Royal Papworth Hospital
NHS Foundation Trust

# Quality and Risk Report Quarter 2 2021/22

**July – September 2021/22**

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# Quality and Risk Report

## Quarter 2 Report 2021/22

## 1.0 PATIENT SAFETY

### 1.1 Patient Safety Incident Trends and Actions

There were a total of 765 patient incidents reported during Q2 21/22 compared to 737 in the previous quarter. In addition, at the time of reporting there were 112 near miss patient safety incidents reported a slight increase (92) from last quarter. This increase appears to be in line with the return to normal services and levels of reporting, as seen in Table 1 and Figure 1 following ongoing easing of the COVID pandemic. There is a healthy safety culture within the Trust and an understanding of the importance of learning from incidents and the Care Quality Commission (CQC) requirements to report under the Key Lines of Enquire (KLOE). The quarters marked with an asterisk (*) include incidents that are still under investigation and some have not yet been graded. Thus future reports will contain verified figures. Where appropriate these have been reported to CQC via the National Reporting and Learning System (NRLS).

| | 20/21 Q2 | 20/21 Q3* | 20/21 Q4 | 21/22 Q1 | 21/22 Q2* | Total |
|---|---|---|---|---|---|---|
| Near Miss | 115 | 127 | 72 | 92 | 112 | 518 |
| Actual incidents | 623 | 750 | 478 | 645 | 653 | 3149 |
| Total | 738 | 877 | 550 | 737 | 765 | 3667 |

Table 1: Numbers of patient safety incidents reported in 2021/22 (Data source: DATIX As of 19/10/2021)

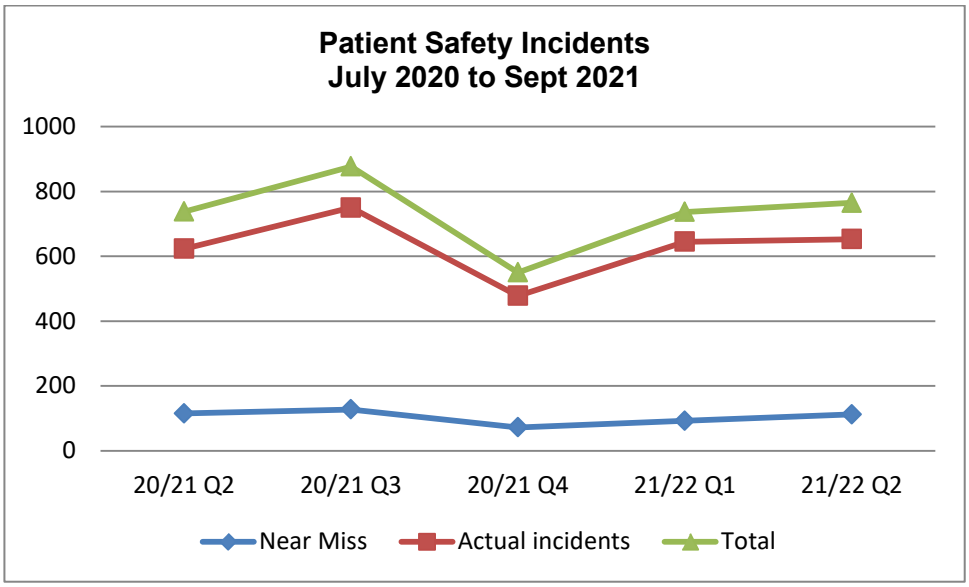



Figure 1: Patient Safety Incidents Actual v. Near miss (Data source: DATIX 19/10/2021)

In quarter, table 2 shows the numbers of patient safety incidents reported by the "Type" - the majority of incidents are relating to Medication/Medical Gases/Nutrition (12%); the majority were related to medication administration/supply from clinical areas.

