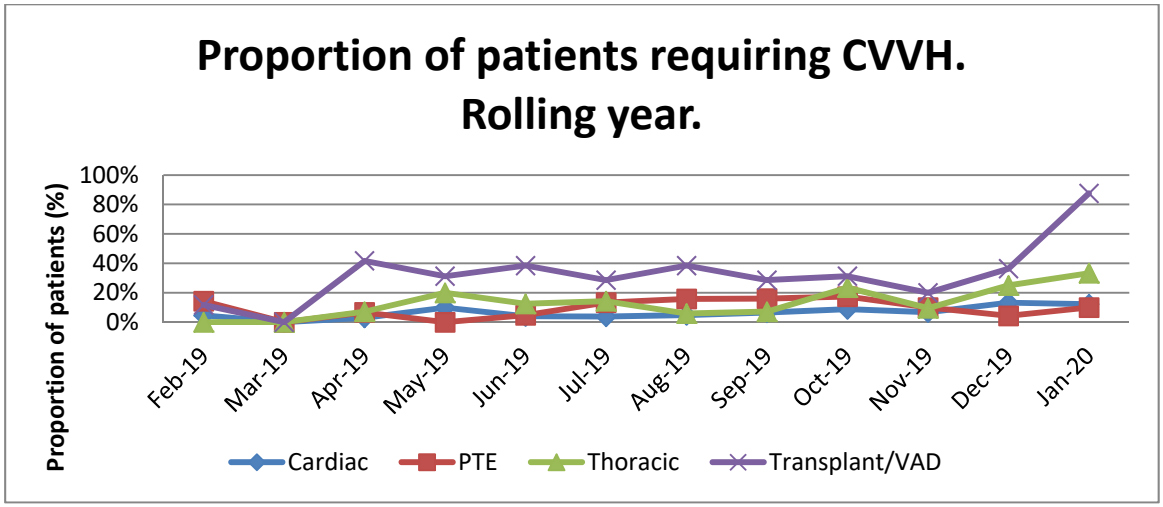
The table below shows the number of patients on the wards who have developed an AKI since our move to the new hospital in May 19.

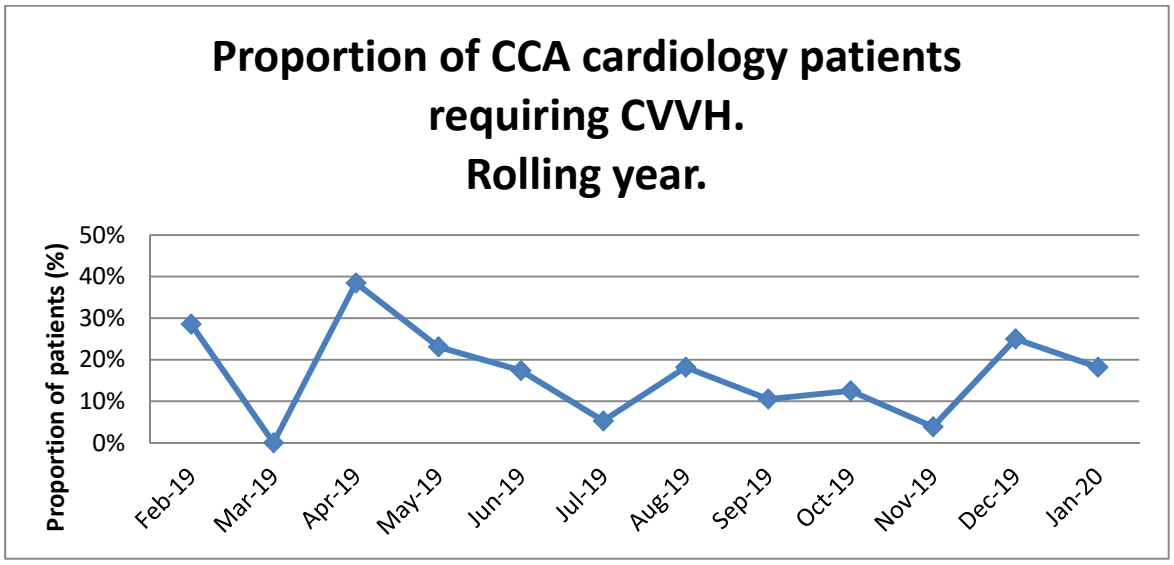


**The drop in patient numbers developing an AKI is a reflection of the drop in patient numbers on the ward during the COVID19 pandemic surge. The above chart does not specify the specialty to which the patient was admitted.

We are currently working closely with the Audit and Research teams to design the most effective way to reproduce the data provided by both CUH biochemistry reporting and the AKI data that is extrapolated from Lorenzo and found in the intranet's 'Data Warehouse'. It is hoped that we will have a robust format in which to show a true picture of AKI in the trust.

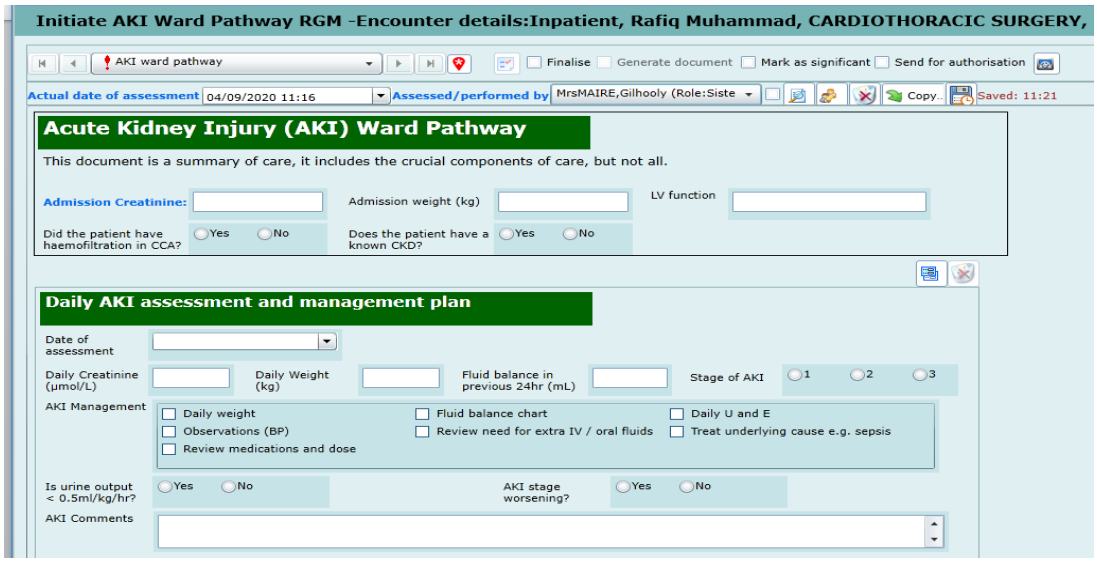
We continue to receive regular reports on the number of patients who require haemofiltration in Critical Care. Below are the most recent reports:





For our ward patients, we have our Alert teams and Ward Based ANP's who provide support to ensure our AKI pathway is completed for all patients who develop an AKI. There is ongoing training for all staff in accessing and completing these forms. Each ward area has a member of the nursing team identified as the link person for AKI.

Below is the updated version of the AKI pathway in use on the wards through Lorenzo:



Our ward pharmacists offer day to day guidance on safe prescribing to our medical teams for patients who have developed an AKI. Previous initiatives to ensure we provide our primary care teams with up to date information of Acute kidney injury when the patient is discharged home continues through the electronic discharge document which is sent directly to the patient's GP on discharge. Ward Based ANP's and junior doctors are responsible for the completion of the discharge summaries and include instructions for the primary care teams in managing and keeping up surveillance on any patient who has developed an AKI during their hospital admission.

Acute Kidney injury remains on the mandatory training schedule for all qualified staff. We continue to report the incidence of Acute Kidney injury through our laboratory reporting system currently in place. The patient is identified as either Acute Kidney injury stage 1, 2 or 3. We now also regular reporting of the patient's eGFR ; the marker of a patient's existing renal function which is essential to know to ensure the safe management and prescribing for every patient. There is ongoing training for all staff in accessing and completing these forms.

Pressure Ulcers

Pressure Ulcer Report: April 2019-March 2020

Pressure ulcers (PUs) have been defined as ulcers of the skin due to the effect of prolonged pressure in combination with a number of other variables including: patient co-morbidities and external factors such as shear and skin moisture. In June 2018, in their detailing of how trusts should report PUs, NHSI described six principle PU categories, ranging from 1 to 4, plus deep tissue injury (DTI) and an unstageable category. The NHSI paper details that these six categories will be reported on.

In addition, NHSI asked organisations no longer to use the terms avoidable or unavoidable, as all PUs are harm. This organisation has replaced avoidable with “acts/omissions in care” and unavoidable with “all care in place”.

All care in place (previously classed as unavoidable) PUs will not stay at a standard rate, and it is not appropriate to compare rates year on year. It is important to note that because all care in place PUs mainly occur in patients within this Trust who have had complex cardiothoracic surgery with long theatre times, and these critically unwell patients have restrictions on repositioning when they are physiologically unstable, alongside high doses of vasopressors (drugs to increase circulation to major organs, but restrict circulation to the peripheral areas such as heels), we continue to scrutinise the RCA investigation findings in this group of patients. Pressure ulcer incidents included on the agenda for review at the Pressure Ulcer Scrutiny Panel will have this root cause analysis (RCA) carried out by the associated clinical area in advance of the panel meeting.

It was recognised that the reporting of pressure ulcers in COVID 19 patients underrepresented the actual number of ulcers that occurred. A separate audit in this patient group taken from their electronic patient records starting in March 2020 has been undertaken to establish the true extent of ulceration in this group. The audit is currently been reviewed in draft format by the Q&R panel.

New and continued initiatives for 2020/21 include:

- The Scrutiny Panel continue to scrutinise all category 2, 3, 4, DTI, or unstageable PUs developed within the Trust in order to identify lessons learnt and share good practice.
- Biannual PU prevalence audits and a new biannual dynamic mattress audit
- Continue DATIX incident reporting for all category 2, 3, 4, DTI, and unstageable PUs developed within the Trust and all category 2, 3, 4, DTI, and unstageable PUs admitted/transferred into the Trust.
- Ensure that the rates of PUs developed at Royal Papworth Hospital continue to be displayed in all clinical inpatient areas for patients, relatives and staff to see.
- Have a standing agenda item in the Quality and Risk Management meeting to report the PU rates.
- Continue education on PU prevention, identification, reporting and management across the trust. These include tissue viability link and associate link nurses teaching to facilitate their development in the specialty. We are exploring different

ways of providing in house and virtual PU prevention training in view of COVID19 face to face teaching challenges.

- Recruitment of a band 4 assistant practitioner in wound care for a six month fixed period to support pressure ulcer prevention strategies.

Goal 2019/20	**Outcome**	**Goal 2020/21**	**Outcome**
To increase tissue viability link nurse involvement in PU prevention education within their ward areas.	On-going	To increase tissue viability link nurse involvement in PU prevention education within their ward areas	On-going
Continue to embed the new PU categorisations introduced by NHSI June 2018	On-going	Continue to update clinical staff on categorisations introduced by NHSI June 2018	On-going
Continue quarterly Trust-wide PU prevalence audits.	Achieved and on-going	Biannual prevalence audits and biannual dynamic mattress audit	Achieved and on-going
Work with IT to develop in house PU training online; to include mattress training	On-going	Work with IT assets to establish in house PU training online	On-going
NA		Recruit a band 4 assistant practitioner in wound care for a fixed term of 6 month to support PU care & education	Ongoing
NA		Purchase and deploy dynamic mattress systems to replace a number of foam mattresses in Critical Care to support pressure ulcer prevention.	Ongoing

Actual pressure ulcers reported April 2019 to March 2020

* March 2019 figures reported separately in order to move to a reporting year of April-March

Category	2	3	4	DTIs	Unstageable
Pressure ulcers reported from April 2019 to March 2020	10 (8 all care in place, 2 acts/omissions in care)	0	0	8 (6 all care in place 2 acts/omissions in care)	2 (2 all care in place)
March 2019 *	1 (1 acts or omissions in care)	1 (1 all care in place)	0	0	0
Number of reported 2018/19 figures up to end of February 2019	19 (13 all care in place, 6 acts/omissions in care)	2 (1 all care in place, 1 acts/omissions in care)	1 (1 acts/ omissions in care)	10 (8 all care in place, 2 acts/omissions in care)	0
Number of reported 2017/18 figures up to end of February 2018	16 (5 unavoidable, 11 avoidable)	1 (unavoidable)	0	23 (19 unavoidable, 4 avoidable)	Not counted till Oct 2018

Patient Safety Incidents – Severity

Severity	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3*	19/20 Q4*	Total
Near Miss	98	112	156	125	112	603
No harm	473	675	619	590	408	2765
Low harm	120	143	169	217	173	822
Moderate harm	7	5	2	3	1	18
Severe harm	1	0	2	1	1	5
Death caused by the incident	0	0	0	1	0	1
Death UNRELATED to the incident	6	1	3	2	2	14
Under investigation, not yet graded	0	0	0	3	45	48
Total	705	936	951	942	742	4276

Table 3 – Incidents by Severity (Data source: DATIX 29/04/20)
*Correct at the time of production. Some incidents have been downgraded in severity following investigation.

Fluctuating numbers of patient safety incidents have been reported during the financial year. Those graded as near miss (14%), no/low harm over the last 12 months (84%) demonstrates a continuous readiness to report and learn from all types of incidents. There has been a request for staff to report incidents in order to demonstrate an open and fair culture of learning and no blame. This process also captures the clinical consideration given to all types of incidents, with moderate harm incidents and above being reviewed at the Trust's new Serious Incident Executive Review Panel (SIERP).

The level of investigation carried out after a patient safety incident is determined by its severity. All moderate harm incidents and above have investigations and associated action plans, which are managed by the relevant business unit and monitored by the Quality and Risk Management Group (QRMG). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and monitored by the QRMG. The (*) signifies a discrepancy in the total number of incidents awarded a severity grading and the total number of patient incidents in the quarter; as at 29/04/2019 not all incidents have been finally approved and grading confirmed. Lessons learnt are shared across the organisation via the quarterly Lessons Learnt report on the intranet, local dissemination via Divisions and specialist meetings.

Never Events

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

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

During the financial year, the Trust has reported one Never Event. In June 2019, the Trust reported an incident relating to a retained guidewire. There was a failure in the processes relating to checking and confirming that the guidewire had been removed prior to the completion of the surgical procedure. There was moderate harm caused to the patient as an additional procedure was required to remove the guidewire. Under our commitment to Duty of Candour a full disclosure was given to the patient and next of kin. A detailed investigation was undertaken and the incident was subject to a full Root Cause Analysis investigation and consideration of human factors. The action plan was monitored by the Quality and Risk Management Group and this was completed and closed in December 2019.

Reducing falls and reducing harm from falls

Falls prevention remains a top priority for the Trust and is monitored through incident reporting and the Safety Thermometer. Under Health and Safety law, the Trust has a responsibility to protect all patients from harm and "so far as is reasonably practicable" carry out "suitable and sufficient" risk assessments to that ensure they remain safe. In addition, the Trust has carried out a large piece of Quality Improvement project work, spanning nearly two years and the transition to the new Royal Papworth site with single side rooms. There was concern that with the move to side rooms, falls would increase however this has not proved to be the case.

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

During the calendar year there has been a regular occurrence of assisted falls to the ground, recorded as “near miss”; actual falls have been graded from no harm to moderate and severe harm. Falls resulting in moderate injury have Root Cause Analysis (RCA) performed and falls that result in severe harm have a full Serious Incident (SI) investigation. All RCA falls investigations are reviewed at QRMG and at the Band 7 Nurses meetings.

There was one RCA undertaken on a moderate harm incident (which was subsequently downgraded) and one SI investigation in this financial year.

The first (32980) involved a patient who had an unwitnessed fall. The patient had a history of falls. The patient had a long spell first in CUH, where he fell, and was transferred to Royal Papworth for further assessment. On mobilising independently, the patient tripped over a trailing cable and sustained a hip fracture. The patient was transferred back to CUH and eventually discharged home with a care package.

The second (33082) involved a patient who also had an unwitnessed fall, had a complex respiratory history and was in Royal Papworth for intensive anti-biotic therapy. She was determined to mobilise independently on the ward and she too had a history of falling in the community, with previous severe fractures sustained. Independent mobilisation is important for patients, in order to maintain their capabilities and prevent deconditioning. This patient, who was extremely frail, may have sustained a compression fracture to the coccyx as a result of the fall. She was discharged home. Following review and investigation this incident was downgraded.

Concerning the fall that required a serious incident investigation in 2019/20, a number of actions have been put in place as a result:

- Improve documentation relating to the Falls Policy and the assessments contained within it by redesigning the falls risk assessment and care plan
- Ongoing training provided for all clinical staff on falls prevention
- Promote role of Falls Link Nurse to strengthen teaching on the wards
- Purchase clips to help prevent cables trailing and causing trip hazards
- Review and promote use of falls alarms when appropriate
- Intentional Rounding has been implemented throughout the hospital

The table below demonstrates the number of actual falls per quarter across the year. Falls are reviewed quarterly at the Falls Meeting, which now forms part of the Sisters Meeting. The learning from falls incidents is shared at QRMG and among various clinical and nursing forums.

Financial Year	Q1	Q2	Q3	Q4	Total
2016/17	57	39	55	30	181
2017/18	46	30	56	38	170
2018/19	48	34	42	56	180
2019/20	42	30	51	45	168
Total	193	133	204	169	699

Source DATIX 26/08/2020

Falls incident data by location 01/04/2019 – 31/03/2020

Incidents by Directorate and Incident date (Quarter)

Directorate	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
NPH Ambulatory Care	1	1	0	0	2
NPH Cardiology	8	5	17	10	40
NPH Cath Labs	0	0	1	0	1
NPH Patient Services	0	0	0	1	1
NPH Professional Support Services	1	1	2	5	9
NPH Radiology	0	0	0	1	1
NPH Surgical	11	15	20	19	65
NPH Theatres, Critical Care and Anaesthesia	2	1	0	1	4
NPH Thoracic	5	6	8	6	25
NPH Transplant	0	1	3	2	6
Cardiology (Old Site)	2	0	0	0	2
Professional Support Services (Old Site)	1	0	0	0	1
Surgery (Old Site)	6	0	0	0	6
Thoracic (Old Site)	5	0	0	0	5
Total	42	30	51	45	168

Data source: DATIX™ 26/08/2020

Prevention of venous thromboembolism (VTE)

With an estimated incidence rate of 1-2 per 1,000 of the population, VTE is a significant cause of mortality and disability in England with thousands of deaths directly attributed to it each year. One in twenty people will have VTE during their lifetime and more than half of those events are associated with prior hospitalisation. At least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis, however currently VTE is one of the most common forms of hospital mortality. (All-Party Parliamentary Thrombosis Group Annual Survey Results, November 2019 www.apptg.org.uk)

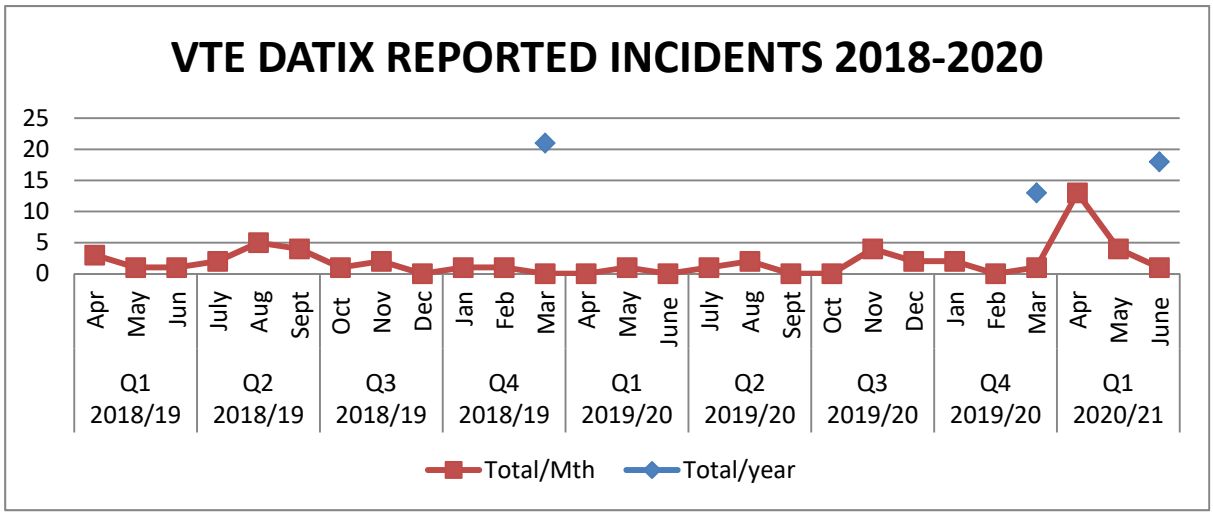
Best practice in VTE prevention is summarised in NICE Quality Standard 3 (Venous Thromboembolism Prevention Quality Standard (https://www.nice.org.uk/guidance/qs3) first published in June 2010 and updated in August 2019 (https://www.nice.org.uk/guidance/ng89). The VTE medical and nursing leads have reviewed recent October 2019 NCEPOD PE Know the score guidance (https://www.ncepod.org.uk/2019pe.html) and shared with imaging leads in the Trust. Our internal policy DN521 on management of VTE has been updated with the recommendations from the NCEPOD PE Know the score guidance.

VTE prevention remains a clinical priority at Royal Papworth Hospital and the updated recommendations in the revised NICE quality standard have been incorporated into the Trust procedure on VTE prevention. VTE prevention is well established in the daily clinical care of patients within the Trust. We are also auditing and monitoring omissions with prescribed prophylaxis doses of Tinzaparin and Enoxaparin.

Royal Papworth Hospital has previously been recognised with a National award from Lifeblood: The Thrombosis Charity, for best VTE Prevention Programme. Royal Papworth Hospital successfully revalidated as a VTE Exemplar Centre in 2017 and contributes to National Nurses and Midwives Network (NNMN) for VTE (http://www.vteengland.org.uk/). In 2018, the VTE medical lead was thanked by the Royal College of Physicians and the National Guideline Centre for her commitment, time, expertise and dedication in the development of NICE VTE guideline NG 89. In 2019, the VTE medical lead was thanked by the CEO of NCEPOD for her enormous contribution to the assessment of cases and the discussions which led to the NCEPOD PE report. The VTE medical lead was the Respiratory expert on the updated NICE VTE guidelines NG158, which was published in March 2020.

The NHS Standard Contract for Acute Services introduced the requirement for a root cause analysis (RCA) on all VTE episodes identified in inpatients and patients discharged within 90 days. The Trust is compliant with this requirement and conducts RCAs on all VTE events known to the Trust.

We have recorded data from 2018-2020 showing an overall reduction in VTE events within the Trust as outlined below. We have had 1 moderate harm incident in relation to a confirmed VTE event due to failure to complete a VTE risk assessment on a patient whom developed a DVT. We have seen an increase in COVID19 related VTE events (the majority acquired in referral hospitals) as outlined below, the findings of which have been provided to referring centres. In light of the growing evidence of COVID19 coagulopathy including immunothrombosis, a RPH SOP was developed with collaboration from CUH and the VTE exemplar network for COVID19 patients in CCA. We have contributed to the VTE Exemplar Network Survey of hospital guidelines of VTE prevention measures in people with COVID19



Where the findings of the RCA conclude that more could have been done to reduce the risk of VTE in RPH, this is communicated to the patient by their Consultant in line with the statutory Duty of Candour in the NHS. We have incorporated VTE RCA into our DATIX system to streamline reporting and ensuring sign off by the scrutiny panel is document and evidence of how lessons learnt at shared.

We continue to scrutinise VTE events at a quarterly scrutiny panel meeting consisting of the VTE medical, nursing leads and critical care, pharmacy and consultant representation. We provide a local meeting with VTE link nurses in all clinical areas on a quarterly basis and attend/support work with the National Nurses and Midwives Network (NNMN) for VTE. We also raise awareness of VTE during patient safety month and annually on thrombosis awareness week. At induction, medical staff are advised on and shown the location of the VTE risk assessment on Lorenzo.

