Royal Papworth Hospital
NHS Foundation Trust

Quality and Risk Report Quarter 3 2019/20

October - December 2019

Assistant Director for Quality and Risk

Quality and Risk Report

Quarter 3 Report 2019/20

Patient Safety

1.1 Patient Safety Incident Trends and Actions

There were a total of 891 patient incidents reported during Q3 19/20 compared to 944 in the previous quarter. At the time of reporting there are 120 near miss incidents reported and 771 actual incidents. The reduction in reporting of near miss incidents may reflect the link between a rise in patient care activity and staffing levels. Despite this, there is confidence in the immediate action having been taken to rectify any issues by the departmental staff. This continues to demonstrate a healthy safety culture and a willingness of staff to see the benefit of reporting and learning from all types of incident investigations across the hospital environment. The quarters marked with an asterix (*) include incidents that are still under investigation and some have not yet been graded. Thus future reports will contain verified figures. Where appropriate these have been reported to Care Quality Commission (CQC) via the National Reporting and Learning System (NRLS).

	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2*	19/20 Q3*	Total
Near Miss	108	98	111	156	120	593
Actual Incidents	618	607	820	788	771	3604
Total	726	705	931	944	891	4197

Table 1: Numbers of patient safety incidents reported in 2019/19-19/20 (Data source: DATIX 22/01/20)

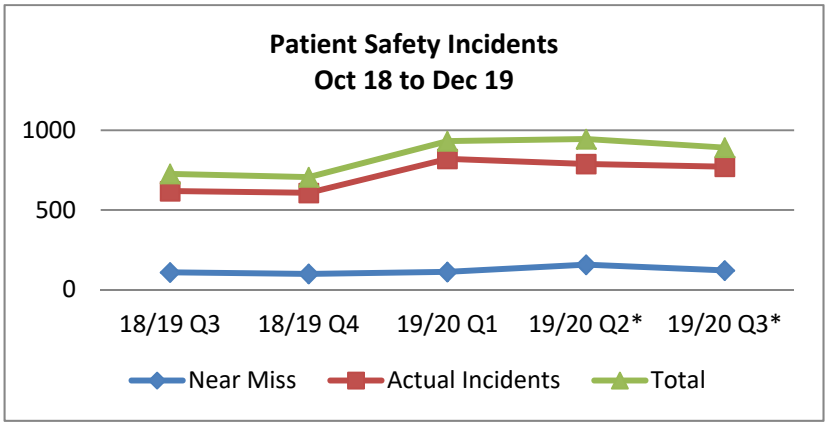


Figure 1: Patient Safety Incidents Actual v. Near miss (Data source: DATIX 22/01/20)

In quarter, table 2 shows the number of patient safety incidents reported by the “Type”, the majority of incidents continue to involve administration/bookings (n=143) and medication incidents (n=137). All are under investigation by the local line managers and reviewed at operational business unit meetings.

Type	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	Total	Q3 % of Total
Accidents	52	59	56	43	58	268	6%
Administration - admission/discharge/transfer	151	124	151	201	143	770	15%
Anaesthetics	8	7	2	5	8	30	1%
Behaviour/Violence Aggression	12	8	12	10	11	53	1%
Blood Plasma Products	43	39	33	39	46	200	5%
Communication/Consent	36	33	59	54	32	214	3%
Data protection	25	17	15	18	15	90	2%
Diagnosis Process/Procedures	47	30	103	65	35	280	4%
Documentation	55	57	73	63	53	301	6%
Environmental Hazards/Issues	3	1	11	6	11	32	1%
Infection Control	21	17	13	22	27	100	3%
Information Technology	9	11	15	10	10	55	1%

Medical Devices	30	31	59	80	63	263	7%
Medication/Medical Gases/Nutrition	106	81	92	97	137	513	15%
Nutritional Feeding (Prescribed Feeds)	4	12	4	1	3	24	0%
Organisational Issues/Staffing	23	55	66	68	90	302	10%
Pressure Ulcers	38	41	58	81	81	299	9%
Radiology	6	2	11	8	11	38	1%
Security incidents	3	4	10	11	8	36	1%
Treatment/Procedures	54	76	93	71	96	390	10%
Total	726	705	936	953	938	4258	100%

Table 2: Numbers of patient safety incidents by Type reported in Q3 2019/20 (Data source: DATIX 22/01/20)

The top five types of incidents are depicted below in figure 2 by financial quarter; this demonstrates a reducing trend in administration incidents continuing from the last three quarters. This indicates that the investigation and learning as part of SUI-WEB29551- delayed clinical letters, is taking effect, with improved booking templates and reduced complaints. The review of the bookings process continues which is linked to the out-patients room optimisation project. Incident trend information is provided in the paragraphs below.

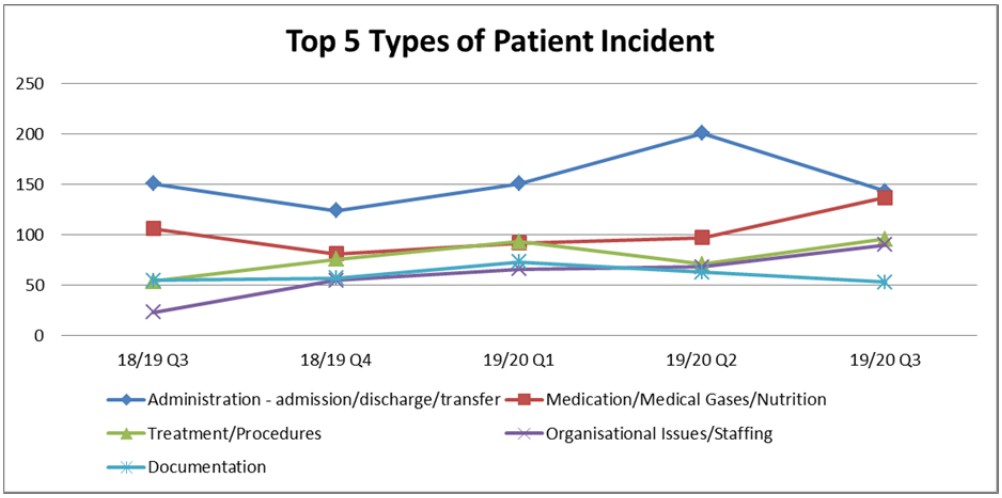


Fig 2: Patient Safety Incidents for Q3 2018/19 – Q3 2019/20 (Data source: DATIX 22/01/20)

INCIDENT TRENDS AND ACTION:

Administration Incidents

During the quarter, the number of incidents linked to bookings for general appointments and procedures have reduced slightly. All booking issues are reported per/person to ensure that all errors are being captured for the Administration team to review against their new procedures. A general assessment links many of the issues to human error several months ago prior to the implementation of the new processes. The linked risk continues to be monitored by the senior management.

Treatment and Procedures

There continues to be a fluctuating trend of reporting incidents coded as treatment and procedure/ this includes issues noted to be unexpected outcomes of surgical procedures. 97% of the incidents recorded, where graded, have a severity of no/low harm. Of these the most common are categorised as "Treatment and Procedure delayed (n=21)". A review of these incidents demonstrates that they are spread across the hospital and involve all types of staff and a variety of treatment. Capturing these incidents demonstrates good governance processes.

Medication
During quarter 3 the Trust noted an increase in medication incidents, in particularly linked to prescribing and omission. Where the incidents have been graded, 100% have been recorded as near miss, no/low harm, but have resulted in delays in receiving the treatment; including insulins. The Diabetic Specialist nurses receive all of these incidents and are developing further awareness training for diabetes management; this includes linking with the junior doctors training programme.. All medication incidents are reviewed by the pharmacy leads and reported to the Medications and Therapeutics Committee.

Pressure Ulcers (PU)
During quarter 3 the number of pressure ulcer incidents have remained the same as quarter 2 when the Trust initiated the revised national reporting for pressure ulcers; this now includes all category 1 PUs and moisture lesions. During the quarter 81 PUs incidents were reported which included a mix of externally acquired issues, PUs acquired in house and those that were shown to be medical device related etc. All have been graded as no/low harm. It has been noted by the Tissue Viability leads that nationally pressure ulcers are being captured differently, which includes grading. An internal review will be undertaken to ensure that the Trust meets the national standards aimed at introduction in April 2020.

1.2 Severity of Patient Safety Incidents

The fluctuating number of near miss to low harm incidents linked with the new building is likely to continue due to the requirement to report all PFI issues e.g. cleaning & portering. These numbers have reduced as PFI services have become embedded with NHS service requirements. Furthermore the actual number of moderate harm incidents initially reported following investigation are often downgraded as it is proven that the Trust has not demonstrated any acts or omissions. These include the unexpected outcomes of treatment and rare, but known complications. As a result five have been reported this quarter. The level of investigation is determined by the severity as detailed in the policy DN070. 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 & Risk Management Group (QRMG). The (*) signifies a discrepancy in the total number of incidents awarded a severity grading and the total amount of patient incidents in quarter; not all incidents have been finally approved and grading confirmed at the time of this report. Lessons learnt are shared across the organisation via the quarterly Lessons Learnt report on the intranet and local dissemination via Business Units and specialist meetings.

Severity	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2*	19/20 Q3*	Total
Near Miss	108	98	111	157	121	595
No harm	485	473	672	613	575	2818
Low harm	123	120	143	169	212	767
Moderate harm	6	7	5	2	7	27
Severe harm	1	1	0	2	1	5
Death caused by the incident	1	0	0	0	0	1
Death UNRELATED to the incident	2	6	1	3	2	14
Total	726	705	932	946	918	4227

Table 3 – Incidents by Severity (Data source: DATIX 07/01/20)
*Correct at the time of production. Some incidents have been downgraded in severity following investigation.

