NHS
Royal Papworth Hospital
NHS Foundation Trust




Royal Papworth Hospital NHS Foundation Trust

Quality Report 2020 / 2021

Royal Papworth Hospital NHS Foundation Trust

Quality Report 2020/21

Contents

Part 1 Statement on quality from the Chief Executive

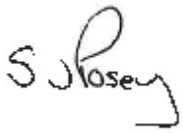
Providing high-quality, safe and effective care is at the heart of everything we do here at Royal Papworth Hospital. We are extremely proud to have gained an excellent reputation for quality in heart and lung medicine, but we know we must continually work to improve the care we provide to our patients. This Quality Account provides an overview of the quality of services that we have provided to patients during 2020/21 as well as our key priorities for improving quality in the year ahead.

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.

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 2021/22 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 safe and high quality care throughout 2020/21 recognising 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
24 June 2021

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.*

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 2020/21.

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

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

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2.1 Priorities for improvement

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

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2021/22 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 2020/21 priorities

Our 2019/20 Quality Report set out our quality priorities for 2020/21 under the three quality domains of patient safety, clinical effectiveness and patient experience. *See our 2019/20 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 2020/21 together with the outcomes. The tables below demonstrate achievements against the 2020/21 Goals.

Priority 1: Safe
Priority 2: Effective / Responsive services
Priority 3: Well Led
Priority 4: Communications
Priority 5: Digital Quality Improvement

2020/21 Priority 1: Safe

Objective 1: Build and develop QI capability within the QI team and across the organisation

Objective	Update (March 2021)
Develop a QI road map: 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	This has been on hold due to COVID-19. To be refreshed and relaunched following COVID19 recovery phase. This will be refreshed and re launched following the recovery phase when the COVID pandemic has resolved.
Rebuild the QI team: 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	This is ongoing with 2 vacancies being recruited to. This has been delayed due to the COVID Pandemic response
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	This has been on hold during 2020/21 due to the pandemic. This has been funded and we continue to communicate with EAHSN regarding re launching the Master Calls programme in 2021/22.
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 continue to sign post to the online Bronze QI training online. During 2020/21 14 staff have accessed this online training. In addition, 18 staff have received face to face training delivered by the Clinical Audit and Quality Improvement team.
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 Quality Improvement and Clinical Audit Steering group has been relaunched and is running bimonthly

Objective 2: **Implement SCORE Culture Survey in selected clinical areas**

This was carried over from 19/20 however funding from Eastern Academic Health Science Network (EAHSN) is no longer available. As culture improvement is now part of the Collective & Compassionate Leadership programme this priority will not be continued.

Objective 3: Improved diabetes management

Objective	**Update (April 2021)**
All patients with diagnosis of diabetes to be identifiable on Lorenzo	This remains on hold due to pressures of COVID19. Carried over to 21/22.
Referral of patients to Diabetes Specialist Nurse within 24 hours of admission	All referrals now completed via Lorenzo. Ongoing biannual audit of compliance scheduled.
Assessment of patients within 24 hours	Audit of compliance completed in April 21 [including prescription times; assessment for self-administration of insulin]
Patients to have diabetes care plan initiated within 24 hours of admission	The Diabetes care plan went live on 26.04.2021. To be monitored with bi-annual audit**.**
Patients to have a discharge summary	This remains on hold due to pressures of COVID19. Carried over to 21/22.
All HCSW and nurses to have appropriate training on safe use of insulin and main diabetes harms [with annual refresher]	• New induction presentation written to incorporate the safe use of insulin, and the main diabetes harms and how they can be prevented. • Induction with voice over made for junior doctors for when not face to face • New preceptorship programme written with online questions. Voice over now available. • Proposal to access to Cambridge Diabetes Education Programme (CDEP) for Royal Papworth Hospital staff is no longer financially viable; alternative means of funding access to CDEP are being explored. Carried over to 21/22.
Develop a system to provide annual diabetes refresher training for existing staff involved in diabetes care, and track compliance.	This remains on hold due to pressures of COVID19. Carried over to 21/22.

2020/21 Priority 2: Effective / Responsive services

Objective 1: Improving Same Day Admission

Objective	Update (March 2021)
All appropriate elective patients are pre-assessed prior to admission.	Pre-admission assessments were virtual at time of writing report due to COVID19 restrictions.
3-4 of all appropriate 1st cases to be SDA per day	In light of the pandemic this was not achievable and the Trust is actively looking at making 2nd and 3rd cases same day admission.
Monthly 50% SDA target to be met.	Performance has been adversely impacted as a consequence of the pandemic as a result of 72-hour testing, lack of pre-assessment and the additional clerking needs for the ANP and Ward nursing team. Currently the pathway is admission the day before for first cases to ensure there are no delays to theatre start times and lost cases due to theatre over-run. Thoracic continues to be a challenge due to constrained pre-assessment capacity for short notice cancer patients. Trust wide optimisation work remains ongoing to improve access to pre-assessment. 2nd case cardiac surgery is now being routinely scheduled as SDA unless there is a clinical contra-indication. Data in PIPR M11 shows 41.22% and 19.18% for SDA Cardiac and Thoracic surgery respectively.

Objective 2: Pre-admission

Objective	Update (March 2021)
Introduction of video consultations	Since April 20, preadmission has been delivered virtually; patients are telephoned by a specialist nurse, an anaesthetist and a pharmacist who undertake the assessments. This prevents patients having to visit the hospital, making it safer for them as well as reducing footfall in the building. A daily clinic was established to allow preadmission patients to attend for the required blood tests and for COVID19/MRSA swabs in advance of their admission for surgery.
Clinical risk stratification of patients before preadmission	When reviewed in clinic, patients are clinically prioritised but re assessed if changes occur. Surgical patients are reviewed and categorised in line with P1/P2/P3 at their first appointment and re stratified in line with the Trust Harm review process, depending on outcomes. A Clinical Prioritisation process is being written.
All specialties to come through the same model	The same process is used for all specialities – shorter lead times are mitigated by using SAMBA - (SAMBA II analysers provide a simple and semi-automated process for testing nose and throat samples for COVID19, delivering a result in 90 minutes). The notice for Thoracic oncology patients is shorter so there is little lead time for COVID 19 testing.
Collate measures of patient experience on the virtual model	This went live on 19.01.21 for all patient encounters – virtual, telephone and in person. In ward areas participation rates are on a par with feedback collected by paper but in Out Patients the response rate has improved significantly.

Objective 3: Early identification of care needs and rehabilitation opportunity

Objective	Update (March 2021)
100% of all elective cardiac surgery, PTE patients and IHU patients to have the option of completing a digital ‘All About Me’ booklet.	Digital ‘All About Me’ development was postponed due to COVID19. Digital workload and project approval process is being reinvestigated.
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.	OT pre-assessment of 90% of patients with clinical frailty score of 4 and above has not been achieved due to virtual nature of all pre-assessment clinics.
90% of IHU patients to be screened by Occupational Therapy on admission.	As many as possible have been seen however interrupted due to COVID19.

2020/21 Priority 3: Well Led

Objective 1: Collective and Compassionate Leadership programme

The Trust made three key appointments in late 2020, a Equality Diversity and Inclusion Manager, a Compassionate and Collective Leadership Project Manager and a Workforce Health and Wellbeing practitioner and by doing so has been able to take significant steps towards achieving the strategic objectives. Since compassionate and collective leadership, EDI and staff health and wellbeing are so closely related it is inevitable that any actions taken in one area will often result in positive outcomes in another priority area and the following update as at March 2021 groups the priorities to reflect this.

Priority - Valuing difference

- Engagement and connection with EDI Network Chairs feeding into projects reports such as WDES Action Plan, EDI Action plan, WRES action plans.
- Connected all Network Chairs with other Chairs from CPFT and CUH (regional) to share best practice, events and experiences.
- Engaged with a range of stakeholders within the Trust (Execs, Non Execs, Heads of Workforce Departments, Head of Finance, Head of Charities, FTSU Guardian, Nursing staff, Career coach, Regional Non Execs)
- Engaged with a range of EDI Leads both Regional and National to make sure any reports are written to the same standard linking the right data to the right metrics.
- Collaborated with the Deputy Chief Nurse over Christmas to buddy our staff from different countries, to feel supported and less alone.
- Engaged with the Trust's Stepping Up Alumni, and worked on a staff story published in February around staff experience of this programme.
- Developed an EDI Calendar published on 25th January 2021, and worked closely with the Charities team.
- Supported staff as part of the Staff Liaison Team, making a real difference to staff and managers.
- Triangulated work and outcomes with FTSU guardian and Network leads.
- Successfully led a programme of activities designed to address vaccine hesitancy in staff from BAME backgrounds resulting in a significant improvement in vaccination rates across our BAME staff community.
- Instigated funding applications to RPH Charity for a moving hamper: a one off payment to provide our overseas staff members with warm clothes and duvets etc. Up to £500. Awaiting funding outcomes.
- Explored with Charities Funding for additional equipment for staff with disabilities who are working from home. Awaiting funding requirements and outcome.

Priorities - Personal responsibility and empowerment, Compassion, Professional and personal development, Values and behaviours, Developing and supporting line managers, and Teamwork

Whilst for much of 2002, work on progressing the compassionate and collective leadership programme was paused, since late 2O20 we have:-

- Provided compassionate and collective leadership training sessions on the new sisters and charge nurses development programme;
- Providing compassionate and collective leadership discussion events at staff meetings;
- Progressed the development of our values and behaviours framework which in March 21 was going through a peer review process with a view to presenting the framework to the Board in June 2021.
- Commenced the procurement process for coaching for inclusion training, this work supports the Building Leadership for Inclusion (BLFI) strategy, Talent Management strategy and the National Coaching and Mentoring strategy. Coaches will be trained on

inclusion and to deploy powerful coaching interventions with participants on our positive action programmes.
- Provided training to support managers to develop coaching cultures and coaching conversations in their teams.
- Established a staff experience committee with formal reporting lines to the Board to provide a more focused arena for staff experience topics.

Priority - Health and wellbeing

It has become even more of an imperative as a consequence of the pandemic emergency and the concerns at the damaging physical and mental impact of this on healthcare staff. At the end of 2020 we:

- Appointed a Health and Wellbeing Practitioner with funding support from the Royal Papworth NHS Foundation Trust.
- Identified two Mental Health and Wellbeing Facilitators within the Critical Care Unit to support staff specifically within that area. There are further plans to roll this out in other departments where certain Health and Wellbeing initiatives are already underway.
- Provided a central point of contact for anything relating to general Health and Wellbeing of staff at the Trust
- Provided 121 on site counselling service for staff within the trust;
- Created six dedicated wellbeing spaces for staff to use as and when required
- Developed close links with the Equality, Diversity and Inclusion Manager once a month to tie together works that may overlap and share best practice
- Developed 'Health and Wellbeing Conversation' scripts for Managers them to use as a starting point. We hope to be able to offer more tailored training on particular topics that staff have requested such as '*Building Resilience'* and '*Knowing What Language to Use*.'
- Introduced a support line for staff to use and access to a psychological wellbeing service with free cognitive behaviour therapies.
- Provided emphasis via the Weekly Briefing on the need to treat our colleagues with compassion and respect.

Objective 2: ED Led STP system leadership initiative

Objective	Update (April 21)
Develop a surge plan to deliver Critical Care Capacity for the region, including the lessons learned from the first surge.	• RPH remained part of the Cambridge Biomedical Campus Regional Surge Centre for the East of England (in partnership with Cambridge University Hospitals). • RPH planned and utilised in practice a surge plan to expand Critical Care Area (CCA) capacity through the first surge. This was shown to be very effective taking our usual CCA capacity of 33 to a capacity of 95 (our maximum was 61 CCA patients in the first surge). • During the second surge RPH was able to use the lessons learned from the first surge and adapt the second wave surge plans. The second surge implemented plans to take RPH to 66 CCA beds. • In addition to this, during the second surge RPH also supported: ➢ An "O+" (Oxygen plus) surge response lead by the Thoracic Division ➢ A sustained increase (25% increase in activity) response in emergency Cardiology ➢ Further increase up to 25 beds for the ECMO Service in CCA Provided and staffed a regional critical care ambulance transfer service
Develop a network of hospitals that will provide mutual aid in the event of a second surge.	• RPH remained part of the Cambridge Biomedical Campus Regional Surge Centre for the East of England (in partnership with Cambridge University Hospitals). • As the second surge of the pandemic progressed it became clear that mutual aid from partner organisations was not going to be possible. This was because of the rapid growth of the surge across the United Kingdom, involving all organisations.
Engage the system and region in the Clinical Decision Cell to ensure best possible outcomes for patients through advice and support to clinical teams.	• Membership of the CDC at RPH is multi professional (clinical and operational). • Daily regional call attended by the Medical Director (or deputy) which feeds into the RPH CDC. • CDC liaison maintained with the Critical Care Network; ECMO Network; and Respiratory Network calls. • Daily CDC meetings at RPH, which were increased to seven days a week during the height of the surge. • Regional Transfer Service set up by RPH through liaison with the Region.

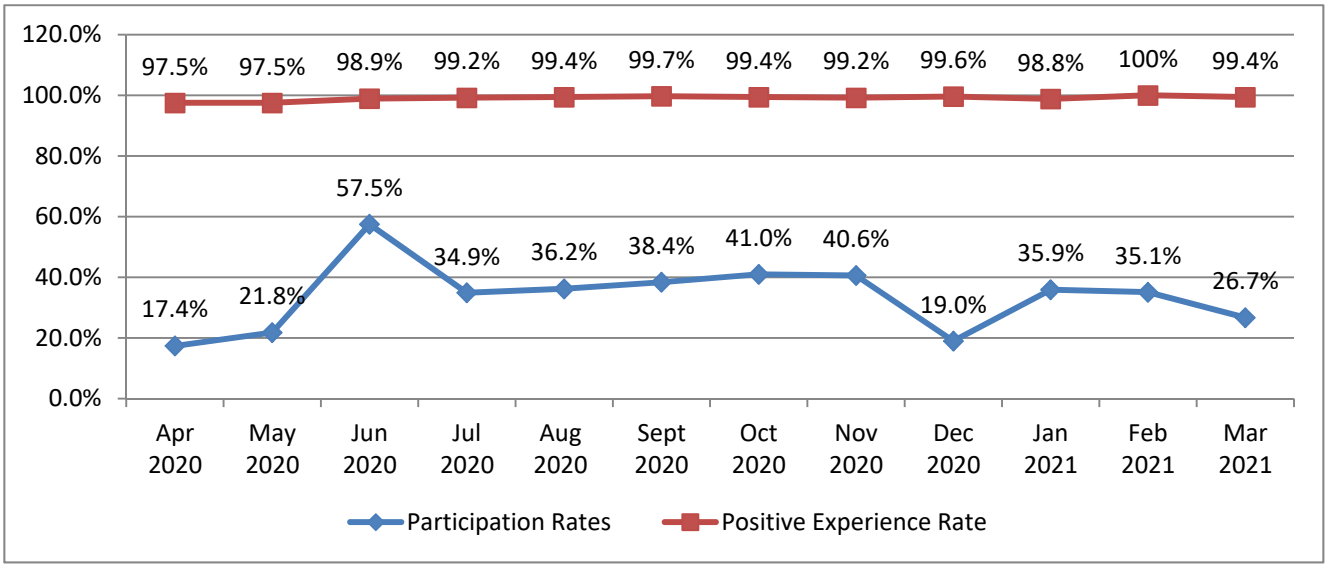
Objective	Update (April 21)
	• Duty Clinical Director in place 24/7 to give clinical advice and guidance for CCA and respiratory surge patients.
Develop and communicate a health and well-being package for staff to ensure resilience and support during a second wave.	See Priority 3, Objective 1

2020/21 Priority 4: Communications – to improve patient experience at RPH

Objective	Update (April 2021)
To increase the participation rates of F&F by using electronic media	The tables and graphs below show the inpatient and outpatient 'participation rates' for the 2020/21 reporting year. For information and perspective, they also display the 'positive experience rate' (formerly known as the recommendation rate) for the same period. In April 2020, RPH procured iPads and implementation of the project started. Due to some delays impacted by the COVID19 pandemic, launch of the inpatient and outpatient iPad surveys started in December 2020 (it took approximately two weeks for full roll out). SMS messaging for outpatients started mid Jan 2021 and ramped up to include the vaccine clinic in February 2021. The biggest increase in participation rates can be seen in Outpatients since the introduction of electronic media in December 2020. Outpatients was the area where we were initially hoping to see the greatest improvement in participation rates, so this is positive news. The inpatient participation rates have remained reasonably static. It is also acknowledged that at RPH we continued to monitor FFT, despite this being paused nationally during the COVID19 NHS response as the next paragraph highlights. The latest national inpatient response rates published are 24.4% (Feb 2020) 24.0% (Jan 2020). FFT reporting was paused nationally after this due to the COVID19 pandemic. Data submission and publication for the FFT restarted for acute and community providers from December 2020 following the pause during the response to COVID19. Outpatient response rates are not published nationally.