VTE Action Plan

Following a recent review of VTE and falling compliance against 95% target of VTE risk assessment on admission a local action plan is in place. This involves key staff within the organisation to affect change and optimisation of Lorenzo and Metavision to capture data for audit. NHS Improvement is also working with us to monitor compliance and the improvement of risk assessment on admission. This will be monitored through QRMG and shared with the Quality and Risk Committee. We have seen sustained improvement in late 2019/20 shown below with increased compliance above 95% in three consecutive quarters.

The table below illustrates the percentage of patients who were risk assessed for VTE on admission to Royal Papworth Hospital:

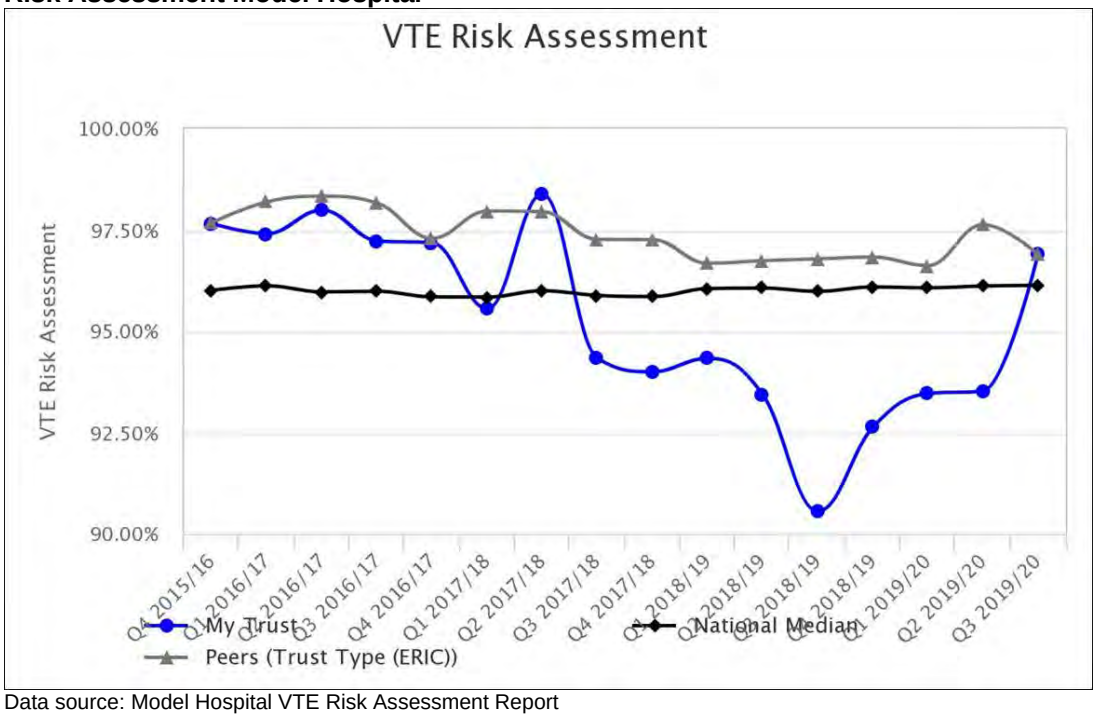
Percentage of patients risk assessed for VTE Q1-Q4 2018/21

		% of In-Patients Risk Assessed for VTE (Unify)	Quarterly %
April 2018	**Q1**	94.00	**94.33%**
May 2018		94.00	
June 2018		94.33	
July 2018	**Q2**	94.33	**93.44%**
August 2018		94.50	
September 2018		94.24	
October 2018	**Q3**	92.04	**90.56%**
November 2018		92.00	
December 2018		86.64	
January 2019	**Q4**	86.66	**92.76%**
February 2019		96.66	
March 2019		93.00	
April 2019	**Q1**	97.00	**93.50%**
May 2019		90.00	
June 2019		93.00	
July 2019	**Q2**	97.00	**93.53%**
August 2019		93.34	
September 2019		90.02	
October 2019	**Q3**	97.00	**97.33%**
November 2019		100.00	
December 2019		95.00	
January 2020	**Q4**	97.00	**97.00%**
February 2020		97.00	
March 2020		96.66	
April 2020	**Q1**	100.00	**96.63%**
May 2020		93.33	
June 2020		96.66	
July 2020	**Q2**		
August 2020			
September 2020			
October 2020	**Q3**		
November 2020			
December 2020			
January 2021	**Q4**		
February 2021			
March 2021			

Data source: NHS Digital database as reported in Quality and Risk Management Group Report

There is a variation in the data on P48 obtained from central reporting and the figures above. The compliance data submission is based on a monthly audit of 30 records rather than a patient census and the achievement figures submitted to Unify are based on whole numbers of admissions to which the audit compliance figure is applied. NHSI are aware of the basis for this submission by the Trust. This data above also has a more up to date figure for compliance in December 2019 this follows case review.

Risk Assessment Model Hospital



Data source: Model Hospital VTE Risk Assessment Report

Sharing lessons learnt and good practice

All hospital associated VTE events are reported on DATIX. Findings from the RCAs are reported back via email to the Consultant and teams involved in the care of the patient, Clinical Director and QRMG, together with a copy of the RCA report from DATIX. We continue to share information of our VTE pharmacological prophylaxis omissions audit and an anonymised VTE RCA at the National Nurses Midwives Network (NNMN) for VTE meetings in 2019/20.

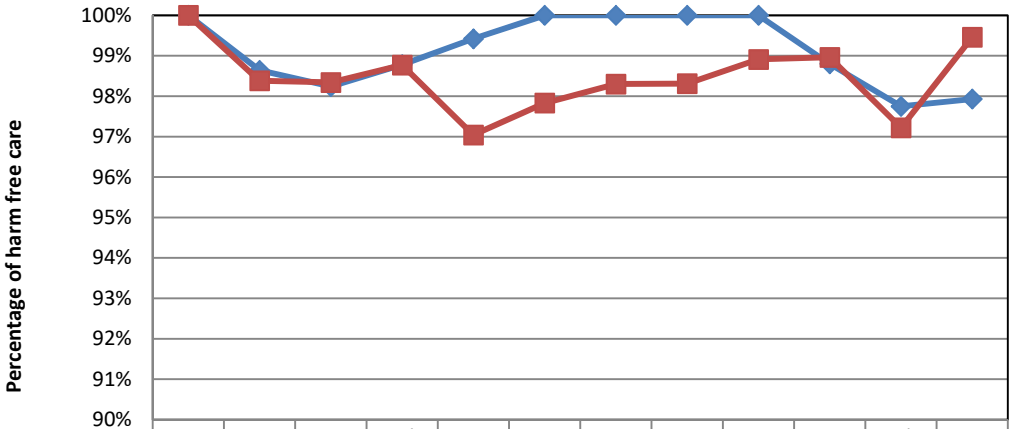
We are contributing to the National Getting It Right First Time (GIRFT) VTE audit to contribute to National audit of risk assessments and confirmed Hospital Acquired Thrombosis (HAT). This audit commenced in October 2019 and runs until March 2020, the results will be published later in the year.

Delivery of Harm-Free Care

Harm-free care is defined by the absence of pressure ulcers, falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections (CAUTI). The Trust continues to use the NHS Safety Thermometer (a point of care survey instrument) whereby teams measure and report harm and the proportion of patients who are “harm-free” during one day each month.

The Chart below demonstrates Royal Papworth Hospital’s rolling two-year comparison data

Patient Safety Thermometer - Harm Free Care - rolling year comparison

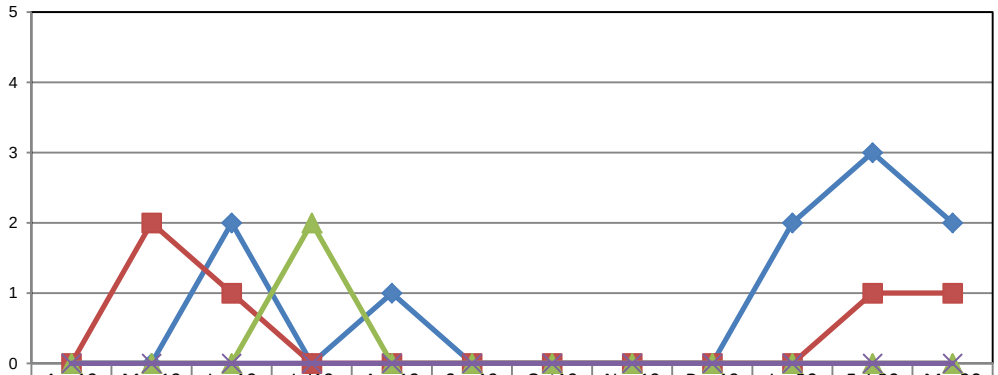


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm Free 2019/2020	100%	98.64%	98.24%	98.78%	99.42%	100%	100%	100%	100%	98.80%	97.75%	97.93%
Harm Free 2018/2019	100%	98.38%	98.34%	98.77%	97.04%	97.83%	98.30%	98.31%	98.91%	98.96%	97.22%	99.46%

Safety Thermometer

The graph below provides a breakdown of the types of harm.

Types of Harm: patients with each type of Harm



	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20	Mar20
Pressure Ulcers	0	0	2	0	1	0	0	0	0	2	3	2
Falls	0	2	1	0	0	0	0	0	0	0	1	1
Catheter & UTI	0	0	0	2	0	0	0	0	0	0	0	0
New VTE	0	0	0	0	0	0	0	0	0	0	0	0
Patients	186	147	170	164	171	168	191	189	160	181	178	145

Patient Safety Rounds (PSR)

Patient Safety Rounds (PSR) are a method of ensuring that leaders are informed first hand of the patient safety concerns of frontline staff as well as demonstrating visible commitment to safety by listening to staff raising concerns. PSR can act as a useful tool to:

- demonstrate organisational commitment to patient safety
- support open communication within the organisation
- identify opportunities for change and promote a culture of safety improvement
- encourage reporting of safety incidents, patient harm and near misses

The groups undertaking the PSR are typically made up of a mix of staff to promote a multidisciplinary view

- Matron
- Operational Manager
- Pharmacy representative
- Consultant
- Executive Director
- Non-Executive Director
- Patient / Lay representative

The local leadership team receives verbal feedback from the PSR team at end of visit. The aim is to provide an on the spot temperature check of safety in the respective area. The feedback should be constructive and immediate to allow for local learning and effective and timely actions if required. A written summary report is produce and shared with the Divisional/ BU teams and monitored via the Quality and Risk Management Group. Any actions identified from the PSR will be monitored locally.

PSR take place bi-monthly; during 2019/20 we undertook 4 of the planned 5 visits starting September 2019 following a successful move of the hospital earlier this year. Unfortunately, the PSR in their formal format have been suspended from Q4 19/20 during the COVID19 Pandemic.

Location	**4 South**	**Theatres**	**3 North**
Date	24/09/2019	26/11/2019	28/01/2020
Facilitator	Matron Cardiology	Matron Surgery	Matron Thoracic
Visiting team	Pharmacist Consultant Surgeon Patient representative / Governor Non-Executive Director	Operational Manager Pharmacist Non-Executive Director	Pharmacist Non- Executive Director Matron

The PSR visits will be re-established as soon as the hospital becomes operational again under business as usual. This may not be until later in 2020/21.

Patient experience domain

Patient Stories at Board

Patient stories have continued to form an integral element of capturing the patient experience throughout 2019/20. Senior nurses and Matrons have presented at the Board of Directors and at professional meetings such as C-PAC, Sister's Forum, Management Executive and the Patient Experience and Safeguarding groups. Patient stories are also included in monthly Matron reports to divisions and this provides a valuable opportunity for discussion directly with the senior multidisciplinary team and reports are circulated to teams for further learning. This practice will continue during 2020/21. The process was extended to more non-clinical meetings including Board sub Committees to assist in focussing effort on ensuring the best possible patient experience.

Patient Stories-Matrons

The Matrons liaise with the ward team to identify a patient who would be willing to spend some time reflecting on their experience with the Matron. Feedback is promptly provided to the care team and immediate action is taken if concerns are raised. Individual patient stories are recounted at the start of Trust meetings of all types, including at Trust Board, to help focus the attendees on our patients. The stories are reviewed by Heads of Nursing and the responses themed. A quarterly report is submitted to the Clinical Professional Advisory Committee so the information can be shared with the wider Nursing and Allied Health professional teams.

Themes identified from our patient stories have included:

What is the best thing about your stay or treatment at the Trust?

- Kind, considerate staff
- Expert care
- Professionalism of staff
- Respect and courtesy afforded by staff
- Welcoming environment
- Patients felt well looked after
- Single rooms were a very positive measure in the control of infection

What is the worst thing about your stay?

- Cancellation and delays of procedures
- Poor communication between medical teams
- Doctors and agency staff not introducing themselves
- The impact of delays in transport
- There was difficulty in identifying who staff were when in scrubs.
- Concern that some questions were repeated over and over
- Noise from monitors on the ward
- Some isolation because of single rooms
- Unable to see faces of staff in PPE and difficulties in communication for lip readers

Having reflected on your experience of being a patient at Papworth, are you able to suggest areas we can improve on?

- Need to improve communication related to cancellations and delays
- Need to improve communication of results of investigations

Actions taken from the patients stories:

- A standard operating procedure to manage communication related to late cancellations of procedures has been implemented
- A formalised induction checklist for agency staff that covers staff introducing themselves to patients; explains the use of intentional rounding and the plan for medicines rounds.

- Projects have been stepped up that look to address social isolation on the wards. These had been planned ahead of the move and were led by OT colleagues and included lunch clubs, crafts and games.
- Staff name badges had been ordered that were clearer to read
- Team were looking at the issue of repetitive questions and how we could use our systems to address this.
- Monitors were being reconfigured to address the noise on the wards.
- Consideration with procurement for clear facemasks to assist with communication for lip readers and enable faces to be more visible.

What would you want us ALWAYS to do?

- Always keep me informed about what is happening
- Always treat me with respect
- Always ensure there is time for my questions
- Always ensure that the environment is clean
- Always be honest and open about things

Dementia

Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. The condition has a significant impact on a person's health, personal circumstances and family life.

It is well documented that inpatients with dementia are more likely to have adverse incidents, such as falls or poor nutrition, and have longer hospital stays than people with equivalent health needs who do not have dementia.

There is also increasing recognition that hospital staff and services need to understand the complexity of caring for and treating people living with dementia. The Alzheimer's Society reported in 2016 only 2% of people living with dementia felt, in their experience, that all hospital staff understood their specific needs.

The aim for all people living with Dementia is set out in the Prime Minister's challenge on dementia 2020 which states that:

> 'We want the person with dementia – with their carer and family – to be at the heart of everything we do. We want their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services, recognising that each person with dementia and their carer is an individual with specific and often differing needs including co-morbidities'.

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

Royal Papworth Hospital Dementia strategy was created in 2015 and was due to run until 2018. It's review had been extended to take us through the 2019/20 year following the delay to our move and it is now scheduled for review in January 2021 following a further extension as a result of COVID19. The new Royal Papworth Hospital has enabled some great spaces and design that will really benefit our patients. Extending this Strategy will enable us to better understand our new environment and the new ways of working and ensure that -we can really use the amazing space for our Dementia patients and others
Patients with dementia will have safe individualised care, be treated with respect, and be well informed whilst in our care. Care is set around what the person needs and who they are. Our patients with dementia will receive the essentials of care that are right first time every time. Patients who are vulnerable and those who require reasonable adjustments are identified daily in the site safety briefing and adjustments are made by senior nurses as necessary and this has become embedded during previous years.

Aims for Patients with Dementia

1. To use Lorenzo (EPR) to ensure that Staff are able to access person centred care plans to address needs, that they are able recognise patients who may have Dementia, respond accordingly and record reasonable adjustments, activity and outcomes for these patients.

    - Alerts for confirmed and suspected Dementia are created but not always used.
    - Smart lists to highlight presence of patient with an alert in hospital have been enabled.
    - Use of alerts is not yet embedded in service and training needs to be established to promote better understanding of this functionality within Lorenzo

2. Lead nurse for Dementia routinely sees patients who are identified as having Dementia or those patients whose behaviour gives concern. She carries out a detailed assessment of their needs.
3. One of the aims in the design of New Royal Papworth Hospital was to include measures to reduce disorientation and to promote a dementia friendly environment for our patients. As we have been in the new hospital for just under a year we need to evaluate whether the design has meet this aim.
4. Having a knowledgeable and caring workforce is essential. The study day on 30/10/2019 for Frailty, Falls and Dementia was exceptionally well attended. There are also eLearning resources available for staff.
5. Work is progressing regarding the care and treatment of frail patients and increased understanding of frailty and the impact of hospitalisation have on this group. By nature many patients with Dementia are frail and will benefit this work should lead to better outcomes for patients. An initial 3 month trial of IHU patients with a score of 5 or above who were all seen by the IHU frailty team were their suitability for surgery or less invasive alternatives were considered was concluded before Xmas and evaluation of the project is expected. Plans are underway to roll this out for all patients.
6. The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards expected in October 2020 will impact on those patients with Dementia who lack capacity to consent to their care arrangements are expected and training is already underway.

Learning Disabilities & Autism

Learning Disability is defined by Mencap in the following way:

> *A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.*

People with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable, and therefore unjust and unfair. The health inequalities faced by people with learning disabilities in the UK start early in life, and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. People with a learning disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006).

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

The Department of Health and Social Care have continuously emphasised the importance of Primary, Acute and Specialist NHS Trusts in meeting the health care needs of people with learning disabilities (DoH, 2015). The Governments mandate to the NHS 2017-18 published by DOH makes it clear that it supports the principles of reducing health inequalities. One of the aims of the NHS Long term Plan is to

- *Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families (NHS, 2020).*

In 2018 Royal Papworth Hospital published its Learning Disability Strategy. The strategy recognised that "It is so important that even though the numbers are small (learning disability admissions equate to 0.3% of activity), that every person with learning disabilities receives the care they need and want and that this reasonable adjustment is recorded " The numbers of Patients attending with Learning Disabilities is still small) and it is likely that the increase is down to greater recognition rather than increased attendance. We had 83 contacts (Inpatient stays/outpatient appointments) in 2018/19, this was made up of 45 unique patients, this increased to 120 contacts which was made up of 50 unique patients in 2019/20

July 2018 saw the publication of the learning disability improvement standards for NHS trusts. In October and November 2018 Royal Papworth Hospital undertook a self-assessment as part of the NHSI improvements Standards for Learning Disability to better understand the experience of our patients. The self-assessment was revisited again in 2019 with the submission of our data in February 2020

As a trust we have

1. Produced a Learning Disability & Autism Policy. This outlines the care and pathways for this patient group within our hospital and is now progressing through the process for trust approval.
2. Identified and supported 2 staff members to undertake LeDeR training and to participate in the regional LeDeR steering group.
3. Increased knowledge through safeguarding Newsletters and resources on Hospital Intranet.
4. Committed to hear the voice of our patients with Learning Disability & Autism through patient stories and to embed that learning within the trust.
5. We have developed some communication resources for patients with Learning Disabilities which are available for staff use.
6. Establish a system to monitor incidents reported through Datix affecting people with Learning Disabilities. Lessons from this are reported through the Joint Safeguarding Committee.

In 2020/21

We are planning to increase staff knowledge of learning Disability and Autism through training both face to face and via elearning. This training will also address the use of Alerts for patients with Dementia, Learning Disabilities or Autism.

We are developing a patient facing internet site to help our patients and families with Learning Disability and Autism get the most out of their visit to Royal Papworth Hospital

The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards expected in October 2020 will impact on those patients with Learning Disabilities and Autism who lack capacity to consent to their care arrangements are expected and training is already underway to prepare for these changes.

Frailty

The Trust has progressed work on identification of frailty since 2018. Alongside the Specialised Clinical Frailty Network (SCFN) we took part in Wave 1 (TAVI) and Wave 2 (Critical Care (IHU) and are now progressing through Wave 3 (Elective cardiac surgery). We have added the Rockwood Clinical Frailty Score (CFS) to Lorenzo and is steadily improving compliance with the assessment of frailty using this score for all patients admitted to the hospital. The CFS is also embedded within preadmission clinic for all pathways.

Overview of Frailty Programme

Wave 1 – TAVI: The project objective was to strengthen clinical assessment of clinically frail patients with Aortic Stenosis, reduce the number of inappropriate physician referrals for specialised commissioning interventions including transcatheter aortic valve implantation (TAVI), and enhance the shared decision making process with patients/family to ensure the most appropriate care package for those patients.

The TAVI team concentrated on the "All about me" booklet and improving its utilisation for patients accepted on the TAVI Pathway. The Cardiology ACP team undertook telephone assessments' using the CFS; the score and associated information gathered was used to improve the discussions and

decision-making at TAVI MDT. EBD Questionnaires were also given to patients at follow-up clinics to assess quality of life and CFS post procedure.

Wave 2 Critical Care (IHU): Every patient will have Rockwood Frailty Score undertaken. Any patient scoring five or more was referred to the Anaesthetic lead in order that a Papworth Perioperative Assessment (Complex Geriatric Assessment) could be undertaken. This identified need for pre-optimisation and/or appropriate decision making alongside a designated multi-disciplinary team. The time available for pre-optimisation in the IHU pathway for patients referred from other DGH's was very short and limited our ability to pre-optimise but enabled us to further analyse the interventions that we could have undertaken with additional time and the effect that this could potentially have on patient outcome, length of stay and reduction in postoperative complications.

We have developed our 'All about me' booklets to include quality of life pre and post-surgery.

We have progressed Grant application to support research in the domain of frailty and cardiac surgery.

We continue to share good practice and initiatives at national and international conferences including members of the project team attending the Specialised Clinical Frailty Network Wave 1 and Wave 2 national sharing events in 2018 and 2019.

Overview of 2019/20 and future plans

Wave 3 Elective Cardiac Surgery: To ensure 100% compliance with completion of CFS for all elective patients accepted for cardiac surgery, and to implement appropriate frailty assessment triggers that will effectively identify patients with CFS 4 or more. By adding grip strength and Short physical performance Battery alongside CFS we hypothesise that patients will be referred more appropriately and we will identify other aspects of pre-optimisation such as nutritional deficiency, potential swallowing issues and will also be able to offer individualised OT and physio pre-optimisation plans that the patient will follow whilst waiting for surgery.

All patients with CFS 5 or more will have a complex geriatric assessment undertaken by a designated Frailty Advanced Practitioner who is supported by an Anaesthetic and Surgical lead.

To implement a frailty multi-disciplinary team whose responsibility is to manage the pre-optimisation of patients prior to their surgery; this will reduce inefficient delays in the pathway and will ensure effective use of the time taken to wait for surgery. Patients will follow an individualised pre-optimisation pathway written by OT, Physio, Dietetics, Discharge team whilst the Frailty Practitioners will optimise any blood abnormalities i.e. anaemia, refer to specialist services for additional support e.g. smoking cessation, alcohol misuse and psychiatric support as appropriate and ensure the patient is fully prepared and ready for surgery. Communication will be improved with bookings to ensure patients are allocated surgery slots efficiently and can be brought in as same day admission (SDA) thereby reducing bed days and improving flow. We also hypothesise that Length of stay (LOS) in CCA and postoperatively will be reduced due to improved pre-habilitation and ability to undergo complex surgery.

A project team have been assembled with the assistance of the business change team. Fortnightly meetings have been conducted to develop a Frailty Optimisation Pathway, we have utilised audit to look at CFS compliance all patients admitted in 2019 and we have collected data on all patients referred within Wave 3 to understand our baseline data and patient group, we have also mapped 15 past patients through their pathway to learn about time delays with referral, first outpatient appointments, preadmission clinic, surgery date and postoperative recovery which has helped the team understand current issues in order that we can develop our frailty pathway. The team are currently in the process of developing a business case to be taken to Living With COVID Steering Group to request support for a pilot phase of implementation.

We will use EBD patient and staff questionnaires to assess baseline and monitor improvement in patient experience during the pilot phase.