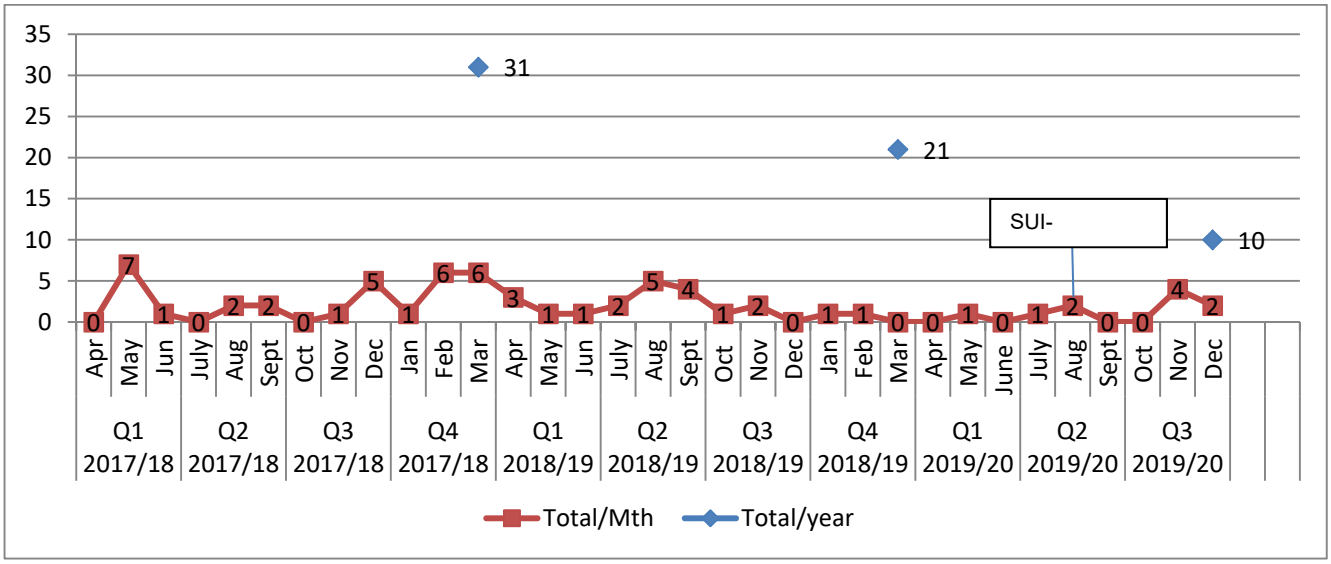
1.3 Patient incidents resulting in Moderate or Severe Harm inclusive of Serious Incidents (SI's)

In Q3 there have been four SI's reported to the CCG. This compare to 2 in Q2. There were three incidents reported as moderate/severe harm requiring investigation. Full Duty of Candour was undertaken with the patient and/or family for all SI's. A detailed breakdown of contributory factors identified from SI investigation is taken to the Serious Incident Executive Review Panel (SIERP). Human Factors is a recurring theme.

1.4 Incidents / Requests for patient Safety feedback from outside of Royal Papworth Hospital
The Trust receives a number of incidents for investigation from outside our Trust. These are shared with the relevant service area for investigation and feedback provided to the requesting organisation. The Trust received 4 requests for investigation / feedback in Q3 19/20.

1.5 VTE Monitoring

VTE Events 2017-2019



The graph above shows the number of VTE events from Q1 2017/18 to Q3 2019/20. We are advised of these confirmed VTE events by Royal Papworth staff, radiology alerts, patients, GPs or healthcare professionals in the local hospitals. There may be a considerable delay from the date of the VTE diagnosis to when the event is investigated if the information is not received at the time of diagnosis. We were informed of 3 VTE events in Q2 2019/20. We have been informed of 6 VTE events in Q3 2019/20 the investigations are ongoing and assigned on DATIX. Additionally there were 31 events in 2017/18 compared to 21 in 2018/19 this represents a significant reduction in reported VTE events. Currently we have 10 for 2019/20 with 3 months remaining for the financial year. All reported VTE events are discussed at the VTE scrutiny panel.

VTE SUI (WEB32357) Moderate Harm incident
Summary:
Patient did not have VTE assessment completed on admission from local DGH to RPH. Admitted on 16/08/19. Patient had no prophylaxis prescribed despite being immobile due to stroke and on flowtron boots at DGH. Discovered patient had developed DVT in left leg on 20/08/19.

Actions undertaken on discovery of incident 20/08/19:
Patient's left calf felt warm and was swollen. Measured calfs - Left calf measured 33.5cm, right was 29cm. Bloods taken including d-dimer, 502 informed. Patient went for ultrasound of leg which confirmed DVT. Treatment Tinzaparin prescribed and administered. VTE assessment now complete. Family informed.

Initial findings:
No VTE risk assessment completed on admission
No medical review of the patient documented into Lorenzo from Friday – Monday
DATIX completed regarding lack of medical review for a whole section of the ward noted for Saturday

VTE Risk Assessment
VTE risk assessment compliance with 95% continues to be a challenge on a monthly basis. Year to date compliance is 93%, compliance in Q1 was 92%, Q2 compliance increased to 93.53% and Q3 data is currently being validated. YTD Compliance 94.67% (standard 95%) the Trust is in the lower

quartile for VTE risk assessment in comparison with all Trusts. Current compliance is outlined in Nov 19 PIPR below:

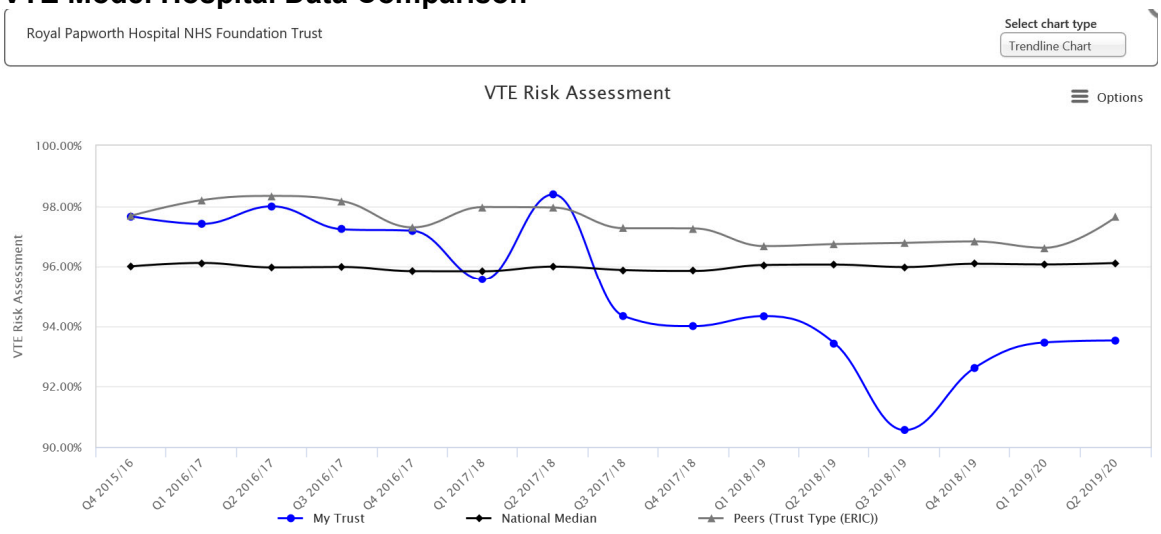
At a glance – Externally reported / regulatory standards

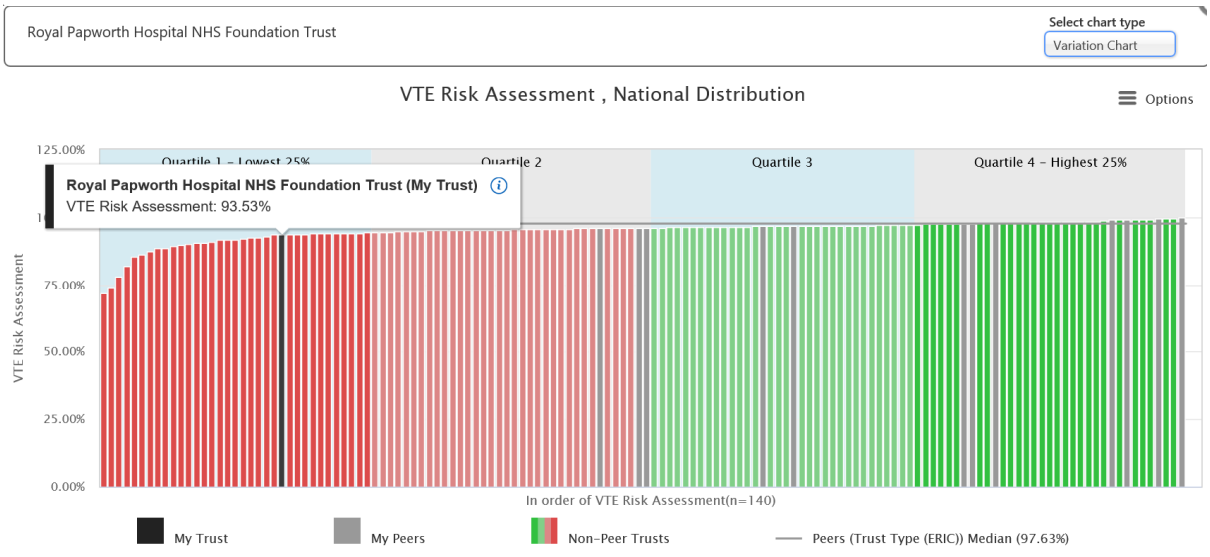
1. NHS Improvement Compliance Framework

NHSI Targets	Measure	Data Quality	NHSI Target	Month	YTD	Previous quarter	Forecast	Comments
C. Difficile	Number of C.Diff cases (sanctioned) year to date	5	11	0	0	0		
	Monitoring C.Diff (toxin positive)	5	Monitor only	0	5	3		
RTT Waiting Times	% Within 18wks - Incomplete Pathways	4	92%	91.60%		90.33%		Monthly measure
Cancer	31 Day Wait for 1st Treatment	3	96%	90.00%	86.86%	98.7%		Current month provisional as going through verification process.
	31 Day Wait for 2nd or Subsequent Treatment - surgery	3	94%	100.00%	100.00%	100.0%		Current month provisional as going through verification process.
	62 Day Wait for 1st Treatment	3	85%	40.00%	64.24%	78.2%		Current month provisional as going through verification process. Data is after reallocations
VTE	Number of patients assessed for VTE on admission	3	95%	94.67%		93.44%		Clinical Governance are reviewing data quality regards this metric with Lorenzo
Finance	Use of resources rating	5	3	3	3	4	3	