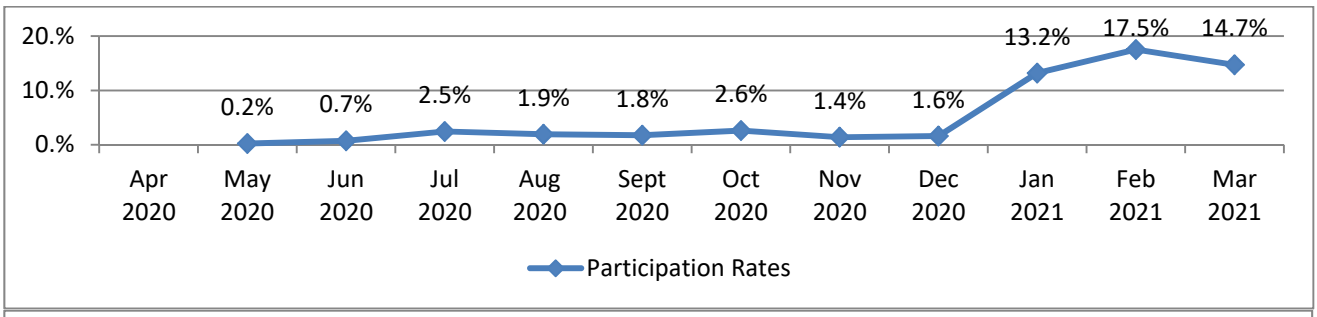
INPATIENT RESULTS

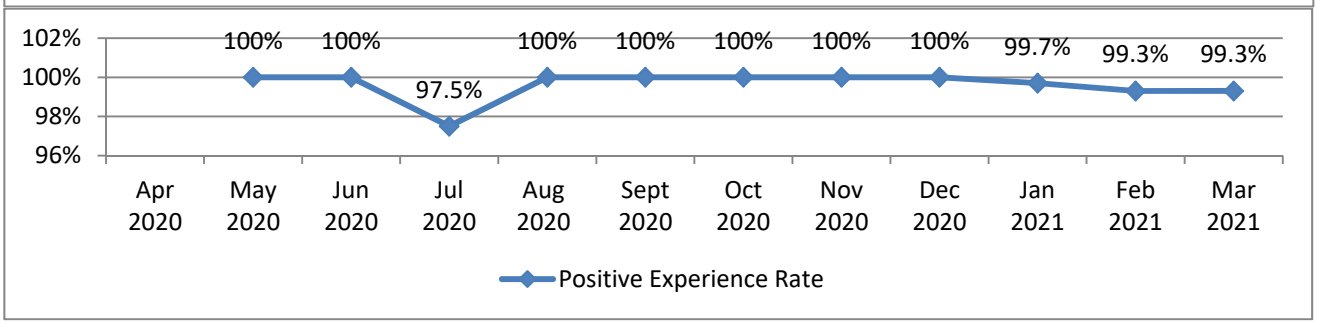
	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Participation Rates	17.4%	21.8%	57.5%	34.9%	36.2%	38.4%	41.0%	40.6%	19.0%	35.9%	35.1%	26.7%
Positive Experience Rate	97.5%	97.5%	98.9%	99.2%	99.4%	99.7%	99.4%	99.2%	99.6%	98.8%	100%	99.4%



F&F OUTPATIENT RESULTS

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Participation Rates		0.2%	0.7%	2.5%	1.9%	1.8%	2.6%	1.4%	1.6%	13.2%	17.5%	14.7%
Positive Experience Rate		100%	100%	98%	100%	100%	100%	100%	100%	99.7%	99.3%	99.3%





Objective	Update (April 2021)
Implementation of real-time Friends and Family feedback from attendance at Virtual clinics	This went live in January 2021. This is for all outpatient encounters, virtual, in person and by telephone. Can be interrogated by individual clinic and clinician. Results are fed directly to Business Intelligence who interpret and present the data.
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	A pilot group of 10 RSSC patients were enrolled in November 2020 which has remained active throughout the pandemic. Feedback has been positive and testing continues. Once testing is complete RSSC will look to expand the number of users. Other departments are currently in the early stages of investigating using Patient Aide. As soon as RSSC is working effectively other consultants will be invited to review this to see whether it will add quality to the care of their patient group. It will be an opt-in facility.
Ensure Patient Stories are presented at various forums.	Patient stories are shared regularly at Board, Q&R, CPAC, Band 7 and BU meeting level. Variety of staff groups have presented: AHPs, Safeguarding staff, Theatre and Ward Matrons, etc.
Circulate quarterly Survey Monkey Questionnaires. Working with divisional triumvirates in the development of standardised Survey Monkey questionnaires and providing feedback at divisional performance meetings	This was specifically related to the impact of COVID and the lack of visiting opportunities open to relatives. One survey monkey was carried out following the first surge.
Partnership working with PALS	Partnership working continues as BAU with feedback shared quarterly at QRMG and through monthly business unit meetings on the Quality report. PALS are members of and regular attenders at the Trust Patient and Carer Experience Group (PCEG).

2020/21 Priority 5 – To Deliver Digital Quality Improvement

Objective	Update (April 2021)
To deliver a more stable user experience by: • Reducing the number of hours lost to system crashes and slowness. • Continued monitoring of the 100 most common user activities on Lorenzo and benchmark these as a measure of performance.	• Additional hard drives purchased for older PC's to improve performance as some PCs had no space left, this was noted to improve performance. • Continued monitoring shows monthly improvement.
Ensure local network is robust and not contributing to system issues.	Independent review completed, no major issues with network found. Second review also conducted by DXC and some recommendations made.
Implementation of real-time bed management	This is only live in one ward at present as clinical areas have higher priorities at present and unable to work with digital team on a go-live.
Patient Aide Portal – To enable patients to see a limited view of their medical record from a portal view, allowing better management of chronic conditions.	A pilot group of 10 RSSC patients were enrolled in November 2020 which has remained active throughout the pandemic. Feedback has been positive, and testing continues. Once testing is complete RSSC will look to expand the number of users. Other departments are currently in the early stages of investigating using Patient Aide. Once RSSC is working effectively other consultants will be invited to review this to see whether it will add quality to the care of their patient group. It will be an opt-in facility.
Closed loop medication distribution to reduce medication related incidents	There are two projects, unfortunately neither of which are yet live. 1. JAC Transfer system - The closed loop system will cut out the manual transfer therefore eliminating the risk of errors in the transcription process. A test system is now in place with expected delivery of go-live Mar – May 2021. 2. Bar-code scanning - this is a closed Loop medicines administration system which aims to reduce the risk of errors at the point of administration to the patient. This project has been delayed due to COVID19 however expected go-live date of July/Aug 2021 is anticipated.
Vein to vein blood administration, reducing the risk of transfusion incidents	Some parts of the pathway are already electronically tracked and tracking on the whole process is not far from go-live.
Connection with other EPR's and GP systems to enable clinicians to have increased information available when treating patients, including allergies and medications from the GP practice.	GP Connect awaiting sign-off from pilot trust, RPH planned rollout 1-month post pilot trust rollout. Connection with CUH in early phases, delayed due to Epic upgrade and COVID. C/F to 21/22.
Working with STP partners towards development of Local Health and Care Record (LHCR) to enable system wide care.	Carried forward to 21/22.

Priorities for 2021/22

Our priorities for 2021/22 reflect the domains of quality: patient safety, clinical effectiveness, well led and patient experience. Our priorities are:

Quality Account 2021/22 Priority 1: Safe:

Objective: Build and develop QI capability within the QI team and across the organisation.

Quality Account 2021/22 Priority 2: Safe/Effective:

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

Quality Account 2021/22 Priority 3: Well Led:

Compassionate & Collective (C&C) Leadership:
Objective 1: Progress the implementation of the C&C leadership programme
Objective 2: Create an equitable, inclusive and healthy working environment

Quality Account 2021/22 Priority 4: Patient Experience

Digital Quality Improvement
Objective 1: Deliver a more stable user experience
Objective 2: Support the delivery of a quality patient experience
Objective 3: Delivery of a joined-up health record

Quality Account 2021/22 Priority 1: Safe

Objective: 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.

This aim will continue for 2021/22 in line with the 3-year ambitions outlined in the Trust Quality Strategy.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can this be measured?
Continue to develop a QI road map to articulate the direction of travel and in particularly 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. Clinical Audit and Quality Improvement steering group to identify the next round of QI Priorities in Q1 2021/22.	This has been on hold during 2020/21 due to the pandemic.	Ratified document available to articulate processes and priorities for QI/ Audit BAU monitoring of Clinical Audit and QI programme status through minutes of Clinical Audit & Quality Improvement Steering group. KPI: Number of projects registered under the QI programme evidencing the use of IHI improvement methodology
Continue to access local and national training to support and develop the QI capability within the QI support team. Develop an in-house QI faculty supported by the leadership team to deliver local QI training with a curriculum based against the training dosing matrix within the quality strategy.	This has been on hold during 2020/21 due to the pandemic. This has been funded and we continue to communicate with EAHSN regarding re launching this Master Calls programme in 2021/22	Completion of the "Train the Trainer QI Masterclass" in 2021/22. KPI: Number of QI Trained Staff at RPH
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 continue to sign post to the online Bronze QI training online. During 2020/21 14 staff had accessed this online training. In addition, 18 staff had received face to	Refreshed intranet pages containing a comprehensive suite of reference materials to be launched by late FY 21/22. Internal QI Curriculum to be developed and available for staff to book into by late FY21/22

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can this be measured?
	face training delivered by the Clinical Audit and Quality Improvement team.	
Develop the remit of the Clinical Audit & Quality Improvement Steering Group (QISG) to support and lead operational engagement with QI.	The QISG Steering group was due for relaunch at the end of 2020, however a wait until a return to BAU seemed more sustainable/long term was deemed more appropriate. It is hoped to reinvigorate the steering group in early 21/22.	Minimum of 6 meetings per year Wider engagement with a focus on developing the quality improvement programme. Agreed Quality Improvement Management Plans in place with each division.

Executive Lead:
Ivan Graham, Acting Chief Nurse

Implementation Leads:

- Assistant Director for Clinical Governance
- Mike Bates, Clinical Audit and Improvement Manager
- Sarah Powell, Clinical Governance Manager

Quality Account 2021/22 Priority 2: Safe

Objective: 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 accompanied the report which had 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.

Goals:
1. Patients with a diagnosis of diabetes are to be easily identifiable on admission, using the electronic patient record.
2. Patients with diabetes to have diabetes update added to the e-discharge summary.
3. 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

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
Objective 1: Patients with a diagnosis of diabetes to be easily identifiable using the electronic patient record.		
Patients with diabetes will be easily identifiable on EPR	It is currently difficult to identify patients with diabetes as the diagnosis can be documented in different sections of the EPR depending on the person completing the documentation.	Diabetes identifier present on Lorenzo, ideally on ward pegboard Implement audit cycles to improve compliance by using the new identifier when in place.
Objective 2: Diabetes update to be added to the e-discharge summary.		
For patients with diabetes, discharge summary to include (where applicable): • Diabetes treatment changes • Complications during admission • Follow up arrangements	Diabetes is rarely mentioned in the current e-discharge summary. The Discharge Specialist Nurse (DSN) currently writes a separate GP letter to inform of diabetes issues. Meeting to be arranged with DSN.	Diabetes section added to e-discharge summary. Base line audit initial and then audit cycles to improve compliance. Quarterly audit report

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
Objective 3: Healthcare professionals caring for people with diabetes will have core training on the safe use of insulin, and the main diabetes harms and how they can be prevented.		
i. Healthcare professionals caring for patients with diabetes will have completed an identified Diabetes Education Programme Safe Use of Insulin module as a minimum (90%).	Courses and funding options being pursued.	Course and funding identified. Set compliance standards Fewer incidents reported on Datix. Diabetes monthly score card.
ii. Develop a system to provide annual diabetes refresher training for existing staff involved in diabetes care, and track compliance.	Update training is offered to wards, but uptake and attendance is poor. Exploring potential ways of offering training updates. Monthly score card in development.	Refresher training identified. Fewer incidents reported on Datix. Diabetes monthly score card.

Monitoring & reporting: The Diabetes team will be responsible for producing a monthly score card, and quarterly audits which will be 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

Quality Account 2021/22 Priority 3: Well Led: Compassionate & Collective (C&C) Leadership

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

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

Objective 1: Progress the implementation of the C&C leadership programme
Objective 2: Create an equitable, inclusive and healthy working environment.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
Objective 1: Progress the implementation of the C&C leadership programme		
1. Implementation of Value and Behaviours (V&B) Framework	V&B Framework in development @ April 2021	Final framework published and communicated for cascade through organisation. Training for staff and managers rolled out.
2. Line management development	Being scoped in Q1	Attendance levels and feedback forms monitored. Measure of longer-term positive impact on staff experience / productivity to be scoped in Q1.
3. Undertake a review of the individual performance review (IPR) process to embed values, behaviours and conversations about wellbeing and career development.	Work starting in Q2 after implementation of V&B Framework	Revised IPR process rolled out by Q4. Improved feedback from staff on their experience of the Appraisal Review in the staff survey.
Equitable & Inclusive 1. Engagement and involvement	Equality, Diversion and Inclusion (EDI) Lead appointed and taking forward widening participation agenda with diverse range of stakeholders and underrepresented groups.	Coherent EDI action plan in place, monitored and reported at Quality & Risk. Consistent improved involvement in the EDI network. Allyship programme in place. Improved survey response.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
2. Compliance management / governance and data collection analysis	Working with Workforce Information team to define data set needed for monitoring compliance, trend reporting and defining priorities.	Data sets agreed and provided (frequency to be scoped in Q1) Trend analysis available and reported (frequency to be scoped in Q1) with consequent action plans in place. Compliant with Accessible Information Standards.
3. Talent management and training	Resource library procured. Training for cultural competency procured and significant work undertaken on understanding issues, raising the profile of agenda and shaping future direction.	To be scoped in Q1
4. Coaching/mentoring and sponsorship	Accepted onto Reciprocal Mentoring Programme (RMP) which will commence in 21/22. Accepted onto the Diversity and Inclusion (D&I) Partners Programme Cohort 2. Work has started on sharing the future direction of this work.	RMP and D&I Partners Programme in place. Specific methods of evaluation to assess benefits of programme will be scoped in Q1.
Healthy 1. Safe at work – ongoing workplace and individual risk management, PPE, access to rest spaces	Significant work on risk assessing workplace for COVID19 has occurred over past year. Need now to embed COVID Risk Assessment and support for staff into 'Business Aa Usual'.	Staff Risk Assessment process reviewed and approved for 2021/22. PPE available to all staff. Rest areas available for all staff groups.
2. Fit for purpose OH services.	Review of existing service completed and specification for new service in development. Potential for an ICS wide service being explored.	New OH contract in place. Service evaluation by RPH managers and service users to be scoped in Q1.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
3. 90% compliance - staff Flu/ COVID19 Immunisation Programmes	90% achieved for 2020/21. Flu planning programme team set up for 2021. Awaiting update on COVID 19 booster.	90% of staff vaccinated.
4. Protection from Bullying and Harassment and Violence in the workplace	Dignity at work policy under review. Data being collated. Action planning for 2021 taking place.	Audited Dignity at Work policy in place. Improved staff survey response in this area. Staff survey response measures to be scoped.
5. Agile/Flexible Working	Much work has been undertaken to enable staff to work flexibly over the last year in response to COVID19. Work is now underway to make flexible working business as usual. New agile working policy in place.	Evaluation and outcome measures to be scoped in Q1
6. Physical and Mental Health and Wellbeing support in place	Well-being practitioner appointed and providing direct counselling to staff. Portfolio of health and wellbeing support available to staff (mental health and wellbeing resources both local and access to national products, career coaching, staff recognition and appreciation fund, hardship fund, dedicated health and wellbeing spaces, sleep pods etc) Health and wellbeing champions and link nurses appointed.	Evaluation of the service the role provides required to be scoped in Q1.

Executive Lead: Oonagh Monkhouse, Director of Workforce & Organisational Development
Implementation Lead: Larraine Howard-Jones, Deputy Director of Workforce & Organisational Development

Quality Account 2021/22 Priority 4: Digital Quality Improvement

Objective 1: Deliver a more stable user experience
Objective 2: Support the delivery of a quality patient experience
Objective 3: Delivery of a joined-up health record

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
Objective 1: Deliver a more stable user experience		
a. Reduce the number of hours lost to system crashes and slowness.	To improve functionality new baseline specification set to 16GB RAM and 256 SSD. Priority 1 or 2 incident reduction currently 30 in 20/21 Average time to all cause system recovery where EPR unavailable is currently 5.6 hours Identify issues within Lorenzo which are causing system slowness and instability.	Measure % of machines meeting this specification No of incidents reduced by 25% Reduce time for all cause system recovery by 20%, through faster triage of problems and quicker escalation with suppliers. Ward rounds completed per week (target 3)
b. Ensure local network is robust and not contributing to system issues.	Continued monitoring shows improvement in performance. Local Virtual Private Network (VPN) access being increased to account for increased demand post COVID. VPN line peak usage currently 90% of bandwidth Health and Social Care Network (HSCN) (NHS Internet) maximum usage currently 85% and growing. Specialist remedial support providing independent report and action plan	Reduce VPN line maximum usage to 75% Maintain HSCN line maximum usage at or below 85% Network availability (target >98%) Server availability (target >95%)
c. Improve stability of core infrastructure systems (e.g. Health and Social Care Network (HSCN), Viaduct integration engine (connects all clinical systems to one another), Image Exchange Portal (IEP which is used to allow radiology image sharing)	Current key systems with high failure rates • Lorenzo (2/year) • Viaduct (10/year) • HSCN (6/year) • IEP (18/year) Supplier meetings currently annually held	Measurement of number of downtime incidents with a target reduction of 25% for each key system. (Refer to Chief Information Officer's (CIO) report). Improved supplier management through increased meeting frequency and Terms of Reference for management with all

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
		suppliers (quarterly or where instability monthly).
Objective 2: Support the delivery of a quality patient experience		
a. Implementation of Patient Aide portal to enable patients to see a limited view of their medical record from a portal view, allowing better management of chronic conditions.	Pilot system in RSCC (10 patients) to validate system upgrades. Expected expansion of users to improve patient experience and reduce the need to ask repeated questions Cardiology investigating opportunities for use of Patient Aide. Satisfaction survey with App and also numbers of patients enrolled	Expected expansion of users within RSSC and across other specialities is being scoped in Q1 Patient experience / satisfaction metrics: – plan to survey patients using app at intervals to understand impact
b. Implementation of JAC Transfer system (JAC is the pharmacy stock control system).	Currently drug prescriptions are printed out from Lorenzo in Pharmacy and then manually typed into JAC which then dispenses the drugs. The closed loop system will cut out the manual transfer therefore eliminating the risk of errors in the transcription process. Test system in place with expected delivery of go live April/May 2020. (Awaiting completion of similar project elsewhere before adopting at RPH).	Reduction in medication related incidents: The closed loop system will cut out the manual transfer therefore eliminating the risk of errors in the transcription process. 80% reduction in wrong patient, wrong drug, and wrong strength/form errors for those prescription types for which the system is in use, noting that the system will be implemented in a phased way across inpatient, outpatient and discharge prescriptions from May/Jun 21.
c. Engagement with Digital	% of user group meetings which were quorate: 3 meetings in last 48 months.	Improve quoracy to 6 per year.
Objective 3: Delivery of a joined-up health record		
a. Connection with other EPR's and GP systems to enable clinicians to have increased information available when treating patients, including allergies	GP Connect awaiting sign-off from pilot trust, RPH planned rollout 1-month post pilot trust rollout.	Implementation of systems connections to GP Connect: plan for national GP connection by November 2021

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?
and medications from the GP practice. Implementation of the ShCR enables visibility of patient history across the ICS, region and the wider community.		
b. Working with ICS partners towards development and implementation of a Shared Health and Care Record (SHCR) to enable system wide care.	In procurement for a SHCR at present, shortlisting for provider/supply commencing in Feb 21 with an aim for a functional go-live Sept 21.	There is a connection to and a minimum data set being shared through the Implementation of SHCR Minimum viable Solution by End Sept 2021

Executive Lead: Andy Raynes, Director of Digital & Chief Information Officer
Implementation Leads: Eamonn Gorman, Deputy Director of Digital and Chief Nursing Information Officer

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 2020/21 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by Royal Papworth Hospital NHS Foundation Trust for 2020/21.