We are due to share our work in Wave 3 with the SCFN at their sharing event on 9 November 2020.

Family Liaison Service (FLS) in Critical Care

This bespoke service had been conceived to enable patients to keep in touch with their relatives since restrictions to visiting had been implemented on 26th March 2020. The FLS had set out to manage expectations of loved ones and had committed to a daily catch up with one key member of the family. The equivalent of i-pads and face time had been introduced to aid connection between patients and relatives. This had proved challenging at times if carers were wearing full PPE however generally the service had been successful. Medical updates from clinicians had also been organised. From mid-July PALS were supporting the function of the FLS with families signposted to PALS should they require additional support. Families are now able to phone the bedside nurse looking after their loved one with regard to arranging visits. There can be two visitors at any one time and long term patients can have 3 visits per week. There are 3 set visiting slots per day and 3 bookings can be accommodated at any one time.

Patient Led Assessments of the Care Environment (PLACE) Programme 2019

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50 per cent patient assessors. All healthcare providers are required to undertake part in the national annual inspections. The assessment measures standards covering:

- Cleanliness
- Food & Hydration
- Privacy, Dignity & Wellbeing
- Building condition, appearance & maintenance
- Dementia friendly environment
- Disability friendly environment

PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

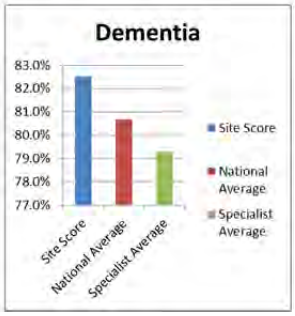
The PLACE collection underwent a national review, which started in 2018 and concluded in summer 2019. The question set has been significantly refined and revised to ensure that the collection remains relevant and delivers its aims. As the changes have been extensive, it is important to note that the results of the 2019 assessments are not comparable to earlier collections.

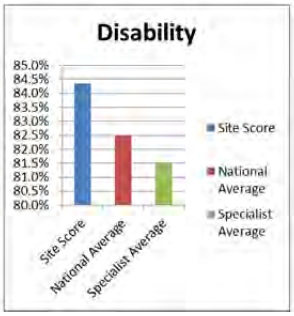
The latest published assessment was undertaken in November 2019 and is available at:
https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/england---2019

The Trust results and actions are set out in the table below:

Area	2019 Site Scores	2019 National All Sites	2019 National Specialist	Comments
Cleanliness	98.9%	98.6%	98.6%	On the whole the scoring was exceptionally positive for cleanliness, with majority being passes. There were however a few qualified passes regarding curtains not being dated or out of date (Floor 3) and glazing being marked (Day Ward).
Food	95.8%	92.2%	92.1%	We believe this was marked down as assessors were not able to taste food on the ward, this was tasted within the meeting room. All other scores were recorded as good.
Org Food	94.8%	91.0%	92.3%	Protected mealtime could not be discussed with staff, which marked the score down and Day Rooms were not set up for meal times. Also, one assessor selected a 'gluten free' meal which was not correctly served, reducing the score.
Privacy, Dignity & Wellbeing	85.5%	86.1%	84.9%	The score is 0.51% below the national site average but above the specialist national average. The scoring was mostly positive but there are a few common areas that were qualified passes, these include; no access to telephone in bedrooms or patient rooms; no separate treatment rooms across wards, patients are treated in bedrooms. Patient data (i.e. names) can be viewed through glazed bedroom doors and patient data boards are stored outside each room in holders. Reception and self service check-in points highly visible . Next year we would recommend not scoring Out Patients as a Ward as this brought the scoring down, is it a Department.
Condition, Appearance & Maintenance	98.3%	96.4%	96.6%	The score reflects the new condition of the hospital, which is expected after the short duration we have been here. There were a few qualified passes including floor and internal decorations in communal and bedroom areas on Floor 3.
Dementia	82.5%	80.7%	79.3%	The score reflects that quite few areas are qualified pass only , such as sign visibility; clock visibility; clock size only 30cm not 45cm; Outpatients – no date on staff board; no dimmer switches; en-suites only have a shower symbol; toilets show pictures only (no text); some signs too high; no art work on walls (wards) and wards looks clinical and bare.
Disability	84.3%	82.5%	81.5%	There are a few areas which were registered as qualified passes, these include; main entrance door requires a higher contrast, wheelchairs missing at south entrance, no braille in lifts or raised buttons, better in lift info required

The tables below plot the national and specialist average scores against the Trust's 2019 scores for each category assessed. As shown, the Trust out performs the national average against all categories apart from Privacy & Dignity





Action Plan

Royal Papworth hasn't scored highly against Privacy, Dignity & Wellbeing, Disability and Dementia. The Trust is not the lowest scoring in this comparison but other specialised Trusts have scored 90% and over in each category and so this sets an ambition for the Trust to achieve in 2020. Actions against these areas are set out below.

Dementia – The criteria against this topic will always be difficult to achieve top marks but there are some areas the Trust could improve upon. This includes the placements of signs to ensure that they are appropriate and can they be seen (including height, which could be subjective), the toilet signs require both text and pictures (we only provide pictures) and there is no art work in ward areas and bedrooms (this is a Trust decision to avoid disorientation in bedrooms). There are some elements of the design of the building that will prevent the Trust reaching 100%, unless there is significant investment but there are smaller changes we could undertake.

Disability - There are a few areas registered as qualified passes which could see our score improved over the coming year, these include; the main entrance door requires a higher contrast film, wheelchairs missing at south entrance, no braille in lifts / no raised buttons, better 'in lift' information required. As with the Dementia criteria, these changes could require significant investment so they would need to be reviewed in detail to ensure we get the quality and conditions we require to achieve the best patient experience.

In addition changes will need be made to working practices to improve privacy, dignity & wellbeing. This is being taken forward between Estates & Facilities and the Matrons team.

Summary

The Trust is pleased with results gained from the first PLACE audit at the new Royal Papworth Hospital site. The results all sat above the specialist average and 7/8 were above the national average, with just Privacy, Dignity & Wellbeing falling 0.5% below the national average.

There are small changes that can be made within the Trust to improve scores across the board but the scoring system and broad nature of the questions mean there will always appear to be results that are lower then expected, such as no "telephones in bedrooms" impacting the 'Privacy' scores.

It is worth noting that Royal Papworth is a small Trust in comparison to others so the opportunity to score highly becomes more difficult as a non-compliance score could drop us by 10%, whereas for other larger Trusts it may only affect their overall scores by 1%.

Listening to Patient Experience and Complaints

Listening to the patient experience and taking action following investigation of complaints is an important part of our Quality Improvement framework. In 2019/20 Royal Papworth Hospital received 74 formal complaints from patients. Of the 74 complaints reported (39 inpatient and 35 outpatient complaints) 70 were relating to NHS provided services with 4 complaints related to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has increased on the numbers received during the previous year when 54 complaints were received (a 37% increase from 2018/19).

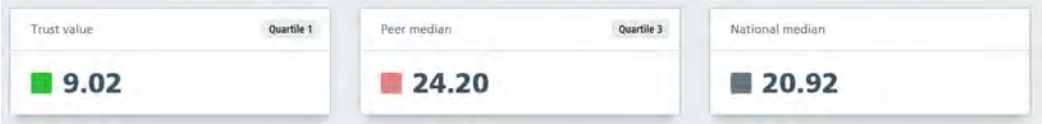
Where a patient and/or family member wish to escalate their concerns in a more formal way but do not wish to register their concern as a formal complaint, we log these concerns as “Enquiries”. Investigation of the issues raised follows the same robust process as a formal complaint and a written response, including any actions identified as a result of raising their concern, is provided. The Trust received 33 enquiries in 2019/20, a significant increase from the previous year (12 in 2018/19)

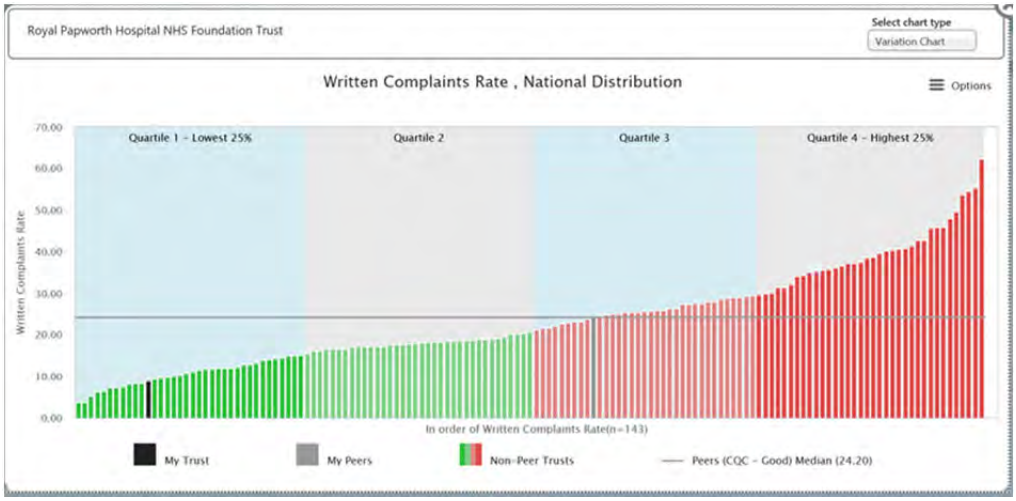
National benchmarking

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

April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	March 2020
7.80	10.20	10.30	8.00	8.50	11.70	12.60	12.50	9.10	9.50	8.40	8.90

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





However, Royal Papworth Hospital takes all complaints very seriously and we encourage feedback from our service users to enable us to maintain continuous improvement. All formal complaints received are subject to a full investigation, and throughout the year service improvements have been made as a result of analysing

and responding to complaints. Not all complaints are upheld following investigation and the table below shows the number of complaints received and of those, the numbers upheld or part upheld. Out of the 74 complaints received in 2019/20 55% were upheld or partly upheld following investigation (2018/19: 70%).

Quarter	Number of complaints received (including private patients)	Complaints upheld/ Part upheld
Q1 2019/20	18 (1 PP)	11
Q2 2019/20	12 (2 PP)	12
Q3 2019/20	17	12
Q4 2019/20	18 (1 PP)	3*

*Not all complaints for Q4 have been closed

The communication/information category continues to be one of the highest reasons for complaints from patients and/or families over the past five years. In 2019/20, we have seen an increase in the number of complaints associated with clinical care/clinical treatment. 37% of complaints received in 2019/20 related to concerns regarding clinical waiting times, medical care, treatment, diagnosis and/or outcome. A comparison of complaints raised by primary subject by year is shown below.

Complaints received by primary subject	2019/20	2018/19	2017/18	2016/17	2015/15	2014/15
Appointments	3	0	0	0	0	1
Staff attitude	0	1	2	5	4	4
Clinical Care/Clinical Treatment	28	12	8	17	21	20
Nursing Care	1	0	5	4	6	2
Catering	0	1	0	1	0	1
Patient charges	0	0	0	1	0	1
Communication/Information	27	28	41	18	20	8
Delay in diagnosis/treatment or referral	7	10	9	6	4	6
Discharge Arrangements	1	1	2	2	2	0
Equipment Issues	0	0	1	1	0	0
Privacy and Dignity	1	0	1	0	0	0
Environment - Internal	3	0	0	1	0	0
Medication issues	2	1	0	0	2	0
Transport Issues	1	0	1	1	2	0
Totals	**74***	**53***	**70**	**57**	**61**	**43**

Complaints by primary subject (Data source DATIX 23/04/2020)
**The total number of complaints includes those related to Royal Papworth Private Care*

Selection of actions taken as a result of upheld and part upheld complaints – 2019/20
Improved the communication to patients regarding cancellations.
Implemented a Trust wide escalation procedure and monitoring against 28 day target for surgical cancellations.
Reviewed the current staffing model to utilise capacity on critical care to reduce surgical cancellations.
Cascade information and raise awareness amongst staff regarding the angiography stents used at Royal Papworth Hospital containing Nickel & Cobalt. This included highlighting the process for ensuring the Cath Lab Coordinator is aware of any patient allergies relating to Nickel & Cobalt.
Re-education of ward staff in relation to discharge procedures and protocols in relation to medication to take home
For those upheld or partially upheld complaints where no particular action was identified the complaint is discussed and shared with the relevant teams for learning and to identify any areas

for improvement.
The ICD booklet has been amended regarding which patients need to inform DVLA of pacemaker implant
Recruiting a CSS coordinator as a part of service improvements to the CPAP outpatient and outreach clinics
Revised all outpatient letters to ensure up to date information in relation to the use of the calling screens in outpatients is communicated to all patients before they attend the hospital.
We have shared the learning from complaints to improve the standard of documentation and communication

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

Care Quality Commission (CQC) Inspections

Royal Papworth Hospital has an excellent working relationship with the CQC Relationship Manager. The last CQC inspection was undertaken in June & July 2019. The rating of the trust improved and it received an overall rating of Outstanding. The CQC looked at all of our core services (with the exception of end of life care) and its overall assessment was outstanding:

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

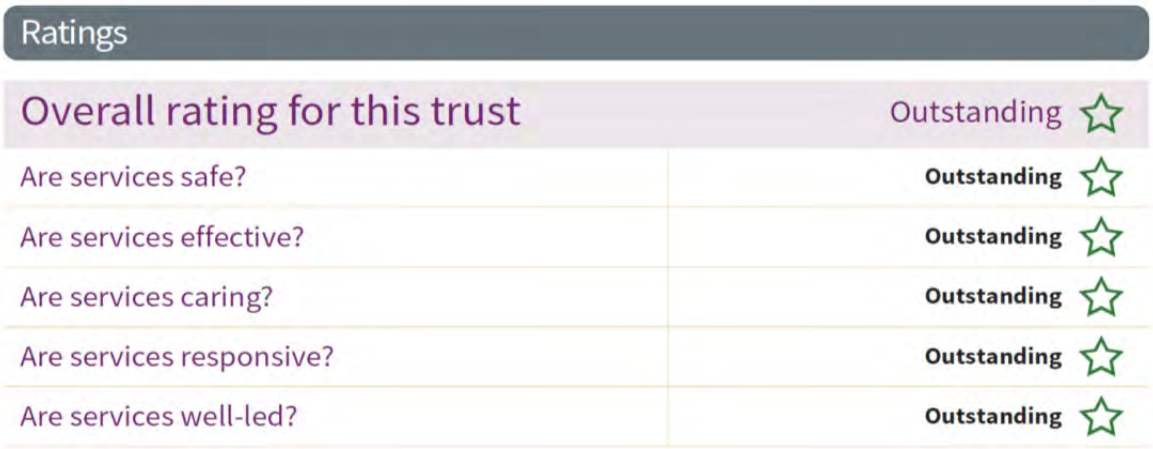
The aggregated rating for well-led at core service level was outstanding and the CQC rated well-led at trust-wide level as outstanding. When aggregated with the core services, this gave a rating of outstanding for the overall trust.

The CQC talked with patients and staff from all the ward areas and outpatients services. The CQC observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records.

This outstanding achievement is a reflection of the dedication of the staff at RPH to get it right first time and every time for the patients within their care. RPH has a commitment to work in an open and transparent way with staff and patients and takes engagement very seriously ensuring that we continuously learn and develop.

There were areas identified in which Royal Papworth Hospital could improve and action plans have been put in place to address these.

The ratings for Royal Papworth Hospital against the five key questions used by the CQC in their inspections of services are shown in the following table:



The full inspection report is available at https://www.cqc.org.uk/provider/RGM/reports

CQC Internal Mock Inspections

The Trust undertook a CQC Mock inspection in February 2020 which assessed against the CQC key lines of enquires (KLOE) for the whole organisation. This followed an unannounced format and brought in support from external assessors. The review team were asked to explore the Key Lines of Enquiry (KLOE) and look for good practice and those areas that need improvement. All the reports were collated. The overall rating for the organisation was **Good**.

The outcome of the inspection was shared with all departments, and they each developed action plans to address recommendations from the review. The Quality and Risk Management Group holds departments to account on delivery of agreed plans.

In 2019/20, The Trust has continued its focus on the fundamental standards – the standards below which care must never fall and the Fundamentals of Care Board has continued to support the work on well led recognising the work required to routinely self-assess against CQC standard regulations.

The Board agreed its latest self-assessment in February 2020 and the outcome is set out in the table below:

Service	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
Medicical Care	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding
Critical Care	Good	Outstanding	Outstanding	Good	Good	Outstanding
Outpatients	Outstanding	Good	Outstanding	Good	Good	Outstanding
Diagnostic Imaging	Good	Good	Outstanding	Outstanding	Good	Outstanding
End of Life Care	Good	RI	Good	RI	RI	RI
Overall	Good	Good	Outstanding	Good	Good	Good

CQC Board Self-Assessment 03 February 2020

Clinical effectiveness of care domain

Operational Response to COVID19

Royal Papworth Hospital (RPH), as a nationally recognised centre of excellence for specialist cardiothoracic health care, continues to play a leading role in the national, regional and local response to the COVID19 pandemic. The Trust has taken roles in both an advisory capacity, and in the capacity of a direct provider of health care to the population.

In response to the pandemic the Trust developed its operational response and this 'Surge Plan' was taken to an Extraordinary Board meeting on 20 March 2020. The purpose of the plan was to maximise survivorship of COVID19 and non-COVID19 patients across the region and to keep staff safe in the delivery of services. This was achieved by:

- Reducing the volume of business as usual activity to around 35% of normal levels. This limited the pathways the Trust was treating to those where the patient required emergency treatment, urgent treatment or treatment for cancer, i.e. those where a delay to treatment was likely to result in a significant increase in mortality;
- Focusing on the most likely regional infrastructure requirement that RPH could physically provide (i.e. ventilated critical care beds), and explaining how, through a series of stepped increases (6 surge zones), the trust could increase capacity from a business as usual critical care capacity of c.27 beds, to a total surge capacity of c.100 ventilated critical care beds; and;
- A move to a staffing model that focused on the safe delivery of care (as agreed with the Chief Nurse), which included the redeployment and retraining of staff to deliver care to the increased number of critical care beds.

The Trust established a Clinical Decision Cell (CDC) in response to the COVID19 pandemic and as the imperative changed from the COVID19 urgent response to responding to, and meeting the requirements of the Sir Simon Steven letter and the requirements for recovery, the CDC managed the response to this process through the development of the medium and long term CDC strategies which are appended to this Quality Report.

It is in the context of both recovery and preparation for a second COVID19 wave that the CDC longer term strategy has been prepared. All possible opportunities to deliver the business as usual activity and go beyond pre COVID19 activity levels where practicably possible will be pursued. It is recognised that in the event of a second COVID19 wave the approach to delivering BAU will need to maximise continuity alongside the COVID19 service lines.

The outcomes for patients treated at RPH have been reported by ICNARC and a copy of their most recent outcomes report is appended to this Quality Report. This report covers the outcomes data for the 103 patients admitted to our Critical Care Unit reported to 30 July 2020.

Royal Papworth Hospital Cardiovascular Outcomes – NICOR report 2015-2018

Royal Papworth Hospital is one of the best-performing NHS hospitals in the UK for cardiac surgery survival, according to the latest NICOR annual report. Over a three-year period, the hospital had a risk adjusted survival rate of >98%, and was above the national average. During that time, Royal Papworth performed the 5422 procedures, one of the largest case volumes in the UK. The data comes from the National Institute for Cardiovascular Outcomes Research (NICOR) report, which looked at hospital performance between 2015 and 2018.

Cancer - 62-day wait for first treatment from urgent GP referral

Background
This is the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. For the definition of this indicator see Annex 4.

Royal Papworth Hospital is the tertiary/specialist hospital for lung cancer in the west half of the Anglia region. Patients seen by their GP with suspected lung cancer are referred first to their local district general hospital (DGH), and then onto Royal Papworth for further investigation if lung cancer seems likely, and if the recommended treatment is likely to be potentially curative. The main treatment modality delivered at Royal Papworth is thoracic surgery. Patients who require chemotherapy, radiotherapy or other treatments are treated at Cambridge University Hospitals or at their referring trust.

Like all other hospital trusts, Royal Papworth is expected to treat 85% of patients referred on this pathway within 62 days of referral. For the purposes of cancer waiting times (CWT) where patients are seen at multiple hospitals, a patient is split between the 'first seeing' hospital and the treating hospital. The network pathway means that Royal Papworth is not the first Trust to see any patients and therefore Royal Papworth is usually only accountable for 50% of any pathway where the patient is treated here. This means the numbers of treatments Royal Papworth records is very small for the 62 day pathway, which is only a small percentage of the patients it has on its Patient tracking list at any one time. Where patients are referred to Royal Papworth late (after 16 days as agreed in accordance with the regional best practice Lung pathway) in has been agreed that these breaches can be negotiated to be reallocated to the referring hospital, although these are not reflected in the nationally reported figures.

Performance against the 62-day target 2019/20

Indicator	Target pa	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD actual
62 day cancer wait *	>85%	66.7%	62.5%	60.0%	50.0%	80.0%	80.0%	66.7%	44.4%	60.0%	87.5%	100%	71.4%	67.0%

At the start of the year the Trust faced a challenging position in relation to cancer waiting time. The deterioration in performance resulted from higher than expected levels of referrals and restricted capacity during the hospital move period. The Trust put in place remedial actions to address performance including:

- Adjustments to optimise the interim Histopathology solution including the use of digital review of slides to facilitate early ordering of reflex testing.
- Transfer of the Histopathology service to CUH in August 2019 which was completed on schedule.
- Adjust to treatment capacity with the addition of an additional thoracic operating day each week from June 2019.
- Close tracking of patients and escalation of delays in the pathway.
- Working closely with providers who refer to us late in the pathway to review the pathway timings and identify areas of improvement.
- Continue liaison with the PET CT service to ensure timely access to scans.

Following the move the Trust saw an improvement in position (see above figures for 2019/20 and comparative figures for 2018/19). However performance declined in March 2020 with a significant reduction in referrals for 62 day pathway and clinical decisions taken to defer treatment for some patients in light of safety concerns in response to the COVID19 pandemic. The Trust is now seeing near normal referral levels and a recovery in performance from July 2020.

Theatre Cancellations

Cancellation of scheduled activity has been an area of concern in 2019/20 with a total number of 636 (2018/19 636). The four main reasons for cancellations were: Insufficient CCA staff; All CCA beds full with CCA patients; No ward bed available to facilitate transfer of patient out of CCA; Emergency and transplant operations took theatre time. Measures to address theatre productivity and cancellations were taken forward in 2019/20 through the Hospital Optimisation Programme.

Hospital Optimisation

Following the move to the new site the Hospital Optimisation Programme was established with the overall aim to improve patient flow through in-patient areas and to increase activity and income to the 2019/20 operating plan. To achieve this, the following Optimisation projects were established:

- Maximise the use of outpatients
- Improve access to pre-assessment and same day admissions
- Booking and admin processes
- Maximise theatre utilisation including turnaround times / delays
- Maximise cath lab utilisation including turnaround times / delays
- Optimise the use of Day Ward
- Maintain bed capacity to support activity
- Staffing of CCA and ward beds
- Impact of ward bed closures
- Open Theatre 6
- Transplant activity and escalation of activity

The Hospital Optimisation Project Group met fortnightly to review the progress of individual Optimisation projects against the programme plan. The Project Group reported to the Executive Committee and the Strategic Projects Committee (SPC). Summary reports were submitted to the SPC and focused on the delivery of the following projects:

Outpatient utilisation
This delivered a greater targeting of resources understanding of constraints; significant improvement in thoracic and cardiology clinics bookings and a refined process of tracking and recording rooms enabling staff to predict what space might be available to improve utilisation.

Opening Theatre 6/Optimisation of flow through theatres and cath labs
The Trust opened Theatre 6 as planned in September 2019. Achieving a reduction in theatre cancellations remained challenging as critical care bed capacity remained an issue.

Critical care staffing
Tighter project monitoring and reporting allowed the impact of recruitment and retention initiatives to be tracked against trajectory. Bed numbers (predicted and actual) were reported daily and an escalation policy developed. This project will continue until commissioned beds are fully open in a safe and sustainable way.