Given the SUI noted above and the requirement to gain greater traction in mandatory risk assessments on Lorenzo this has been escalated further to the Director of IT and is noted in PIPR. Clinical areas are required to monitor and escalate all patients who require a VTE risk assessment where this is not completed. This is reported on DATIX.

VTE Model Hospital Data Comparison





VTE Omissions Audit

VTE omissions of prescribed doses continue to be audited by deputy chief pharmacist (report enclosed below). Clinical areas should continue to record reason why prescribed doses not given and aim to reduce the not known/unknown reasons. The omissions data has been shared with all directorates to increase local improvements within ward areas.

Omitted Doses - September 2019

	Status															
	Administered		Home Leave		Not Administered		Not Known		Omitted by Prescriber		Self Administered			Total Number	Total %	
Ward	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%				
3 North East	158	91.33%		0.00%	8	4.62%	4	2.31%	3	1.73%		0.00%		173	100.00%	
3 South East	182	68.94%		0.00%	43	16.29%	25	9.47%	14	5.30%		0.00%		264	100.00%	
3 South West	171	68.67%		0.00%	50	20.08%	21	8.43%	7	2.81%		0.00%		249	100.00%	
4 North East	11	73.33%		0.00%		0.00%	1	6.67%	1	6.67%	2	13.33%		15	100.00%	
4 South East	5	100.00%		0.00%		0.00%		0.00%		0.00%		0.00%		5	100.00%	
4 South West	171	94.48%	4	2.21%	5	2.76%	1	0.55%		0.00%		0.00%		181	100.00%	
5 North East	338	93.11%		0.00%	12	3.31%	10	2.75%	3	0.83%		0.00%		363	100.00%	
5 North West	276	93.24%		0.00%	8	2.70%	10	3.38%	1	0.34%	1	0.34%		296	100.00%	
5 South East	222	91.74%		0.00%	11	4.55%	9	3.72%		0.00%		0.00%		242	100.00%	
5 South West	306	91.07%		0.00%	13	3.87%	14	4.17%	2	0.60%	1	0.30%		336	100.00%	
Grand Total	1840	86.63%	4	0.19%	150	7.06%	95	4.47%	31	1.46%	4	0.19%		2124	100.00%	

	Status
Reason	Not Administered
Clinical Reason	131
Incorrect Route	1
Nil by Mouth	1
Patient Refused	10
Patient Refused Without Capacity	1
Patient Unavailable	3
Wrong Action Selected	2
(blank)	
Grand Total	149

VTE Link Meeting

The next link meeting for VTE leads in clinical areas is taking place on Wednesday 29th January 2020 1130-1230hrs in the ground floor rehab seminar room.

All clinical areas have been asked to send at least 1 representative.

VTE Action Plan

- VTE actions continue to be progressed, still awaiting confirmation from DXC (Lorenzo) when the mandatory VTE form will be added to all patients for whom a drug chart is commenced. Deputy Chief Nurse has included in September PIPR following further discussion with Digital.
- The VTE RCA tool is now live on Datix
- VTE scrutiny panel continues to meet and review VTE events.

General Update

- VTE information displayed on World Patient Safety stand in September. Reminder sent around to all clinical areas to review clinical indicators on Lorenzo.

- VTE reminders to be added to screen savers – Head of Nursing and VTE Nurse Lead to discuss with comms team. Actioned in October 2019.
- Head of Nursing and VTE Nurse Lead attended National Nurses and Midwives VTE meeting on 06th November.
- Head of Nursing and VTE Nurse Lead was due to attend All Party Parliamentary Group meeting on VTE at the House of Commons on 28th November. Meeting was cancelled due to purdah regulations following the announcement of general election in December 2019.
- Quarterly update also shared with Matrons to discuss at directorate meetings, QRMG for information and PMAC for further discussion.

1.6 Inquests

We have been notified about 19 new Inquests / Coroner's investigations in Q3, this demonstrates a significant workload regarding the inquest process. Any learning points identified at Inquest are discussed at QRMG in quarter. There has been three Pre Inquest Hearings (PIRH) held in Q3. There are 35 open inquests /investigations pending – which includes 3 are out of area.

Learning from Schedule 5s (prevention of future deaths)

The prevention of future death reports are published on the Courts and Tribunals judiciary website and reviewed each month. Any relevant reports or themes are forwarded to the relevant clinical leads and presented at the Quality Risk and Management Group for further dissemination and learning. The Trust has not received any prevention of future death reports in relation to Papworth Inquests in Q3.

1.7 Clinical Negligence Litigation

In Q3 2019/20 the Trust has received 2 new requests for disclosure of records, 1 Letter of Claim and 1 notification of intention to claim.3 cases were settled.

2. Patient Experience

2.1 Complaints and Enquiries

We have received **17 formal complaints and 5 enquiries** for Q3. This is a decrease in formal complaints from the following quarter (Q2; 21). Enquiries are where the complaint requires an investigation and written response, but the complainant has expressly stated they do not wish to make a formal complaint. Enquiries that can be responded to more informally are passed to the PALS team for action. A breakdown of enquiries received in Q3 can be seen at Table 5.

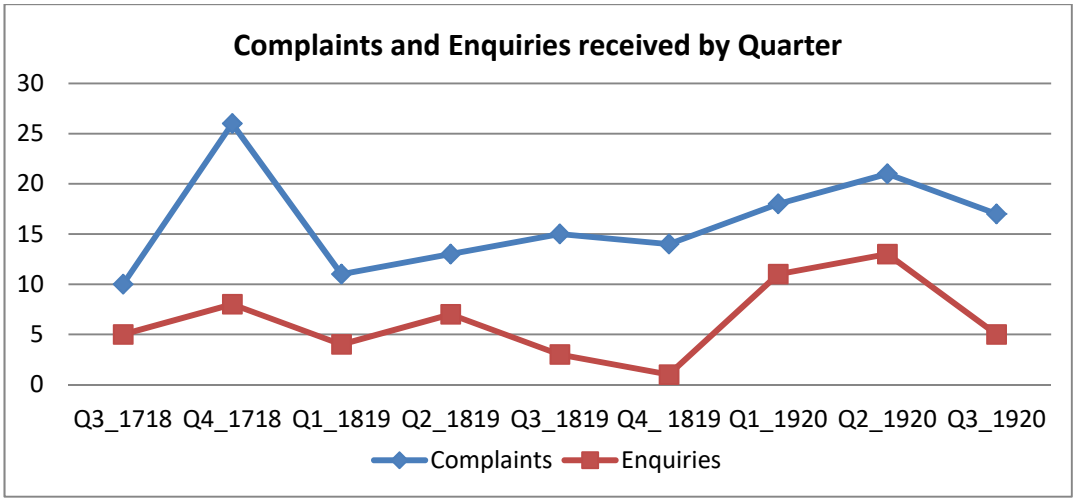


Figure 1: Complaints Vs Enquiries received by quarter (source – Datix 28/01/2020)

**Not all complaints have been fully investigated at the time of this report therefore table 1 shows number of complaints upheld at the time of report. The total number of complaints/enquiries reported in Q3 includes two complaints from private patients. Table 2 and Figure 2 show the primary subject of complaints comparing with the previous quarters.*

Month	No. formal complaints received in Q3 (October - December 2019)	Upheld/Part Upheld	Enquiries for further information
October	5	4	4
November	6	4	1
December	6	2*	0
	17	10	5

Table 1: Numbers of complaints / Enquiries (source: Datix 28/01/2020)

In Q3 we have seen an increase in the number of complaints in the General Medicine category and a reduction in the number of complaints associated with communication and information. Since Q1 2019/2020 Clinical care has been separated by speciality.