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 2020/21, 22 national clinical audits and 0 national confidential enquiries covered relevant health services that Royal Papworth Hospital NHS Foundation Trust provides. During 2020/21, Royal Papworth Hospital NHS Foundation Trust participated in 20 of the 22 (91%) national clinical audits and 0 of the 0 (100%) 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 2020/21, 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 20/22 (91%)		
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
NCAP: Adult Cardiac Surgery	Barts Health NHS Trust	100
National Audit of Cardiac Rhythm Management Devices and Ablation	Barts Health NHS Trust	100
Heart: Myocardial Ischaemia National Audit Project (MINAP) Heart: Coronary Angioplasty (Percutaneous Coronary Interventions)	Barts Health NHS Trust Barts Health NHS Trust	100 100
Heart: National Congenital Heart Disease Audit	Barts Health NHS Trust	100
National Lung Cancer Audit (NLCA)*	Royal College of Physicians	100
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	0
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
LeDeR - Learning Disabilities Mortality Review	NHS England and NHS Improvement	100
National COPD audit	Royal College of Physicians (RCP)	100
Mandatory Surveillance of HCAI	Public Health England	100
National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	100
Surgical Site Infection Surveillance	Public Health England	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)

NCEPOD has not requested any data from RPH in 20/21.

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

The reports of 10 national clinical audits were reviewed by the provider in 2020/21. Below is a sample of audits discussed at relevant group meetings.

Audit Title	Report Published
Case Mix Programme (CMP)	Y
NICOR 2020 Annual Report	Y
National Audit of Cardiac Rehabilitation	Y
National Audit of Pulmonary Hypertension (NAPH)	Y
National Cardiac Arrest Audit (NCAA)	Y
Myocardial Ischaemia National Audit Project (MINAP)	Y
National Adult Cardiac Surgery Audit	Y
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y
UK Cystic Fibrosis Registry	Y

The reports of 34 local clinical audits were reviewed by the provider in 2020/21 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:

Handover of CCA to Ward - Clinical Audit Recommendations:

- All members (surgical, anaesthetists, theatre nurses, ODPs and CCA) must be present at the time of handover
- Electronic handover checklist to be completed by each team in their relevant section.
- All the sections must be made 'mandatory to complete'
- If no specific post-op instructions then 'N/A' can be applied to that section.
- Target 100% completeness of information at handover as per the electronic checklist
- Re-audit in 3-6 months

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 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 3,400. See table below:

Type of research project	No. of participants recruited per financial year			
	2017/18	2018/19	2019/20	2020/21
NIHR portfolio studies	1091	1018	1,406	2246
Non-NIHR portfolio studies	243	33	124	186
Tissue bank studies*	2,110 (2,290)	1987	1,867	968
Total	**3,444**	**3,038**	**3,397**	**3,400**

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. Research conducted by the National Institute for Health Research (NIHR) has shown that research-active hospitals have better health outcomes for patients.

During 2020/21 the Trust recruited to 49 studies of which 43 were portfolio studies (2019/20: 68 studies and 60 portfolio studies). Of these studies 10 were urgent public health studies being run to investigate the diagnosis, treatment, genetics and immunology of COVID-19. These studies alone accounted for 1753 recruits involving both patients and staff. These included the RECOVERY study looking at a number of different treatment options for patients with COVID-19 and a Royal Papworth Hospital lead Urgent Public Health study (HICC) looking at the immune correlates of COVID-19.

Despite the pandemic the hospital recruited 493 patients into 31 non-COVID studies. These included a wide variety of disease groups including lung cancer, atrial fibrillation, cardiac surgery and idiopathic pulmonary fibrosis. The Trust continues to sponsor a number of single and multi-centre studies.

Quality is at the heart of all our research activities and Royal Papworth Hospital ranked as the top recruiting site in the UK for over 50% of the interventional studies we supported. The fantastic recruitment figures are in spite of the pandemic, with R&D staff redeployed across the hospital to support the clinical teams.

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

In non COVID times, under normal commissioning a proportion of Royal Papworth Hospital NHS Foundation Trust's income would be conditional upon achieving quality improvement and innovation goals agreed between Royal Papworth Hospital NHS Foundation Trust and NHS Commissioners, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Due to the pandemic, CQUIN was suspended. As a result there were no specific CQUIN schemes and therefore no requirement for the Trust to achieve specific goals relating to quality improvement and innovation.

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 2020/21. Royal Papworth Hospital NHS Foundation Trust was invited to take part in a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Thematic Review in December 2020; and a Provider Compliance Review (PCR) for cancer, in March 2021. These have been as part of national reviews and to date have not required any specific actions for Royal Papworth Hospital.

Royal Papworth Hospital NHS Foundation Trust is subject to periodic review and was last 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 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 not only does it impact on 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 2020/21 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 99.5%) 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 99.8%) for admitted patient care and 100% for outpatient care (national average 99.7%).

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. Data

Security and Protection Toolkit is the way that we demonstrate our compliance with information governance standards. All NHS organisations are required to make annual submissions to NHS Digital in order to assess compliance.

Royal Papworth Hospital NHS Foundation Trust's information governance assessment report is that the Trust has submitted Data Security and Protection (DS&P) Toolkit in September 2020, which includes requirements relating to the Statement of Compliance and all assurances were declared as met.

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

Clinical Coding

Royal Papworth Hospital's annual independent clinical coding audit was carried out by Jane Wonnacott Ltd in February / March 2021.

Royal Papworth Hospital has achieved the following Information Governance levels:

- Data Quality Assertion Level 1.7 / Information Governance Requirement 14-505: An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months. Attainment level 2: no change from 2019/20.
- Data Quality Assertion Level 3.4 / Information Governance Requirement 14-510: Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards. Attainment level 3: 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 2020 to March 2021, 221 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 61 in the first quarter; 34 in the second quarter; 55 in the third quarter; 71 in the fourth quarter.

By 09/06/21, 49 retrospective case record reviews and 14 incident investigations have been carried out in relation to the 221 inpatient deaths. In 4 cases a death was subjected to both a retrospective case record review and an incident investigation. The number of deaths in each quarter for which a retrospective case record review or an incident investigation was carried out was:

30 in the first quarter; 19 in the second quarter; 6 in the third quarter; 5 in the fourth quarter.

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

One representing 0.5% of the 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. 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; one representing 1.8% for the third quarter; 0 representing 0% for the fourth quarter.

Mortality Case Record Review process

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

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

Lessons learnt & Actions taken in 2020-21

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 COVID-19:

- The COVID pandemic brought about unprecedented changes to the way services were delivered at Royal Papworth. Throughout wave 1 in 2020 and wave 2 in 2021 Royal Papworth provided a leading role in treating patients with COVID from across the East of England region and further afield.

- Royal Papworth played a key role in supporting other organisations by both transferring patients to Royal Papworth for specialist treatment and in providing clinical advice in order to optimise treatment being delivered outside Royal Papworth. Royal Papworth proved to be agile in the rapid delivery of evidence-based services such as Respiratory ECMO, inter-hospital transfers and Enhanced Respiratory Support services.

- All staff within the organisation worked closely together - in particular Critical Care and Respiratory Medicine. Emergency services such as Cardiology, Surgery and Transplant were maintained, and clinical pathways stayed open throughout the pandemic. The emergence of the Clinical Decisions Cell for rapid clinically focused decision-making was a very successful development which will be continued post-pandemic.

Lesson learnt from Medical Examiner Service:

- In 2020-21 the Medical Examiner service has been strengthened by the appointment of two additional Medical Examiners in addition to the Lead Medical Examiner who is also the Regional Medical Examiner for the East of England.

- The Medical Examiner plays a vital role in scrutinising all inpatient deaths and flags up cases for retrospective case record review 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 identified operational difficulties with the Bereavement Service provided for Royal Papworth by a neighbouring organisation.

- 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.

Lessons learnt from Mortality & Morbidity Meetings:

- In response to COVID19 M&M meetings for Cardiology, Surgery, Transplant, Critical Care & ECMO moved online to ensure deaths continued to be reviewed and learning points captured

- Case discussions at Mortality & Morbidity meetings have now embedded the use of the NCEPOD grading tool to make a collective judgement of the overall quality of care

Lessons learnt from Retrospective Care Record Reviews:

- 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 2020-21 the retrospective case record review process did not reveal any patient safety concerns which had not already been reported through the incident reporting system indicating a strong patient safety reporting culture in the Trust.

Lessons learnt from incident investigations:

- Six serious incidents were reported in 2020/21 where the patient subsequently died.

- Of the six serious incidents reported, one serious incident identified the patient's death as potentially avoidable. This case relates to a prescribed medication not being dispensed from the hospital pharmacy at discharge. There are a number of safety checks to ensure patients are discharged with the correct medication. Following reporting of this serious incident the Pharmacy Department immediately reviewed each element of the process, which is reflected in the report's recommendations and action plan.

Impact & Developments in 2020-21

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

- From April 2020 the Patient Advice and Liaison Service (PALS) is now providing a bereavement follow up service for all in-hospital deaths

- From September 2020 the Bereavement Service is now provided directly by Royal Papworth Hospital

- A thematic review of incidents relating to deteriorating patients - review of these incidents has demonstrated good organisational learning and actions being taken to improve patient safety. Ongoing actions are being monitored via the ALERT and Resuscitation Steering Group.

- A multidisciplinary Safe Discharge task and finish group - the group has been established to streamline processes to improve patient discharge. Actions related to preparation for discharge, the ward environment and staff training.

- Human Factors Training - the Clinical Education team will be delivering additional training in human factors awareness across the Trust

- Medical Examiner Officers will be appointed in 2021-22 to further strengthen the Medical Examiner service

0 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.

0 representing 0% of the patient deaths during the previous reporting period 2019/20 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	2019/20 (or latest reporting period available)	2020/21 (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 [Average weighted scores: Data from NHS Outcomes Framework - Indicator 4.2 Responsiveness to inpatients' personal needs]	Trust Score was 74.7 in the 2018/19 survey. National average score was 67.2 National highest score was 85.0	Trust Score was 79.8 in the 2019/20 survey. National average score was 67.1 National highest score was 84.2	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.

Indicator	2019/20 (or latest reporting period available)	2020/21 (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 Benchmark report 2020]	87.4% 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 94.9%. The Lowest scoring specialist trust was 81.0%.	92.4% of the staff employed by, or under contract to, the trust in the 2020 staff survey would recommend the trust as a provider of care to their family or friends. Average for acute specialist trusts was 91.7%. The Highest scoring specialist trust was 95.5%. The Lowest scoring specialist trust was 82.0%.	During 2020/21 we used our Compassionate and Collective Leadership Programme to embed a culture that enables the delivery of continuously improving, high quality, safe and compassionate care. We also focused on ensuring that we provided staff with timely information and updates on the emergency response to the pandemic and critical issues such as PPE, risk assessment processes, health and wellbeing support and the vaccination programme. This had a significant impact on staff engagement.	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. Our Compassionate and Collective Leadership Programme will continue. Please see 2021/22 Quality Priority 3. See also Annual Report – Staff Report section for other information on the 2020 Staff Survey.
Friends and Family Test – In Patient NOT STATUTORY REQUIREMENT	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 restarted from December 2020, following the pause during the response to COVID19. A score of 97.6% was achieved for March 2020 Source: PIPR)	In March 2021 98.4% of our patients would recommend our service. FFT reporting was paused nationally due to the COVID-19 pandemic and restarted in December 2020. The FFT survey does not provide results that can be used to directly compare providers	The Trust continues to promote the FFT test. Further information is provided in the report on 2020/21 Priority 4: Communications. The Trust achieved a 26.7% participation rate in the latest inpatient data. The national response was 18.0% (Mar 21).	The Trust will continue to monitor and promote Friends and Family scores.

Indicator	2019/20 (or latest reporting period available)	2020/21 (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 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 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.* RPH: Q1 96.63% Q2 95.54% Q3 96.66% Q4 96.66%	Following the earlier fall in compliance against the 95% target of VTE risk assessment on admission a local action plan was put in place. We have seen sustained improvement in performance in 2020/21 and have had compliance above 95% in the last six consecutive quarters.	We are undertaking regular spot audits of VTE risk assessments by using the quality indicators tab within the Trust EPR system. Ward and departmental board rounds are also highlighting to medical and advanced nursing staff the need to complete a timely assessment of VTE risk. We share lessons learnt and good practice and further information is provided in the VTE section of the report.
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 1.67 in 2019/20 for Trust attributed patients aged 2 years and over (1 case). Total cases 11 with one attributed to RPH	2019/20 was latest published data	The 2019/20 Trust rate was based on the one cases attributed to the Trust in 2019/20. Infection prevention and control is a key priority for the Trust.	For further information see Part 3 of report – Other Information: Healthcare Associated Infections

Indicator	2019/20 (or latest reporting period available)	2020/21 (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) Number (ii) Rate per 100 admissions (iii) Number and percentage resulting in severe harm/death Note 3	(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 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%.	2019/20 was latest published data	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 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 2020/21

2020/21 has been a very busy year for Royal Papworth Hospital and its staff. We have maintained delivery of a significant volume of our core workload in addition to delivery services in response to the COVID19 pandemic. The Hospital has treated 15,390 inpatient/day cases and 82,855 outpatient contacts from across the UK and managed 331 COVID19 patients. For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2020/21. 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 2019/20 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 2020/21 where these have not been carried forward as key priorities for 2021/22. 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 and has played a major part in the response to the COVID19 pandemic.

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

Our Quality Strategy was published in 2019 and sets our quality ambitions and direction for the three years to 2022. 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. Effective and Responsive Care – Achieve excellent patient outcomes and enable a culture of continuous improvement

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

Early in 2020 we saw the first wave of the COVID 19 Pandemic and throughout 2020/21 we have been challenged and tested as we respond to the huge demands on our specialist services. We have demonstrated heroic efforts and organisational resilience in our ability to provide the specialist care and treatment our patients need. This has necessarily impacted on our ability to develop and meet some of the ambitions set out in the Quality Strategy and is also reflected at a national level with some requirements to meet quality measures and performance indicators suspended. It is now more important than ever that we remain vigilant and agile to ensure continuous delivery of safe and effective care for our patients in these challenging times. Through our ongoing governance and performance monitoring structures and the fantastic commitment and hard work of our staff at all levels of the organisation, we have maintained a high quality and safe service throughout this difficult time. Our Quality Strategy ambitions will continue through to the next full review due in 2022 to provide the opportunity to embed and develop our continuous quality improvement approach

Our 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. We have a formal procedure and guidance for this role to better support staff undertaking this role (DN791). This has been based on family and patient feedback on their experience of being involved in this process. 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). The Trust plans to undertake this audit on an annual basis but this was not undertaken in 2020/21 owing to the exceptional challenges facing the Trust.

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 2020/21 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 2020/21 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).

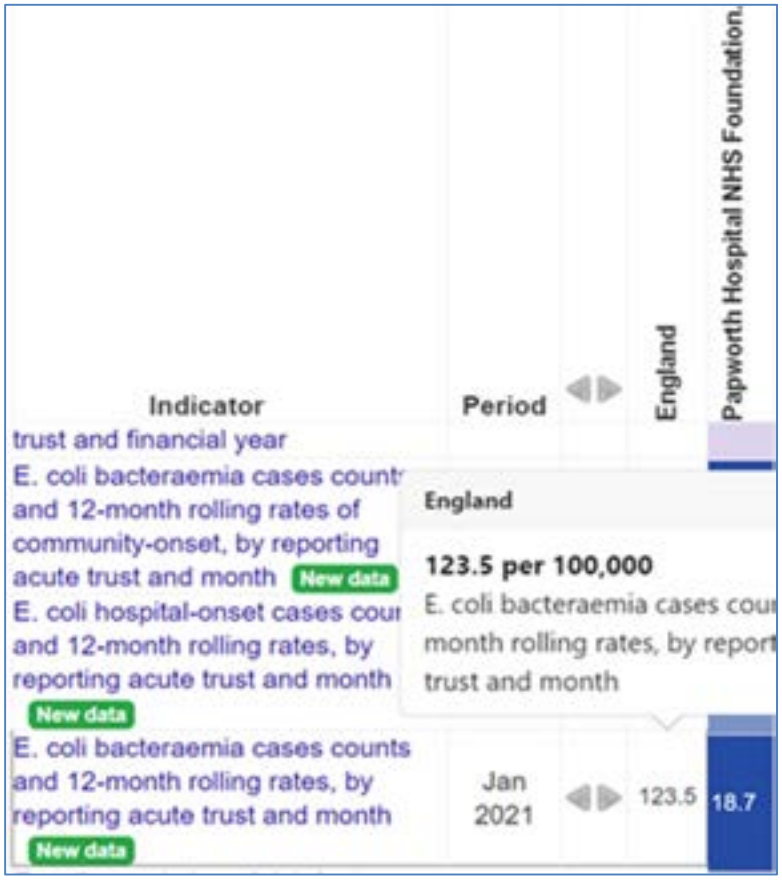
During 2020/21 the total number of Clostridiodies difficile cases were 8, against an objective of 11. There were two cases of MRSA bacteraemia for 2020/21, one case was attributable to Royal Papworth Hospital and one was attributable to another NHS foundation Trust. The ceiling trajectory for MRSA bacteraemias 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 3 or more days into admission or MRSA bacteraemia to review the events and enable continuous improvement of practice. Any subsequent lessons learned are shared with the Commissioners and discussed at scrutiny panels. If the MRSA bacteraemia 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. All C.diff cases reported 3 or more days into admission are now counted towards Royal Papworth Hospitals annual objective regardless of any lapses in care.