Opening of 4 North West
The project achieved its objective of opening 11 beds on 4NW.

The programme for the delivery of the Optimisation projects was due to be completed at the end of March 2020 and each Optimisation Project was being evaluated to assess whether their original objectives had been delivered. Following completion of this project evaluation, new projects were to be established to address any further Optimisation challenges identified. With the onset of the pandemic the work of the Hospital Optimisation Group was paused whilst the Trust focussed the major incident response to the outbreak.

Royal Papworth leads in Transplant Survival Rates

Royal Papworth Hospital had a number of the UK's best survival rates for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in August 2019.

The report identified that the national 30 day rate of survival following adult heart transplantation was 90.3%, which ranged from 78.5% to 94.2% across centres (risk-adjusted), with some evidence of a significantly higher rate of survival at Papworth (94.2%). The national 1 year survival rate was 86.6%, ranging from 78.4% to 91.3% across centres (risk-adjusted), again with some evidence of a significantly higher rate at Papworth (91.3%). The national 5 year survival rate was 69.7%, ranging from 60.5% to 79.3% across centres with a rate of 79.3% at Papworth (risk-adjusted) indicating a rate significantly

higher than the national rate. The report noted that at all time points analysed, there was some evidence of a significantly higher survival rate at Royal Papworth in comparison to the national rate.

For lung transplant the 90-day post-transplant Papworth had a rate of 90.6% (90.2% risk adjusted). This was statistically consistent with the national rate of survival which was 88.8%. The national 5 year survival rate was 56.2%, ranging from 45.7% to 60.7% across centres (risk-adjusted), with no significant outliers. The 5 year survival rate at Papworth was 53.9% (risk adjusted).

According to NHSBT's Annual Report on Cardiothoracic Transplantation, Royal Papworth Hospital performed more adult heart transplants each year than any other hospital in the UK. It also had the lowest decline rate for donor organs, meaning it accepts a higher proportion of organs offered for donation than any other UK centre. This means that we are looking at every possible donor to assess if each donor can be converted to a successful Transplant. We are the only centre in the country that will send one of our DCPs to scout potential donors in an attempt to increase the donor pool by active donor management prior to the retrieval teams' arrival at the donor hospital. We are also by far the busiest Retrieval Team in the country.

Respiratory Extra Corporeal Membrane Oxygenator (ECMO)

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

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

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

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

ECMO is a form of support rather than a treatment, and its aim is to maintain physiological homeostasis for as long as it takes to allow the lung injury or infection to heal. Support time is usually between five and 14 days but sometimes ECMO support is required for longer.

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

The Hospital is registered with the international Extracorporeal Life Support Organisation (ELSO) and is renowned for its experience using ECMO. This long experience in providing a high-quality ECMO service is recognised in the success of the residential Royal Papworth ECMO course, which attracts national and international delegates, with more than 500 delegates from five continents having attended so far. The multidisciplinary team has contributed to multiple scientific communications and articles published in the medical literature.

From December 2011, the service provided by Royal Papworth became part of the national network of services that provide a year-round ECMO service to all hospitals in the country. This includes the retrieval on ECMO of patients from the referring hospital by a dedicated highly-specialised team. Royal Papworth works very closely with the other four national ECMO centres and NHS England to

ensure that all patients have immediate access, all week long and at any time of the day or night, irrespective of their location. Our Consultant Intensivists also provide specialist advice by phone to referring centres when patients are not deemed suitable for ECMO.

In 2014 the service expanded to include a follow up clinic. All patients are seen six months after discharge from Royal Papworth by a Consultant in respiratory medicine or intensive care, and an ECMO specialist nurse. The aim of the clinic is to provide ongoing support where required, evaluate their respiratory function to ensure that best treatment is offered and measure quality of life after ECMO to allow us to refine how we deliver the service.

To ensure best practice across many hospitals, Royal Papworth invites team members of all referring intensive care units to attend an annual meeting to review indications and outcomes, as well as share areas of best practice. The last annual meeting was held in Homerton College in October 2019. The five centres providing ECMO in England meet at least twice a year to review practices and outcomes and have weekly phone conferences to ensure that access to the service is maintained.

In March 2020 Royal Papworth led on the introduction of an online referral service which provided a central referral portal for all ICU's in the country to refer patients to their local ECMO centre. The introduction of this service was integral in facilitating the successful response to the exceptional demand placed on the service during the COVID19 surge.

Whilst difficult to compare due to the multiple conditions treated and the absence of risk stratification, survival rates are in keeping with international figures. The Extra Corporeal Life Support Organisation (ELSO) registry shows in July 2020 a survival of 69% for patients supported with respiratory ECMO.

Summary of ECMO activity at Hospital since December 2011 - March 2020

Year	Referrals	Accepted	Supported with ECMO	Survival to discharge* (ECMO)	Survival to discharge* (all accepted)	30 day survival (ECMO)	30 day survival (all accepted)
Dec 2011/12	25	15	10	50%	66%	50%	66%
2012/13	111	28	22	68%	75%	64%	71%
2013/14	116	35	32	75%	77%	71%	71%
2014/15	152	40	37	76%	75%	76%	75%
2015/16	202	54	50	70%	70%	68%	68%
2016/17	149	36	35	86%	83%	83%	80%
2017/18	177	50	46	78%	78%	68%	62%
2018/19	201	54	54	76%	76%	76%	76%
2019/20	192	42	42	71%	69%	69%	69%

*discharge from Royal Papworth

Pulmonary Endarterectomy

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

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

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

Seven Day Services

The Seven Day Hospital Services Programme (7DS) introduced a new measurement system based on board assurance of the four priority clinical standards to replace the 7DSAT online survey tool from the Autumn of 2018. The intention is to ensure trust board oversight of 7DS and to reduce the administrative burden on trusts. This work is built on 10 clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013. Four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high-quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review at any time on any day of the week. The four priority clinical standards are:

Clinical Standard 2 – First Consultant review within 14 hours	**Clinical Standard 5 – Access to consultant-directed diagnostics**
Assessments based on a triangulation of consultant job plans to deliver 7DS, local audits to provide evidence and reference to wider metrics.	As previously, assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by a formal arrangement with another provider.
Clinical Standard 6 – Access to consultant-led interventions	**Clinical Standard 8 – Ongoing consultant-directed review**
As previously, assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, either on site or by a formal arrangement with another provider.	Assessment based on consultant job plans to deliver 7DS, robust MDT and escalation protocols, local audits and reference to wider metrics.

The NHS Standard Contract requires providers to undertake the 7DS board assurance process bi-annually. The results from this will form a 7DS metric in the clinical

commissioning group improvement and assessment framework to allow CCGs to assess local delivery of 7DS.

The Trust carried out two 7 day audit of emergency admissions between 15 and 21 May 2019 and the 8 and 14 September 2019, both consisting of 21 patients, although 3 did not meet the criteria in the September Audit as they remained in hospital for less than 14 hours and therefore there were 18 patients who met the required criteria in the second audit.

Following validation of the data provided, the Board received assurance that the Trust met all four priority Clinical Standards.

Freedom to Speak Up/Whistleblowing

The Trust has a Freedom to Speak Up Guardian (FTSUG) working alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. In this year we introduced our FTSU Champion roles to support out FTSU Guardian in promoting this agenda.

The FTSU Guardian offers:

- Signposting staff to options for raising their concerns in line with the Trust Raising Concerns Policy
- Recording and monitoring concerns raised so as to identify themes
- Promoting the importance of staff raising concerns
- Independently reporting to the Board on themes of concerns being raised and the "temperature" of the organisation
- Networking with other FTSUGs to share good practice
- Reporting quarterly to the FTSU National Office

Our Quality Strategy ambition to provide a safe system of care and reduce avoidable harm means that we encourage a culture of transparency where patient safety incidents are reported and reviewed to identify learning and improvements needed to promote the safest care.

July 2020 saw the publication of the second-ever annual Freedom to Speak Up (FTSU) report. In which NHS England commissioned the National Guardian's Office to develop the index based on four questions from the annual NHS Staff Survey, including whether staff feel secure in raising concerns if they see something unsafe.

In 2020's edition of the report we came 59th (out of 229) with a score of 80.7%, improving upon a position of 78th and score of 80% in 2019. Clearly there is still work to do in this area to further improve, but it is pleasing to see that through the excellent work of Tony Bottiglieri, FTSU Guardian, and our team of FTSU champions, we are making improvements in this area to ensure that Royal Papworth Hospital is an environment where people feel confident in speaking up.

Compassionate and Collective Leadership programme

One of the key aims of our five-year strategy is to improve our staff experience to ensure staff feel supported and motivated to provide excellent patient care. As part of this, we are undertaking a culture and leadership programme to help us embed a compassionate and collective leadership culture across the organisation.

During the first phase of the project, more than 200 staff members were interviewed as part of 36 focus groups. They were asked questions about a number of themes, including vision and values, teamwork, learning and innovation and compassion, to help us assess our organisation culture.

Following an in-depth diagnostic phase, we have identified eight priority areas to address, including refreshing our values, developing and supporting line managers, valuing diversity and encouraging teamwork. We have received funding from Royal Papworth Hospital Charity and are developing action plans to address these priority areas. Details actions are set out under our Quality Priority 3 for 2020/21.

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

Performance of Trust against selected metrics

Throughout 2019/20 we have continued to measure our quality performance against a number of metrics. The Table below sets out our performance against the national operational metrics identified in Appendix 3 to NHS Improvement's (NHSI's) Single Oversight Framework which are applicable to Royal Papworth Hospital.

Operational performance Metrics

Indicator	Target pa	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	90.47%	90.28%	89.89%	88.94%	89.10%	90.86%	91.20%	91.60%	91.17%	91.52%	90.78%	87.13%	90.25%
62 day cancer wait *	>85%	66.7%	62.5%	60.0%	50.0%	80.0%	80.0%	66.7%	44.4%	60.0%	87.5%	100%	71.4%	67.0%
31 day cancer wait	>96%	84.6%	84.6%	96.0%	100%	96.0%	100%	100%	94.4%	95.5%	100%	100%	100%	95.6%
6 week wait for diagnostic	>99%	99.30%	99.30%	99.23%	99.30%	99.05%	99.66%	99.67%	99.84%	99.44%	99.65%	99.70%	99.44%	99.47%
C. difficile (sanctioned)	Less than 5	0	0	0	0	0	0	0	0	1	0	0	0	1
Number of patients assessed for VTE on admission	>95%	97.00%	90.00%	93.00%	97.00%	93.33%	90.00%	97.00%	100.00%	93.00%	97.00%	97.00%	96.60%	95.5%.

In 2019/20 these indicators have not been subject to independent assurance.
*The definition of this indicator can be found in Annex 4 to the Quality Report

A listening organisation

What our patients say about us

2019 National Adult Inpatient Survey

The inpatient survey is carried out on behalf of the Care Quality Commission. Patients aged 16 or older who had at least one overnight stay were asked a range of questions including whether they had confidence and trust in the doctors, the cleanliness of the hospital, and the quality of the food.

731 of our inpatients responded to the survey and we achieved an overall response rate of 60% (63% 2018). This compares to an average response rate of 45% for 2019.

Trusts were then listed in one of five categories based on the proportion of patients who responded positively compared to the average; 'much better than expected', 'better than expected', 'about the same', 'worse than expected' or 'much worse than expected'.

The Trust's results were better than most Trust's for 44 questions and about the as other Trust's for 17 questions.

There were 17 questions where the Trust results were significantly higher than 2018 and one question where the result was significantly worse:

Q9 From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward? 2019 8.9 (2018 9.5)

Section Score and Banding

The table below sets out the section scores and banding for the Trust.

	Section Scores	
Section	2019 Score	Band
1. The accident and emergency department		
2. Waiting list or planned admission	9.1	
3. Waiting to get to a bed on a ward	8.9	Better
4. The hospital and ward	9.0	Better
5. Doctors	9.3	Better
6. Nurses	9.0	Better
7. Your care and treatment	8.9	Better
8. Operations and procedures	8.7	Better
9. Leaving hospital	7.9	Better
10. Feedback on care and research participation	3.0	Better
11. Respect and dignity	9.7	Better
12. Overall experience	9.1	Better

The 'better' and 'worse' categories, displayed in the column with the header '2019 Band' in the table are based on an analysis technique called the 'expected range'. It determines the range within which the trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'.

Where a trust's survey results have been identified as 'better' or 'worse' than the majority of trusts, it is very unlikely that these results have occurred by chance. If a trust's results are 'about the same', this column will be empty.

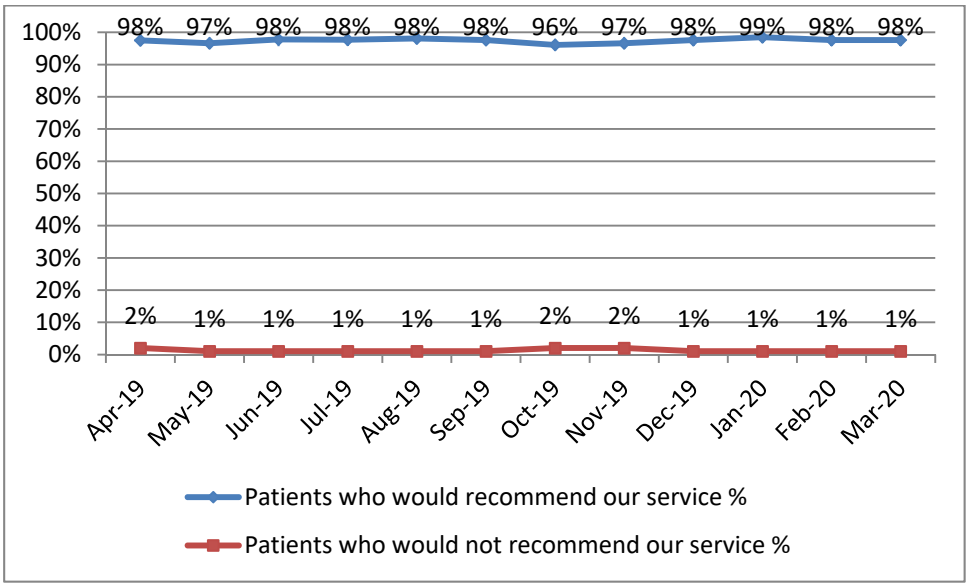
Each of these questions will be explored and an action plan formulated where necessary.

NHS "friends and family" test to improve patient experience and care in hospital

From 1 April 2012, a new question was added to the patient experience survey that is conducted amongst a sample of patients admitted to Royal Papworth Hospital. The question is "how likely are you to recommend our service to friends and family if they needed similar care or treatment?" using an "extremely likely" to "not at all likely" scale. The question is used in other organisations and industries and is believed by the Department of Health and Social Care to give a real-time reflection of standards within a hospital. It allows hospitals to compare themselves and learn from the best performing trusts. Hospitals are required to ask the question to a minimum of 10% of their inpatients and the responses are fed back to the Board. Scores are publicly available, alongside other measures of clinical quality.

In this Trust, the responses are reviewed at the weekly Matrons' Meeting, led by the Chief Nurse, and actions monitored. These are reported to every meeting of the Board.

Friends and Family inpatient results 2019/20



"No reply" or "don't know" excluded from numerator

Patient Support Groups

Royal Papworth has several patient support groups, which include:

The Mesothelioma Social Group – PMSG (www.papworthmesosocial.com) meets monthly. Mesothelioma is a rare type of lung cancer caused by exposure to asbestos. Each year, around 2,500 people in the UK are diagnosed with the condition. Unfortunately at present, there is no cure. The group is for patients and their carers to get together with others experiencing similar concerns and issues. There is opportunity to share ideas and talk freely with supportive people. Some meetings will involve a presentation from an expert about an issue of interest such as breathlessness, exercise, clinical trials and treatments, recent developments with Mesothelioma UK. At other times, the group will go out for a social event such as cream tea at Anglesey Abbey or a cruise along the River Cam. There is also ample opportunity at the meeting for participants to chat over refreshments. Later in the afternoon there is a chance for carers only to meet to discuss their experiences and share their worries with support from a clinical nurse specialist.

Royal Papworth Hospital is one of the few hospitals fortunate to have secured further funding from Mesothelioma UK to support the input of a clinical nurse specialist. Kate Slaven undertakes this role and is currently chair of the social group. The group has a Facebook page and Twitter accounts as well as a website. Social media is helping members to access support remotely when they may not be able to attend the meetings in person.

Royal Papworth Pulmonary Hypertension Patient Support Group

The Royal Papworth Pulmonary Hypertension Patient Support Group is a friendly, welcoming group run by patients for patients with Pulmonary Hypertension.

The group is well supported by the Pulmonary Hypertension staff at Royal Papworth Hospital. They welcome members of all ages and not just from Royal Papworth Hospital but other pulmonary centres as well.

The group meets three times a year and has guest speakers for the meetings who talk about various aspects of Pulmonary Hypertension, including research into new therapies. Presentations are given by the PH specialist nurses, PEA nurses, pharmacists, physiotherapists and others.

In November, the group hold a very popular Christmas party, where members bring their wider families, if they wish, including children and grandchildren.

The group meetings are well attended with 35-40 members at most meetings and twice as many at the Christmas party in November. Young adults transitioning their care from Great Ormond Street Hospital are encouraged to attend the support group as a way of finding out about the Pulmonary Vascular Diseases Unit prior to attending the hospital for the first time.

The group is advertised in several ways; members produce a four page quarterly newsletter and information on the support group can be found on the Pulmonary Hypertension Association UK forum website and social media Facebook page. A small number of patients from other specialist centres such as Sheffield and London also attend the support group.

The group is friendly and sociable and offers support to individuals and their families; members have reported that meeting other patients with the same condition has helped them enormously, for example patients considering PTE surgery have had the opportunity to meet members and their families who have already gone through this procedure. One of the members still comes to the meetings following their transplant surgery and has shared their experience of this aspect as well.

The Royal Papworth Pulmonary Fibrosis Support Group

The PFS group was established in 2010 to provide information for individuals with Pulmonary Fibrosis, to give them support and to establish regular opportunities for the patients and their carers to meet.

Meetings are held every other month at The Hub in Cambourne and are regularly attended by an average of 60-70 participants. The meetings are planned and managed by a small committee who organise speakers and refreshments and give participants plenty of time to socialise.

An annual picnic is now part of the programme and has been successful in bringing together the families of the members as a way to thank them for their support. Recently communication with Idiopathic Pulmonary Fibrosis (IPF) sufferers has been widened with the development of a website accessed through the Trust's public homepage and a regular newsletter.

The Transplant Patient Support Group

The Transplant Patient Support Group is a patient-led body open to all pre- and post- heart and/or lung transplant patients.

As well as providing a focal point for links into the Transplant team on any current issues, it holds four Social and Support group meetings for patients each year, funded by donations. These well-attended meetings have regular guest speakers and allow patients and their families to meet in a friendly, non-clinic environment and share any experiences or concerns that they may have. The group produces its own Newsletter and has a very active Facebook page. They hold an annual patient get together to showcase some of the innovations and changes in Transplantation and to allow patients an opportunity to chat with staff in a more informal setting and to network with others.

The group held a very successful Christmas party in 2019 with 70 in attendance. Mr Catarino, Director of Transplantation gave an excellent, insightful and powerful talk about his department and their achievements.

Our patient support groups have been affected by COVID19 and so more recently have stepped down from face to face meetings but have managed to keep in touch and provide support through virtual events that have been held on line. Further details about the groups and links to information about meetings can be found at:
https://royalpapworth.nhs.uk/patients-and-visitors/pals/patient-support-groups

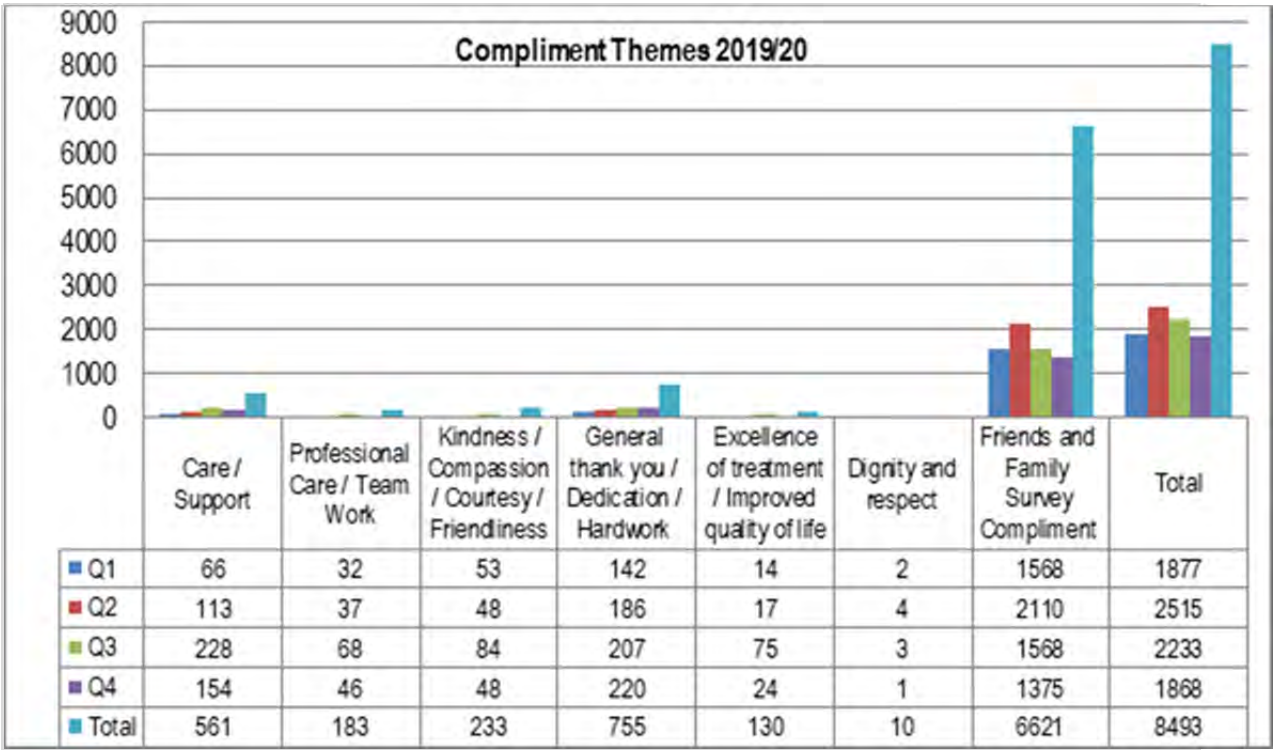
Compliments from patients and families

The Patient Advice and Liaison service (PALS) records compliments received by patients and their family's relating to their experience

There were 7787 compliments received across the Trust during 2019/20. This was an increase of 978 on the previous year (2018/19) when there were 6809. Compliments take a variety of forms – verbal, letters, thank you cards, e-mails, Friends and Family surveys and suggestion cards.

The compliments were analysed for key themes and the top three themes for the year were:
- General thank you/dedication/hard work
- Care/support
- Kindness/compassion/courtesy/friendliness

Compliment Themes	2018/19				2019/20			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Care/Support	49	89	82	71	66	113	228	33
High Quality of Professional Care/Team Work	16	12	30	26	32	37	68	23
Kindness/Compassion/Courtesy / Friendliness	57	36	49	36	53	48	84	12
General Thank You / Dedication/Hard Work	183	120	152	321	142	186	207	102
Improved quality of life/Recovery/Making a Difference / Excellence of Treatment	9	10	712	14	14	17	75	11
Dignity and Respect	0	5	1	2	2	4	3	1
Friends and Family Survey Compliments	0	1796	2178	1452	1575	2110	1568	1164
Total	**314**	**2,068**	**2,492**	**1,922**	**1884**	**2515**	**2233**	**1346**



	Care / Support	Professional Care / Team Work	Kindness / Compassion / Courtesy / Friendliness	General thank you / Dedication / Hardwork	Excellence of treatment / Improved quality of life	Dignity and respect	Friends and Family Survey Compliment	Total
Q1	66	32	53	142	14	2	1568	1877
Q2	113	37	48	186	17	4	2110	2515
Q3	228	68	84	207	75	3	1568	2233
Q4	154	46	48	220	24	1	1375	1868
Total	561	183	233	755	130	10	6621	8493

What our staff say about us

Staff Survey 2019

NHSI's requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2019 and these were included in the Staff Report section of the Annual Report.