Subject	19/20 Q3	19/20 Q2	19/20 Q1	18/19 Q4	18/19 Q3
Clinical Care/Clinical Treatment - General Medicine Group	7	1	4	1	5
Clinical Care/Clinical Treatment - Surgical	3	2	2		
Communication / Information	3	12	10	6	7
Delay in Diagnosis / Treatment or Referral	4	2	0	3	2
Discharge Arrangements	0	0	1	0	1
Environment - Internal	0	0	1	0	0
Staff Attitude	0	0	0	1	0
Privacy and Dignity	0	0	0	0	0
Equipment	0	0	0	0	0
Medication Issues	0	2	0	0	0

Nursing Care	0	1	0	0	0
Parking/Transport	0	1	0	0	0
Catering	0	0	0	0	0
Total	**17**	**21**	**18**	**11**	**15**

Table 2: Primary subject of complaints by quarter (source: Datix 28/01/2020)

Directorate and Speciality	19/20 Q3	19/20 Q2	19/20 Q1
NPH Cardiac Surgery	3	3	0
NPH Cardiology (Risks)	8	7	4
NPH Cath Labs	0	0	1
NPH Critical Care	1	0	0
NPH Interventional Cardiology	0	0	1
NPH Lung Defence	0	1	1
NPH Oncology	0	1	0
NPH Outpatients	0	1	0
NPH PVDU	0	1	0
NPH Respiratory Physiology	1	1	0
NPH Royal Papworth Private Care	1	1	1
NPH RSSC	2	1	1
NPH Thoracic Surgery	0	1	0
Cardiac Surgery (Old Site)	0	2	2
Cardiology (Old Site)	1	0	5
General Radiology (Old Site)	0	0	1
Private patients (Old Site)	0	1	0
Thoracic Surgery (Old Site)	0	0	1
Total	17	21	18

Table 3: Complaints by Directorate and Speciality (source: Datix 28/01/2020)

Quality Dashboard Monitoring – Q3	
Number of complaints responded to within agreed timeframe with complainant	100% **
Number of PSHO referrals in quarter	0
Number of PHSO referrals returned upheld with recommendations and action plans	0

*Table 4: Quality Dashboard monitoring (** 100% of complaints responded to at the time of reporting within timescales agreed)*

Enquiries received in Q3 19/20

Date Received	Reference	Location	Inpatient/Outpatient	Description	Subject
03/10/2019	Q31920-65En	NPH Outpatients	Outpatient	Patient has been unable to contact anyone in PVDU to discuss CT results. Patient unhappy with experience and delay in receiving her results	Communication / Information
09/10/2019	Q31920-67En	Varrier Jones (Old Site)	Inpatient	Patient underwent AVR & CABG August 2012. Care followed up at Ipswich since procedure. Now advised due to condition she will need open heart surgery - has requested clarification of medical information around her procedure.	Communication / Information

21/10/2019	Q31920-69En	Cardiology Outpatients (Old Site)	Outpatient	Daughter unhappy at the difficulty experienced with Communication/Appointments re her late mother	Communication / Information
25/10/2019	Q31920-71En	NPH Outpatients	Outpatient	Patient waiting for CABG advised missed appointments not aware of. Clarification around letters/appointments requested. Also clarification of anticipated date for procedure	Information / Advice Requests
21/11/2019	Q31920-78En	NPH 3 South Cardiology	Inpatient	Patient sustained a fall whilst a treatment plan was being agreed - investigated as a SUI but family have concerns regarding referral and decision making	Clinical Care/Clinical Treatment - General Medicine Group

Table 5: Enquiries received in Q3 2019/20 (Source Datix 28/01/2020)

2.2 All upheld or part upheld complaints receive a full explanation and an appropriate apology.

Identified actions arising from complaints upheld or partially upheld in Q3 2019/20

Complaint Reference	Complaint Overview	Outcome	Action(s) identified - Highlighted actions are outstanding and monitored via the Quality and Risk Management group for completion
Q31920-79F	Patient has raised concerns about the cancellation of her appointment on two occasions	Upheld	Improve critical care unit staffing levels **– June 2020**
			Improve communication regarding cancellations to patients **– March 2020**
			Escalation procedure in place. Monitoring against 28 day target. **- COMPLETED**
Q31920-74F	Patient unhappy with the lack of communication prior to her procedure and the delay in having the procedure due to waiting for particular stent	Upheld	Ward staff education – Cascade information relating to the issue of our angiography stents containing Nickel & Cobalt to all ward staff **- COMPLETED**
			Share with the Consultant Team the requirements for requesting a Titan Optimax stent from Hexacath and the minimum information required **- COMPLETED**
			Raise awareness amongst the Cardiology team, share learning at team meeting to ensure appropriate actions are taken, including the process for highlighting allergies of this nature to the Cath Lab Coordinator **- COMPLETED**
Q31920-83F	Patient has raised a number of issues relating to information provided on discharge and delays and potential error with discharge medication	Upheld	Ward Sister and Matron to meet with Lead Pharmacist to discuss the issues related to discharge lounge and identify potential improvements **- COMPLETED**

			The re-education of staff on 3 South that the overnight patients from day ward do not need TTO **– February 2020**
			Amend the ICD booklet regarding which patients need to inform DVLA of the implant **– February 2020**

Table 6: Actions arising from investigation of complaints upheld /part upheld in Q3

2.3 Local Resolution Meetings in Q3 - The Trust has not held a local resolution meeting in Q3.

2.4 Ombudsman's Referrals - No New Ombudsman's Investigations notified in Q3 and none outstanding.

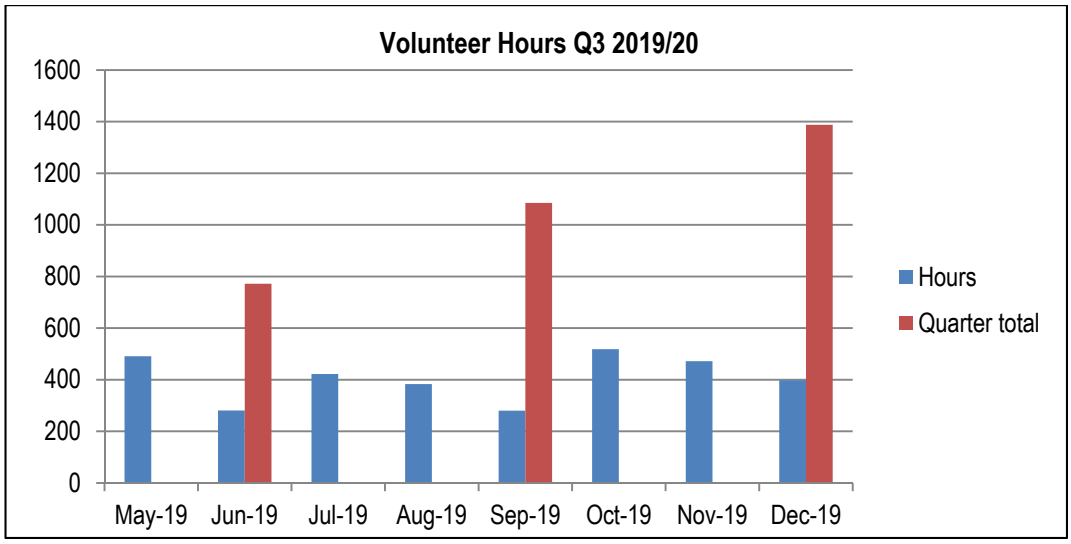
3 Patient Advice and Liaison Service Q3 Report 2019/20

3.1 Patient Carer Experience Group (PCEG) Meeting

- The meeting held on the 14th October 2019 was well attended. The agenda includes a patient story, current issues, updates regarding volunteers, patient representatives on committees, support groups, friends and family survey information and health watch.

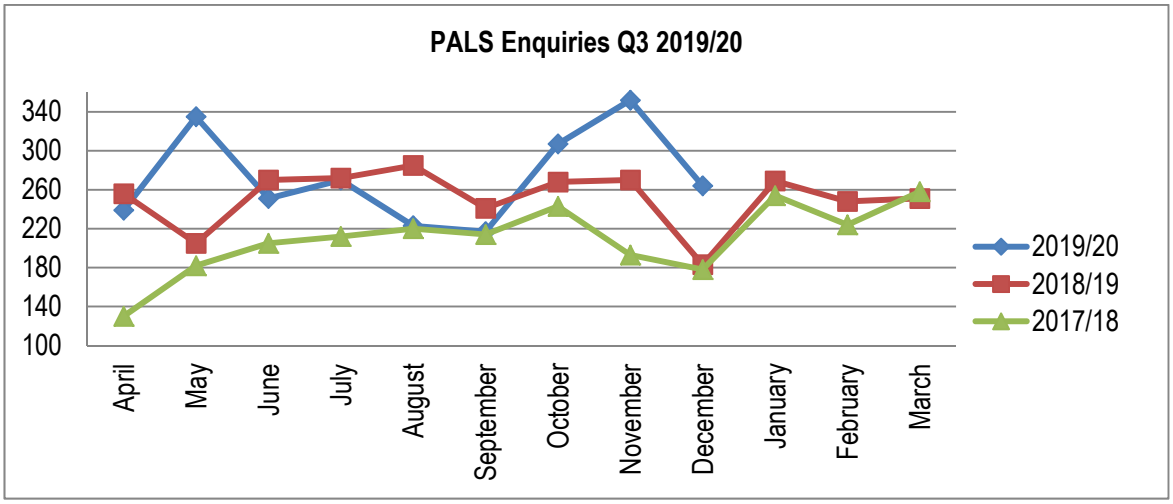
3.2 Volunteers

- In Q3 there were 63 active hospital volunteers, supporting the clinics, wards, meetings, proof reading and administration.
- 18 volunteers completed their Fire and BLS face to face training in November 2019.
- There are 19 volunteers that need to complete their fire and BLS training. Fire will be attended as part of the regular staff training dates. The BLS is now online and will be completed as part of the mandatory online training programme.
- There are currently 18 volunteers going through the recruitment process and they will start in January and February 2020.
- Our volunteers contributed 1388 hours during this quarter. We implemented collation of volunteering hours in May 2019.
- PALS are still liaising with the HR/workforce team regarding the online mandatory training; we hope to get the new process in place by the end of February 2020.
- Uniforms have still not arrived; the Deputy Chief Nurse is supporting this process and chasing delivery.