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 2020/21.

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:



Source: Public Health England

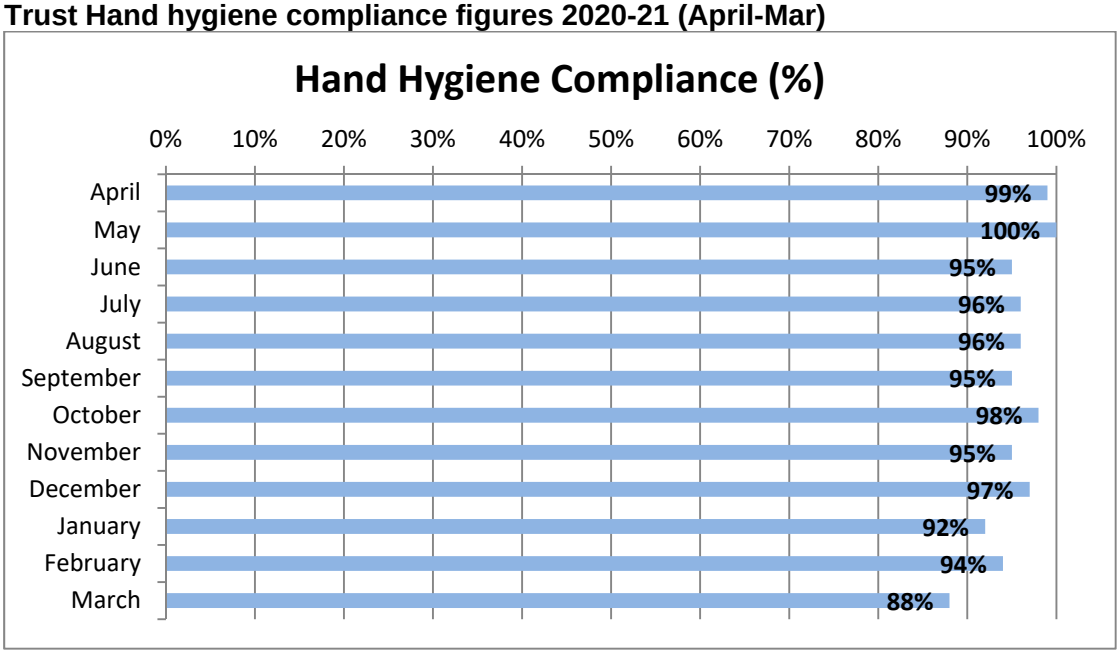
As can be seen from the table above Royal Papworth E.coli rates are 18.7 per 100 000 compared with 123.5 in England. Therefore, they remain low.

In absolute numbers we had 14 cases last year. The yearly audit will be carried out in due course.

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
The Ongoing M.abscessus outbreak is coordinated by the newly formed Oversight Committee now. Epidemiological study has been commissioned by RPH on the advice of PHE in order to look for potential causes. No new positive transplant or respiratory patients have been identified in recent months. Hospital water is tested for Mycobacteria monthly by Estates, results showed that M.abscessus colony counts have decreased significantly but M.abscessus is still present in the water. The Trust has implemented stringent measures to ensure that only filtered tap water is used for patient care for vulnerable groups and is monitoring compliance.

Trust Hand hygiene compliance figures 2020-21 (April-Mar)



MRSA bacteraemia and C. difficile trajectory infection rates*

Goals 2018/19	Outcome 2018/19	Goals 2019/20	Outcome 2019/20	Goals 2020/21	Outcome 2020/21
No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia
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	No more than 11 C.difficile	Total for the year = 8 all cases are now counted toward RPH's objective
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%	Achieve 100% MRSA screening of patients according to agreed screening risk	Figures not yet available for 2020/21

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/ yearly objectives.

COVID-19 Pandemic

The Trust coped successfully with the second surge of the COVID pandemic. Currently, only few COVID patients admitted at the beginning of the year remain in the hospital recovering from prolonged illness. No nosocomial cases have been recorded since April 2020. However, preparedness to the possible next COVID wave remains a high priority.

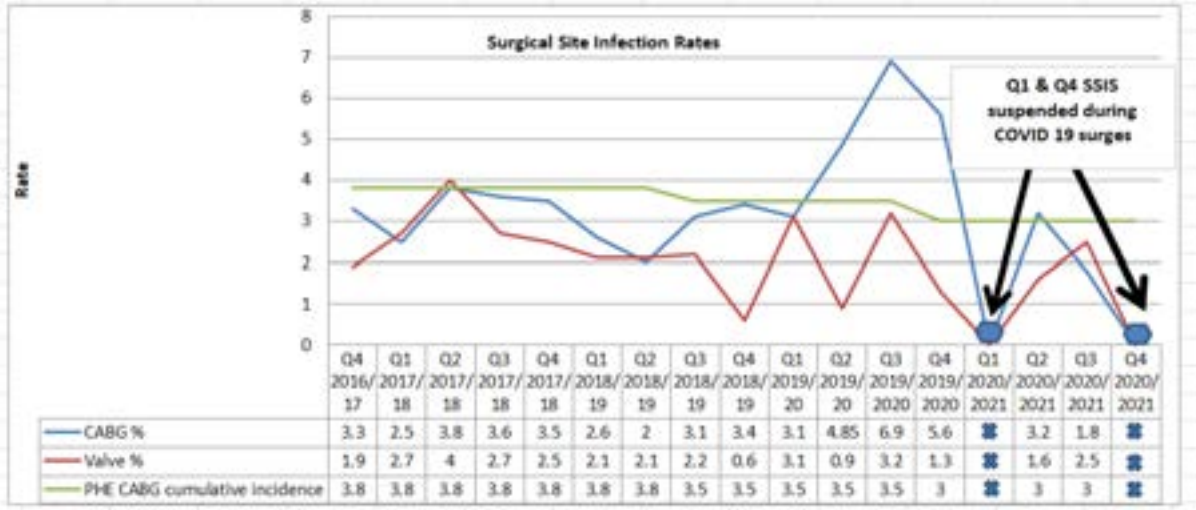
The COVID-19 pandemic continues to be managed within the organisation through the Command and Control centre. Meetings are continuing, these will be stood up again as required. The Clinical Decision Cell continues to meet regularly, these meetings monitor and contribute to the management of the current situation.

COVID19 Nosocomial Infections
Five patients have been identified as acquiring healthcare associated COVID-19 whilst an inpatient at Royal Papworth Hospital. There have been no nosocomial acquisitions since April 2020. COVID-19 acquisitions continue to be closely monitored by the Trust, Microbiology and Infection Control on a monthly basis.

Surgical site surveillance

Headlines
Following a challenging year in 2019/20, which covered the period of the move to new Royal Papworth Hospital, a rise in SSI above the national benchmark was recorded. The SSI surveillance team reports a return to infection rates below the national benchmark for this reporting year.

Table 1: SSI runchart



	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	Q1 2020/2021	Q2 2020/2021	Q3 2020/2021	Q4 2020/2021
CABG %	3.3	2.5	3.8	3.6	3.5	2.6	2	3.1	3.4	3.1	4.85	6.9	5.6		3.2	1.8	
Valve %	1.9	2.7	4	2.7	2.5	2.1	2.1	2.2	0.6	3.1	0.9	3.2	1.3		1.6	2.5	
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		3	3	

Reporting
Two quarters of valve and CABG infection rates were reported on this year. Quarter 1 and quarter 4 surveillance were suspended as members of the SSI surveillance team were redeployed to other duties in support of the COVID-19 surge and cardiac theatre activity was curtailed significantly.

We are pleased to report in quarter 2 and quarter 3 where surgical activity returned to near normal levels of activity, infection rates in both valve surgery and CABG surgery returned to sub-benchmark rates (Table 1).

SSI stakeholder group
The SSI stakeholder group was established in late 2019 to deliberate over the rise in deep wound infection rates and instruct and monitor actions aimed at reducing SSI following an increase in infection rates after the move to new Royal Papworth Hospital in May 2019. Engagement was sought from each department involved in the patient journey from admission to discharge.

Qualitative activities and considerations were reviewed by the group including pre-operative decolonisation practices, the theatre environment and theatre clinical practices, post-operative care and follow up. Pre-operative anti-microbial administration compliance standards were reviewed as a part of the project.

The consensus is that the rise in infections was likely due to multifactorial reasons. However, the only contributory quantitative data that could be identified as a part of the project was

around the administration of pre-operative anti-microbial compliance. Audit data gathered during a period of elevated rates of wound infection noted compliance with standards in this respect was not optimal (Please see attached audit documents). On feedback to the lead anaesthetist for theatres, strong engagement was forthcoming with the stakeholder group. The most recent audit notes increasing compliance with the standards of administration and this coincides with a reduction in SSI rates to sub-benchmark levels (table 2 and see attached). It must be recognised that the interventions in response to audit data feedback in this respect were well led and executed. It is also likely that the raised awareness of infection rates in interested clinical groups and departments led to changes in qualitative practices which are more difficult to measure and, in all likelihood, contributed to a return to bench mark rates of surgical site infection. It is recognised that engagement from interested groups associated with qualitative practices was strong.

Aspects of measures	Standard	August 2020
Correct choice of Antibiotics for surgical prophylaxis	100%	100%
Correct dose of flucloxacillin administered	100%	95.72%
Correct dose of Gentamicin administered	100%	81.82%
Flucloxacillin or Vancomycin administered between 15minutes to 120 minutes of skin incision	100%	91.3%

Table 2: Pre-operative anti-microbial administration audit data August 2020

The SSI stakeholder group will continue to meet in the near term in view of the disruption to patient pathways caused by the most recent COVID-19 surge and evaluate if the disruption to patient flow and theatre activity impacts on SSI outcomes into 2021.

Influenza

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for “frontline” staff 2020/21 was 83% Trust wide.

In 2020/21, the Trust continued to receive flu related ECMO patients into the Critical Care Unit. However, the Trust noticed a significant decrease in ECMO admissions relating to flu throughout 2020/21. It is suspected that this decreased is related to the COVID-19 pandemic.

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. This report covers data for patients admitted in ward areas (excluding the Critical Care) as validated by the Nurse Consultant for the ALERT/ surgical ward ANP teams.

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%

Sepsis audit analysis data (trust-wide excluding CCA)

A detailed breakdown of the Q1-Q3 data of patients who were diagnosed with sepsis and their management as per sepsis 6 guidelines is shown in the tables below.

Q1 20/21:
April – June: 44 patients were identified as requiring sepsis screening with only 4 of those patients diagnosed as having had sepsis. The sepsis bundle was fully completed for 50% of these patients and there were all already on antibiotics.

	Sample Size	**Required Sepsis screening**	**Screening Completed**	**IV antibiotics given within 1 hour (excluding pts already on antibiotics)**
April	3	3	2	Already on antibiotics
May	0	0	0	N/A
June	1	1	0	Already on antibiotics
Quarter 1	4	4	2	N/A
Compliance		100% (4/4)	50% (2/4)	N/A

Q2 20/21:
July – Sept: 110 patients were identified as requiring sepsis screening with only 3 of those patients diagnosed as having had sepsis. 67% of these patients had their sepsis bundle fully completed and received antibiotics as required within the hour.

	Sample Size	**Required Sepsis screening**	**Screening Completed**	**IV antibiotics given within 1 hour (excluding pts already on antibiotics)**
July	1	1	1	Already on antibiotics
August	2	2	1	1
September	0	0	N/A	N/A
Quarter 2	3	3	2	1/2
Compliance		100% (3/3)	67% (2/3)	67% (2/3)

Q3 20/21:

Oct – December: 99 patients were screened. 3 patients were diagnosed as having sepsis. 67% of these patients had their sepsis bundle fully completed and received antibiotics as required within the hour.

	Sample Size	**Required Sepsis screening**	**Screening Completed**	**IV antibiotics given within 1 hour (excluding pts already on antibiotics)**
October	1	1	1	Already on antibiotics
November	2	2	1	1
December	0	0	N/A	N/A
Quarter 3	3	3	2	2/3
Compliance		100% (3/3)	67% (2/3)	67% (1/3)

Actions ongoing:

The following actions are in place and led by the ALERT team:

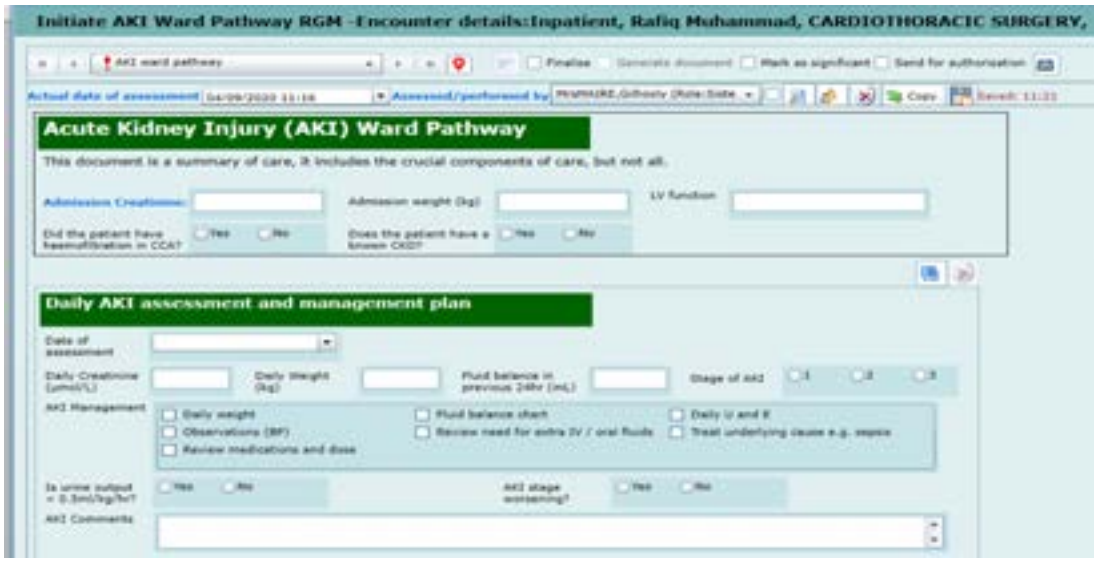
- sepsis care bundle compliance by ward teams
- appropriate use of the term 'sepsis'
- sepsis training during preceptorship and deteriorating patient study days

Acute Kidney Injury (AKI)

Acute kidney injury is a common complication in hospitalised patients and is associated with increased risk of morbidity and mortality. The numbers of patients who develop an Acute Kidney injury continues to fluctuate as the incidence can be dependent on patient acuity & planned procedures. This report covers data for patients admitted to the hospital and validated by the Lead Nurse for ALERT/ surgical ward ANP teams.

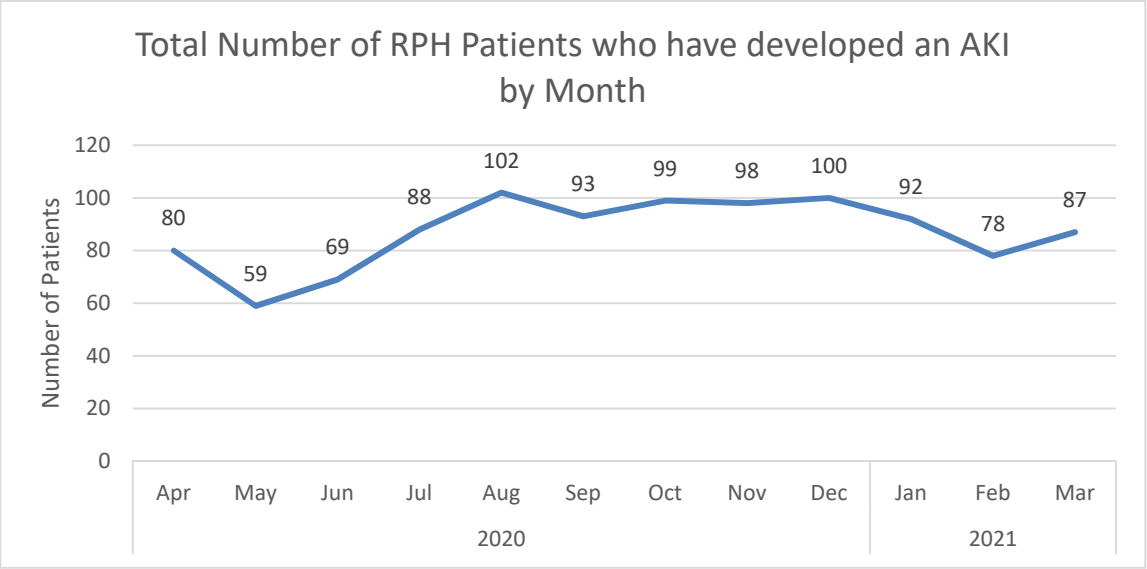
It is imperative patients with or at risk of developing AKI are recognised at the earliest opportunity following hospital admission and early management is directed at minimising further injury in line with NICE guidance (2019). AKI guidelines are available on the intranet for the recognition & management of AKI in line with the aforementioned national standard.

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



AKI remains part of the agenda for The Deteriorating Patient & Preceptorship Study Days which are facilitated regularly throughout the year. To offer further support, each ward area has a member of the nursing team identified as the link person for AKI.