| Type | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| Accidents | 51 | 68 | 41 | 38 | 57 | 255 |
| Administration - admission/discharge/transfer/waiting list | 96 | 156 | 70 | 86 | 87 | 495 |
| Anaesthetics | 7 | 5 | 4 | 6 | 4 | 26 |
| Behaviour/Violence Aggression | 13 | 10 | 10 | 16 | 13 | 62 |
| Blood Plasma Products | 35 | 32 | 19 | 16 | 23 | 125 |
| Communication/Consent | 35 | 44 | 22 | 33 | 31 | 165 |
| Data protection | 19 | 28 | 9 | 17 | 31 | 104 |
| Diagnosis Process/Procedures | 29 | 34 | 42 | 35 | 37 | 177 |

| Type | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| Documentation | 51 | 59 | 23 | 58 | 70 | 261 |
| Environmental Hazards/Issues | 5 | 5 | 5 | 13 | 2 | 30 |
| Fire Incidents | 0 | 0 | 0 | 0 | 1 | 1 |
| Infection Control | 34 | 31 | 21 | 57 | 59 | 202 |
| Information Technology | 5 | 20 | 6 | 14 | 7 | 52 |
| Medical Devices | 39 | 54 | 31 | 47 | 34 | 205 |
| Medication/Medical Gases/Nutrition | 113 | 91 | 69 | 91 | 93 | 457 |
| Nutritional Feeding (Prescribed Feeds) | 2 | 8 | 3 | 2 | 4 | 19 |
| Organisational Issues/Staffing | 38 | 22 | 5 | 24 | 24 | 113 |
| Pressure Ulcers | 52 | 93 | 90 | 88 | 88 | 411 |
| Radiology | 6 | 10 | 4 | 12 | 6 | 38 |
| Security incidents | 13 | 10 | 1 | 6 | 3 | 33 |
| Treatment/Procedures | 95 | 97 | 75 | 78 | 90 | 435 |
| Total | 738 | 877 | 550 | 737 | 764 | 3666 |

Table 2: Numbers of patient safety incidents by Type reported in Q2 2021/22 (Data source: DATIX 19/10/2021)

The top five types of incidents are depicted below in figure 2 by financial quarter; this demonstrates Incident trend and information is provided in the paragraphs below.

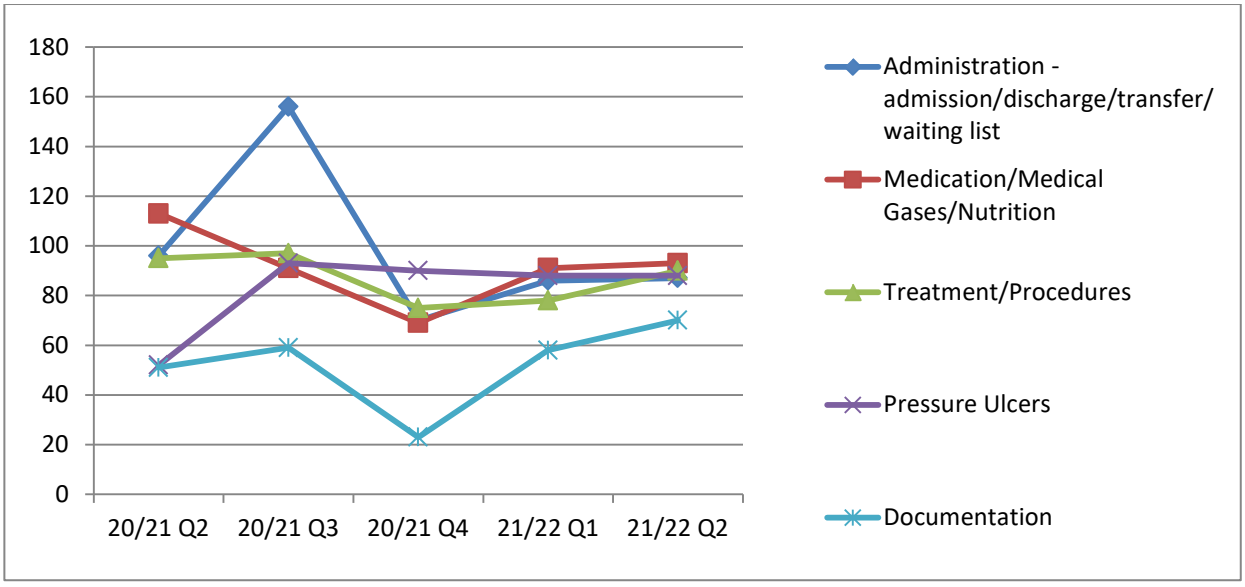



Fig 2: Patient Safety Incidents Q2 2021/22 (Data source: DATIX 19/10/2021)

## 1.2 Top Five Incident Trends and Details:

**Administration Incidents**

During this quarter, the number of incidents linked to administration issues have remained almost the same compared to the last quarter. Of those the majority are related to appointment booking and issues related to admission/discharge. All booking issues are reported per/person to ensure that all errors are being captured for the Administration team to review against their procedures.