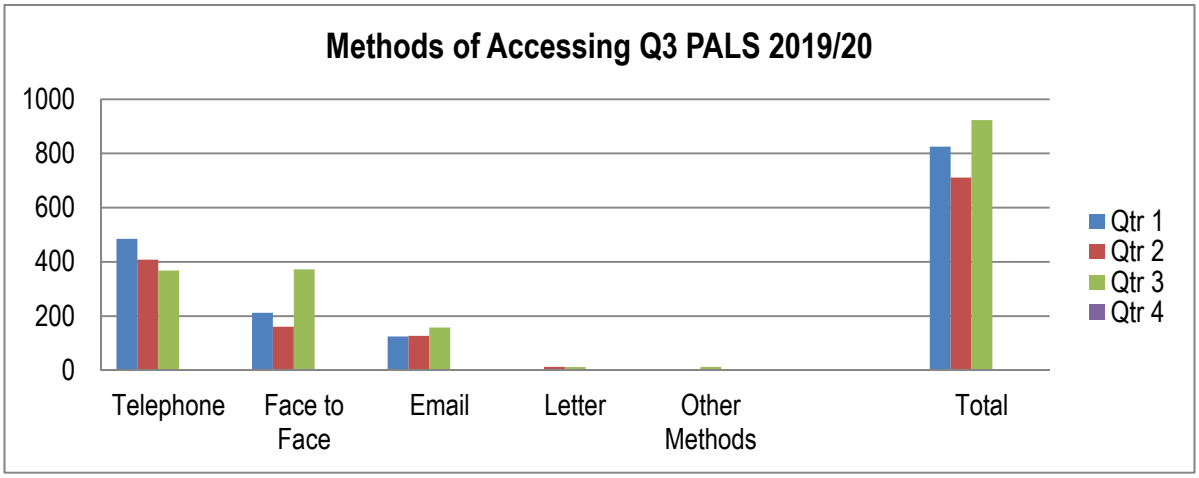


3.3 Patient Advice and Liaison Service (PALS)

During Q3 2019/20, the PALS Service received **923** enquiries from patients, families and carers. This was an increase of **202** on the number recorded in Q2 2018/19 which was **721.**



The table below shows how patients, relatives and carers have accessed the PALS Service during Q3:



Concerns Raised
The table at Appendix 1 shows the concerns by category for Q3 in 2019/20.

Key themes raised from PALS enquiries in Q3 2019/20

Subject (Primary)	Number of enquiries received	Details
Information and Advice	447	This is an increase of 3 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes: 110 related to onsite directions 69 related to accommodation 60 related to telephone contact number
Communications	154	This is an increase of 38 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes: 46 related to requests for clarification of medical information 26 related to phones unanswered 21 related to contact phone numbers
Delay in diagnosis/treatment or referral	72	This is a increase of 25 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes:

Subject (Primary)	Number of enquiries received	Details
		30 related to waiting times for appointments 19 related to delay in diagnosis/treatment 11 related to waiting time for operation/procedure
Parking	70	This is an increase of 40 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes: 28 related to parking charges 28 related to parking letter 9 related to 'other parking issue'
Transport	73	This is an increase of 45 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes: 30 related to local transport information 22 related to travel claims 13 related to hospital contract transport
Medical Records	26	This is an increase of 14 enquiries compared to the same quarter last year (Q3 2018/19) Top three themes: 20 related to access to medical records 3 related to update medical records 3 related to 'records other'
Environment - Internal	6	This is an increase of 6 enquiries compared to the same quarter last year (Q3 2018/19) 5 related to poor environment 1 related to inadequate facilities for disability
Nursing Care	2	This an increase of 1 enquiry compared to the same quarter last year (Q3 2018/19) 1 related to dissatisfied with nursing care/treatment 1 related to dissatisfied with personal care provided
Environment - External	10	This is an increase of 10 enquiries compared to the same quarter last year (Q3 2018/19) 10 related to poor environment
Staff Attitude	7	This is an increase of 2 enquiries compared to the same quarter last year (Q3 2018/19) 4 related to rudeness 3 related to uncaring behaviour
Equipment Issues	12	This is the same as the same quarter last year (Q3 2018/19) 8 related to lack of/inadequate equipment 2 related to return of equipment 2 related to CPAP machines
Medication Issues	1	This is a decrease of 6 enquiries compared to the same quarter last year (Q3 2018/19) 1 related to prescriptions
Discharge Arrangements	6	This is the same as the same quarter last year (Q3 2018/19) 3 related to lack of arrangements for home after discharge 2 related to wait to transfer to other facility 1 related to delay in discharge
Clinical Care	2	This is the same as the same quarter last year (Q3 2018/19) 2 related to dissatisfied with medical care/treatment/diagnosis
Property	22	This is an increase of 16 enquiries compared to the same quarter last year (Q3 2018/19) 22 related to loss/damage of property
Admissions Arrangements	5	This is an increase of 4 enquiries compared to the same quarter last year (Q3 2018/19)

Subject (Primary)	Number of enquiries received	Details
		3 related to visiting hours 2 related property/clothes required for admission
Catering	6	This is an increase of 6 compared to the same quarter last year (Q3 2018/19) Top three themes: 2 related to poor quality of food 2 related to poor service in restaurant 2 related to lack of adequate choice of food
Patients Charges	2	This is an increase of 2 compared to the same quarter last year (Q3 2018/19) 1 related to payment incorrect 1 related to 'other' charges

There were 4 enquiries regarding private patients. The table below shows the breakdown by subject.

Subject	No. PALS Enquiries
Communication/Information	1
Information/Advice Requests	1
Delay in Discharge/Treatment/Referral	1
Patient Charges	1
Total	**4**

During Q3 no PALS enquiries were escalated to formal complaints. **2** enquiries were signposted to organisations external to the Trust.

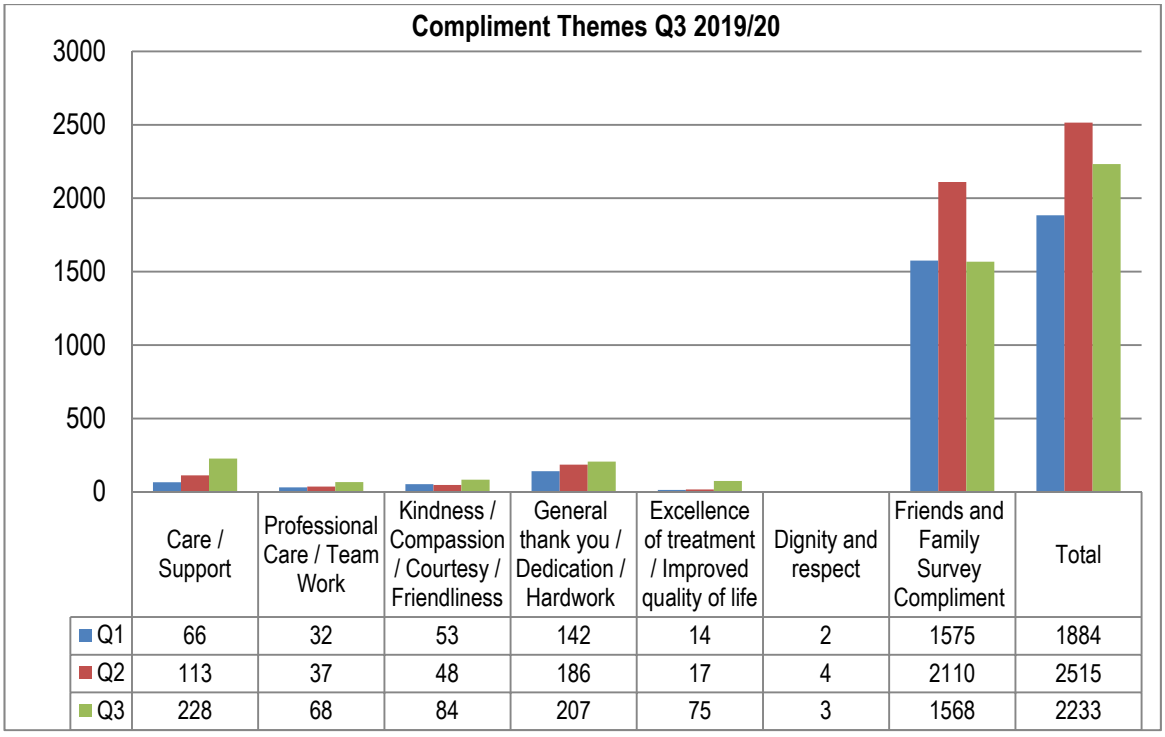
3.4 Compliments

There were 2233 compliments received across the Trust during Q3 2019/20, this is a decrease of 272 on the same time last year (Q3 2018/19)

Compliments are received verbally, letters, thank you cards, e-mails, suggestion cards and Friends and Family Surveys and via the CEO.