Incidence of AKI



The above chart identifies the number of patients who developed AKI from 1st April 2020 – 31st March 2021. The increase in numbers of AKI is not comparable to previous years due to the COVID-19 pandemic. All elective admissions were cancelled and COVID positive patients requiring respiratory support were prioritised. This incidence of AKI is a reflection of the complexity & acuity of this patient group.

Actions ongoing:

The following actions are in place:

- Incidence of AKI on the wards
- AKI training during preceptorship and deteriorating patient study days

Future actions:

The following actions are planned:

- Measure compliance with AKI bundle by ward teams
- Compliance of fluid balance charts by ward teams

Pressure Ulcer Report: April 2020-March 2021

Pressure Ulcer Report: April 2020-March 2021

Pressure ulcers have been defined as ulcers of the skin due to the effect of prolonged pressure in combination with a number of other variables including: patient co-morbidities and external factors such as shear and skin moisture (NPUAP, 2016).
In their detailing of how trusts should report pressure ulcers, NHSE and NHSI (2018, appendix 1) describe eight principle pressure ulcer categories, ranging from category 1 to 4, deep tissue injury (DTI), an unstageable category and medical device related skin pressure ulcers along with moisture associated skin damage (MASD). The paper details that all pressure ulcers with the exception of category 1 ulcers and all MASDs will be reported on through a local reporting system.

The Wound Care Nurse Consultant initially reviews the pressure ulcer reports to establish if all cares were in place prior to ulcer formation. Should the documented evidence or clinical review of the patient lead to a query around care delivered to the patient, the incident will be further examined in detail by the relevant clinical area who conduct this examination through a root cause analysis (RCA) of the incident. The RCA will be reviewed at the Pressure Ulcer Scrutiny Panel who meets quarterly. The panel, made up of trust wide nursing representation, reviews the RCAs and concludes whether all care was in place and the ulcer could not be prevented or if there were acts/omissions in care that may have contribute to ulcer formation.

How we monitor pressure ulcers:

NHSE and NHSI (2018) guidance directs trusts to validate rates of pressure ulcers using multimodal monitoring strategies.

This is because it is recognised that no single system of pressure ulcer monitoring is infallible in representing rates of pressure ulcers experienced by patients (Fletcher 2018, Smith et. al., 2017). For example, Datix which is our primary reporting system is reliant on the clinician recognising the correct category of ulcer and then reporting it appropriately following training in how to use the system. Prevalence audits demonstrate the numbers of pressure ulcers on a set date and are useful in validating trends identified through Datix but are only a snapshot and must be carried out regularly in order to establish reliable and valid trends. Audit of electronic patient records play an important role in identifying trends. However, they too are reliant on clinicians categorising the ulcer correctly and completing the relevant documentation accurately. A strong clinical presence by the Wound Care TVN team is also a key part of our monitoring strategy as visibility and availability plays an invaluable role in the correct grading of pressure ulcers. This expert clinical presence supports NHSE and NHSI standards around confirming the category of deep ulcers before they are reported to commissioning groups.

The combination of these differing methodologies helps ensure if one monitoring system does not pick up a trend, another monitoring system will. In this reporting year, we reported the patient's experience of pressure ulcers through all these differing methodologies to gain reliable and valid data in support of patient care and to inform us where to direct our resources towards.

For the purposes of the two COVID-19 surge periods experienced by the hospital in this reporting year, it was recognised in the clinical area where members of the Wound Care Tissue Viability Nurse (Wound Care TVN) team were redeployed to, there was a reduced correlation between the numbers of pressure ulcers experienced by patients and the number of pressure ulcers report through Datix. A retrospective audit of pressure ulcers experienced with data collected from electronic patient records to cover this period of the

first surge in spring/summer 2020 was performed to help identify rates of ulcer formation during this challenging period. Both surges were associated with a rise in pressure ulcers rates due to the high number of critically unwell patients admitted to the hospital.

Outcomes:

Pressure ulcers developed at Royal Papworth Hospital (excludes pressure ulcers transferred in)

Datix reported the following:

188 pressure ulcers were reported through Datix (table 1). 22 of these ulcers were of category 2 or above. Only 1 of these numbers were a category 3 and there were no category 4 ulcers developed this year. The balance of reported pressure ulcers were low harm MASD, category 1 ulcers and MDRPU. The deep tissue injuries and ungradable ulcers identified were subsequently found to have not evolved into deep category 3 or 4 ulcers.

There was a significant increase in reporting through Datix during the final two quarters compared to the first two quarters. This followed an expansive education initiative between COVID-19 surges aimed at increasing reporting. Of note, despite the clinical pressures the second COVID-19 surge placed on clinical teams, reporting through Datix in the final two quarters was almost double what was recorded in the first two quarters (64 incidents versus 124 incidents).

	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
Deep Tissue Injury (Developed at Papworth)	4	1	2	2	9
Medical Device Related Pressure Ulcer (Developed at Papworth)	11	5	14	27	57
Moisture Associated Skin Damage (Developed at Papworth)	10	16	26	26	78
Pressure Ulcer Category 1 (Developed at Papworth)	9	4	11	7	31
Pressure Ulcer Category 2 (Developed at Papworth)	3	1	5	1	10
Pressure Ulcer Category 3 (Developed at Papworth)	0	0	1	0	1
Ungradeable (Developed at Papworth)	0	0	1	1	2
Total	37	27	60	64	188

Table 1: Pressure ulcers report through Datix

Prevalence audit reported the following:

Trust wide prevalence audits usually occur twice per year. There was limited trust wide audit this year due to demands on the Wound Care TVN team associated with COVID-19 clinical activity. A prevalence audit was carried out in CCA at the peak of the second surge to establish the rates of MASD in CCA ECMO patients. This type of pressure ulcer is a superficial skin injury and is caused primarily by incontinence. It is often described as unavoidable in long term CCA patients who frequently experience periods of incontinence during their admission and the aim of intervention is to minimise severity. This audit was prioritised as learning from the first COVID-19 surge indicated that the challenge to skin integrity in this patient group was primarily moisture incontinence damage to the skin and not direct pressure injury.

The audit (table 2) was also necessary to establish if a new skin protection protocol introduced towards the end of the first surge was effective in managing MASD. The results indicated that the protocol was effective in limiting damage to skin caused by moisture/incontinence.

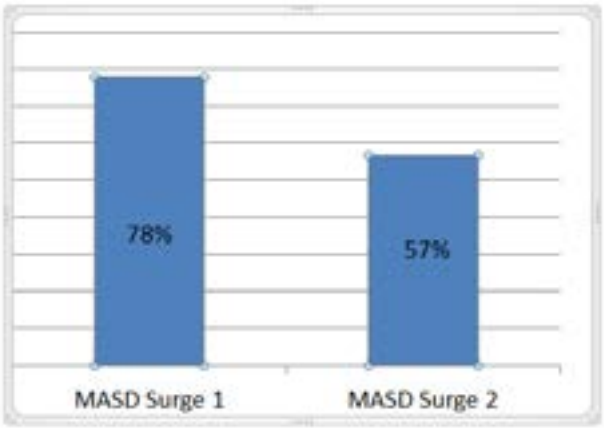


Table 2: MASD in COVID-19 ECMO patients

COVID-19 Skin Injury Audit reported the following:

The audit (appendix 2) was performed to identify the extent of skin injury (all pressure ulcers, MDRPU and MASD) in patients who were admitted to Royal Papworth Hospital in the first COVID-19 surge in spring 2020. As detailed earlier in the report, the audit was carried as it was recognised that there was underreporting of pressure ulcers in this period. The number of pressure ulcers reported can be explained in view of the majority of COVID-19 patients been cared for were admitted to CCA in a critically unwell condition.

The nature of this patient group who were immobile and supported with an array of sedatives, vasoactive drugs and medical devices, did mean they were at increased risk of pressure ulcer formation. The audit found that the dominant skin injury was superficial MASD and MDRPU. There were no category 3 or greater pressure ulcer developed by any patient who did not have one before admission.

It is suspected that the low rate of deep pressure ulcers can be explained by the majority of patients been bed bound for most of their admission period and the early implementation of a turning team known as the Essential Care Team (ECT).

There was additional investment in pressure offloading equipment in support of COVID-19 surges with acquisition of several new dynamic mattress systems and heel pressure offloading devices. There are now a total of 143 fully operational dynamic mattress systems available in the trust for patient care which equate to a dynamic mattress to bed frame ratio of approximately 1:2 with all beds in CCA matched to a dynamic mattress system. The high rate of MASD was linked to non-standardisation of hygiene and skin protection practices in the early days of first surge. This challenge was supported with the provision of education and clinical support for the ECT team and the introduction of standardised practices to protect skin known as ‘The One Approach’ (appendix 3).

The prevalence audit detailed above in the second surge noted that both prevalence and severity of MASD skin injury in the second surge was significantly less as the new protocols and educated turning teams were in place from the start of the second surge. The rate of MDRPUs can be explained by the unprecedented number of CCA admissions due to COVID-19. This patient group was supported with critical medical devices such as ECMO, endotracheal tubes and nasogastric tubes whose presence increase the risk of pressure

ulcer formation. The ratio of trained CCA staff to patients in CCA during both surges was lower than the normal GPICS standard the trust achieves in normal times. Care of this patient group was supported by redeployed staff, many of whom would have limited experience in managing such devices and this in all likelihood influenced observed rates.

In summary, consistent with other methodologies described here to establish the rate of pressure ulcer formation, the audit presents high levels of reporting with a low severity of harm experienced by patients in this group.

The information gathered in the audit confirmed there was underreporting of pressure ulcers through Datix in the first COVID-19 surge (table 3). This underreporting was likely to be due to a number of factors. The surge in CCA beds outside of the normal unit footprint required redeployed staff to care for a number of these patients. Many redeployed staff were not familiar with ways of workings and reporting standards for pressure ulcers. There was a significant education initiative delivered between both surges and resulted in a strong improvement in reporting for the rest of the year (table 1).

Hospital wide trends in Datix reporting		
Patients who required a Datix to be completed based on documented evidence i.e. category two pressure ulcers and greater, MDRI but not MASD	49/129	38%
Patients who did not have a Datix completed out of the 49 identified above	28/49	57%
Patients who required a Datix for MASD	58/129	45%
Patients who had a MASD Datix completed	2/58	3%

Table 3: Hospital wide trends in Datix reporting COVID-19

The Wound Care TVN team observed the following:

The Wound Care TVN team was alerted to and reviewed 1 category 3 pressure ulcer in the reporting year. This is consistent what was reported through Datix. The team report that they observed MASD and MDRPU most frequently in the clinical area with category 2 ulcers and deep tissue injuries observed infrequently. This is again consistent with what Datix suggest was happening in the clinical area.

Summary:

- Total number of pressure ulcers (Category 1-4, DTI, unstageable, MDRPU and MASD): 272
- 188 pressure ulcers were reported through Datix and an additional 84 more pressure ulcers were identified in the COVID-19 Skin Injury Audit
- These additional pressure ulcers identified through audit were mainly recorded in COVID-19 CCA patients
- 8% of patients (22/272) experienced a category 2,3,4, DTI or unstageable pressure ulcer in this reporting year This compares to 11% (20/181) of patients who experienced category 2,3,4, DTI or unstageable in the previous reporting year
- All incidents that required further scrutiny were presented to the Pressure Ulcer Scrutiny Panel regardless of whether they were captured through Datix or the COVID-19 Skin Injury Audit
- 17 out of 272 pressure ulcers were reviewed at Scrutiny Panel this year. The panel identified that there were 12 pressure ulcers where there were acts/omissions in care that may have contributed to ulcer development. This compared to 22 out of 181

pressure ulcers in the previous reporting year been reviewed by the panel who identified there were 5 pressure ulcers where there were acts/omissions in care that may have contributed to ulcer development (table 4). The relative increase is associated with the unprecedented number of admissions of COVID-19 patients to CCA and a substantial education initiative aimed at increasing reporting rates of pressure ulcers as detailed earlier in table 1.

	Category 2	Category 3	Category 4	Deep Tissue Injury	Unstageable
2020/21	10 (4 all care in place, 6 acts/omissions in care)	1 (1 acts/omissions in care)	0	6 (1 all care in place, 5 acts or omissions in care)	0
2019/20	11 (8 all care in place, 3 acts/omissions in care)	1 (1 all care in place)	0	8 (6 all care in place 2 acts/omissions in care)	2 (2 all care in place)
2018/19	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

Table 4: Reviewed at *Pressure Ulcer Scrutiny Panel* outcomes

Conclusion

- There were very low rates of deep category 3 or category 4 ulcers developed in the trust
- There has been no year on year change in rate of category 2,3,4, DTI & unstageable pressure ulcers even though reporting levels increased over the year
- There was only one moderate harm pressure ulcer developed in the trust
- MASD and MDRPU remain a principle challenge in respect to prevention
- There is a strong and robust reporting culture in place to record pressure ulcers using a multi-modal monitoring strategy

Notable practices:

- Introduction of ECT/turning teams to support essential patient care during both COVID-19 surges. Their presence may explain the low rate of deep pressure ulcers experienced by COVID-19 patients
- Introduction of a standardised skin protection protocol to support COVID-19 critically ill patients. This protocol is in the process of been extended to all clinical areas. This protocol has been shared with the National Working Group for Pressure Ulcer Prevention in the Critically Unwell. Just fewer than 700 UK and international delegates attended a virtual webinar which focused on our findings and what we practised to

minimised deep pressure ulcers in the critically unwell COVID-19 patient. Frimely Park NHS Trust is currently implementing core elements of this protocol

- Investment in additional dynamic mattress systems to support COVID-19 patients. We now have a ratio of dynamic mattress surfaces to bedframes of 1:2. The high ratio of these mattresses surfaces may also explain the low rate of deep pressure ulcers experienced in the trust
- A culture of executive support of clinical decision making to identify and employ cost effective resources that will best support pressure area care
- Reporting of pressure ulcers through Datix almost doubled in the second half of the reporting year following an expansive educational effort to increase reporting through Datix. This increase in reporting was maintained through the second COVID-19 surge despite immense clinical pressures
- The rostering of dedicated wound care link hours in CCA before and between COVID-19 surges likely impacted on the improved reporting through Datix and supported efforts to maintain low rates of deep pressure ulcers
- Employment of a fixed term contract wound care TVN to support COVID-19 recovery within the team

Notable challenges:

- Maintaining the impact of the skin protection protocol in limiting rate and severity of MASD
- Reducing MDRPU rates
- Maintaining the low rates of deep pressure ulcers
- Reducing the numbers of cases where there were acts or omissions in care with a focus on effective documentation of care delivered

Strategies and initiatives for 2021/22:

- The Scrutiny Panel continues to examine all category 2, 3, 4, DTI, or unstageable PUs developed within the Trust in order to identify lessons learnt and share good practice
- Biannual pressure ulcer prevalence audits and annual mattresses surface audit
- Continue Datix incident reporting for all MASDs and 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.
- Maintain a standing agenda item in the Quality and Risk Management meeting to report pressure ulcer rates
- Continue with education focusing on pressure ulcer 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 pressure ulcer prevention training in view of COVID-19 face to face teaching challenges
- Working with wound care industry partners to support training in pressure ulcer management

Patient Safety Incidents – Severity

Incidents by severity	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
Near Miss	61	114	126	68	369
No harm	239	452	513	265	1469
Low harm	155	154	217	172	698
Moderate harm	4	9	6	4	23
Severe harm	0	5	0	1	6
Death UNRELATED to the incident	1	2	4	4	11
Not yet graded	0	1	8	14	23
Total	460	737	874	528	2599

Patient Safety Incidents by Severity (Data source: DATIX 10/05/21)
*Correct at the time of production. Some incidents may be downgraded in severity following investigation.

Fluctuating numbers of patient safety incidents have been reported during the financial year linked to the COVID pandemic. There is a healthy safety culture within the Trust and an understanding of the importance of learning from incidents and the CQC requirements to report under the Key Lines of Enquire (KLOE).

Those graded as near miss (14%), no/low harm over the last 12 months (83%) demonstrates a continuous readiness to report and learn from all types of incidents. The Trust culture ensures staff report incidents in order to demonstrate an open and fair culture of learning 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 Serious Incident Executive Review Panel (SIERP).

The level of investigation carried out after a patient safety incident is determined by the level of severity. All moderate harm incidents and above have investigations and associated action plans which are managed by the relevant divisions and monitored by the Quality & Risk Management Group (QRMG). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and supported by the Clinical Governance and Risk Team. The (*) signifies 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 as at 10/05/2021. Lessons learnt are shared across the organisation and with associated stakeholders in addition to quarterly Lessons Learnt reports via the intranet, presentations and local dissemination via Divisions and specialist meetings.

Never Events

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

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

The Trust did not report a Never Event during 2020/21 however in May 2021 a Never Event occurred where a misplaced nasogastric tube was not checked prior to administering medication (there was no harm to the patient). Immediate actions were taken and the investigation is ongoing. The Care Quality Commission (CQC) and NHS Improvement (NHSI) were informed immediately.

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.

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.

2020-2021 has proved an unusual and challenging year due to COVID-19. Low patient numbers due to the pandemic impacted on the overall falls data, making the falls per thousand bed days appear higher than normal. There were 2 COVID-19 surges that fell into the financial year 2020-2021, one in spring 2020 and one in winter 2020.

During the financial year there have been regular occurrences of near miss falls, patients being lowered to the ground, no and low harm falls and moderate harm falls. Falls resulting in moderate injury have Root Cause Analysis (RCA) performed and falls resulting in severe harm have a full Serious Incident (SI) investigation. All RCA falls investigations are reviewed at QRMG and at the Band 7 Nurses meetings.

There were no serious incidents from falls in the financial year 2020-2021 but there were 6 moderate harm incidents, including two hip fractures, one incidence of fractured ribs, one wrist fracture, one intracranial bleed and one fractured ankle.

Themes arising from falls overall, were patient frailty, trailing ECG cables and association with bathrooms. The majority of all falls were unwitnessed and only one of the moderate harm falls was witnessed.