Royal Papworth Staff Awards and Long Service Awards

In November 2019, we held a Long Service Awards ceremony at the hospital to recognise staff who had served 15, 20, 25 or 30 years of service at Royal Papworth Hospital.

We had to cancel its planned ceremony in March 2020 but we were able to hold a virtual and socially distanced annual staff awards ceremony at the hospital on Wednesday 17 June to recognise all our fantastic nominees. We received more than 500 nominations for awards - a significant increase on the previous year – in a range of categories from The Lifetime Achievement Award to The Student/Apprentice of the Year Award. We would like to thank the award sponsors: Royal Papworth Hospital Charity, Philips UK, Troup Bywaters + Anders, Canon, Meridian, Jones AV, Gamma, Mindray, and Media Studio as their support allowed us to reward some of the remarkable achievements of our staff.

Valuing Volunteers

We continue to be indebted to our volunteers. They give their time, energy and experience to aid patients and staff and contribute greatly to the 'patient experience'. Volunteers enrich the lives of patients and their families, contributing significantly to the overall success of patient care. All the staff and patients at Royal Papworth are extremely grateful for the hard work and commitment which our volunteers provide. We have a Volunteers Strategy and this aims to:

- Create and support a volunteer service at Royal Papworth Hospital that brings added value to our patients.
- Promotes and gives opportunities for people to volunteer.

- Develops partnership and networking with national, charitable and third sector organisations including volunteer support groups

Our strategy will deliver the following benefits:

For patients and their families/carers

- Enhanced experience of services.
- Peer support and social interaction.
- Increased self-esteem and confidence.

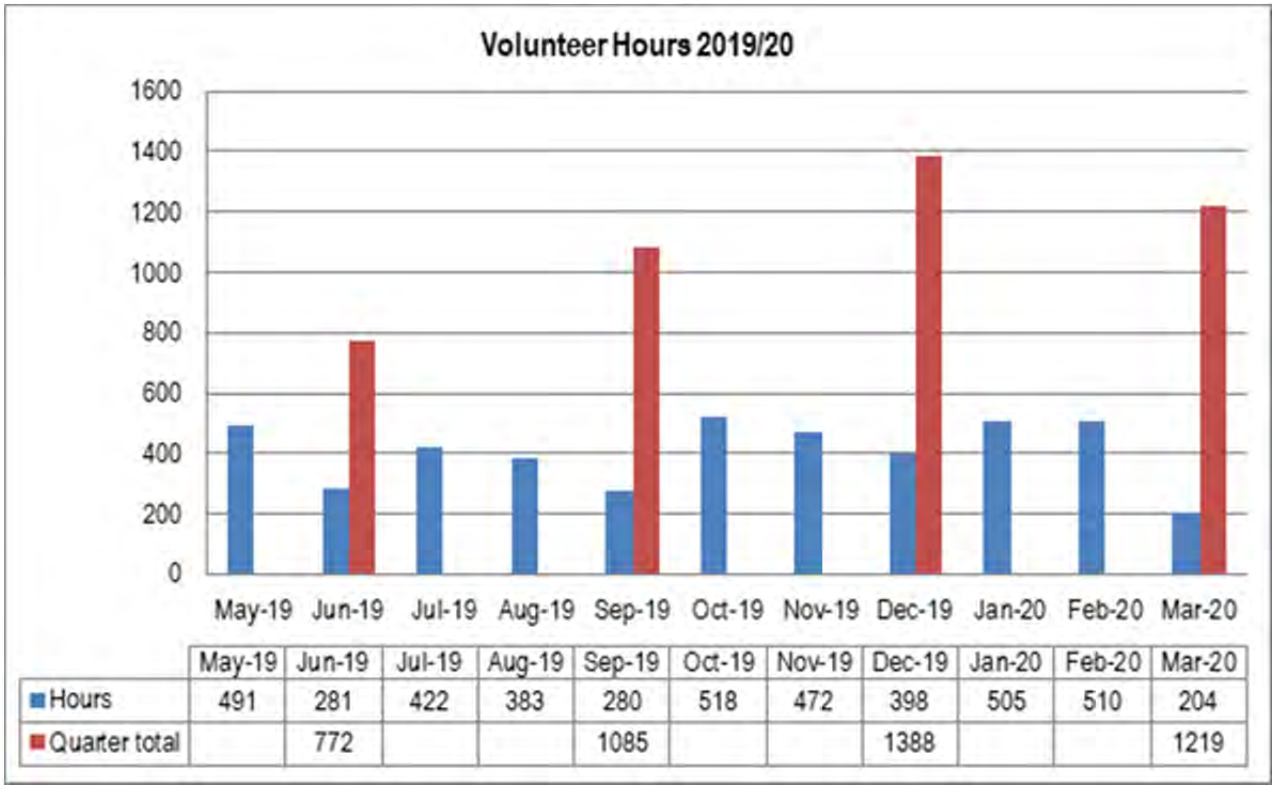
For staff

- Additional help and support.
- Improved patient experience.
- More diverse and inclusive working environment.
- Learning from people with different expertise, giving opportunities to enhance skills/experience.
- Frees up capacity to concentrate on specialist care and clinical roles, which can improve productivity and reduce stress.
- Opportunities to develop people management skills.

And for the Trust

- Provision of better services.
- Improved patient experience.
- Greater involvement of local community whilst promoting the Trust's values and achievements within the community
- Provides support to achieve strategic and organisational objectives.
- Better two-way communication with patients.

Volunteers hours for 2019/20
The hours delivered by our volunteers is set out below:



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hours	491	281	422	383	280	518	472	398	505	510	204
Quarter total		772			1085			1388			1219

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

Summary of CQUIN performance 2019/20

	Scheme	Total Available 19/20		Achievement					
				Q1	Q2	Q3	Q4	2019/20	
		£'k	%	£'k	£'k	£'k	£'k	£'k	%
NHSE	GE3 Hospital Medicines Optimisation Trigger 5	73.7	10%	18.4	18.4	18.4	18.4	73.7	100%
	Rethinking conversations/Shared decision making	250.5	34%	0.0	50.1	100.2	100.2	250.5	100%
	NSTEMI pathway	206.3	28%	51.6	51.6	51.6	51.6	206.3	100%
	Cardiac Clinical Network	206.3	28%	10.3	134.1	30.9	30.9	206.3	100%
	NHSE	**736.7**	**100%**	**80.3**	**254.2**	**201.1**	**201.1**	**736.7**	**100%**
C&P CCG (& Associates)	CCG 2 Staff Flu Vaccinations	79.1	20%	0.0	0.0	0.0	79.1	79.1	100%
	CCG 3a Alcohol & Tobacco - Screening	79.1	20%	19.8	19.8	19.8	19.8	79.1	100%
	CCG 3b Tobacco Brief Advice	79.1	20%	19.8	14.8	19.8	19.8	74.2	94%
	CCG 3c Alcohol Brief Advice	79.1	20%	19.8	19.8	19.8	19.8	79.1	100%
	CCG 7 Three High Impact Actions to Prevent	79.1	20%	19.8	19.8	19.8	19.8	79.1	100%
	C&P CCG (& Associates)	**395.7**	**100%**	**79.1**	**74.2**	**79.1**	**158.3**	**390.8**	**98.7%**
	Trust Total	**1132.4**		**159.4**	**328.4**	**280.3**	**359.4**	**1127.5**	**99.6%**

The CQUIN (Commissioning for Quality and Innovation) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed.

The two main commissioning contracts at Royal Papworth have different CQUIN targets in place. Nationally determined CQUINs cover both contracts, with the remainder down to local negotiation between the Trust and commissioner. The individual CQUIN targets are weighted resulting in the final financial value paid for achievement of each area. Non-achievement of a particular CQUIN results in a reduction of income equivalent to the CQUIN weighting multiplied by the overall CQUIN value. The planning for CQUINs for 2020/21 remains on hold in line with guidance was issued from NHSE/I as a result of the COVID19 pandemic.

Royal Papworth Hospital
NHS Foundation Trust

Clinical Decision Cell:
medium term strategy

29 June 2020

Royal Papworth Hospital
NHS Foundation Trust

Executive Summary (1 of 2)

Context

RPH moved rapidly into surge capacity in early April in its response to COVID-19 and has consistently seen the highest level of critical care patients and ECMO patients in the region. The Trust experienced a significant reduction in non elective demand through the peak of the pandemic, and elective activity was almost entirely supressed following national directives.

A rebound in emergency demand has been experienced, particularly in Cardiology since mid-May. Patients are also presenting with higher levels of acuity e.g. >25% of PPCI activations have required CCA admission on arrival in June 2020.

The curve for patients receiving respiratory ECMO has lagged a few weeks behind the national curve of COVID-19 admissions and therefore RPH has continued to experience a sustained level of demand for this resource intensive service and continues to care for circa. 8 ECMO patients, with a average LOS of 45 days currently from a pre COVID19 average of 1-2 patients; ave LOS 20 days.

As a result the demand on the Intensive Care Unit continues to exceed normal levels and it will only be possible to re-establish previous elective throughput with a increased bed base.

The initial 3 week short term Clinical Decision Cell Clinical Strategy has run from 8th June 2020 – 29th June 2020 operationalised by the Living with COVID-19 Steering Group.

To develop this further the support this, the Clinical Decision Cell has developed a further 2 month Clinical Strategy for July and August. This has been supported by the dynamic modelling tool to map out the hospital's capacity and utilisation pre-COVID-19 and understand the impact of various clinical strategies on the Trust's resource base.

Clinical Decision Cell (CDC) output

The CDC has considered:

- The clinical strategy for the next 2 months given the resources currently in place and the constraints to reaching this state.
- The desired end state of the hospital and the constraints to reaching this state.
- The best possible clinical prioritisation and outcomes for the Trust's patients with the physical resources we have.

The next 2 months

This document focuses on the next 2 months and sets out the high level % of business as usual activity volumes that the Trust will work towards. This broadly sees the continued prioritisation of non-elective demand, with a phased return of elective activity volumes, however this is limited by ICU capacity and infection control impacts on productivity. A summary by service line set out in the next section.

The CDC's view is that this scenario is the best possible clinical prioritisation given the resource constraints in place.

This decision will not eliminate all clinical risk and the key implications of this decision over the next 12 months will be:

- The reduced ability to shorten waiting lists for elective activity with the potential commensurate increased clinical risk to patients where services are ICU dependent
- The continued but significantly reduced need for staff to cross-cover and work flexibly across areas recognising the need to advocate staff wellbeing
- The need for effective and responsive booking and other administrative processes to support increasing activity levels
- National and regional commissioning strategies are not known and may impact on some of our services e.g. lung transplantation

This will need to be supported by a clear communications plan to ensure the organisation is aligned to our medium term goals.

Executive Summary (2 of 2)

Constraints to long term position

The CDC believes that over the long term the Trust will be able to return to 100% of business as usual activity, as well as accommodating new COVID-19 service lines (including additional ECMO activity), and grow by absorbing demand from neighbouring providers (e.g. CUH bronchoscopy).

This is dependent on the following constraints being resolved:

- Staffing resource – at headline volumes and in specific specialty areas (e.g., ICU nurses, radiographers, physiologists etc.);
- Infection Control requirements that are impacting on productivity across the Trust and limiting what capacity is available;
- Changes in productivity due to increased turnaround times in cath labs, theatres and radiology;
- Admin and booking capacity to ensure activity throughput at the levels desired;
- Unknown future demand to meet COVID-19 surges

If these constraints cannot be mitigated, the Trust is likely to be unable to return to the desired levels of activity over the longer term.

Recommendations for the Living with COVID-19 Steering Group

Recommendations are set out by the CDC for the Living with COVID Steering Group for the next phase of the Clinical Strategy (29th June to 31st August 2020). These build on those recommendations within the short term strategy which ran from 8th June – 29th June 2020.

Operational and workforce action plans to be put in place to achieve the 2 month desired state:

- Change within admin and booking functions to ensure patient access to agreed service levels as defined by CDC strategy with a weekly monitoring report of performance
- Prioritise clinical work by ensuring clinical staff are deployed to support clinical work as promptly and safely as possible, supporting the risk assessment process and reducing headroom to at least 27%
- Continue to review productivity and Infection Control assumptions to maximise use of key limited resources of theatres, cath labs, ward beds, diagnostics, bronchoscopy and outpatients in addition to shared resources of recovery, discharge lounge capacity
- Deliver at least 80% of pre COVID-19 BAU diagnostic activity to ensure clinical services are not constrained by diagnostic and support services. Support pathways through new capacity and new ways of working
- Expansion of Cardiology bed base to meet non elective demand in full and the higher acuity of patients impacting on LOS and ICU from coronary intervention in particular
- Intensive care capacity to remain at a minimum of 33 beds average to support ongoing COVID-19 patient need including 8 respiratory ECMO beds which will requires urgent targeted nurse recruitment and education strategy
- Plan to expand intensive care capacity to 36 beds (and then 40) to reflect longer LOS for COVID-19 ECMO patients, increased demand from Cardiology patients and need to address surgical waiting list beyond the 2 month strategy
- Deliver RSSC day case and inpatient activity to achieve 100% of templated activity
- All urgent non elective respiratory pathways to achieve 100% of BAU levels and urgent elective patients to meet 70% of BAU demand.
- Deliver cardiothoracic surgery activity to 75% of elective workload in addition to non elective demand
- Progress the transfer of Bronchoscopy activity from CUH to utilise available capacity and explore further clinical pathway changes with CUH to maximise use of our estate
- Establish Heart MDT and adjust capacity to reflect any impact;
- Follow up clinic for COVID-19 patients to be commissioned and fully operationalised
- Service development focus on Regional Adult Critical Care Transfer Service, Regional Weaning Service and the impact of Cardiology GIRFT alongside other partnership opportunities to maximise the use of RPH facilities .
- Support each division to reopen research activities paused during the COVID-19 pandemic and ensure that these patients are not disadvantaged in their access

Royal Papworth Hospital
NHS Foundation Trust

Current position

The table below sets out the current bed usage across the hospital compared to the three week vision set out by CDC to the end of June. This shows the midday count and the midnight count to ensure the most accurate representation of bed usage.

Whilst a useful indicator a ready reckoner for what we have been able to achieve, this will not represent the full picture of % of business as usual services that the Trust has returned to.

There is likely to be variation as how service usage compares to the CDC strategy and this will be reviewed for future reports once the June coding position is finalised in the first couple of weeks of July.

The information is taken directly from Lorenzo and therefore is dependent on accurate bed move information being recorded in each area. Teams are asked to ensure that this data is being captured accurately on Lorenzo to make this snapshot as accurate as possible.

Shading key:
Orange = below scenario
Green = at or above scenario

						Bed state as at:			
Ward Area	**Snapshot time**	**Avg bed occupancy pre-COVID**	**Pre-COVID avg bed occupancy (before occupancy adj)**	**Pre-COVID avg bed occupancy (after occupancy adj)**	**Bed requirement (adjusting for average occupancy pre-COVID)**	**07/06/2020**	**11/06/2020**	**15/06/2020**	**22/06/2020**
5N	23:59	90%	37	41	25	39	42	29	41
	12:00					41	47	36	45
5S	23:59	76%	31	41	33	5	3	8	16
	12:00					4	5	7	15
4N	23:59	35%	8	22	11	0	0	0	0
	12:00					0	0	0	0
4S	23:59	54%	21	40	19	12	18	18	16
	12:00					11	19	21	15
3N	23:59	44%	14	31	32	5	7	6	8
	12:00					5	7	7	8
3S	23:59	78%	32	41	37	30	38	27	26
	12:00					29	35	27	29
Day Ward	23:59	73%	8	11	10	0	0	0	0
	12:00		8			0	10	8	17
Critical Care	23:59	85%	25	30	31	20	20	24	26
	12:00					19	21	24	26
Grand Total	23:59		**176**	**257**	**198**	**111**	**128**	**112**	**133**
	12:00					**109**	**144**	**130**	**155**
Total (wards only excl. CCU and Day Ward)	23:59		**143**	**217**	**157**	**91**	**108**	**88**	**107**
	12:00					**90**	**113**	**98**	**112**

Royal Papworth Hospital NHS Foundation Trust

The next 2 months (1 of 5)

Productivity and Resource Constraints Assumptions

The CDC has considered the clinical strategy for the next 2 months given the resources currently in place and the constraints to reaching this state. This includes:

- critical care beds capped at 33 beds after adjusting for average occupancy of 90%. This equates to c29 beds in the model. This also includes 8 COVID-19 ECMO beds with an average length of stay of c30 days.
- non-elective activity returns to 100%, with cardiology coronary intervention non-elective activity moving to 110%.

The next slides set out a map of capacity using these assumptions, assuming no changes in productivity and headroom. However to deliver the activity as set out, it is expected that the Trust will need to:

- **improve productivity in theatres and cath labs beyond the previous assumption of cases taking twice as long (including turnaround time) to taking a maximum of 30% longer than pre-COVID-19.**
- **manage workforce headroom to within 27% (as opposed to the 22% pre COVID-19)**

The key limiting factors for activity beyond these levels are:

- **critical care capacity** – restricting to 33 beds including increased ECMO restricts the amount of surgical and transplant activity that can be delivered. This is before any change is factored in for higher acuity cardiology work, which would have the impact of restricting capacity further.
- **productivity assumptions** – any improvement beyond the levels listed will allow for more activity.
- **headroom/staffing** – any ability to re-purpose existing staff not working / shielding or reduce absence, will allow for more activity.

KEY:

NEL – non elective activity EL - elective activity DC - day case activity

Minimum percentage of pre-COVID-19 ("business as usual") services

Service	NEL	EL	DC
Cardiac Rhythm Management	100%	65%	65%
Cardiac Surgery	100%	70%	70%
Cardiology other	100%	65%	65%
Coronary Intervention	110%	65%	65%
Cystic Fibrosis	100%	60%	40%
ECMO	100%		
ILD	100%	50%	40%
Lung Defence	100%	50%	40%
Non Coronary Intervention	100%	65%	65%
Oncology		100%	100%
PTE		75%	75%
PV Diseases	100%	50%	50%
RSSC	100%	100%	100%
Thoracic Medicine other	100%	50%	50%
Thoracic surgery (exc PTE)	100%	70%	70%
Transplant	100%	45%	45%
VAD	100%	45%	

Number of COVID beds

Critical care beds	Ward beds
8	4

Key assumptions for resource constraints

Changes to Business As Usual

Time taken compared to previous BAU (model assumption)	
Emergency Theatres	200%
Elective Theatres	200%
Emergency Cath labs	200%
Elective Cath labs	200%
MRI	143%
CT	138%
Bronchoscopy	200%

Time taken compared to previous BAU (model assumption)	
Emergency Theatres	130%
Elective Theatres	130%
Emergency Cath labs	130%
Elective Cath labs	130%
MRI	143%
CT	138%
Bronchoscopy	100%

Staffing Assumptions

Change in headroom (base 22%)	8%	Change in headroom required to deliver activity (base 22%)	5%

Royal Papworth Hospital NHS Foundation Trust

The next 2 months (2 of 5)

Summary of utilisation vs pre-COVID-19 average utilisation

The below maps out the average utilisation at any given point in time vs. the total theoretical physical capacity, to help the identification of constraining factors in ramping up activity. The table shows the average number of beds occupied at any given point in time before COVID-19 and compares this to desired levels over the next 9 weeks. The 9 week map shows the requirement before and after the application of an estimated occupancy %. All figures are rounded to the nearest bed/%/hour. Spare capacity is based on physical infrastructure and **not** staffed infrastructure, to enable constraints to be identified. This does not factor in any restrictions due to Infection Control e.g. green / purple zone demarcations. This would need to be separately modelled.

Resource		Pre-COVID-19 utilisation pre-COVID			Next 2 months map before changes to productivity & headroom				2 months map with…	
		Average beds / hours / WTE used at any point in time on any given day *(not adjusted for occupancy %'s / utilisation)*	Spare capacity / (gap)		Requirement	Spare capacity / (gap)		Beds: adjusted for assumed occupancy target factor of 85% for wards; 90% on ACC	If productivity improves in theatres & labs	If headroom 27%
Ward beds	5N	37	4	9%	31	10	25%	36		
	5S	31	10	25%	28 (incl. x4 C-19)	13	31%	33		
	4N	8	33	81%	5	36	89%	6		
	4S	21	20	48%	14	27	67%	16		
	3N (see note below)	14	27	66%	14	27	67%	16		
	3S	32	9	22%	30	11	26%	36		
Critical Care beds		25	21	45%	29 (incl x8 C-19)	17	36%	33		
Day Ward beds		16	24	60%	10	30	74%	12		
Theatre hours		41	43	48%	65	19	22%		42	
Cath Lab hours		36	60	63%	55	41	43%		36	
MRI hours (per day)		11	25	69%	16	20	56%		16	
CT hours (per day)		13	23	63%	17	19	52%		17	
Bronchoscopy hours (per day)		6	30	82%	17	19	53%		17	
Staff (WTE) required to deliver activity		c1,968*			c2,264*	(295)			c2,090	c2,215

Note: 3N & day case bed utilisation to be viewed with caution. 3N total theoretical capacity includes x8 beds currently used for day case activity which need to be viewed with caution as they are unlikely to be able to be utilised in the same way as inpatient capacity.