The top themes for compliments for Q3 in 2019/20 were:

- General thank you/dedication/hard work
- Care/support
- Kindness/compassion/courtesy/friendliness



	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	1575	1884
Q2	113	37	48	186	17	4	2110	2515
Q3	228	68	84	207	75	3	1568	2233

Examples of feedback taken from 'Thank you cards':

- 'Your care and kindness was outstanding'
- 'Keep up the amazing work that you do. Your skill and dedication are what makes the hospital so special'
- 'I just wanted to thank you for getting me so well for my wedding. We had the most amazing day and it wouldn't have been the same had I not been so well. Thank you again you're the best team'

3.5 Friends and Family Surveys collected during Q3 19/20

Survey Name	Number Collected
Outpatients	778
Inpatients – Day ward	876
Inpatients	907
Private Outpatients	5
Private Inpatients	25
Total	**2591**

3.6 Changes made following feedback:

Examples include:

- Feedback received regarding issues with blue badge parking at RPH. PALS supported 6 patients/relatives with the appeal process following their cars being ticketed. PALS fed this back to the senior team and requested that it be reviewed. Following a review immediate action was taken to change the process allowing blue badge holders to park in all the bays for a period of up to 4 hours, if a disabled bay was not free.
- Feedback received regarding gluten free diets. PALS contacted the catering manager to clarify what arrangements were in place for patients requiring a gluten free diet. Catering manager visited the patient to discuss their feedback. Awareness sessions will implemented to all housekeeping staff regarding individual dietary requirements of patients.
- Feedback regarding the revolving doors into the hospital, following a patient being injured. Signs are now in place to alert patients/visitors when and where to enter and exit the doors.

3.7 Bereavement Services

- 47 patients passed away in Q3.
- PALS continued to provide all clinical areas with the relevant and up-to-date paperwork for when a patient dies.
- Supported, facilitated and provided information to all medical staff regarding the online coroner's portal and the process on how to log in and use the service.
- Continued to work with the Medical Staffing team to ensure that we are provided with starter and leaver lists, so that the portal is managed and maintained with accurate information. This will guarantee that all relevant doctors have access.
- Supported our Bereavement Care and Mortuary team at CUH with chasing outstanding paperwork and completion of the bereavement process.
- Organised 4 follow up meetings with families and medical teams.

4. Risk Management

4.1 Non Clinical Accidents/Incidents

During quarter 3 there have been 260 accidents/incidents (including near misses), similar to previous quarters in this financial year, which have involved staff/contractors/organisation or visitors. This represents a sustained increase in reported incidents since moving in to the new hospital; a proportion of which captures staffing and bed access incidents which are shared with the Heads of Nursing and the issues fed into the Hospital Optimisation project. The number of issues linked to the contractor incidents e.g. failure of cleaning services will continue to be reported and are being investigated by them, with learning being captured on Datix. Table 1 shows the incidents by type, the majority continue to relate to Organisational Issues and staffing (37%). The increase is due to a raised awareness and capture of issues to ensure they are visible to a wider proportion of staff. Staffing is monitored at Board level and reported in the monthly PIPR. The second most common incidents relate to Administration issues (12%) which link to process across the Trust and are being reviewed as part of the Trust Optimisation project (see section 1 – patient incidents).

Type	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	Total	% of Q3 Total
Accidents	4	3	7	3	6	23	2%
Administration - admission/discharge/transfer	37	21	14	38	32	142	12%
Anaesthetics	1	0	0	1	2	4	1%
Behaviour/Violence Aggression	4	1	5	1	2	13	1%
Blood Plasma Products	2	1	6	7	4	20	2%
Communication/Consent	11	5	13	14	6	49	2%
Data protection	8	8	10	15	6	47	2%
Diagnosis Process/Procedures	3	3	6	6	5	23	2%
Documentation	11	7	21	22	10	71	4%
Environmental Hazards/Issues	17	6	13	24	21	81	8%
Fire Incidents	2	1	0	2	2	7	1%
Infection Control	15	17	11	8	9	60	3%
Information Technology	20	3	26	17	8	74	3%
Medical Devices	8	16	20	16	14	74	5%
Medication/Medical Gases/Nutrition	20	31	27	24	21	123	8%
Nutritional Feeding (Prescribed Feeds)	0	0	0	0	1	1	0%
Organisational Issues/Staffing	31	31	65	52	96	275	37%
Pressure Ulcers	0	0	0	0	2	2	1%
Radiology	1	2	3	0	2	8	1%
Security incidents	3	3	4	10	2	22	1%

Treatment/Procedures	4	3	6	5	9	27	3%
Total	202	162	257	265	260	1146	100%

Table 1 – Non-clinical Incidents Reported for 2019/20 (Data source: DATIX 22/01/20)

4.2 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)
During quarter 3 there have been three new RIDDOR reportable incidents which required reporting to the Health & Safety Executive (HSE).

4.3 Risk Register
There are currently a total of 617 open project, BAF and business risks; with a proportion linking directly to health & safety/staff wellbeing. This demonstrates that the Trust is actively updating their risks and checking them for relevance in the new hospital environment. Of which 201 are overdue with 16 being graded as Extreme risk. A monthly reminder schedule is being set-up for both overdue Corporate Extreme risks and overdue action plans. Updating of risk records is key to the Risk Manager "new" quarterly report to the Board and the further maturity of the Trust Risk processes; escalation of these risks are noted at QRMG. A central folder has been created which can be accessed by all staff and all non BAF Trust wide risks are located here. All new risks graded 12 and above are shared at QRMG & Q&R in addition to departmental meetings.

All departments have access to their risk register information via the Datix Risk Management dashboards. Corporate and Board level risks are presented to the Trust Audit Committee.

A review of the general health and safety risks is underway to ensure that overall aspects of legislation are being complied with. This review will highlight actions for the next financial year.

4.4 Non-clinical claims
There are no new claims brought against the Trust. There are 5 ongoing claims. All claims are shared with the local department and Root Cause Analysis reports requested at the time of the incident.

4.5 Safety Alerts
The Safety Alert information is monitored monthly by the QRMG and at local Business Unit Meetings. Alerts are then stored for historical reference within the RIMS (Risk Information Management System - Datix).

Throughout quarter 3 2019/20 the Trust has received 38 Safety Alerts and Field Safety Notices and an additional 4 update notices. Of the 38, 27 (plus four update notifications) were formal Safety Alerts raised through the Central Alerting System (CAS), and 11 additional Field Safety Notices raised by manufacturers. This does not account for medication safety alerts which are managed by the pharmacy team. All medication alerts are now alerted via the CAS system only, however the CAS system does not require a formal response. Table 1 represents the data reported publicly through the CAS including the updates of previous alerts. At the close of the financial quarter all externally reported deadlines were met as they fell due.

Central Alerting System Quarter 3 2019/20

Status\Alert Type	MDA	PSA	EFA	DDL	CMO	SDA	CHT	Total
Assessing Relevance	0	0	0	0	0	0	0	0
Action Not Required	14	1	0	0	0	0	0	15
Action Required/Ongoing	0	1	1	0	0	0	0	2
Action Required/Completed	0	1	0	0	1	12	0	14
Total	14	3	1	0	1	12	0	31
Breached	0	0	0	0	0	0	0	0

TABLE 1

Key for Alert Type: MDA – Medical Device Alert, PSA – Patient Safety Alert, EFA – Department of Health – Estates & Facilities Alert, DDL – Dear Doctor Letter, CMO – Chief Medical Officer, SDA – Supply Distribution Alert, CHT- Central Alerting Helpdesk Team

5.0 Effectiveness of care

5.1 Quality and Safety Measures

A summary of the ongoing monitoring for the Safety Thermometer, mortality monitoring and NICE Guidance is presented in appendix 2 - 4

5.2 Clinical Audit

National Audits

A number of national audits have been published in Q3. These are listed below and have been disseminated via QRMG.

NCAP Annual Report – The 2019 National Cardiac Audit Programme (NCAP) Annual report was published in September 2019. The NCAP Annual Report summarises over 300,000 submissions across 6 national clinical audits. The report groups quality recommendations across 5 clinical domains (Congenital Heart Disease, Heart Attack, Percutaneous Coronary Interventions, Adult Surgery and Heart Failure), recommendations against a 6th clinical domain, Cardiac Rhythm Management will be published at a later date.

NCEPOD Know The Score (Pulmonary Embolism) - The aim of this study was to highlight areas where care could be improved in patients with a new diagnosis of acute pulmonary embolism (PE). The report consists of 6 core quality improvement themes. A progress update against delivery of these quality improvement themes has been requested by QRMG in Q4 19/20.

Local audit

The table in appendix 3 illustrates the completed audits for Q3. The number of local audits completed remains consistent with Q2, as the team continues its transition to become the Clinical Audit & Improvement team. The team is currently working with business units to ensure any risk associated with reduced audit activity is managed. The team has started preparatory work to ensure the 20/21 plan is manageable and fully supported. This includes new internal processes being developed within the team, as well as an updated Clinical Audit procedure to be shared with the wider organisation in Q4.

NSF / NICE Guidance received in quarter & progress

A total of 7 NICE guidance documents were disseminated for feedback during Q2.
Please see appendix 4 for a list of applicable guidance and compliance ratings.

5.3 Quality Improvement

The Trust has identified 3 key priority projects for Quality Improvement which is aligned with the Quality Account priorities. An update on the progress to date is provided below:

In House Urgent Pathway (IHU)

Aim for 2019/20:

- 98% of patients who are on an IHU pathway will be assessed at MDT within 1 day once compliant with the Minimum Data Set (MDS) requirements
- 98% of patients on IHU pathway will have their surgery within 10 days (start date = when fit for surgery)
- 98% of all cancelled surgery will be rescheduled within 5 days

Goals for 2019/20

- Develop pathway standards for referral, MDT, Cardiology and Surgery
- Agree ownership of IHU patients between Cardiology, Surgery and ANP
- ANP to attend twice weekly bed meeting
- To engage with central bookings team to ensure accurate and equitable allocation of IHU capacity
- Daily monitoring of IHU spreadsheet, referrals and waiting times for IHU surgical slots

- Operational Manager to assist with the scheduling and rescheduling of IHU patients
- Theatre Manager to assist in the allocation of IHU patients and procedure for rescheduling within 5 days
- Review IHU pathway staffing requirement
- Review the IHU / elective surgical waiting lists
- Update the PRIS Referral Form / System

Project update January 2020

- Entire pathway review
- Pathway standards agreed (Referrals, MDT, Cardiology, Surgery) with exception of patient ownership between Cardiology and surgery
- Data accuracy improved through daily monitoring of IHU spreadsheet
- Minimum dataset standard for referrals agreed and work ongoing to make mandatory field in PRIS
- 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
- Increase in theatre capacity to 15/week since opening of Theatre 6
- Cancellations tracked and recorded with any unfit / suboptimal work up cancellations reviewed by IHU team
- SCN frailty project set up and commencing wave 3
- Ongoing monthly data collection

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

Deteriorating Patients

Aim: For 100% patients on 5 North ward with a NEWS2 of 5 or more will receive the correct actions according to RPH escalation guidelines by [*timeframe TBC*].