Of the moderate harm falls, all of the patients had significant frailty including osteoporosis, mild dementia, balance issues, neurological issues and delirium.

Concerning the moderate harm falls and continuing on from previous work, a number of actions have been put in place as a result:

- Purchase of alarm units for trialling in bathrooms to alert staff to patient movement
- Ongoing training provided for all clinical staff on falls prevention
- Thematic review of all falls
- Promotion of frailty scoring to highlight vulnerable patients
- 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
2020/21	28	41	56	34	159
Total	221	174	260	203	858

Source DATIX 21/05/2021

Falls incident and near miss data by location 01/04/2020 – 31/03/2021

Location	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
NPH 4 North West	0	1	3	2	6
NPH 3 North Sleep Lab	1	0	0	0	1
NPH 3 North Thoracic	1	4	9	8	22
NPH 3 South Cardiology	7	7	11	8	33
NPH 4 North/South - Respiratory Specialties	3	0	0	6	9
NPH 4 South CMU	0	0	0	0	0
NPH 5 North Surgical	8	15	12	6	41
NPH 5 South Surgical	5	9	17	3	34
NPH Critical Care	2	2	2	0	6
NPH Day Ward	0	2	0	1	3
NPH Fourth Floor	1	0	1	0	2
NPH Ground Floor	0	1	1	0	2
Total	28	41	56	34	159

Incidents by Directorate and Incident date (Quarter)
Data source: DATIX™ 21/05/2021

Severity of incidents	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
Near Miss	3	2	3	6	14
No harm	21	24	36	19	100
Low harm	4	13	15	7	39
Moderate harm	0	2	2	2	6
Severe harm	0	0	0	0	0
Death caused by the incident	0	0	0	0	0
Death UNRELATED to the incident	0	0	0	0	0
Total	28	41	56	34	159

Incidents by Directorate and Incident date (Quarter)
Data source: DATIX™ 21/05/2021

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).
During COVID19 the Trust has adopted National guidance on the management of VTE in patients presenting with acute COVID.

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 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/). We participated in the National Getting It Right First Time Thrombosis Survey in 2020. The VTE medical lead was a peer reviewer in the 2019 National Confidential Enquiry in the Patient Outcome and Death Pulmonary Embolism survey and an expert panel member in the 2020 NICE COVID-19 Thromboembolism guidelines (NG186). Trust procedures are updated in line with National recommendations.

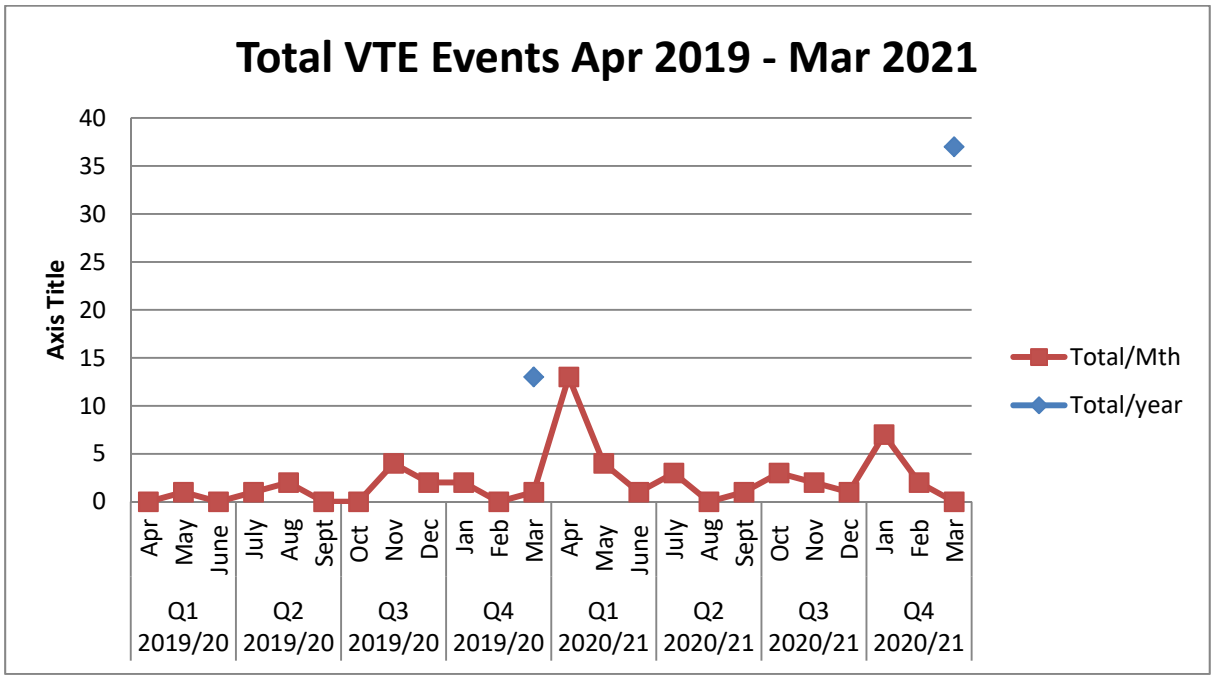
The NHS Standard Contract for Acute Services introduced the requirement for a root cause analysis (RCA) on all VTE episodes identified in inpatients and patients discharged within 90 days. The Trust is compliant with this requirement and conducts RCAs on all VTE events known to the Trust.

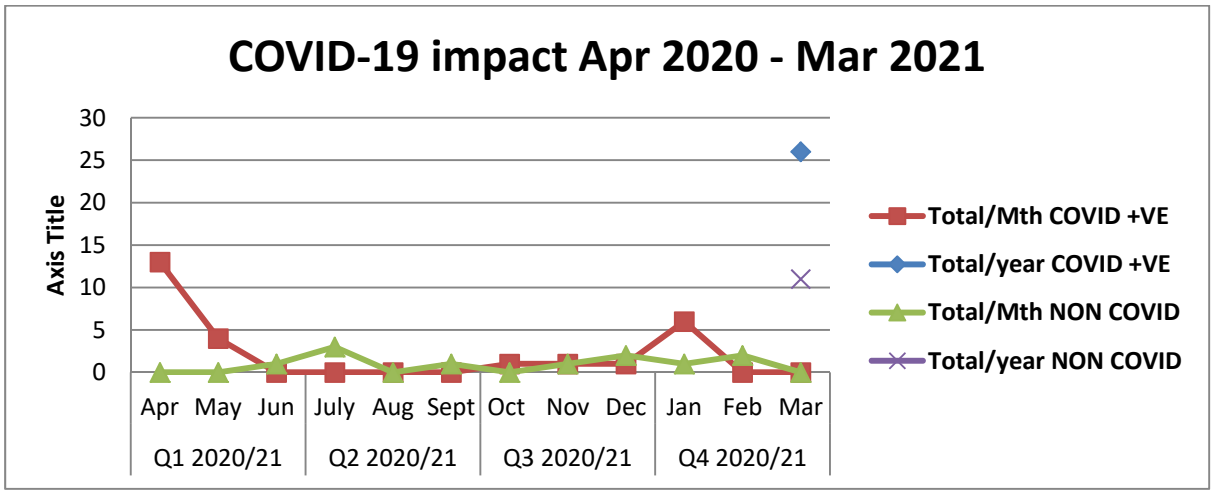
We have recorded data from 2018-2021 showing low VTE events within the Trust as outlined below. This includes community or hospital associated VTE events. The last moderate harm incident was August 2019 in relation to a confirmed VTE event due to failure to complete a VTE risk assessment on a patient whom developed a DVT.

VTE during COVID-19 outbreak

We have seen an increase in COVID-19 related VTE events (the majority diagnosed on admission to Royal Papworth Hospital) as outlined below, the findings of which have been provided to referring centres. Notably the two spikes within the graph below highlight peak response times within the NHS responding to the pandemic.

There were 13 reported VTE events in CCA in COVID-19 positive patients during April 2020 and 4 in May 2020. This is a known complication as part of the coronavirus disease pathway however, all 17 have been reported as DATIX incidents and have had a full RCA completed. These have been discussed at monthly scrutiny panel with nursing, medical and pharmacy input and areas for improvement have been shared with referring organisations and internal RPH staff. As we conclude the 2nd surge in COVID-19 admissions we have reviewed VTE events for COVID positive patients. In Q4 there have been 6 VTE events for COVID-19 positive patients taking the total to 26 since the beginning of the pandemic. The remaining 11 are non COVID taking the in year total to 37 VTE events. Comparable to 2019/20 data excluding COVID VTE cases we continue to have low cases of VTE events all remaining as low harm.

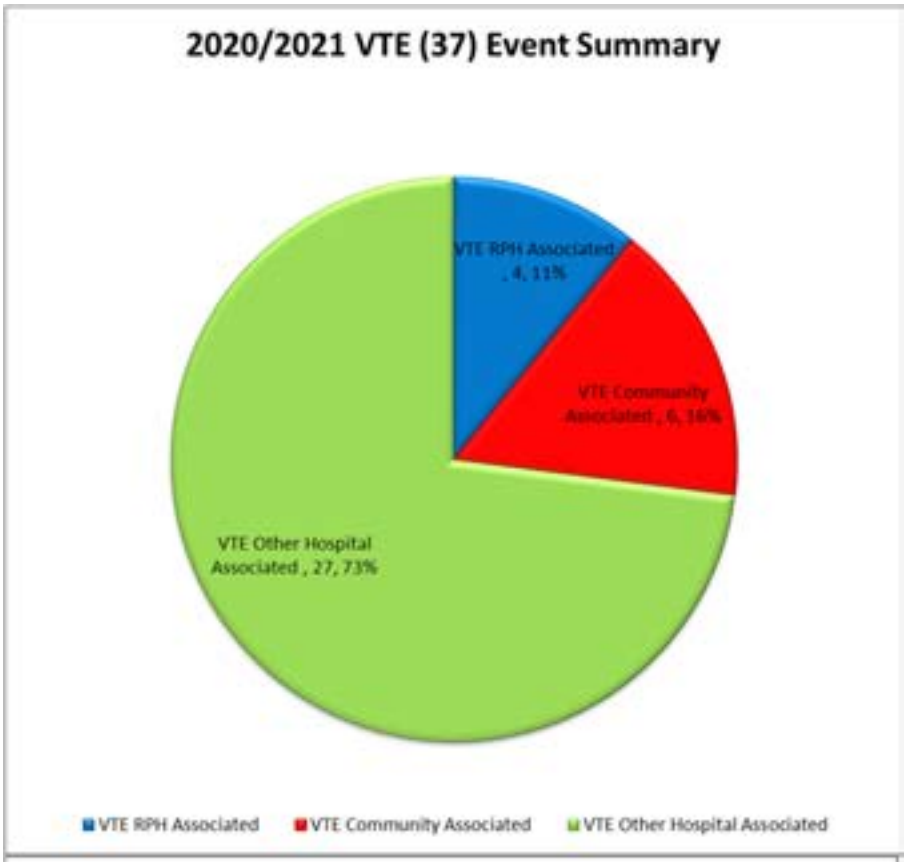


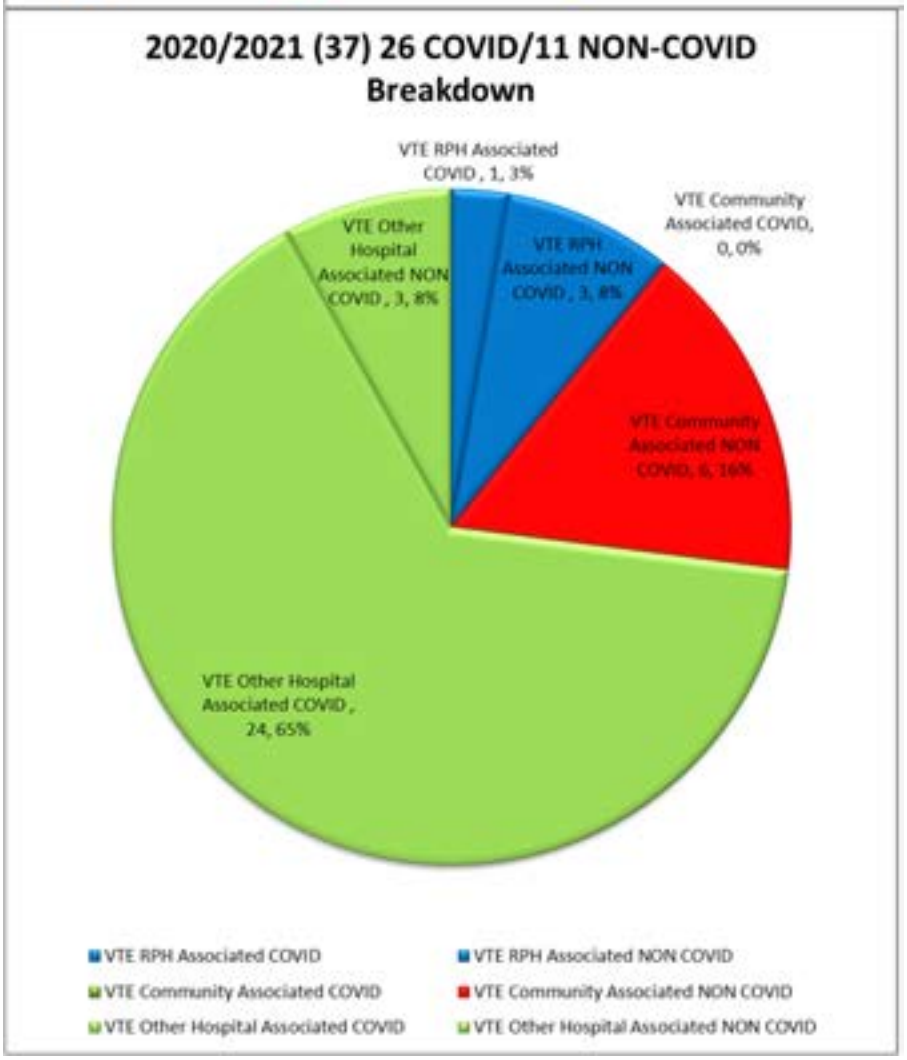


Where the findings of the RCA conclude that more could have been done to reduce the risk of VTE in RPH, this is communicated to the patient by their Consultant in line with the statutory Duty of Candour in the NHS. We have incorporated VTE RCA into our DATIX system to streamline reporting, ensuring sign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

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. At induction, medical staff are advised on and shown the location of the VTE risk assessment on Lorenzo.

The pie chart graphs below highlight the COVID and NON-COVID breakdown and whether the VTE event was community, other hospital or Royal Papworth acquired.


2020/2021 VTE (37) Event Summary
VTE RPH Associated , 4, 11%
VTE Community Associated , 6, 16%
VTE Other Hospital Associated , 27, 73%
VTE RPH Associated
VTE Community Associated
VTE Other Hospital Associated


2020/2021 (37) 26 COVID/11 NON-COVID Breakdown
VTE RPH Associated COVID , 1, 3%
VTE Community Associated COVID, 0, 0%
VTE Other Hospital Associated NON COVID , 3, 8%
VTE RPH Associated NON COVID , 3, 8%
VTE Community Associated NON COVID, 6, 16%
VTE Other Hospital Associated COVID , 24, 65%
VTE RPH Associated COVID
VTE RPH Associated NON COVID
VTE Community Associated COVID
VTE Community Associated NON COVID
VTE Other Hospital Associated COVID
VTE Other Hospital Associated NON COVID

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 was in place. We have seen sustained improvement in late 2019/20 shown below with increased compliance above 95% in six consecutive quarters.

Percentage of patients risk assessed for VTE Q1-Q4 2019/21

2020/21	% of In-Patients Risk Assessed for VTE	Quarterly %
April 2020 **Q1**	100	**96.63%**
May 2020	93.3	
June 2020	96.6	
July 2020 **Q2**	96.6	**95.54%**
August 2020	90	
September 2020	100	
October 2020 **Q3**	96.6	**96.66%**
November 2020	96.6	
December 2020	96.6	
January 2021 **Q4**	96.6	**96.66%**
February 2021	96.6	
March 2021	96.6	

2019/20	% of In-Patients Risk Assessed for VTE	Quarterly %
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	**98.00%**
November 2019	100.00	
December 2019	97.00	
January 2020 **Q4**	97.00	**97.00%**
February 2020	97.00	
March 2020	96.66	

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. We are undertaking regular spot audits of VTE risk assessments by using the quality indicators tab within the Trust EPR system. Ward and departmental board rounds are also highlighting to medical and advanced nursing staff the need to complete a timely assessment of VTE risk.

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 2020/21. We have recently shared findings of a moderate harm incident in relation to anti-embolic stockings with staff internal and external to Trust to aid with wider learning. We have published the Trust's experience with thrombosis and bleeding in COVID-19 VV ECMO patients in a peer reviewed international journal.

Delivery of Harm-Free Care

NHS Safety Thermometer: The NHS Safety Thermometer is no longer in use and so reporting has been removed.

Patient Safety Rounds (PSR)

Patient Safety Rounds (PSR) have been paused during the response to COVID19. 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 2021/22.

Patient experience domain

Patient Stories at Board

Patient stories have continued to form an integral element of capturing the patient experience throughout 2020/21. 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 2021/22.

The Board have received detailed stories covering a range of areas including:

- The support for patients with COVID and the valuable support provided to the patient's family by our family liaison team.
- The story of one of our heart transplant patients who had an extended stay at the hospital who had identified the impact of pre-operative 'prehabilitation' on his readiness for surgery and his speed of recovery. He had also noted that members of all the hospital teams had worked and contributed to support his emotional well-being.
- The experience of patients with complex needs and whose discharges were effected by issues including homelessness and immigration status.. In these the hospital teams had worked with a range of external agencies to support the patients. One patient had also observed that being treated with kindness had had a very positive impact on their experience of health services.
- The experience of a patient and family who were supported by our palliative care team. The patient had only a short stay with the Trust but there were round the clock communications with the teams, and the family, and the patient died peacefully on Saturday night. This patient story highlighted the importance of role of palliative care and the specialised nursing services at the Trust.