**Treatment and Procedures**

During quarter 2 the number of treatment and procedure incidents have increased compared to previous quarter (n=12). Where the incidents have been graded, majority have a severity of near miss or no/low harm. Two incidents have been graded as moderate harms. All incidents considered to warrant discussion are presented at the Serious Incident Executive Review Panel (SIERP) as part of the scrutiny and confirmation of grading.

**Medication**
During quarter 2 the medication incidents have remained almost the same as previous quarter. Omissions are reviewed with the staff caring for the patients to ensure that learning is shared amongst the team. All medication incidents are reviewed by the pharmacy leads and reported to the Medications and Therapeutics Committee.

**Pressure Ulcers (PU)**
During quarter 2 the number of pressure ulcer incidents has remained the same as previous quarter. As the Trust has emerged from the second surge of the pandemic routine reporting of all categories of PUs and moisture lesions have recommenced on the Datix incident reporting system in line with the national requirements. All reported pressure ulcer incidents are being reviewed by the Tissue Viability Team for further clarification and grading. The Trust also captures all PUs which are identified on admission linked to other care providers. Where the incidents have been graded, majority have been recorded as no/low harm.

**Documentation**
The most common type of documentation incidents reported in Q2 have been related to Electronic Medical Records; majority being EMR ambiguous/incorrect/incomplete/illegible. Where the incidents have been graded the majority have a severity of near miss or no harm.

### 1.3 Severity of Patient Safety Incidents

In Q2 incidents graded as near miss have slightly increased, whereas no harm and low harm incidents have a slight decrease (Table 3a). Furthermore three incidents have been reported as moderate harms but there were no severe harm incidents reported in Q2. These incidents also include the unexpected outcomes of treatment and rare, but known complications. The level of investigation is determined by the severity as detailed in the policy DN070. All moderate harm and above incidents have investigations and associated action plans which are managed by the relevant business unit and monitored by the Quality & Risk Management Group (QRMG).

| Severity | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| Near Miss | 115 | 128 | 72 | 92 | 112 | 518 |
| No harm | 453 | 520 | 291 | 420 | 444 | 2097 |
| Low harm | 154 | 218 | 178 | 210 | 199 | 952 |
| Moderate harm | 8 | 6 | 4 | 12 | 3 | 33 |
| Severe harm | 6 | 0 | 1 | 2 | 0 | 9 |
| Death UNRELATED to the incident | 2 | 4 | 4 | 1 | 3 | 14 |
| Not yet graded | 0 | 1 | 0 | 0 | 6 | 7 |
| Total | 738 | 877 | 550 | 737 | 767 | 3669 |

Table 3a – Patient Safety Incidents by Severity (Data source: DATIX 8/11/21)
*Correct at the time of production. Some incidents may be downgraded in severity following investigation.

For benchmarking purposes - numbers of Moderate Harm/ Severe Harm and above incidents by Division and speciality are displayed in Table 3b below:

| Moderate Harm/ Severe Harm by Division | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| NPH Ambulatory Care | 1 | 0 | 0 | 0 | 0 | 1 |
| NPH Cardiology | 6 | 2 | 1 | 4 | 0 | 13 |
| NPH Cath Labs | 0 | 0 | 0 | 4 | 0 | 4 |
| NPH Surgical | 6 | 2 | 1 | 1 | 2 | 12 |
| NPH Theatres, Critical Care and Anaesthesia | 1 | 2 | 1 | 2 | 1 | 7 |
| NPH Thoracic | 0 | 0 | 2 | 3 | 0 | 5 |
| Total | 14 | 6 | 5 | 14 | 3 | 42 |

Table 3b – Incidents by Severity _ Moderate Harm (Data source: DATIX 19/10/21)
Correct at the time of production. Some incidents have been downgraded in severity following investigation.