**Calculation on bank and agency use has been adjusted to reflect the method used in NHSI/E returns so shows a slight reduction from last time in temporary staff use in BAU. **Assumption that additional c8% of clinical staff are not available for work at any point in time due to shielding, leave etc. This means additional staff are required to deliver activity.*

Royal Papworth Hospital
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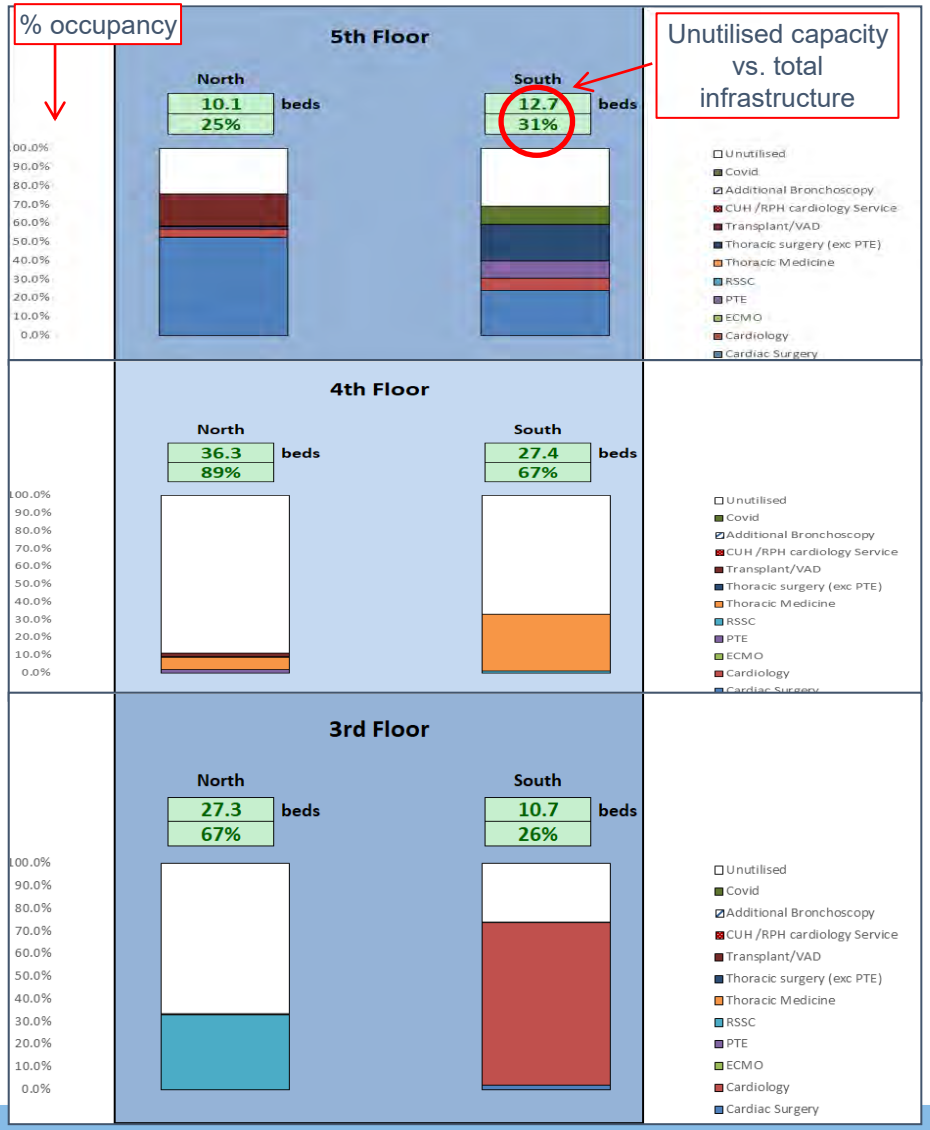
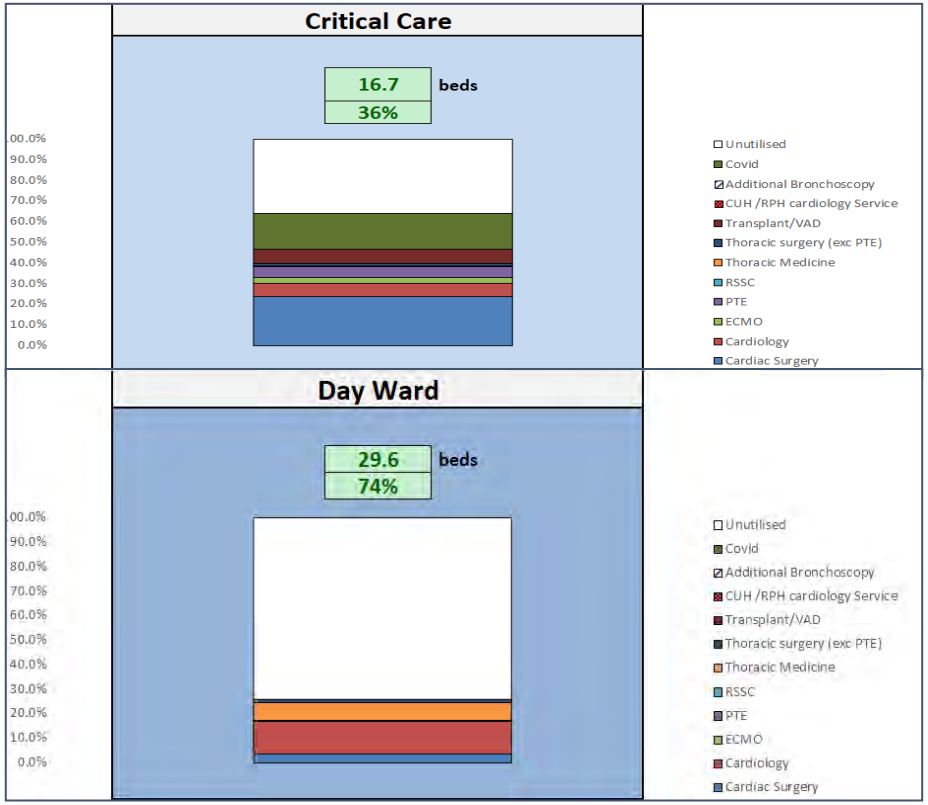
The next 2 months (3 of 5)

Wards & Critical Care



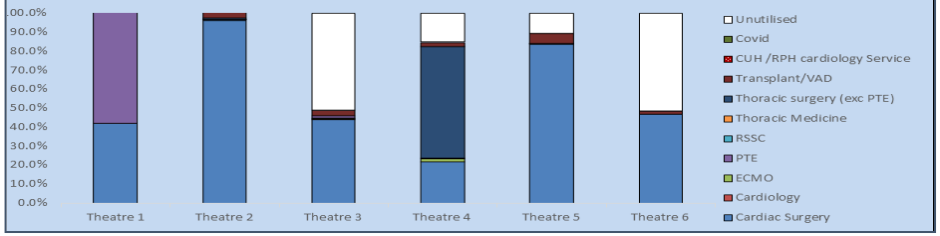


Royal Papworth Hospital
NHS Foundation Trust

The next 2 months (4 of 5)

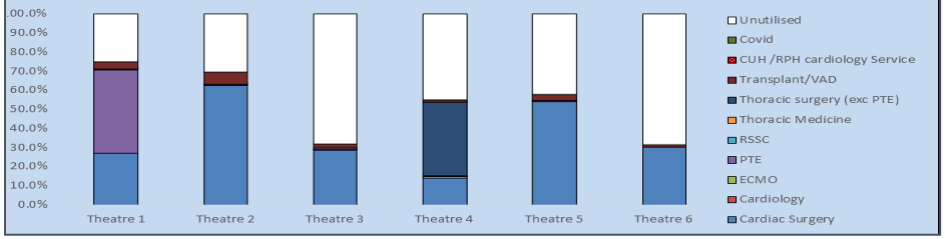
Theatres (at 200% productivity assumption)

Theatre 1	Theatre 2	Theatre 3	Theatre 4	Theatre 5	Theatre 6	
Elective	Elective	Emergency	Elective	Elective	Elective	
-1.8	-0.8	12.2	1.8	1.3	6.2	hours
-15%	-7%	51%	15%	11%	51%	



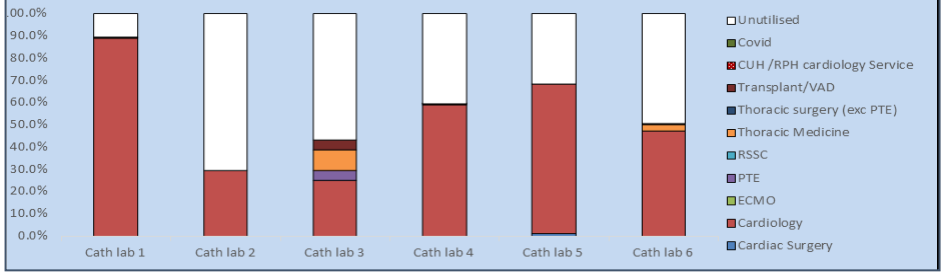
Theatres (at 130% productivity assumption)

Theatre 1	Theatre 2	Theatre 3	Theatre 4	Theatre 5	Theatre 6	
Elective	Elective	Emergency	Elective	Elective	Elective	
3.0	3.6	16.3	5.4	5.0	8.2	hours
25%	30%	68%	45%	42%	68%	



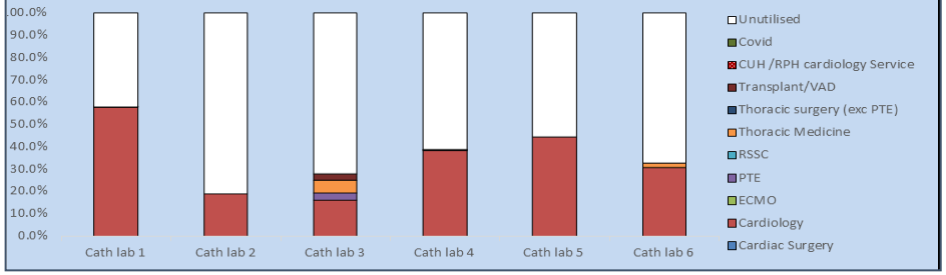
Cath Labs (at 200% productivity assumption)

Cath lab 1	Cath lab 2	Cath lab 3	Cath lab 4	Cath lab 5	Cath lab 6	
Emergency	Emergency	Elective	Elective	Elective	Elective	
2.6	16.9	6.8	4.9	3.8	6.0	hours
11%	71%	57%	40%	32%	50%	



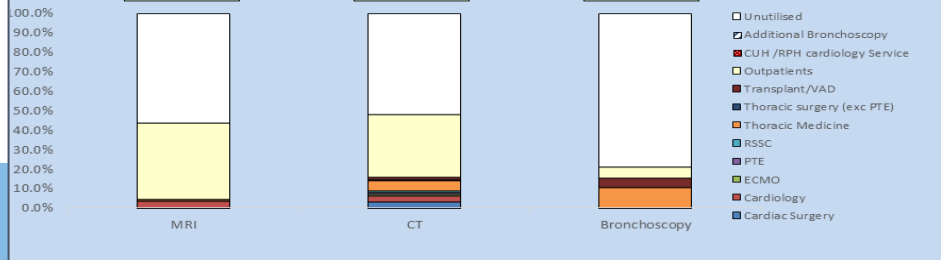
Cath Labs (at 130% productivity assumption)

Cath lab 1	Cath lab 2	Cath lab 3	Cath lab 4	Cath lab 5	Cath lab 6	
Emergency	Emergency	Elective	Elective	Elective	Elective	
10.1	19.4	8.6	7.4	6.7	8.1	hours
42%	81%	72%	61%	56%	67%	



Radiology / other elements (at productivity assumptions per p5)

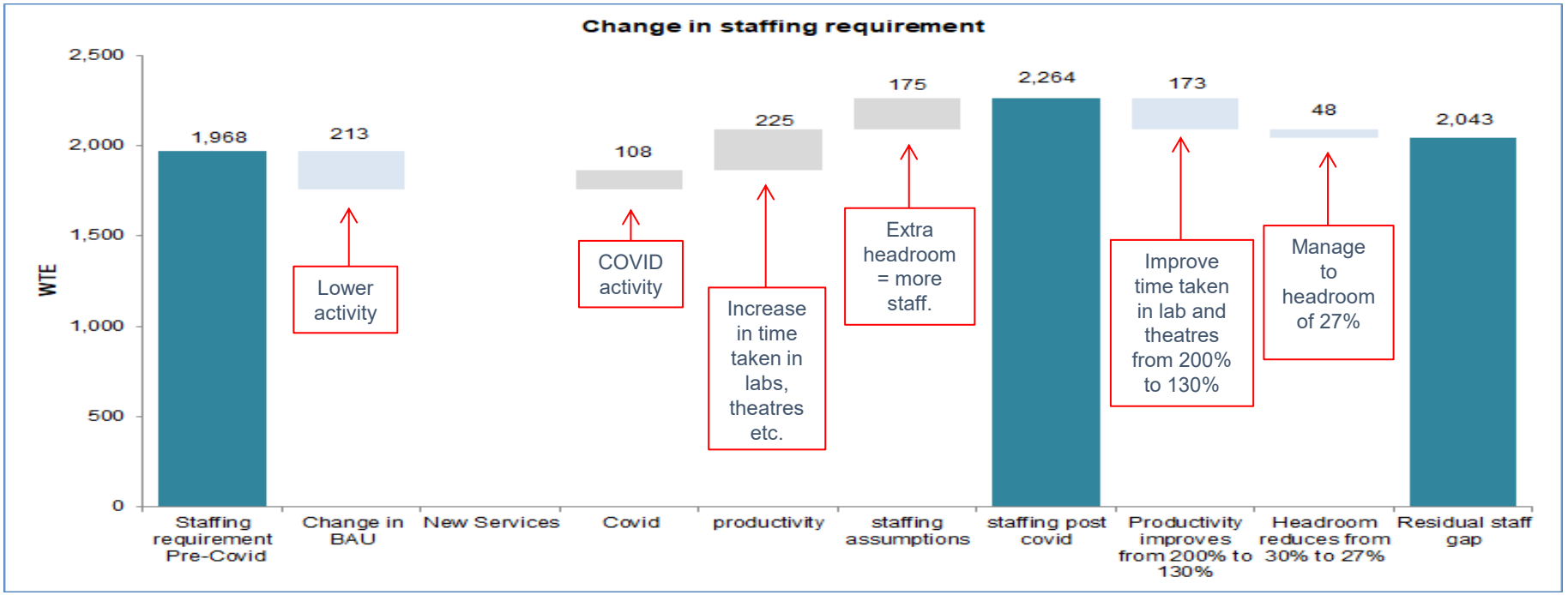
MRI	CT	Bronchoscopy	
20.3	18.7	19.0	
56%	52%	79%	



Royal Papworth Hospital NHS Foundation Trust

The next 2 months (5 of 5)

Staffing requirement vs pre-COVID "business as usual" levels



Since the pre COVID-19 baseline snapshot taken, the Trust has seen an overall increase of around 50 WTE. This represents total staff and includes worked WTE, as well as bank and agency WTE assumptions, to represent the total WTEs used to deliver BAU activity levels.

The waterfall suggests that the Trust can deliver the activity levels set out by the CDC strategy if the Trust can:

- **meet the wte gap in staffing recognising that the shortfall in initially concentrated in key areas such as CCA, diagnostics**
- **improve productivity in theatres and cath labs beyond the previous assumption of cases taking twice as long (including turnaround time) to taking 30% longer than pre-COVID-19**
- **manage workforce headroom to within 27% (as opposed to the 22% pre COVID-19)**

Note: Bank and agency WTE is now based on the same calculation basis as NHSI/E returns i.e. actual cost divided by average cost – this has been revised since the last model but does not impact the proportionate gap shown.

Appendix

Capacity

The table below sets out how the theoretical max infrastructure capacity has been defined for the purposes of this piece of work:

		Hours open	Beds
Wards	5N	24	41
	5S	24	41
	4N	24	41
	4S	24	41
	3N	24	41
	3S	24	41
	Critical Care	24	46
	Day Wards	12	40
Theatres	Theatre1	12	N/A
	Theatre2	12	
	Theatre3 - emergency	24	
	Theatre4	12	
	Theatre5	12	
	Theatre6	12	
Cath Labs	Cath Lab1 – emergency	24	
	Cath Lab2 – emergency	24	
	Cath Lab3	12	
	Cath Lab4	12	
	Cath Lab5	12	
	Cath Lab6	12	
MRI	MRI1	24	
	MRI2	12	
CT	CT1	24	
	CT2	12	
Bronchoscopy		24	

CDC recommendations

Recommendations for the Living with COVID-19 Steering Group

Recommendations are set out by the CDC for the Living with COVID Steering Group for the next phase of the Clinical Strategy (29th June to 31st August 2020). These build on those recommendations within the short term strategy which ran from 8th June – 29th June 2020.

Operational and workforce action plans to be put in place to achieve the 2 month desired state:

- Change within admin and booking functions to ensure patient access to agreed service levels as defined by CDC strategy with a weekly monitoring report of performance
- Prioritise clinical work by ensuring clinical staff are deployed to support clinical work as promptly and safely as possible, supporting the risk assessment process and reducing headroom to at least 27%
- Continue to review productivity and Infection Control assumptions to maximise use of key limited resources of theatres, cath labs, ward beds, diagnostics, bronchoscopy and outpatients in addition to shared resources of recovery, discharge lounge capacity
- Deliver at least 80% of pre COVID-19 BAU diagnostic activity to ensure clinical services are not constrained by diagnostic and support services. Support pathways through new capacity and new ways of working
- Expansion of Cardiology bed base to meet non elective demand in full and the higher acuity of patients impacting on LOS and ICU from coronary intervention in particular
- Intensive care capacity to remain at a minimum of 33 beds average to support ongoing COVID-19 patient need including 8 respiratory ECMO beds which will requires urgent targeted nurse recruitment and education strategy
- Plan to expand intensive care capacity to 36 beds (and then 40) to reflect longer LOS for COVID-19 ECMO patients, increased demand from Cardiology patients and need to address surgical waiting list beyond the 2 month strategy
- Deliver RSSC day case and inpatient activity to achieve 100% of templated activity
- All urgent non elective respiratory pathways to achieve 100% of BAU levels and urgent elective patients to meet 70% of BAU demand.
- Deliver cardiothoracic surgery activity to 75% of elective workload in addition to non elective demand
- Progress the transfer of Bronchoscopy activity from CUH to utilise available capacity and explore further clinical pathway changes with CUH to maximise use of our estate
- Establish Heart MDT and adjust capacity to reflect any impact;
- Follow up clinic for COVID-19 patients to be commissioned and fully operationalised
- Service development focus on Regional Adult Critical Care Transfer Service, Regional Weaning Service and the impact of Cardiology GIRFT alongside other partnership opportunities to maximise the use of RPH facilities .
- Support each division to reopen research activities paused during the COVID-19 pandemic and ensure that these patients are not disadvantaged in their access

Royal Papworth Hospital
NHS Foundation Trust

Clinical Decision Cell:
longer term strategy

7 September 2020

Context, aims and constraints

Introduction

The CDC's ambition is for Royal Papworth teams to optimally use all available resources to achieve sustained and sustainable delivery of clinical activity for the benefit of our patients, engaging with and recognising the priorities set by local, regional and national partners. This strategy specifically focuses on the deliverables up to the end of March 2021 however the CDC goal is an overall increase in activity beyond what has been achieved previously and therefore this strategy also sets a direction of travel for beyond March 2021. This roadmap to full occupancy of RPH is aligned to the principles of the Trust's Strategy 2020-2025.

The progress metrics demonstrate excellent achievement against the objectives of the medium term strategy. It is anticipated that these will largely be met and any exceptions are included in the longer term strategy to ensure continuity of focus. The successful delivery of the longer term strategy requires an alignment of executive, corporate, divisional and Trust wide focus to deliver. The CDC expects agile addressing of any operational interdependencies and enablers that are rate limiting steps to maximum service productivity.

The key constraints that need to be resolved or mitigated at a corporate level are:

- Staffing resource – at headline volumes and in specific specialty areas (e.g., ICU nurses, radiographers, physiologists etc.)
- Responsive and flexible admin and booking capacity to ensure activity throughput at the levels desired;
- Infection Control requirements that are impacting on productivity and useable capacity across the Trust including increased turnaround times in cath labs, theatres, diagnostics and radiology

As the longer term strategy will run through Autumn and Winter 2020-2021 it has become increasingly apparent that a second, perhaps more localised Covid-19 wave must be prepared for alongside the aim to restore service provision. Guidance and advice for this has been taken from the report published on 14 July *Preparing for a Challenging winter 2020-2021* by the Academy of Medical Sciences.

Lessons from the Covid-19 surge in early 2020 continue to be learnt at RPH and on a regional and national level. The useful and positive impact of the multidisciplinary clinical leadership approach of the CDC to managing the pandemic through the Trust command and control structure must be retained. This clinically centered approach ensures responsive and flexible decisions that will ensure the Trust continue to meet all its aims in the longer term. The critical importance of staff well being over the longer term must remain central to any service considerations. The impact of the first Covid-19 peak will continue to ripple throughout the workforce for the forseeable future for many.

The pandemic has shone a light on the health inequalities within our region and the CDC supports that future service planning gives this greater consideration. Working differently with our partners and closely with all its communities required. These contextual shifts give us an opportunity to view our clinical future with a renewed perspective.

The Trust Clinical Ethics Committee established during the pandemic must continue and develop to extend beyond the immediate process of restoring services. It will serve as a guide and guardian on how the Trust can align decisions across the organisation with the limitation to the resources that are available.

The uncertain and changing financial landscape will influence the Trust ability to deliver the entirety of this strategy.

The CDC advocates that priorities should be defined by clinical need and demand, and include the continued delivery of our educational and research ambitions.

Phase 3 letter

On 31 July Simon Stevens and Amanda Pritchard wrote to all NHS organisations setting out the next – third – phase of the NHS response from 1 August 2020.

The letter set out the NHS priorities from August and a shared focus on:

a) Accelerating the return to near-normal levels of non-Covid-19 services, making full use of the capacity available in the 'window of opportunity' between now and winter

b) Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid-19 waves locally and possibly nationally

c) Ensuring the NHS learns lessons from the first Covid-19 peak; locking in beneficial changes; and explicitly tackling fundamental challenges including: support for our staff, and action on inequalities and prevention

The letter required systems to return a draft summary plan by 1 September to cover the key actions set out in the letter, with final plans due by 21 September.

The financial landscape suggests funding to RPH will be in line with activity levels delivered last year. Moreover over performing systems will be remunerated above target activity levels however underperforming systems will have funds removed. This new approach carries significant risk for the organisation, making it clear that progress must be made in the context of delivering a regional system contribution wherever possible.

Forward Look

It is in the context of both recovery and preparation for a second Covid-19 wave that this longer term strategy has been prepared. All possible opportunities to deliver the business as usual activity and go beyond pre Covid-19 activity levels where practicably possible will be pursued. In addition it is recognised that in the event of a second Covid-19 wave the approach to delivering BAU need to maximise continuity alongside the Covid-19 service lines. Scenarios as to what this may entail are set out later in this document.

Technical Specifications used in the model for Phase 3 Planning

October 2020 onwards

NHSI/E percentage of pre-COVID-19 ("business as usual")

Service	NEL	EL	DC
Cardiac Rhythm Management	100%	90%	90%
Cardiac Surgery	100%	90%	90%
Cardiology other	100%	90%	90%
Coronary Intervention	100%	90%	90%
Cystic Fibrosis	100%	90%	90%
ECMO	100%		
ILD	100%	90%	90%
Lung Defence	100%	90%	90%
Non Coronary Intervention	100%	90%	90%
Oncology		90%	90%
PTE		90%	90%
PV Diseases	100%	90%	90%
RSSC	100%	90%	90%
Thoracic Medicine other	100%	90%	90%
Thoracic surgery (exc PTE)	100%	90%	90%
Transplant	100%	90%	90%
VAD	100%	90%	

Number of COVID beds

Covid-19 beds on CCU	5
Covid-19 beds on Wards	0

Key assumptions for resource constraints

Time taken compared to previous BAU	
Emergency Theatres	113%
Elective Theatres	109%
Emergency Cath labs	106%
Elective Cath labs	111%
MRI	110%
CT	110%
Bronchoscopy	111%

Staffing Assumptions

% of staff shielding	0%
Change in headroom	5%

Current position

The table below sets out the current bed usage across the hospital compared to the 2 month vision set out by CDC at the end of June. This shows the midday count and the midnight count to ensure the most accurate representation of bed usage.

Whilst a useful indicator a ready reckoner for what we have been able to achieve, this will not represent the full picture of % of business as usual services that the Trust has returned to.