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. The review of the strategy was extended to 2021 to allow time for the move to the New Hospital and the response to COVID-19 pandemic. The new build was designed with patient feedback in mind to maximise patient experience. A review is needed to look at how the environment has impacted on our patients and how we can ensure the best quality outcomes.
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.

The COVID19 pandemic and the NHS's response to this has affected our plans for further supporting patients with Dementia and their carers. The pandemic has proved especially challenging to those living with dementia who may have memory problems and so struggle with the guidance and rules around coronavirus including frequent handwashing and social distancing.

During the pandemic the revised Dementia-Friendly Hospital Charter was published in October 2020 as a result of the COVID19 pandemic and the challenges of caring for patient living with Dementia. The Charter has a self-assessment tool to look at practice during a pandemic. The trust plans to bench mark its activities during this time against the self-assessment in order to be confident in its practice going forward.

During the Pandemic visiting was suspended at Royal Papworth Hospital and has only had limited relaxation in April 2021. It is currently at Level 2: Limited Visiting. However during the pandemic period the trust made reasonable adjustments to allow family members or carers to support patients living with dementia. The trusts stance was in line with NHS publication 'Visiting healthcare inpatient settings during the COVID-19 pandemic: principles version1 published March 2020'

Staff that identified as having caring responsibilities for others were also supported in the work place having reasonable adjustments to their working arrangement.

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. T
    - 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. We are planning to consider how this can be evaluated during this next year.
4. Having a knowledgeable and caring workforce is essential. During the pandemic because of staff redeployment and the requirements of social distancing dementia eLearning resources are available for staff.

5. The roll out of the lessons from a pilot on Frailty (which by nature includes many patients with Dementia) has yet to be embedded within the organisation.

6. The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards has been delayed nationally - the latest implementation date is April 2022. The publication of the new code of practice is also still awaited.

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 2020 Royal Papworth Hospital published its Care of Patients with Learning Disability & Autism Policy. This replaced the hospitals earlier Strategy. Like the earlier strategy the policy aims 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 & Autism are very small. In the year 2020/2021 see the figures are below

	Contacts	Unique patients
Learning Disabilities	103	43
Autism	8	4

Royal Papworth Hospital participated for a 3rd year running in NHSI improvements Standards for Learning Disability self-assessment to better understand the experience of our patients. Our action plan has again been updated with the progress that is being made to improve the experience of patients with Learning disability & Autism attending the hospital.

The impact of the Covid -19 pandemic has been felt disproportionately by people with Learning disabilities.
In April 2020 a letter from NHS England and NHS improvement emphasised the importance of personalised care plans and advised that the use of the Clinical Frailty Scale may not be a reliable tool for this patient group.

> *"The CFS should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disability or autism. An individualised assessment is recommended in all cases where the CFS is not appropriate*."

Following this advice amendments were made to the RPH Clinical Ethics Committee publication on Resource allocation in a critically resource constraint environment (including CRITCON-4 guidance) DN825
And to the Consent guidance 011G
Both these documents are still awaiting formal approval.

Public health England produced a report in November 2020 reviewing the available data for deaths for people with Learning Disability during the COVID-19 pandemic https://www.gov.uk/government/publications/covid-19-deaths-of-people-with-learning-disabilities
This noted a death rate 4.1 times higher than the general population after adjusting for other factors such as age and sex.

During the Pandemic visiting was suspended at Royal Papworth Hospital and has only had limited relaxation in April 2021- it is now at Level 2: Limited Visiting. However during the pandemic period the trust made reasonable adjustments to allow family members or carers to support patients living with dementia. The trusts stance was in line with NHS publication 'Visiting healthcare inpatient settings during the COVID-19 pandemic: principles version1 published March 2020'

The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards has been delayed and the latest implementation date is April 2022. However we are still awaiting the publication of the code of practice.

Progress as a Trust for patients with Learning Disability and Autism

1. Facilitated 2 staff members to become trained as LeDeR reviewers and to participate in the Cambridge and Peterborough LeDeR Steering Group.
2. Started to consider the training needs of our staff – paused during our response to the COVID-19 pandemic. This will be progressed during this next year.
3. Committed to hear the voice of our patients with Learning Disability & Autism through patient stories and to embed that learning within the trust.
4. We have developed some communication resources for patients with Learning Disabilities which are available for staff use.

5. Established a system to monitor incidents reported through Datix affecting people with Learning Disabilities. Lessons from this are reported through the Joint Safeguarding Committee.
6. Started a process to identify and monitor patients with a learning disability on a waiting lists for our services.
7. 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
8. The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards has been delayed nationally - the latest implementation date is April 2022. The publication of the new code of practice is also still awaited.
9. Royal Papworth Hospitals response to the impact of COVID-19 on patients with Learning Disability has been informed by the published guidance as outlined above
10. Working with Digital colleagues to create an alert icon on Lorenzo for Learning Disability and/or Autism patients.

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

PLACE assessments were suspended in 2020/21. Further information on the PLACE programme can be found in the 2019/2020 Quality Accounts.

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

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 2020/21 Royal Papworth Hospital received 37 formal complaints from patients. Of the 37 complaints reported (25 inpatient and 12 outpatient complaints) 34 were relating to NHS provided services with 3 complaints related to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has decreased in the numbers received during the previous year when 74 complaints were received (a 50% decrease from 2019/20).

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 16 enquiries in 2020/21, a significant decrease from the previous year (33 in 2019/20).

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 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021
7.8	6.2	4.1	4.6	4.6	5.0	4.0	4.5	3.0	3.6	6.9	5.9

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 37 complaints received in 2020/21 35% were upheld or partly upheld following investigation (2019/20: 55%).

Quarter	Number of complaints received (including private patients)	Complaints upheld/ Part upheld
Q1 2020/21	7 (1 PP)	1
Q2 2020/21	10	4
Q3 2020/21	5 (1 PP)	2
Q4 2020/21	12 (1 PP)	6*

*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. Whilst we have received a decrease in the number of complaints associated with clinical care/clinical treatment

consistent with the overall reduction in the number of complaints received in 2020/21, 35% of complaints received in 2020/21 relate to clinical care and 22% relate to communication which remain the highest cause for complaints. A comparison of complaints raised by primary subject by year is shown below.

Complaints received by primary subject	2020/21	2019/20	2018/19	2017/18	2016/17
Clinical Administration and Appointments	2	3	0	0	0
Staff attitude	0	0	1	2	5
Clinical Care/Clinical Treatment	13	28	12	8	17
Patient Care (including nutrition and hydration)	5	0	0	0	0
Nursing Care	0	1	0	5	4
Catering	0	0	1	0	1
Patient Charges	0	0	0	0	1
Communication/Information	8	27	28	41	18
Delay in diagnosis/treatment or referral	0	7	10	9	6
Admissions, discharge and transfers	2	1	1	2	2
Consent	1	0	0	0	0
Equipment Issues	0	0	0	1	1
Privacy and Dignity	1	1	0	1	0
Environment - Internal	0	3	0	0	1
Medication issues	0	2	1	0	0
Facilities including Parking and Transport	4	1	0	1	1
Other	1	0	0	0	0
Totals	**37***	**74***	**53***	**70**	**57**

Complaints by primary subject (Data source DATIX 22/04/2021)
*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 – 2020/21
Provide patients with relevant contact information and a point of contact for the Pacing Team in all patient information.
Improved communication amongst the clinical and nursing teams regarding delirium.
Cascade information regarding the correct procedure for sharing information of COVID result with a patient's next of kin.
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:

Ratings	
Overall rating for this trust	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 for the whole organisation in February 2020 which assessed against the CQC key lines of enquiry (KLOE). The trust had planned to undertake a further mock inspection in October 2020, however due to the Coronavirus pandemic, it was necessary to reduce the size of the inspection. Acknowledging that the 2019 CQC inspection did not independently rate End of Life Care, the trust therefore

decided to focus the October 2020 mock inspection on End of Life Care. During each of these mock inspections, the review team were asked to explore the KLOE and look for good practice and those areas that need improvement.

The outcome of these inspections 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. The trust Quality Compliance Officer maintains liaison and monitoring of the actions plans with each of the owners.

The Board agreed its last Trust wide self-assessment in February 2020 and this has been updated to reflect the outcome of the EoL Inspection in October 2020. The latest scores for the Trust are 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	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding

CQC Board Self-Assessment 03 February 2020

The Trust has also continued with its schedule of CQC Fundamental Standards reviews. The twelve standards are each planned to be reviewed over the course of a year, and whilst this programme has been interrupted in 2020/21 it is planned to use these to inform and support improvements in our standards in 2021/22. 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.

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 designed 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.

Planning for recovery and preparation for subsequent waves of COVID19 was managed through the CDC longer term strategy and recovery plans. All possible opportunities to deliver the business as usual activity and go beyond pre COVID19 activity levels were pursued. The second COVID19 wave saw the approach to delivering BAU maximised alongside delivery of 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 106 patients admitted to our Critical Care Unit reported to 31 March 2021.

Cardiovascular Outcomes – NICOR report 2016-2019

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 >98.5%, and was above the national average. During that time, Royal Papworth performed the 5201 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 2016 and 2019.

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 2020.

The report identified that the national 30 day rate of survival following adult heart transplantation was 91.5%, which ranged from 87.8% to 94.4% across centres (RPH 93.1% risk-adjusted). The national 90 day survival rate was 87.3%, ranging from 80.8% to 91.4% across centres (RPH 90.3% risk-adjusted). The national 1 year survival rate was 83.2%, ranging from 77.1% to 86.7% across centres (RPH 86.7% risk-adjusted). The national 5 year survival rate was 69.9%, ranging from 59.6% to 78.3% across centres (RPH 78.3% risk-adjusted). At 5 years, there was some evidence of a significantly higher rate at Papworth in comparison to the national rate.

The report noted that Royal Papworth's survival rates fell above the upper 99.8% confidence limits at one and five years respectively, indicating significantly high survival from listing at these time points.

For lung transplant the 90-day post-transplant Papworth had a rate of 91.6% (risk adjusted). This was statistically consistent with the national rate of survival which was 90.9%. The national 1 year survival rate was 82.6%, ranging from 74.3% to 87.4% across centres (RPH 80.4% risk-adjusted), with no significant outliers. The national 5 year survival rate was 55.3%, ranging from 32.1% to 59.6% across centres (risk-adjusted). The 5 year survival rate at Papworth was 59.1% (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.

NHSBT Annual Report on Cardiothoracic Organ Transplantation Report for 2019/2020 (1 APRIL 2010 – 31 MARCH 2020) Published August 2020

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 (RPH) has been offering it for a number of years to many patients.

The Hospital is registered with the international Extracorporeal Life Support Organisation (ELSO) and is renowned for its experience using ECMO. This long experience in providing a high-quality ECMO service is recognised in the success of the residential Royal Papworth ECMO course, which attracts national and international delegates, with more than 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 RPHbecame part of the national network of services that provide a year-round ECMO service to all hospitals in the country. This includes the retrieval on ECMO of patients from the referring hospital by a dedicated highly-specialised team. RPH works very closely with the other four English ECMO centres and NHS England to ensure that all patients have immediate access, all week long and at any time of the day or night, irrespective of their location. Our Consultant Intensivists also provide specialist advice by phone to referring centres when patients are not deemed suitable for ECMO.

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

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.

2020/21 has been an exceptionally busy and challenging year as ECMO is the ultimate support for patients with very severe respiratory failure and indeed around 20% of all adult patients with COVID and ventilated in intensive care were referred to the national ECMO service.

While only a proportion were deemed likely to benefit from ECMO support, our ECMO team provided ongoing individualised advice over several days for the majority of the referred patients.

The service also continued to provide for non COVID patients.

To note, the number of patients referred in the month of January 2021 was higher than the total number in any previous year.

Due to this unprecedented demand on the National Service and a prolonged need for support, St Bartholomews Hospital (SBH) in London was recruited as a surge centre to support RPH. Ten patients were diverted to SBH and the RPH ECMO service supported

management of these patients through twice weekly conference calls with the SBH ECMO team.

In March 2020 Royal Papworth worked closely with NHSE to lead 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 59% for patients supported with respiratory ECMO. This is remarkable in patients who were referred because of their high likelihood of death.

Summary of ECMO activity at Hospital since December 2011 - March 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%
2020/21	1012	106	104	64%**	64%**	63%	64%

*discharge from Royal Papworth ** 3 inpatients

Royal Papworth (RPH) Critical Care Transfer Service

The Royal Papworth (RPH) Critical Care transfer service commenced on 4th January to support the East of England Critical Patient and Resource Management Centre (CPRMC) in the transfer of Critical Care patients in the East of England Critical Care Network region. The service provides a team of Consultant and transfer trained critical care nurse from 10:00-22:00, 7 days a week. Amvale provide a critical care ambulance and driver. RPH supplies and maintains all specialist equipment.

The team is using an electronic referral and communication platform (Refer a Patient).Since April 1 transfers are coordinated through the RPH CCA.

To end of March 2021 the service had safely transferred 91 critical care patients, contributing to the East of England response to the unprecedented demand for critical care beds caused by the COVID19 pandemic.

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

Reporting suspended

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.

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

We are planning to launch our new values and behaviours framework in June and July 2021 with a series of staff events. We are also starting development of a training package that we will be recommending is rolled out to all staff that familiarises them with the behaviour framework, gives some simple models of how to give and receive feedback on behaviours and how to raise concerns and support other staff. We are developing the project plan and governance for how we will reflect these values and behaviours across all our workforce practices/policies and will take this forward in 2021/22.

Further information on our Compassionate and Collective programme is included in our Quality Priorities for 2020/21 and 2021/22.

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 2020/21 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-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	79.06%	68.71%	54.72%	50.41%	60.43%	74.06%	86.26%	91.17%	90.55%	85.84%	80.36%	78.47%	78.47%
62 day cancer wait *	>85%	53.80%	41.70%	10.00%	100.00%	66.70%	33.30%	100.00%	100.00%	85.70%	38.50%	75.00%	100.00%	66.70%
31 day cancer wait	>96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
6 week wait for diagnostic	>99%	97.72%	96.70%	96.80%	90.59%	97.63%	98.79%	99.24%	98.92%	98.69%	90.23%	90.03%	89.19%	95.38%
Monitoring C.Diff (toxin positive)	Less than 8	0	1	0	1	0	1	0	0	1	2	0	1	7
Number of patients assessed for VTE on admission	>95%	100.00%	93.30%	96.60%	96.60%	100.00%	100.00%	96.60%	96.60%	96.60%	96.60%	96.60%	96.60%	96.60%

In 2020/21 these indicators have not been subject to independent assurance.
*The definition of this indicator can be found in Annex 4 to the Quality Report (to be published by 30 June 2021).

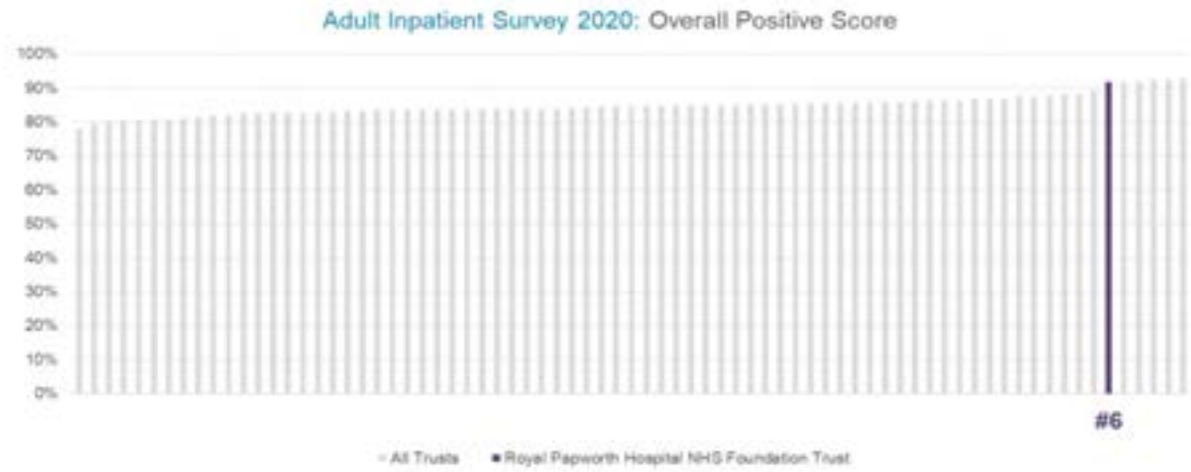
A listening organisation

What our patients say about us

2020 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.

The 2020 results demonstrate once again that we are able to provide excellent care despite the pandemic, which is done to the compassion and commitment of our staff. 825 of our inpatients responded to the survey and we achieved an overall response rate of 68% (60% 2019). This compares to an average response rate of 45% for 2020 for similar organisations.



The league table above shows the Trust's overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Adult Inpatient Survey 2020 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.

For RPH all the responses are above the Picker average with 14 results being better than last year and 9 being worse than last year, 2 staying the same and 18 where there was not comparative data.

Top 5 scores vs Picker Average	Trust	Picker Avg
Q5. Not prevented from sleeping at night	84%	49%
Q47. Asked to give views on quality of care during stay	32%	14%
Q26. Given enough privacy when discussing condition or treatment	99%	81%
Q3. Did not have to wait long time to get to bed on ward	98%	82%
Q2. Did not mind waiting as long as did for admission	83%	68%

There has been a significant improvement in patients being asked about the quality of their stay, and in the proportion of patients rating their overall experience as over 7/10.

Most improved scores	Trust 2020	Trust 2019
Q12. Food was very good or fairly good	83%	73%
Q47. Asked to give views on quality of care during stay	32%	22%
Q38. Given written/printed information about what they should or should not do after leaving hospital	78%	74%
Q10. Able to take own medication when needed to	95%	91%
Q41. Told who to contact if worried after discharge	90%	88%

Of those scores that were worse than last year the percentage range of the decline was between 0.1% and 4.7%. The 4.7% decline was where patients required help with eating meals and they did not get enough help.