Baseline data completed July – Sept 2019
35% documented escalation to medical team, 33% documented escalation to Alert team within baseline period

Issues highlighted:
Significant issues with the communication between Mindray and Lorenzo meant that Obs were not pulling through so unable to determine if obs were repeated within timeframe for majority of audited patients
Issues with bleeps not working in certain parts of the hospital
Data entered into handheld devices currently not retrievable (used by alerts team to note ‘reviewed but not needed to be seen’)

Completed changes:
Education in deteriorating patient study days and band 2/3 competencies ongoing
509 and 502 given mobile phones to make them more contactable if bleeps not working
Safety huddles implemented and work ongoing to improve
Hospital at night policy DN749

Ongoing actions:
Improving the use of SBAR when verbally escalating a patient to the Alert / medical team
Improve communication between IT systems

Change wording on Mindray monitors to escalate to ALERT team rather than 'competent staff'

Patient Falls – December 2019 Update

The aim of the Falls Quality Improvement Project is to reduce falls by 10% per 1000 bed days by April 2020 for Cardiac Surgery patients on 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. 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%).

PALS Enquiries Quarterly Report

Subjects/Sub-Subjects	2018/19				2019/20		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Verbal or Physical Abuse	**1**	**0**	**1**	**0**	**0**	**0**	**0**
Verbal Abuse by Patient	1	0	1	0	0	0	0
Admission Arrangements	**1**	**1**	**1**	**0**	**1**	**4**	**5**
Availability for Wi-Fi	1	1	1	0	0	1	0
Property/Clothes required for admission	0	0	0	0	0	0	2
Visiting Hours	0	0	0	0	1	3	3
Staff Attitude	**2**	**3**	**5**	**16**	**3**	**13**	**7**
Inappropriate manner/behaviour	0	0	1	3	1	2	0
Rudeness	1	0	3	1	1	4	4
Uncaring behaviour	1	3	1	12	1	7	3
Clinical Care	**1**	**10**	**2**	**2**	**1**	**1**	**2**
Disagreement with treatment/outcome/diagnosis	0	5	1	0	0	0	0
Inappropriate treatment given	0	1	0	0	0	0	0
Poor recovery after discharge	0	4	1	0	0	0	0
Dissatisfied with medical care/treatment/diagnosis	1	0	0	2	1	1	2
Infection Control Issues	**0**	**0**	**0**	**1**	**0**	**0**	**0**
Infection/Infection Control query	0	0	0	1	0	0	0
Lack of Cleanliness (Hygiene)	0	0	0	0	0	0	0
Nursing Care	**1**	**1**	**3**	**4**	**1**	**0**	**2**
Dissatisfied with Personal Care Provided	0	0	0	1	0	0	1
Dissatisfied with nursing care/treatment	1	1	3	3	1	0	1
Catering	**0**	**3**	**0**	**1**	**4**	**7**	**6**
Food served at incorrect temperature	0	1	0	0	1	1	0
Inadequate portion size	0	0	0	0	0	1	0
Lack of availability of food	0	2	0	1	0	1	0
Lack of adequate choice of food	0	0	0	0	1	0	2
Poor service in restaurant	0	0	0	0	0	2	2
Poor Quality Food	0	0	0	0	2	2	2
Patient charges	**0**	**0**	**0**	**3**	**2**	**2**	**2**
Eligibility Criteria	0	0	0	0	0	0	0
Other charges	0	0	0	0	0	0	1
Request for payment incorrect	0	0	0	0	0	0	1
Treatment Costs	0	0	0	3	2	2	0
Communication	**129**	**152**	**116**	**110**	**158**	**138**	**154**
Breach of Confidentiality	0	2	3	3	3	0	2
Clarification of Medical Information	47	32	48	47	46	41	46
Consent Issues	0	0	0	0	0	0	0
Diagnosis Query	0	0	0	0	1	1	2
Freedom of information requests	0	0	0	0	0	0	1
Incorrect Information provided	2	5	0	1	0	7	3
Information for patients	0	0	0	0	0	0	1

Subjects/Sub-Subjects	2018/19				2019/20		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Lack of Information for other Professional	0	5	4	3	1	4	1
Lack of Information for Patients	24	15	5	7	16	14	20
Lack of Information for Relatives	7	6	0	3	4	2	4
Lack of Sensitivity in Communication	1	1	2	1	0	2	0
Other communication issues	4	5	4	2	8	2	4
Poor or Conflicting information	5	4	1	5	8	18	12
Translation & Interpretation Services	1	3	2	4	6	1	3
Phones unanswered	21	54	15	20	29	17	26
Contact phone number	12	16	16	4	26	12	21
No response to phone messages	4	1	3	3	3	2	0
Answerphone incorrect	0	1	0	0	0	0	0
Booking Office	0	1	13	4	6	14	5
Compliments	1	1	0	3	1	1	0
Residency form	0	0	0	0	0	0	3
Delay in diagnosis/treatment or referral	**46**	**73**	**47**	**68**	**74**	**41**	**72**
Cancellation of treatment	5	3	5	7	5	8	7
Clinical waiting times	0	3	2	2	6	2	1
Delay in diagnosis/treatment	9	35	9	22	17	10	19
Delay in referral	1	4	5	4	3	0	4
Failure to book treatment/appointment	0	0	0	1	0	1	0
Waiting time for admission to ward	0	0	0	1	0	0	0
Waiting time for appointment	20	21	21	23	31	16	30
Waiting time for operation/procedure	11	7	5	8	12	4	11
Lack of privacy and dignity	**0**	**0**	**0**	**1**	**0**	**1**	**0**
Lack of privacy/dignity on ward	0	0	0	1	0	1	0
Lack of privacy when relaying information	0	0	0	0	0	0	0
Discharge Arrangements	**4**	**5**	**6**	**0**	**4**	**3**	**6**
Delay in discharge	1	3	0	0	0	0	1
Dissatisfaction with discharge to another hospital	1	1	0	0	0	0	0
Lack of arrangements for home after discharge	2	1	6	0	4	2	3
Wait to transfer to other facility	0	0	0	0	0	1	2
Equipment Issues	**9**	**5**	**12**	**6**	**10**	**11**	**12**
Delays in replacing equipment	0	0	0	0	0	0	0
Lack of/Inadequate equipment	9	4	9	6	10	10	8
Return of Equipment	0	1	3	0	0	1	2
CPAP Machines	0	0	0	0	0	0	2
Information/Advice Requests	**427**	**432**	**444**	**475**	**408**	**343**	**447**
Accommodation	15	15	9	6	35	37	69
Appointments	60	59	64	62	60	57	50
Advice on Medication	11	7	4	4	3	10	5
Advice on Equipment	5	15	16	15	15	32	42
Benefits	4	2	1	0	7	3	4
Information on Hospital Services	39	39	36	32	36	44	16
Off Site Directions	2	2	2	1	16	18	13

Subjects/Sub-Subjects	2018/19				2019/20		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
On site directions	211	171	220	201	104	29	110
Other information request	8	6	2	6	2	0	7
Telephone contact number	34	50	35	81	71	64	60
Requests for information on volunteering	14	17	5	20	19	9	11
Bereavement Process	6	15	12	14	6	4	12
Complaints Procedure	3	1	8	6	8	8	22
E-Mail Address	5	16	23	14	12	18	11
Referral Information	7	9	5	11	14	3	14
Sick Note	0	1	0	0	0	0	0
Signposting to other NHS organisation	2	1	1	0	0	2	1
Signposting to other organisation	1	6	1	0	0	2	0
Phones unanswered	0	0	0	2	0	17	0
Environment - Internal	**7**	**5**	**0**	**1**	**9**	**4**	**6**
Cleanliness Toilet	3	2	0	0	0	0	0
Cleanliness of ward	1	0	0	0	0	0	0
Inadequate facilities for disability	0	0	0	0	1	1	1
Maintenance	3	0	0	0	3	0	0
Poor Environment - Internal	0	2	0	0	4	2	5
Temperature on ward too hot/cold	0	0	0	0	0	0	0
Hostel Accommodation	0	0	0	1	0	0	0
Health and Safety	0	0	0	0	0	1	0
Lack of resource	0	1	0	0	1	0	0
Environment - External	**0**	**0**	**0**	**0**	**0**	**9**	**10**
Poor environment	0	0	0	0	0	9	10
Medication issues	**6**	**4**	**7**	**5**	**11**	**6**	**1**
Incorrect medication	0	1	0	1	0	1	0
Failure to provide medication	2	0	1	2	3	0	0
Prescriptions	4	3	5	2	8	4	1
Pain management	0	0	1	0	0	1	0
Parking	**41**	**34**	**30**	**48**	**60**	**42**	**70**
Disabled access	14	2	8	19	8	4	4
Other Parking Issue	5	13	2	5	14	6	9
Parking Charges	14	18	20	22	38	23	28
Parking Directions	8	1	0	2	0	9	1
Parking Letter	0	0	0	0	0	0	28
Lost Property	**12**	**5**	**6**	**6**	**10**	**21**	**22**
Loss/Damage of property	12	5	6	6	10	21	22
Medical Records	**11**	**27**	**12**	**13**	**10**	**19**	**26**
Incorrect information in health record	0	1	1	0	0	1	0
Records Other	3	6	1	1	0	3	3
Request for access to medical records	7	15	8	9	8	11	20
Request to update to records	1	5	2	3	2	4	3
Training	**1**	**0**	**1**	**0**	**0**	**0**	**0**
Request for training placement	1	0	1	0	0	0	0