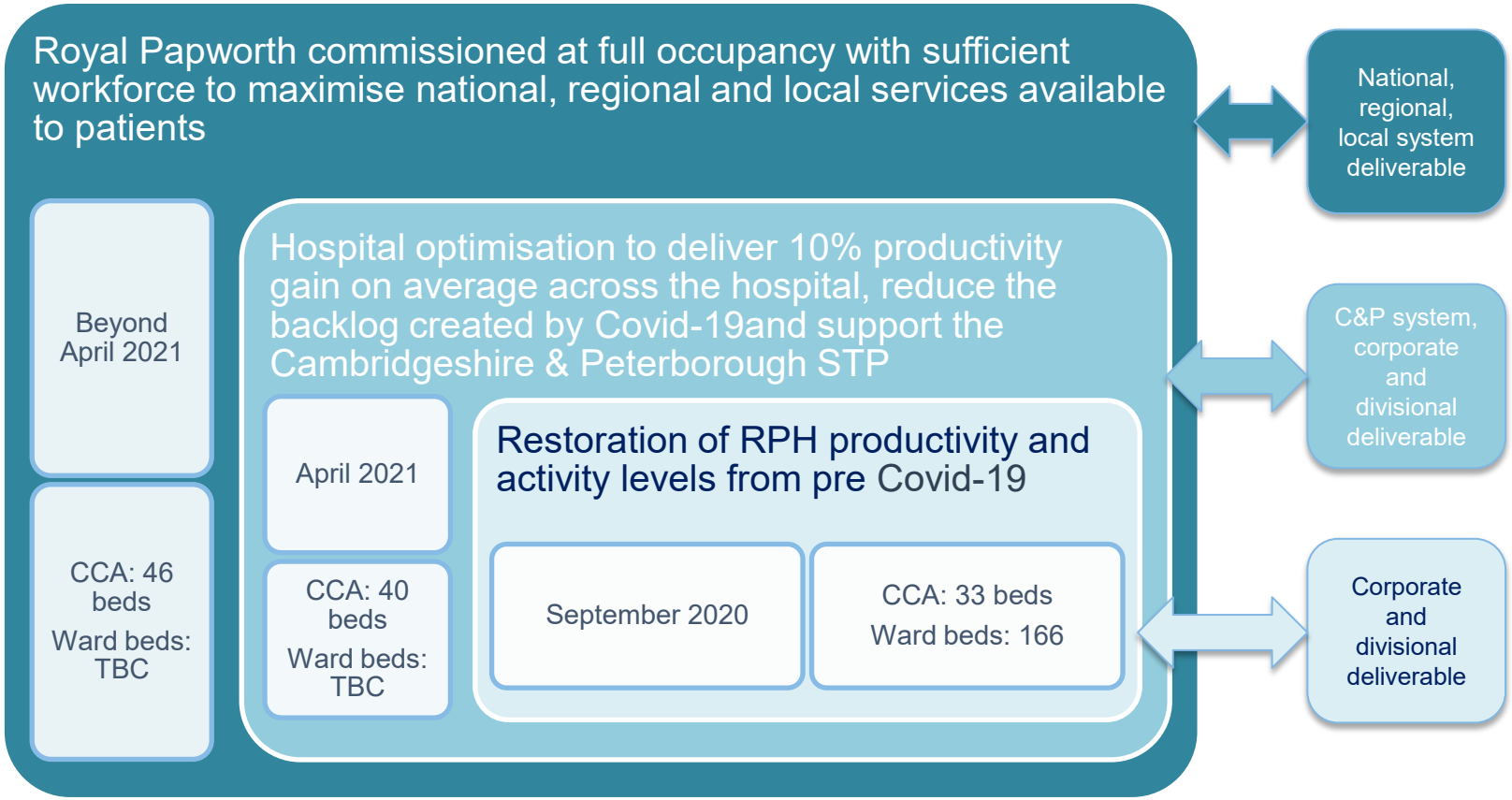
The information is taken directly from Lorenzo and therefore is dependent on accurate bed move information being recorded in each area. Teams are asked to ensure that this data is being captured accurately on Lorenzo to make this snapshot as accurate as possible.

Beds occupied by Covid-19 patients are repurposed to BAU activities as demand decreases and this trajectory will support the restoration of services.

						Bedstate on;								
Specialty	Assumed occupancy target	Pre-COVID avg bed occupancy (before occupancy adj)	Pre-COVID avg bed occupancy (after occupancy adj)	Bed requirement (adjusted for assumed occupancy target factor)	Snapshot time	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug
Cardiology	85%	47	55	49	Avg	46	46	60	61	61	47	43	44	53
					Min	30	34	48	47	49	39	30	31	38
					Max	57	54	65	71	71	55	55	50	61
RSSC	85%	14	16	16	Avg	10	10	12	14	15	11	15	13	11
					Min	8	6	9	10	12	9	11	11	9
					Max	14	14	17	18	20	13	20	17	13
Surgery (excl Transplant)	85%	71	83	67	Avg	58	63	63	62	70	71	85	77	72
					Min	53	57	57	58	67	66	72	72	67
					Max	60	64	65	66	72	75	89	84	75
Thoracic Medicine	85%	30	36	22	Avg	18	25	25	23	22	23	24	28	24
					Min	10	18	18	19	17	17	17	17	17
					Max	21	27	29	26	24	26	28	32	27
Transplant	85%	13	15	11	Avg	11	15	11	10	10	11	12	8	9
					Min	10	14	9	8	8	9	10	6	7
					Max	12	15	11	10	10	11	12	8	9
Covid-19	85%	0	0	11	Avg	9	7	5	5	5	5	3	3	2
					Min	8	6	5	5	5	5	3	3	2
					Max	9	7	5	5	5	6	3	4	2
Grand Total	85%	175	205	177	Avg	152	166	176	175	182	168	182	172	171
					Min	119	135	146	147	158	145	143	140	140
					Max	173	181	192	196	202	186	207	195	187
Total (excl. Covid)	85%	175	205	166	Avg	144	159	171	170	177	163	179	168	169
					Min	111	129	141	142	153	140	140	137	138
					Max	164	174	187	191	197	180	204	191	185

Shading key:
Orange = below scenario
Green = at or above scenario

Roadmap to Full Occupancy



The core purpose for RPH is to deliver care to the maximum number of patients within the physical infrastructure. This will be supported by incremental change to existing services as well as the development of new ones to ensure we remain at the forefront of our specialty services.

Longer Term CDC Strategy – Key Recommendations (1 of 2)

Recommendations are set out by the CDC for the Living with COVID Steering Group for the next phase of the Clinical Strategy (14th September to 31st March 2021). These build on those recommendations within the short term strategy (8th June – 28th June 2020) and the medium term strategy (29th June 2020 - 13th September 2020).

Part 1: Aims are considered to be within the reach of RPH to achieve with a relatively low level of risk and dependency on external factors. Therefore operational and workforce action plans to be put in place to deliver the following:

- Embed the partnerships between booking and clinical services and booking to deliver a responsive and flexible service to maintain a positive trajectory of booked activity
- Decrease staff headroom to at least 26% with targeted work to support those areas more adversely impacted
- Continue to review and improve productivity and infection control assumptions to optimise use of key limited resources of theatres, cath labs, ward beds, diagnostics, bronchoscopy and outpatients and improve beyond overall BAU performance by 10% across the Trust
- Institute Heart MDT and adjust delivery to reflect any impact
- Open 4NE to support thoracic short stay patients (14 beds within budget)
- Open 36 beds in intensive care by October and aim to have 40 beds opened by April 2021 to provide access to regional resource and readiness for future Covid-19 waves.
- Access for any patient must be driven by clinical prioritisation including clinical research and private patients.
- Research and education activities paused during the Covid-19 pandemic must be reinstituted and resilience for future Covid-19 waves planned for.
- Cross specialty review of junior medical workforce to ensure fit for purpose, aligned to training and development strategy in place
- Adapt existing training programmes to meet the needs of all staff utilising new opportunities and managing new constraints
- Develop digital strategies to support remote patient management eg attend anywhere, remote desktop
- Weekly performance monitoring of all CDC Clinical Strategy Metrics

Royal Papworth Hospital NHS Foundation Trust

Longer Term CDC Strategy – Key Recommendations (2 of 2)

Part 2: The following are service development opportunities requiring associated stakeholder support, business case development and commissioning. These aims carry a higher level of risk to delivery due to the increased level of interdependencies. Each of them represents the clinical priorities of the Trust over the next 7 months:

- Transfer cardiothoracic imaging from other Trusts within the STP by utilising capacity created by productivity gains and dependent associated transfer of resources from other organisations
- Expedite the transfer of bronchoscopy activity from CUH to utilise available capacity and explore further clinical pathway changes with CUH to maximise use of our estate and support the C&P system
- Develop cardiology and respiratory mobile diagnostic services to meet campus and potentially STP demand.
- Open 40 beds in intensive care by April 2021 and expand to 46 beds beyond April 2021.
- Develop the case to open additional beds for prehab and enablement on 4NE.
- Expand the Cardiology bed base further to meet demand, including additional activity from E&NH by opening a further 9 beds on 4NW.
- Increase bed base (up to 8) for an expanded regional weaning service in RSSC
- Reinstate RPH private income to activity levels achieved in 2019 with an ambition to grow further once pre Covid-19 BAU specialty activity levels are achieved
- Establish a temporary clinical trial facility to accommodate commercial opportunities
- Support the STP and region to implement the recommendations of the national GIRFT reports
- Service development of Regional Adult Critical Care Transfer Service through the governance of the Critical Care Strategic Programme Board

CDC Scenarios for Long Term Plan (1A)

The following slides contain a number of modelled scenarios using the Trust's dynamic modelling tool. The first set of scenarios set out the quantifiable elements of the CDC long term strategy from two perspectives:

Scenario 1a: Covid-19 response at 5 CCA beds, CCA capped at 36 beds, productivity in theatres/cath labs/radiology to be better than pre-covid levels and slight headroom reduction

The following productivity and staffing assumptions were used for this scenario;

Time taken compared to previous BAU	
Emergency Theatres	90%
Elective Theatres	90%
Emergency Cath labs	90%
Elective Cath labs	90%
MRI	90%
CT	90%
Bronchoscopy	90%

% of staff shielding	0%
Change in headroom	4%

Resource Constraints

- Limiting factor to be physical space BUT no more than an extra 50wte qualified nurses above the July 2020 level.
- We have, at July 2020, already got an extra 56wte nurses (either substantive or bank/agency) on top of the BAU period so the nursing shortfall in the table at the bottom of the page can be up to 106wte and still fulfil the criteria.

Percentage of BAU activity deliverable

Service	NEL	EL	DC
Cardiac Rhythm Management	100%	110%	110%
Cardiac Surgery	100%	110%	110%
Cardiology other	100%	110%	110%
Coronary Intervention	100%	110%	110%
Cystic Fibrosis	100%	110%	110%
ECMO	100%		
ILD	100%	110%	110%
Lung Defence	100%	110%	110%
Non Coronary Intervention	100%	110%	110%
Oncology		110%	110%
PTE		110%	110%
PV Diseases	100%	110%	110%
RSSC	100%	110%	110%
Thoracic Medicine other	100%	110%	110%
Thoracic surgery (exc PTE)	100%	110%	110%
Transplant	100%	110%	110%
VAD	100%	110%	

Staffing shortfall between BAU period (Aug19-Nov19) and scenario

Qualified Nursing	Support to nursing staff	Career staff grades	Trainee grade trust grade	Cons	Other clinical support	Qualified allied health professionals	Support to allied health professionals	Qualified health care scientists	Qualified other STT staff	Support to health care scientists and	Qualified pharmacists	
-105	-25	-6	-6	-12	-2	-11	-3	-7	-2	-3	0	-182

If nursing recruitment continues on the existing trajectory and c. 50 more nurses are added to the workforce alongside the productivity improvements set out in the CDC strategy then activity levels can exceed BAU and waiting lists will be reduced.
The limiting factor for this scenario was the staffing cap. There still remains space on CCA and all other wards.
This scenario is dependent on successful expansion of the workforce. Should the net increase be 0 in nursing then elective and daycase delivery will be reduced to c.94% of BAU

Academy of Medical Sciences
Preparing for a Challenging Winter 2020-2021

In a report published on 14 July *Preparing for a Challenging winter 2020-2021* the Academy of Medical Sciences identified the following challenges likely to face the health and care system this winter:

— A large resurgence of Covid-19 nationally, with local or regional epidemics.
— Disruption of the health and social care systems
— A backlog of non-Covid-19 care
— A possible influenza epidemic that will be additive to the challenges above.

The position may be complicated by lower public adherence to local or national lockdown requirements. Any capacity demands that arise from an autumn/winter Covid-19 surge cannot rely on the same redeployment of space and workforce as was done earlier this year because a greater number of services will need to continue in order to avoid excess deaths in non Covid-19 related illness. Staff wellbeing and resilience will also be a factor in availability and willingness to redeploy in a further Covid-19 wave.

The document also sets out the Academy view of actions that are required locally, regionally and nationally in the following key areas to ensure that the service is prepared for further Covid-19 surges and winter:-

- System capacity
- Workforce requirement
- Infection control and PPE
- Testing
- Social Care
- Communications

The Trust must approach the Winter with this likely context in mind and ensure that it is well positioned to meet the ongoing needs of the local, regional and national populations. To a certain extent the behaviour of the public will also shape our response to the pandemic.

Significant efforts are being undertaken to ensure that wherever possible the backlog created by the first Covid-19 surge is reduced ahead of winter pressures. The Trusts' modelling tool has been used to assess what levels of activity were undertaken across all specialties during the first wave of Covid to act as a baseline for provision in the event of a second wave. These include:

- Thoracic cancer surgery
- Emergency and urgent cardiac surgery
- National organs retrieval service and transplantation
- Emergency and urgent inpatient Cardiology procedures
- Inpatient diagnostics and urgent OP diagnostics
- Virtual follow up OP consultations (all specialties)

In the event of a second wave or unusually high winter pressures our core requirements would also extend to include the following patient cohorts;

1. Clinically critical P* category for elective cardiology patients
2. Deliver urgent non elective respiratory pathways including maximise CPAP and NIV
3. Clinically critical elective P* cardiac and PTE patients

Within our Covid-19 response we are proud of the excellent reported outcomes achieved. In order to build on our strengths we would look to:

1. Prioritise the delivery of national and regional emergency or urgent services
2. Deliver national ECMO requirements including advice on Severe Respiratory Failure
3. Offer regional access to an 8 bedded weaning unit
4. Work with STP partners to offer mutual aid

In supersurge only:

1. Maximise O+ and V patients as part of load levelling across the region

icnarc intensive care national audit & research centre
25 years and counting...

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24 High Holborn
London WC1V 6AZ
email: COVID-19@icnarc.org
www.icnarc.org

ICNARC report on COVID-19 in critical care

Royal Papworth Hospital Critical Care Unit

3 Aug 2020

This report presents analyses of data on patients critically ill with confirmed COVID-19 reported to ICNARC up to 4pm on 30 July 2020 from Royal Papworth Hospital Critical Care Unit. The report accounts for all patients with confirmed COVID-19 admitted to your unit and includes their original admission data (whether in your unit or in a previous unit), their total organ support (from all units) and final unit outcome (whether in your unit or in a subsequent unit).

Reporting process

Critical care units participating in the Case Mix Programme are asked to:

- notify ICNARC as soon as they have an admission with confirmed COVID-19;
- submit early data for admissions with confirmed COVID-19, including demographics and first 24-hour physiology, as soon as possible after the end of the first 24 hours in critical care;
- resubmit data for the whole critical care stay, including critical care outcome and organ support, when the patient leaves critical care; and
- submit final data when the patient leaves acute hospital.

Admissions to critical care

To date ICNARC have received early data covering the first 24 hours of critical care for 105 admissions to critical care with confirmed COVID-19, either at or after the start of critical care, for 103 patients from Royal Papworth Hospital Critical Care Unit. Of the 103 patients, 93 have outcomes reported and 10 patients were last reported as still receiving critical care.

Patient characteristics

Characteristics of patients critically ill with confirmed COVID-19 in Royal Papworth Hospital Critical Care Unit are summarised in Table 1 and Table 2 and compared with patients critically ill with confirmed COVID-19 from all critical care units in the Case Mix Programme.

Table 1. Patient characteristics: demographics

Demographics	Patients with confirmed COVID-19 and 24h data	
	Royal Papworth Hospital Critical Care Unit (N=103)	All critical care units (N=10,624)
Age at admission (years) [N=102]		
Mean (SD)	52.0 (12.8)	58.8 (12.7)
Median (IQR)	51 (45, 62)	60 (51, 68)
Sex, n (%) [N=103]		
Female	25 (24.3)	3159 (29.8)
Male	78 (75.7)	7458 (70.2)
Currently or recently pregnant, n (% of females aged 16-49) [N=14]		
Currently pregnant	1 (7.1)	28 (3.7)
Recently pregnant (within 6 weeks)	0 (0.0)	40 (5.3)
Not known to be pregnant	13 (92.9)	692 (91.1)
Ethnicity, n (%) [N=98]		
White	67 (68.4)	6765 (66.2)
Mixed	5 (5.1)	186 (1.8)
Asian	13 (13.3)	1593 (15.6)
Black	8 (8.2)	981 (9.6)
Other	5 (5.1)	690 (6.8)
Index of Multiple Deprivation (IMD) quintile *, n (%) [N=89]		
1 (least deprived)	25 (28.1)	1400 (14.4)
2	22 (24.7)	1572 (16.2)
3	27 (30.3)	1912 (19.7)
4	12 (13.5)	2318 (23.9)
5 (most deprived)	3 (3.4)	2496 (25.7)
Body mass index *, n (%) [N=93]		
<18.5	0 (0.0)	77 (0.8)
18.5-<25	19 (20.4)	2581 (25.6)
25-<30	34 (36.6)	3466 (34.4)
30-<40	29 (31.2)	3163 (31.4)
≥40	11 (11.8)	794 (7.9)

* Please see Definitions on page 8.

Table 2. Patient characteristics: medical history and indicators of acute severity

Medical history	Patients with confirmed COVID-19 and 24h data	
	Royal Papworth Hospital Critical Care Unit (N=103)	All critical care units (N=10,624)
Dependency prior to admission to acute hospital, n (%) [N=99]		
Able to live without assistance in daily activities	97 (98.0)	9387 (89.7)
Some assistance with daily activities	2 (2.0)	1039 (9.9)
Total assistance with all daily activities	0 (0.0)	39 (0.4)
Very severe comorbidities *, n (%) [N=102]		
Cardiovascular	0 (0.0)	68 (0.6)
Respiratory	0 (0.0)	128 (1.2)
Renal	0 (0.0)	180 (1.7)
Liver	0 (0.0)	47 (0.4)
Metastatic disease	0 (0.0)	60 (0.6)
Haematological malignancy	0 (0.0)	201 (1.9)
Immunocompromise	0 (0.0)	367 (3.5)
Prior hospital length of stay [N=103]		
Mean (SD)	2.0 (4.3)	2.5 (6.3)
Median (IQR)	0 (0, 2)	1 (0, 3)
CPR within previous 24h, n (%) [N=102]		
In the community	1 (1.0)	58 (0.5)
In hospital	2 (2.0)	73 (0.7)
Indicator of acute severity		
Mechanically ventilated within first 24h *, n (%) [N=102]	60 (58.8)	6090 (58.8)
APACHE II Score [N=103]		
Mean (SD)	13.3 (4.3)	15.0 (5.3)
Median (IQR)	13 (11, 16)	15 (11, 18)
PaO_2 /FiO_2 ratio † (kPa), median (IQR) [N=100]	14.3 (10.5, 20.0)	15.8 (11.3, 22.2)
PaO_2 /FiO_2 ratio †, n (%) [N=100]		
$<$ 13.3 kPa ($<$ 100 mmHg)	43 (43.0)	3637 (36.8)
13.3-26.6 kPa (100-200 mmHg)	46 (46.0)	4731 (47.9)
$\geq$ 26.7 kPa ($\geq$ 200 mmHg)	11 (11.0)	1517 (15.3)

* Please see Definitions on page 8. Indicators of acute severity are based on data from the first 24 hours of critical care. † Derived from the arterial blood gas with the lowest PaO_2 during the first 24 hours of critical care.

The distribution of age and sex is presented in Figure 1. The distribution of ethnicity, matched on 2011 census ward for location of patients critically ill with COVID-19, is presented in Figure 2.

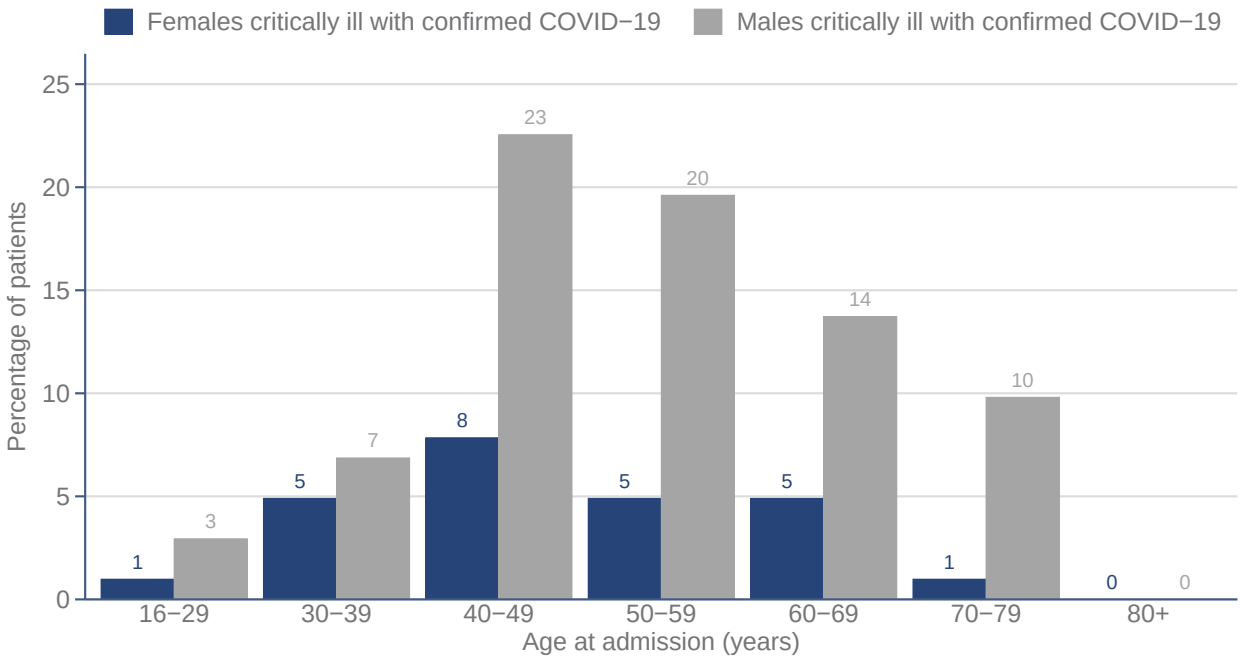

Figure 1. Age and sex distribution of patients critically ill with confirmed COVID-19

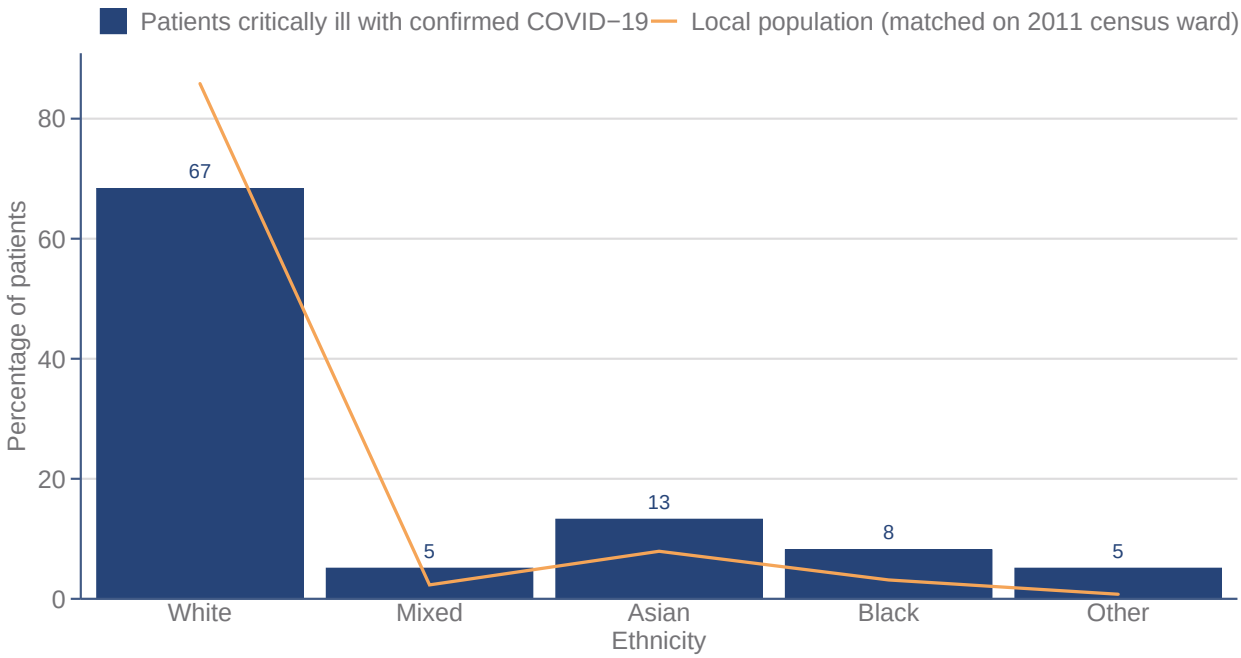

Figure 2. Ethnicity distribution of patients critically ill with confirmed COVID-19 compared with the local population (linked to 2011 census ward)

The distribution of Index of Multiple Deprivation (IMD) is presented in Figure 3. The distribution of body mass index (BMI), compared with an age- and sex-matched population (from the Health Survey for England 2018), is presented in Figure 4.