Most declined scores	Trust 2020	Trust 2019
Q13. Got enough help from staff to eat meals	91%	96%
Q42. Staff discussed need for further health or social care services after discharge	87%	90%
Q15. Doctors answered questions clearly	98%	99%
Q2. Did not mind waiting as long as did for admission	83%	83%
Q36. Staff discussed need for additional equipment or home adaptation after discharge	89%	89%

The free text report, provides areas for improvement and themes around discharge, aftercare and food can be seen as areas to continue to work on. Each of these questions will be explored and an action plan formulated where necessary.

The full results of the Adult Inpatient Survey for 2020 can be found on the CQC website.

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

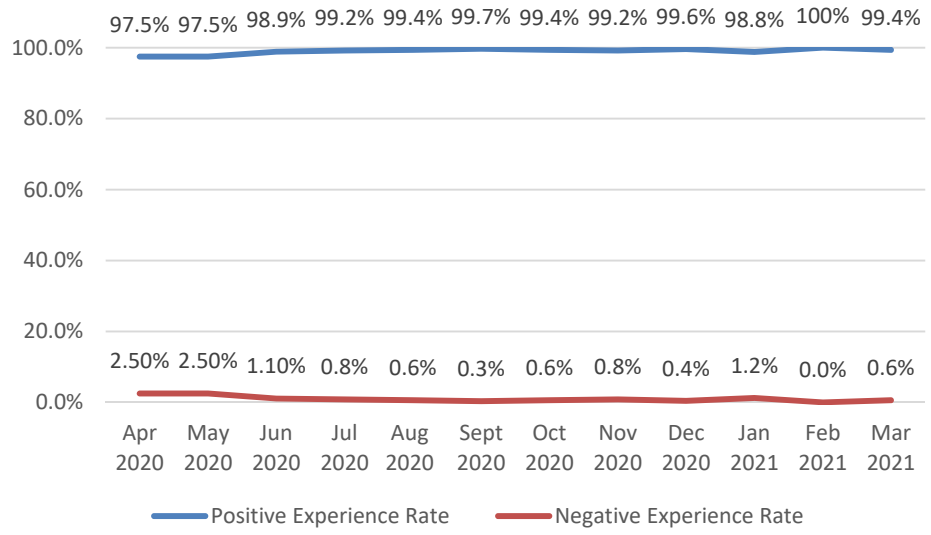
From December 2020, the trust updated the friends and family test questions in use. This was to make the friends and family test more accessible to patients and easier to complete, as well as to facilitate our new digital data collection process.

The updated question is "Overall, how was your experience of our service?" using a "Very Good" to "Very Poor" scale. The survey then offers open text boxes for the questions “Please can you tell us why you gave this answer” and “Please tell us about anything that we could have done better”.

The trust offers the survey to all patients who use our services, utilising digital surveys via tablet onsite (inpatient, outpatient and day case), and a text messaging service for all outpatients.

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 2020/21



“No reply” or “don’t know” excluded from calculation

Detail of the Friends and Family Performance for 2020/21 is in include in the summary of performance against 2020/21 Priority 4: Communications – to improve patient experience at RPH

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

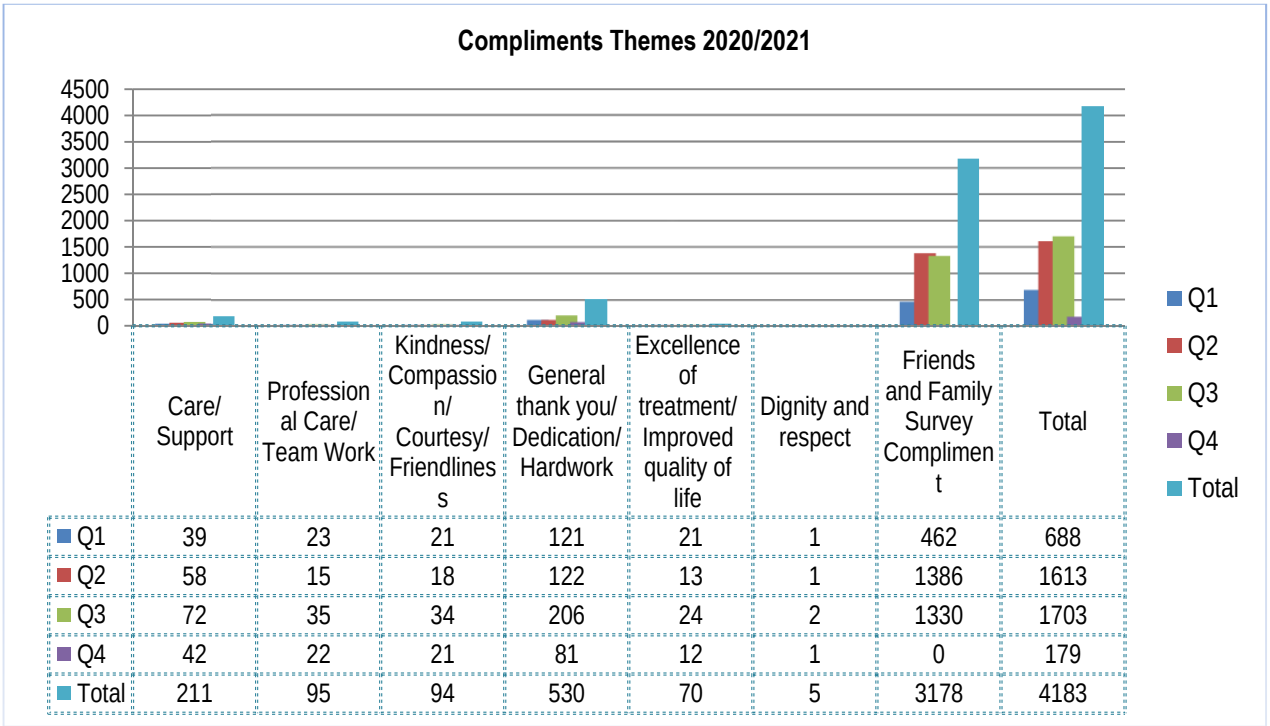
The Patient Advice and Liaison service (PALS) records compliments received by patients and their family's relating to their experience

There were 4183 compliments received across the Trust during 2020/21. This was a decrease of 4310 on the previous year (2019/20) when there were 8493. The reduction in numbers is primarily due to the change in process for the Friends and Family surveys. PALS no longer collect the surveys from the wards and departments as this is now done electronically, so therefore PALS are unable to include the positive feedback in these figures.

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
- Professional care/team work



	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	39	23	21	121	21	1	462	688
Q2	58	15	18	122	13	1	1386	1613
Q3	72	35	34	206	24	2	1330	1703
Q4	42	22	21	81	12	1	0	179
Total	211	95	94	530	70	5	3178	4183

What our staff say about us

Staff Survey 2020

NHSI's requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2020 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.

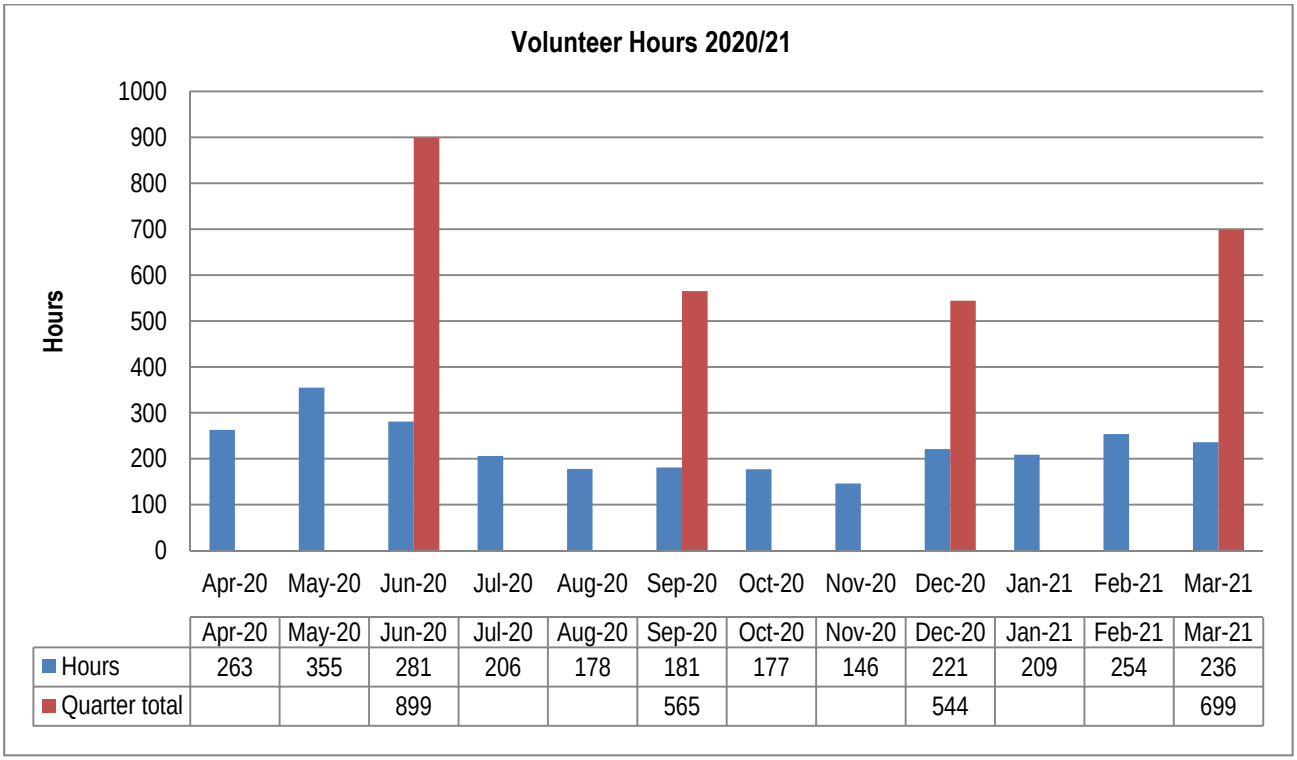
Valuing Volunteers

The PALS Team have maintained contact with all volunteers via email throughout the pandemic and will continue to do so. We have 54 active hospital volunteers who are looking forward to returning to their work supporting clinics, wards, patient/carer meetings, Pharmacy, IT, Charity, proof reading and administration.

Our Volunteer Strategy supports the development of a volunteer service that brings added value to our patients, promotes and gives opportunities for people to volunteer and develops partnership and networking with national, charitable and third sector organisations including volunteer support groups. The PALS team is also researching how the hospital can implement volunteering opportunities for the under 18s and hope to trial a small cohort as a pilot project in 2021/22.

Volunteers hours for 2020/21

The hours delivered by our volunteers is set out below:



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Hours	263	355	281	206	178	181	177	146	221	209	254	236
Quarter total			899			565			544			699

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

Annex 1: What others say about us

Cambridgeshire and Peterborough Clinical Commissioning Group (incorporating feedback from NHS Specialised Commissioning East of England Hub)

Cambridgeshire and Peterborough CCG

Stakeholder Feedback – Royal Papworth Hospital Quality Account 2020/21

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has reviewed the Quality Account produced by Royal Papworth Hospital (RPH) for 2020/21.

The Trust are to be commended at publishing such a comprehensive document at a time of significant challenge to the organisation, their staff and for their patient population due to the Covid19 pandemic.

The Quality Account is transparent to all and demonstrates the excellent work that the organisation has carried out during a year of significant challenge.

The CCG and RPH have continued the commitment of close working together to review performance against Nationally and Locally agreed quality indicators and ensure that any concerns are addressed.

The CCG Chief Nurse and Deputy Chief Nurse have continued to attend Quality Assurance meetings which has representation from Chief Nurse, Medical Director and key stakeholders including NHS England /Improvement. The Committees ensures that RPH provide quality services and reports on any actions that require consideration allowing commissioner oversight throughout the year. The CCG is pleased to be part of this effective board, with excellent challenge primarily through Non-Executive Director and patient membership engagement.

From a quality and patient safety perspective RPH is a nationally recognised centre for excellence in specialist cardiothoracic healthcare and has continued to provide quality care to patients at the peak of Covid19 Pandemic and is highly commended for the work. Quality improvement remained the focus for the trust, with analysis of all incidents, complaints, feedback in maintaining continuous improvement. The Trust has continued to have a positive reporting culture to the management of incident processes and all serious incidents reported have been met within the National set time frames. Overall the volume of all Incidents reported in the Trust is low.

The CCG infection prevention and control (IPC) team have closely worked with the Trust to manage infections safely with minimal impact on patient harm. In an environment where patients with serious life limiting and life changing interventions take place, infection rates have been low. The Trust is responsive to reporting mandatory reportable organisms and involves the CCG with Scrutiny Panels including representation for out of area patients. This year has seen changes and investment of staff in the Trust IPC team to enable a high standard of specialist support and advice.

Currently RPH have an overall Care Quality Commission rating of Outstanding, which the CCG would like to congratulate them on. The leadership team have committed to maintaining this rating throughout the Pandemic with the quality ambitions; Safe; Effective and Responsive and Patient Experience being at the core of care delivery.

What is clear from presentations is the utilisation of feedback from both staff and patients in the continuous improvement of services, flexibility of staff and adapting to the needs of the Covid 19 demand pressures. The CCG would like to commend RPH on all their success stories including the utilisation of critical care capacity, covid surge response, introduction of virtual clinics, critical care transfer and the family liaison service to enable patients to be in contact with loved ones whilst in hospital. The projects have demonstrated the care and compassion towards patients to improve their hospital stay during the pandemic where visiting was restricted and has enable the patient experience to be improved; particularly in Critical Care and where patients may have been placed from out of area both within the East of England and nationally.

The CCG would like to thank all of the staff of RPH for the supreme efforts taken on behalf of the NHS, and for patients during the Covid19 Pandemic and beyond.

Overall Cambridgeshire and Peterborough CCG agree the RPH Quality Account is a true representation of quality during 2020/21.

Cambridgeshire and Peterborough CCG

Stakeholder Feedback – Royal Papworth Hospital Quality Account 2020/21

The comments of this statement are also supported by NHS England/ Improvement who recognise the remarkable contribution that RPH have made to the management of the pandemic in the East of England and Nationally and recognition of the quality of care given to the patients during a very testing time.

Carol Anderson
Chief Nurse
Cambridgeshire and Peterborough CCG

17 June 2021

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru | Welsh Health Specialised Services Committee

Welsh Health Specialised Services who commission services on behalf of the seven Welsh Health Board endorse and support the quality report. We are pleased to have a positive relationship with the Trust and are grateful for the opportunity to comment on the draft report. The Trust is always responsive to feedback and we welcome the work being undertaken on capturing the patient experience in what has been a difficult year for patients and staff alike.

Carole Bell
Cyfarwyddwr Nyrsio ac Ansawdd
Director of Nursing and Quality

25 June 2021

Healthwatch Cambridgeshire and Peterborough

Royal Papworth Hospital Quality Account Statement 2020/21

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.

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

We acknowledge the efforts and dedication of teams working across the Trust during the Covid-19 pandemic and note the significant role the Trust played in the provision of ECMO support (Extra Corporeal Membrane Oxygenator).
We heard from meetings the emphasis the Trust has put on positive mental health support for their staff.
Patient experience
Healthwatch welcomes the opportunities to communicate with the Trust through our representation on the Patient and Carer Experience Group and the Patient and Public involvement meetings. We also send representation to the Trust Board meetings.

We support and welcome the continuing commitment to learning from PALS and complaints. Communication has been an issue which was highlighted in 20/21. Patients sought information about cancelled appointments and procedures, and families wanted information about the condition of their loved ones whilst visiting was suspended. Some people contacted us about difficulties in finding out what was going to happen next after tests. Others found some of the letters about appointments confusing. For people with complex conditions, good communication between the different professionals involved in their care was important, especially in terms of discharge and ongoing care.

The development of Patient Aide will be of help to many patients in managing their long-term condition. However, not all people are able to access online information. It is important the digital developments are accompanied by other means of access

to avoid deepening health inequalities. Information also needs to be available in formats suitable for people's communications needs.

It is pleasing to note the commitment made to improving care for people with dementia, learning disability and/or autism.

Healthwatch Cambridgeshire and Peterborough

22 June 2021

Cambridgeshire County Council, Health Committee

Feedback awaited.

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.

19 May 2021

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 2020/21 and supporting guidance 'Detailed requirements for quality reports 2019/20.'*

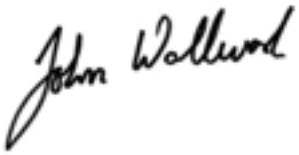
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2020 to 3 June 2021
  - Papers relating to quality reported to the Board over the period April 2020 to 3 June 2021
  - Feedback from Cambridge and Peterborough Clinical Commissioning Group which incorporates feedback from NHS Specialised Commissioning East of England dated 17 June 2021
  - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated 19 May 2021
  - Feedback from Healthwatch Cambridgeshire dated 22 June 2021
  - Feedback from Cambridgeshire Health Committee (awaited)
  - The Trust's "Quality and Risk Report: Quarter 4 and annual Summary 2020/21";
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2020 National Inpatient Survey
  - The 2020 National Staff Survey
  - The Trust's Annual Governance Statement 2020/21
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated 03 June 2021
  - CQC Inspection Reports published 16 October 2019

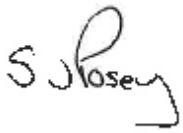
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance 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: 24 June 2021 Chairman



Date: 24 June 2021 Chief Executive

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

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 2020/21 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. As above, but the procedure is urgent and the patient is admitted to

Primary percutaneous coronary intervention (PPCI)	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	An inflammatory state affecting the whole body, frequently a response of

Inflammatory Response Syndrome (SIRS)	the immune system to ischemia, inflammation, trauma, infection, or several insults combined.

U

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

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

A member of

CAMBRIDGE UNIVERSITY
Health Partners

Knowledge-based healthcare

Royal Papworth Hospital NHS Foundation Trust
Papworth Road | Cambridge Biomedical Campus | Cambridge | CB2 0AY

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