Subjects/Sub-Subjects	2018/19				2019/20		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Transport Issues	**32**	**37**	**28**	**19**	**59**	**46**	**73**
Hospital contract transport	3	0	3	2	4	2	13
Local transport information	21	9	10	2	35	16	30
NHS transport Issues	7	8	9	10	10	5	5
Other Transport issue	0	17	4	2	3	5	3
Travel Claims	1	4	2	3	7	18	22
Total Number of Enquiries:	**731**	**798**	**721**	**773**	**825**	**711**	**923**

Please note that within each enquiry there could be multiple subjects and sub-subjects

Local Clinical Audit Summary

The table below illustrates the completed clinical audit & effectiveness projects for quarter 3

Title	Quarterly report: Quarter 3 (Oct - Dec)
Review of 'Urinary Retention' in post-operative thoracic ward patients with epidural or extra-pleural analgesia	5/18 developed symptoms of urinary retention 2/5 resolved without intervention, 3/5 required urinary retention All the patients who experienced urinary retention were receiving extra-pleural analgesia There were a total of 5 patients receiving epidural analgesia over a 6 month period – maintaining competence is potentially an issue.
Scrubbing and gowning (Infection control / Theatres crossover)	**Findings:** This re-audit shows excellent adherence and understanding of the scrubbing and gowning procedure, with only 1 observation out of 39 using an incorrect method for 4 out of the 13 aspects of the measured criteria. 'Aspects of scrubbing and gowning to be measured 4.1' has dropped to 60% which is actually only due to 2 out of 5 people, needing to be challenged and asked to re-scrub. **Recommendations** To scrub assess all new starters prior to being exposed to the surgical field and then carry out annual assessment of scrubbing and gowning technique. Closed technique continues to be demonstrated on audit morning teaching sessions until next audit. Re-audit with regard to the drop to 60% measured on 4.1
Surgical skin prep (infection control / Theatres crossover)	**Findings:** This continues to be a positive report with 18 standards maintaining or improving compliance. **This re-audit demonstrates a decline in compliance for standards 11 and 12 but as the previous audit showed, this can be attributed to only one person not following the correct procedures. Standard 4iii 'under the area close to the diathermy plate' shows the highest drop in compliance since the last audit from 100% to 88%, as a result of 2 people not adhering to the correct procedure.** **Recommendations** It should be determined by the Infection Control team whether the Consultants prepping preferences are appropriate. If deemed to be putting patients at risk of infection, further education and training should be given about the wearing of a sterile gown and double gloves to minimise the risk of surgical wound infection in the patient and at the same time protecting the team from exposure to blood and body fluid contamination.
Completeness of workup for surgery (re-audit cycle 3)	Report not sent through
Subdural haemorrhage in patients undergoing Pulmonary endarterectomy	**Data collected June 2014 – Dec 2016. Delay in receiving report.** **Findings:** • Incidence of Subdurals post PTE has decreased from 9% to 6.5% • VIT K administration pre surgery needs to be strictly implemented. • Post-operative serum urea levels were significantly higher in subdural group. – This factor may need to be further studied to answer whether this rise in urea is as a part of maintaining a strict negative balance or due to AKI sustained during the surgery. • Most of the subdurals were diagnosed in the first week post PTE. But can occur as late as 31 days post PTE.
Avoidable ABG sampling (CCA)	As part of the Choosing Wisely initiative which aims to increase awareness of unnecessary medical tests, treatments, and procedures, some authors have described too frequent sampling routines. **Findings**

	Marked and sustained reduction in unnecessary blood gases in CCA demonstrated following educational efforts and increased awareness. However, 39% of the testing doesn't lead to medical action and a significant number of ABGs remain redundant and therefore avoidable. This data encourages the implementation of ongoing educational efforts directed at further reducing ABG and optimizing indication for sampling.
Q3 commodes	Findings: All wards scored 100% except for 4 SW (83%), 5 South (94%). Recommendations/Actions: Areas of concern were Commodes not correctly cleaned and Commodes not correctly stored. Ward managers notified and advised to familiarise staff with DN11 section 6
Q3 Raised Toilet Seats	Findings: 4 North East scored 100%, 3 South, 4 South West and 5 North scored below 95% by not marking the toilet seat as clean and storing correctly Recommendations/Actions The area of concern was the raised toilet seats were not correctly stored. Ward managers notified and advised to familiarise staff with DN11 section 6
Linen	Findings: • Components scoring less than 95% compliance: o Clean linen store is clean and free from dust (88%) CCA o Bags are less than 2/3 full and are capable of being secured (88%) 5N o Bags are stored correctly prior to disposal (88%) 5N o Linen skips and the appropriate bags are taken to the area required. (Staff are not carrying soiled linen or leaving it on the floor) (88%) 5N Recommendations/Actions • Wards which scored less than 95% compliance across the different components were 5N and CCA. Ward Managers were informed and results discussed at the link nurse meeting in December.
Hand Hygiene Obs	Findings: The results of this audit are extremely positive with 9 out of 11 standards showing above 95% in each of the audit criteria. Standard showing less than 95% were: • Standard 8 - Dry hands thoroughly using paper towel (90%) - gave the poorest result, with 14 people failing to use the correct technique. • Standard 7 - Rinse hands under warm water (90%) - was a result of two people not wetting their hands under warm water when needed. Recommendations/Actions IPC will highlight this at the next link meeting and ask the Link Nurses to focus on technique when they are doing their hand hygiene training on the wards

Observational Audit of Scrubbing and Gowning in the operating theatre	Findings This re-audit shows excellent adherence and understanding of the scrubbing and gowning procedure, with only 1 observation out of 39 using an incorrect method for 4 out of the 13 aspects of the measured criteria. 'Aspects of scrubbing and gowning to be measured 4.1' has dropped to 60% which is actually only due to 2 out of 5 people, needing to be challenged and asked to re-scrub. Recommendations/Actions Senior staff during induction to assess all new starters on the closed gowning and gloving technique prior to being exposed to the surgical field and then carry out annual assessment of scrubbing and gowning technique. Closed technique continues to be demonstrated on the audit morning teaching sessions quarterly until next audit.
Antibiotics For Surgical Prophylaxis Audit	Findings: The results from interrogating the electronic prescribing systems show that we are not meeting the desired standards regarding antibiotics for surgical prophylaxis. This is in regards to choice of antibiotic(s), dose of antibiotic chosen and timing of antibiotic administration recorded with respect to knife-to-skin time. Recommendations/Actions • Discuss results with anaesthetist/theatre matron to identify contributory factors and potential actions for improvements. • Present audit at Anaesthetics M&M meeting on 27/11/19. • Review current guidelines and implement changes as appropriate. • Send laminated decision aid posters to theatres.
PSS	Findings: • 100% of ward serving meals during times specified by PLACE. • 100% wards all displaying Protected Mealtime information on entrance monitors. • 100% wards have environment conducive to eating. • 100% wards have visitors present at mealtimes. • 87 % wards had other staff members present carrying out non patient tasks. • 62% wards stopped other activities. Unfortunately this was not to help with meal service. • 25% of wards had no patients interrupted. Recommendations/Actions • Discuss with maintenance and cleaning team management ways to avoid disturbing patients at meal times • Chief nurses to be made aware that this not always happening and for them disseminate to ward staff • To review form in order to simplify and make easier to complete report • Publicise audit results to relevant groups/ members of staff • Inform wards of own results

Appendix 3

NEWLY PUBLISHED NICE GUIDANCE AND QUALITY STANDARDS

7 NICE Guidance published and disseminated to Papworth Hospital NHS Trust during Quarter 3 of 2019/2020, awaiting confirmation from leads regarding relevance and compliance.

No	Name	Month Published	Compliance status
NG142	End of life care for adults: service delivery	Oct-19	Compliant
NG19	Diabetic foot problems: prevention and management	Oct-19	Partially compliant with actions
DG37	Point-of-care creatinine devices to assess kidney function before CT imaging with intravenous contrast	Nov-19	TBC
ES21	Antimicrobial prescribing: meropenem with vaborbactam	Nov-19	TBC
NG146	Workplace health: long-term sickness absence and capability to work	Nov-19	Compliant
ES22	Antimicrobial prescribing: ceftolozane with tazobactam for treating hospital-acquired pneumonia, including ventilator-associated pneumonia	Dec-19	TBC
QS17	Lung cancer in adults	Dec-19	TBC

No Quality Standard or Guidance updates in Q3.

A re-audit of NICE Guidance compliance against procedure was undertaken in Q3 19/20

Monitoring of NICE guidance and quality standards is undertaken by the Quality Compliance Officer and the Clinical Audit Co-ordinators via;

- Tabled at relevant management and steering group meetings
- Follow up via email and phone
- If necessary, escalation to directorate managers via the Quality and Risk Management Group