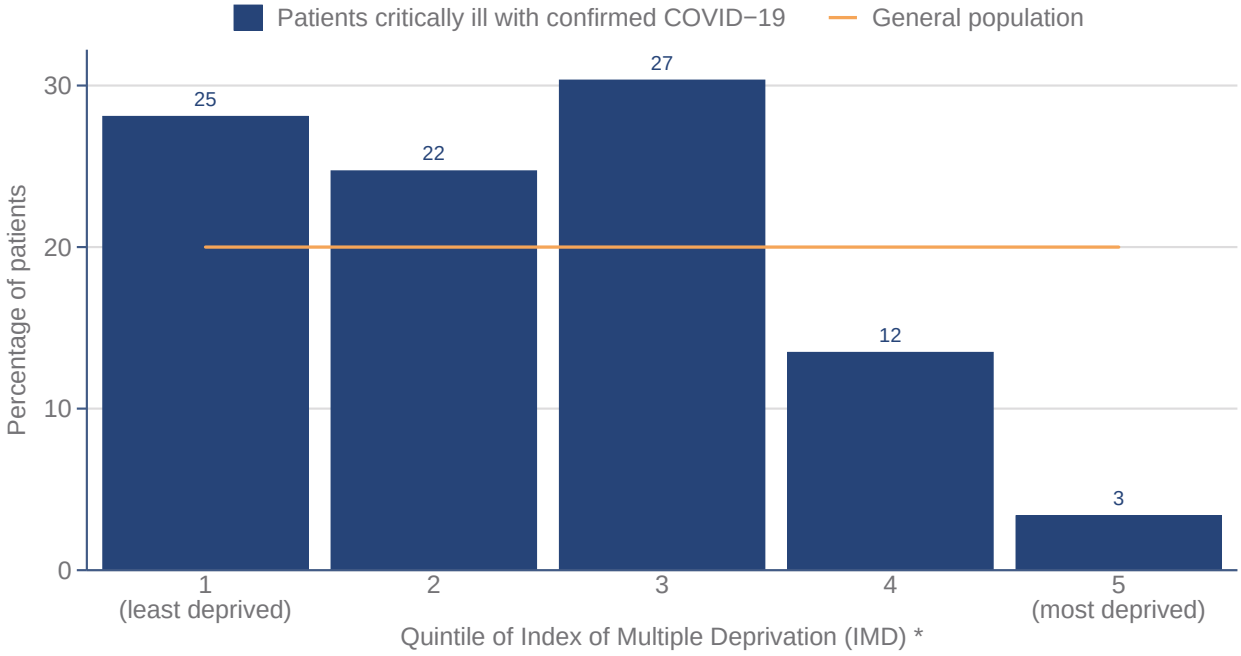

Figure 3. Index of Multiple Deprivation (IMD) * distribution of patients critically ill with confirmed COVID-19 compared with the general population

* Please see Definitions on page 8.

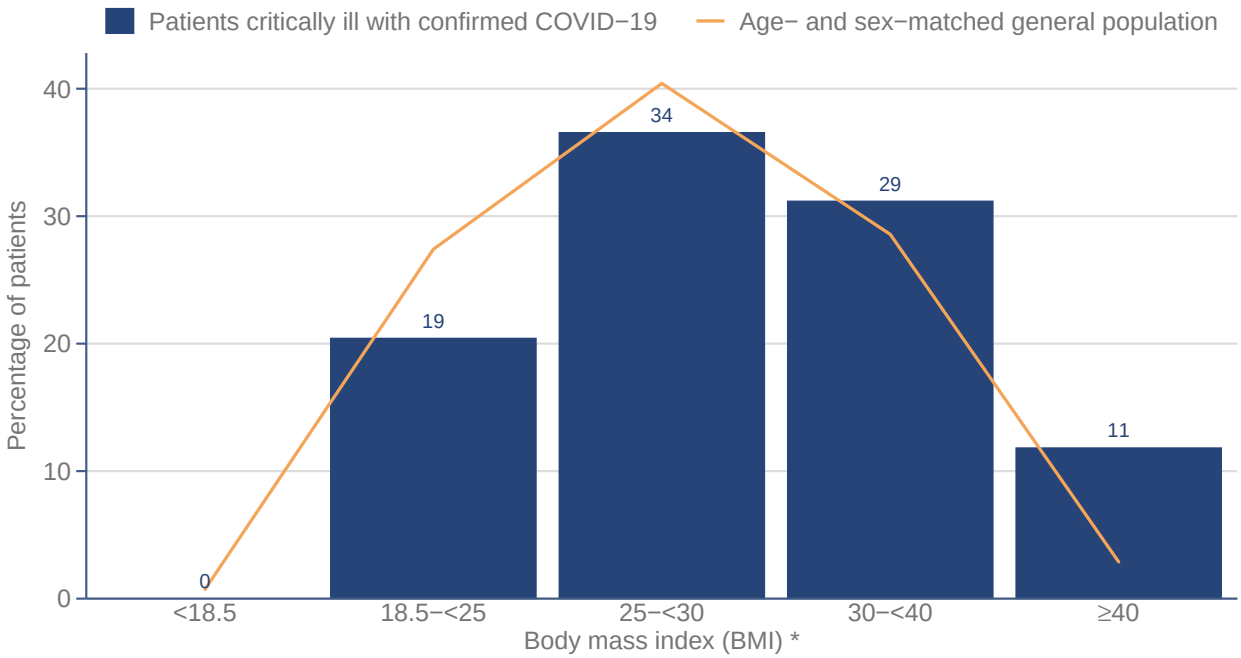

Figure 4. Body mass index (BMI) * distribution of patients critically ill with confirmed COVID-19 compared with the age- and sex-matched general population (Health Survey for England 2018)

* Please see Definitions on page 8.

Outcomes, duration of critical care and organ support

Critical care outcomes have been received for 93 (of 103) patients. Of these, 21 have died, 72 have been discharged from critical care and 10 were last reported to still be receiving critical care.

Critical care outcome, duration of critical care and organ support for patients critically ill with confirmed COVID-19 in Royal Papworth Hospital Critical Care Unit for whom critical care outcomes have been received are summarised in Table 3 and compared with patients critically ill with confirmed COVID-19 from all critical care units in the Case Mix Programme.

Table 3. Critical care outcome, duration of critical care and organ support

Critical care outcome	Patients with confirmed COVID-19 and outcome received	
	Royal Papworth Hospital Critical Care Unit (N=93)	All critical care units (N=10,341)
Outcome at end of critical care, n (%) [N=93]		
Discharged	72 (77.4)	6232 (60.3)
Died	21 (22.6)	4109 (39.7)
Duration of critical care		
Duration of critical care (days) †, median (IQR) [N=92]		
Survivors	28 (8, 47)	12 (5, 28)
Non-survivors	20 (14, 31)	9 (5, 16)
Organ support (Critical Care Minimum Dataset) *		
Receipt of organ support, at any point, n (%) [N=90]		
Advanced respiratory support	77 (95.1)	7425 (72.1)
Basic respiratory support	62 (76.5)	6975 (67.7)
Advanced cardiovascular support	43 (60.6)	3081 (29.9)
Basic cardiovascular support	87 (100.0)	9578 (92.9)
Renal support	40 (64.5)	2738 (26.6)
Liver support	0 (0.0)	104 (1.0)
Neurological support	5 (10.2)	898 (8.7)
Duration of organ support (calendar days), median (IQR) [N=90]		
Advanced respiratory support	21 (10, 35)	13 (7, 23)
Total (advanced + basic) respiratory support	25 (14, 37)	11 (5, 21)
Advanced cardiovascular support	3 (2, 7)	3 (2, 6)
Total (advanced + basic) cardiovascular support	29 (15.5, 42.5)	11 (5, 22)
Renal support	13.5 (6, 20.5)	8 (3, 15)

Please note that owing to the emerging nature of the epidemic, the sample of patients with confirmed COVID-19 represented in this table is biased towards patients with shorter lengths of stay in critical care prior to discharge or death, i.e. those who died or recovered quickly. * Please see Definitions on page 8. † Duration of critical care is from original admission to critical care until final unit outcome and includes any time spent outside critical care areas (e.g. prior to any readmissions).

Outcomes by patient characteristics

Critical care outcomes for patients critically ill with confirmed COVID-19 in Royal Papworth Hospital Critical Care Unit across major patient subgroups are summarised in Table 4 and compared with patients critically ill with confirmed COVID-19 from all critical care units in the Case Mix Programme.

Table 4. Critical care outcome by patient characteristics

	Patients with confirmed COVID-19 and outcome received		
	Royal Papworth Hospital Critical Care Unit		All critical care units
Patient subgroup	Discharged alive from critical care n (%)	Died in critical care n (%)	Died in critical care (%)
Age at admission to critical care			
16-49	34 (81.0)	8 (19.0)	(18.9)
50-69	31 (75.6)	10 (24.4)	(40.4)
70+	7 (70.0)	3 (30.0)	(59.2)
Sex			
Female	18 (78.3)	5 (21.7)	(35.1)
Male	54 (77.1)	16 (22.9)	(41.7)
BMI			
<25	10 (58.8)	7 (41.2)	(40.5)
25-<30	23 (76.7)	7 (23.3)	(42.1)
≥30	32 (88.9)	4 (11.1)	(36.1)
Assistance required with daily activities			
No	67 (77.0)	20 (23.0)	(38.7)
Yes	1 (50.0)	1 (50.0)	(48.1)
Any very severe comorbidities *			
No	71 (77.2)	21 (22.8)	(38.7)
Yes	0 (.)	0 (.)	(50.2)
Any respiratory support *			
Basic only	4 (100.0)	0 (0.0)	(19.5)
Advanced	56 (72.7)	21 (27.3)	(48.0)
Any renal support *	25 (62.5)	15 (37.5)	(57.0)

Please note that owing to the emerging nature of the epidemic, the sample of patients with confirmed COVID-19 represented in this table is biased towards patients with shorter lengths of stay in critical care prior to discharge or death, i.e. those who died or recovered quickly. * Please see Definitions on page 8.

Definitions

Index of Multiple Deprivation (IMD) is based on the patient's usual residential postcode (assigned at the level of Lower Layer Super Output Area) according to:

- English Index of Multiple Deprivation 2019 for postcodes in England
- Welsh Index of Multiple Deprivation 2019 for postcodes in Wales
- Northern Ireland Multiple Deprivation Measure 2017 for postcodes in Northern Ireland

Body mass index is calculated as the weight in kilograms divided by the height in metres squared. Weight and height values may have been measured or estimated.

Very severe comorbidities must have been evident within the six months prior to critical care and documented at or prior to critical care:

- Cardiovascular: symptoms at rest
- Respiratory: shortness of breath with light activity or home ventilation
- Renal: renal replacement therapy for end-stage renal disease
- Liver: biopsy-proven cirrhosis, portal hypertension or hepatic encephalopathy
- Metastatic disease: distant metastases
- Haematological malignancy: acute or chronic leukaemia, multiple myeloma or lymphoma
- Immunocompromise: chemotherapy, radiotherapy or daily high dose steroid treatment in previous six months, HIV/AIDS or congenital immune deficiency

Mechanical ventilation during the first 24 hours was identified by the recording of a ventilated respiratory rate, indicating that all or some of the breaths or a portion of the breaths (pressure support) were delivered by a mechanical device. This usually indicates invasive ventilation; BPAP (bilevel positive airway pressure) would meet this definition but CPAP (continuous positive airway pressure) does not.

Organ support is recorded as the number of calendar days (00:00-23:59) on which the support was received at any time, defined as:

- Advanced respiratory: invasive ventilation, BPAP via trans-laryngeal tube or tracheostomy, CPAP via trans-laryngeal tube, extracorporeal respiratory support
- Basic respiratory: >50acute deterioration, physiotherapy/suction to clear secretions at least two-hourly, recently extubated after a period of mechanical ventilation, mask/hood CPAP/BPAP, non-invasive ventilation, CPAP via a tracheostomy, intubated to protect airway
- Advanced cardiovascular: multiple IV/rhythm controlling drugs (at least one vasoactive), continuous observation of cardiac output, intra-aortic balloon pump, temporary cardiac pacemaker
- Basic cardiovascular: central venous catheter, arterial line, single IV vasoactive/ rhythm controlling drug
- Renal: acute renal replacement therapy, renal replacement therapy for chronic renal failure where other organ support is received
- Liver: management of coagulopathy and/or portal hypertension for acute on chronic hepatocellular failure or primary acute hepatocellular failure
- Neurological: central nervous system depression sufficient to prejudice airway, invasive neurological monitoring, continuous IV medication to control seizures, therapeutic hypothermia

Annex 1: What others say about us

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NHS Specialised Commissioning East of England Hub Statement Response 2019/20

We are happy to support the Quality Accounts

Joanne Pope
Head of Nursing, Direct Commissioning
NHS England & NHS Improvement – East of England

Cambridgeshire and Peterborough Clinical Commissioning Group

The Trust has not received a response to date.

Healthwatch Cambridgeshire and Peterborough

Royal Papworth Hospital Quality Account Statement 2019/20

Summary and comment on relationship

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

Healthwatch is pleased to have a positive relationship with the Trust. The Trust is always responsive to feedback and we welcome the commitment to learning and improving.

The Trust is to be congratulated on the CQC rating achieved in October 2019, and for being the first Trust in the country to achieve 'Outstanding' in all five domains.

It is very pleasing that the hospital move to the Cambridge Biomedical campus was completed as planned and without incident. Feedback from Healthwatch was welcomed during this time and swiftly acted upon.

Healthwatch receives overwhelmingly positive feedback from patients and their families regarding the Royal Papworth Hospital.

Towards the end of the 2019/2020 period, it has been necessary for the trust to adapt and respond to the Covid-19 pandemic. We acknowledge the efforts and dedication of teams working across the Trust during this unprecedented situation.
From May to September 2020, Healthwatch Cambridgeshire and Peterborough have surveyed local people to hear about the impact of service changes during Covid-19. Our report shows that:

- Older people, those with disabilities or long-term health conditions and those not online were hit hardest
- Three in ten people avoided getting help for a health problem
- But of those that did get help, three out of four rated it highly
- One in three people told us there was a high or significant impact on their mental health and wellbeing
- Although some people have taken to online hospital or GP appointments, they do not work for everyone. Many people do not have the internet and those with sensory impairments find remote consultations hard to access.

During the pandemic our Healthwatch has heard from many people across Cambridgeshire and Peterborough who are concerned about their treatment and care and have not received any information. Whilst this feedback is not specific to the Royal Papworth, we agree that communications with patients can always be improved. We therefore support and welcome the commitment to learning from PALS and complaints.

It is pleasing to note that the Trust is committed to implement innovation and continue the learning from this difficult period. We would stress however, that not all people are able to access online consultations and that face to face consultations should be available for those people who need them. Information also needs to be available in formats suitable for people's communications needs.

Cambridgeshire County Council, Health Committee

THE ROYAL PAPWORTH HOSPITAL TRUST
QUALITY ACCOUNTS 2019/20
STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL - HEALTH COMMITTEE

The Health Committee welcomes Royal Papworth Hospital Trust (RPT) quality account which reflects on a challenging year in which the Trust moved from Papworth to its new building on the Cambridge bio-medical campus, underwent a CQC inspection and experienced the start of the COVID19 pandemic impact.

It is encouraging to see that the Trust was able to deliver some of the best outcomes for patients during wave 1 of the pandemic and also that it has been busy learning lessons from this about its role across the region: developing a surge plan, developing its network for mutual aid and system engagement and supporting staff for a second wave.

Four inter-connected quality priorities highlighted for 2019-20 related to patient safety, ensuring a safe move to the new site, optimising Lorenzo and a focus on workforce and organisational culture. Patient safety was identified for further work especially in the areas of falls prevention and managing the deteriorating patient, where training has been extended. The committee would welcome information on the percentage of existing staff that have received this training in the past year.

Falls prevention analysis has proved illuminating, with an anticipated decline in the new hospital not initially delivered (Q3), but subsequent data indicating that falls were declining from Q4. One of the priorities for 2020-21 relates to identifying frail patients and using OT ‘pre-habilitation’ to improve ability to undergo surgery and aid post-operative recovery. This would appear to support the falls prevention strategy, though it is not linked.

It is clear that the move to Cambridge, while a challenge in terms of logistics and sustaining treatment levels, has been very successful. The CQC inspection in October 2019 resulted in a verdict of ‘outstanding’ across core areas (safe, effective, caring, responsive and well-led) with further areas of improvement identified.

We noted last year that optimising Lorenzo was proving challenging, with staff training and adjustment seen as work in progress during 2017-18 and 2018-19. Maximizing the benefit of Lorenzo through competency programmes of learning was impacted by the move to the new site and work has not yet started on the ward and trust dashboard for quality assurance research and audit.

The interesting section on the 2020-21 priority for digital quality improvement flags three required deliverables: a joined up health record, a safer and improved patient experience and ‘a more stable user experience, reducing numbers of hours lost to system issues’. There are some really challenging targets in the detail here and clear evidence that optimizing the functioning of Lorenzo and creating dashboards and portals (for example the innovative Patient Aide portal) is bound up with several other 2020-21 priorities, not least staff training and support for changing ways of working. The building of QI capability is ongoing for 2020-21, including developing a QI road map, finalizing the rebuilding of the QI team and rolling out further QI training at various levels.

The critical role of staff runs like a thread through the report and there are thoughtful comments about workforce and organizational culture in Part 1 which flag the challenges the Trust faces in the era of COVID19. Some actions related to career progression and discrimination, which it was hoped would be tackled during 2019-20, were delayed and the Compassionate and Collective Leadership programme to support change was only able to restart in Autumn 2020. It is therefore reassuring to see the high priority given to workforce development for 2020-21 with a clear diagnostic phase signalling relevant interventions designed to achieve a set of ambitious KPIs by Q4 2021.

The Health Committee is in the process of establishing informal liaison meetings with Royal Papworth NHS Trust and looks forward to discussing further with the trust the development and improvement issues identified in this informative quality account.

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

During 2019/20 the Council of Governors continued to work with the Board of Directors to ensure that the Trust continues to deliver services which meet the needs of patients, carers, staff and local communities. During the year three new Non-Executive directors were appointed following approval by the Council.

As well as chairing committees Governors have sat as members or observers on others and have been encouraged to attend the monthly Board meetings. In addition a Governor Focus Group fed into the CQC inspection in July 2019 and the Governors welcomed the outstanding CQC rating that was awarded to the Trust recognising the exceptional performance that is represented through these Quality Accounts.

2020 has been a challenging year and Governors have been kept informed of how the challenge of the pandemic has affected the hospital and how everyone rose to the challenge. Governors have been forced to educate themselves in digital conferencing thereby enabling meetings to resume once the hospital was returning to a degree of normality. Board meetings were observed, the quarterly Council meetings joined and committee participation ensured. Whilst not ideal these new methods of communication do at least mean that Governors were kept informed and could contribute. Needless to say the vital work of the hospital continued, albeit using different methods such as phone or video consultations for out-patients.

Before the current restrictions Governors were also involved are 15 steps, PLACE, Patient Safety Rounds and mock CQC inspections. A number of Governors also undertake voluntary positions which give them the opportunity to spend time talking to patients, carers and staff thereby providing valuable feedback. We are looking forward to returning to these roles in person as soon as that is possible.

Quality Priorities are selected each year by the Governors and the 2020/21 priorities are:-

1. Safe: Quality Improvement and Patient Safety
2. Effective: Responsive Services.
3. Well Led: Leadership and Culture Programme.
4. Patient Experience: Communications
5. Digital Quality Improvement

At the quarterly Council of Governor meetings in addition to the executive reports, clinicians gave presentations on the role of Healthcare Science at Royal Papworth Hospital; the launch of the Rapid NSTEMI Pathway and as well as these patient stories have been related by Matrons or Senior Sisters which has provided an extra insight into the patient experience.

Dr Richard Hodder, Lead Governor.

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

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

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

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

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

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

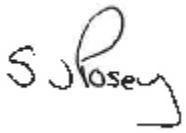
  - Board minutes and papers for the period April 2019 to 3 December 2020
  - Papers relating to quality reported to the Board over the period April 2019 to 3 December 2020
  - Feedback from Cambridge and Peterborough Clinical Commissioning Group (awaited)
  - Feedback from NHS Specialised Commissioning East of England dated 27 November 2020
  - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated 27 November 2020
  - Feedback from Healthwatch Cambridgeshire dated 3 November 2020;
  - Feedback from Cambridgeshire Health Committee dated 16 November 2020
  - The Trust's "Quality and Risk Report: Quarter 4 and annual Summary 2019/20";
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2019 National Inpatient Survey
  - The 2019 National Staff Survey
  - The Trust's Annual Governance Statement 2019/20
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated 10 June 2020
  - CQC Inspection Reports published 16 October 2019

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

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

By order of the Board

Date: 3 December 2020 Chairman



Date: 3 December 2020 Chief Executive

Annex 3: Limited Assurance Report on the content of the Quality Report and Mandated Performance Indicators

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INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

This requirement has been removed for 2019/20 Quality Report.

Annex 4: Mandatory performance indicator definitions

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

Source of indicator definition and detailed guidance

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

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

Detailed descriptor

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

Numerator

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

Denominator

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

Accountability

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

Indicator format

Reported as a percentage

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

Detailed descriptor[1]

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

Data definition

All cancer two-month urgent referral to treatment wait

Numerator

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

Denominator

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

Accountability

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

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

ANNEX 5 Glossary

C

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

D

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

Department of Health and Social Care (DHSC formerly DH or DoH)	The Government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk/

E

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

F

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

G

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

H

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

I

Indicator	A measure that determines whether the goal or an element of the goal has been achieved.
Information Governance Toolkit	Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The toolkit provides NHS organisations with a set of standards against which compliance is declared annually.

Inpatient survey	An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate.

L

Local clinical audit	A type of quality improvement project that involves individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team

M

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

N

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

NHS Improvement (NHSI)	NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHSI offers the support these providers need to give patients consistently safe, high-quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHSI help the NHS to meet its short-term challenges and secure its future. From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together: • Monitor • NHS Trust Development Authority • Patient Safety, including the National Reporting and Learning System • Advancing Change Team • Intensive Support Teams NHSI builds on the best of what these organisations did, but with a change of emphasis. Its priority is to offer support to providers and local health systems to help them improve.
NHS Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. From July 2012 data collected using the NHS Safety Thermometer is part of the Commissioning for Quality and Innovation (CQUIN) payment programme.
NHS number	A 10 digit number that is unique to an individual. It can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NMC	Nursing and Midwifery Council
NSTEMI	Non-ST-elevation myocardial infarction

P

PALS	The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Patient and Public Involvement Committee (PPI)	A Committee of the Council of Governors that provides oversight and assurance on patient and public involvement.
PEA (formally PTE)	Pulmonary Thromboendarterectomy or Pulmonary Endarterectomy.
PHE	Public Health England
PLACE	Patient-led assessments of the care environment (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013.
Pressure ulcer (PU)	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
Percutaneous coronary intervention (PCI)	The term percutaneous coronary intervention (sometimes called angioplasty or stenting) describes a range of procedures that treat narrowing or blockages in coronary arteries supplying blood to the heart.
Primary percutaneous coronary intervention (PPCI)	As above, but the procedure is urgent and the patient is admitted to hospital by ambulance as an emergency.

Priorities for improvement	There is a national requirement for trusts to select three to five priorities for quality improvement each year. These must reflect the three key areas of patient safety, patient experience and clinical effectiveness.

Q

Quality Account	A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012. NHS England or Clinical Commissioning Groups (CCGS) cannot make changes to the reporting requirements.
Quality Report	Foundation trusts are required to include a Quality Report as part of their Annual Report. This Quality Report has to be prepared in accordance with NHSI annual reporting guidance, which also incorporates the Quality Accounts regulations. All trusts have to publish Quality Accounts each year, as set out in the regulations which came into force on 1 April 2010. The Quality Account for each foundation trust (and all other types of trust) is published each year on NHS Choices.

R

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

S

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

U

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

Digital)

V

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

W

WRES	Workforce Race Equality Standard

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