### 1.4 Patient incidents resulting in Moderate or Severe Harm inclusive of Serious Incidents

Below in Table 4 are the brief details of the incidents that have been graded moderate harm or above within the quarter, these are still under investigation. Full Duty of Candour is undertaken with the patient and/or family for all SI's. A detailed breakdown of contributory factors identified from SI investigation is taken to the Serious Incident Executive Review Panel (SIERP). Human and patient factors are recurring themes.

| Trust ref / Level of Harm | Date of incident | Details | Duty of Candour | Actions |
|---|---|---|---|---|
| Serious Incidents Reported to CCG in Q2 21/22 | | | | |
| None reported | | | | |
| Moderate/Severe Reported in Q2 21/22 | | | | |
| WEB40377 | 14/08/2021 | Emergency chest re-opening following aortic dissection surgery due to hemodynamic collapse and hypertension | Yes | Ongoing Investigation |
| WEB40431 | 20/08/2021 | Pacing Device Malfunction | Yes | Ongoing Investigation |
| WEB40716 | 13/09/2021 | Death in theatre | Yes | Ongoing Investigation |

Table 4 – Monitoring of SI and Moderate/Severe Harm Incidents (Data source: Datix 19/10/21)

### 1.5 Incidents/Requests for patient Safety feedback from outside of Royal Papworth Hospital

The Trust receives a number of incidents for investigation from outside our Trust. These are shared with the relevant service area for investigation/ learning and feedback is provided to the requesting organisation. The Trust received 2 requests for investigation / feedback in Q2 21/22.

| Date | Requester | Summary details |
|---|---|---|
| 02/08/2021 | CUH | Lack of pressure relief care |
| 18/08/2021 | WSH | Inadequate information provided within the discharge information |

Table 5: Requests for investigation/ feedback from organisations outside of Royal Papworth Hospital

### 1.6 VTE Monitoring

The graph below (Figure 3) shows the number of VTE events from Q1 & Q2 2021/22. We are advised of these confirmed VTE events by Royal Papworth staff, radiology alerts, patients, GPs or healthcare professionals in the local hospitals.

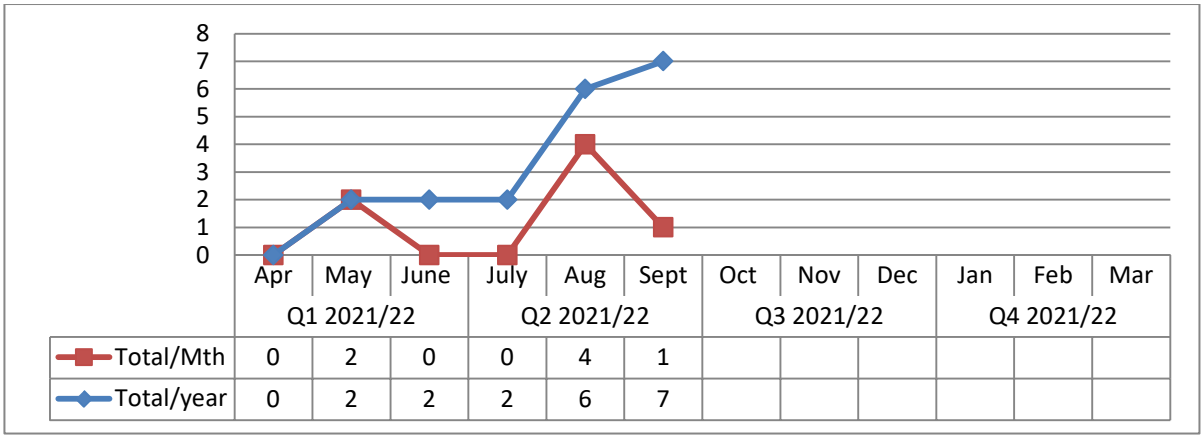



Figure 3: VTE Incident Events April-March 2022

There may be a considerable delay from the date of the VTE diagnosis to when the event is investigated if the information is not received at the time of diagnosis.

We have been informed of 5 VTE DATIX events in Q2 2021/22 (as seen in Figure 3) the investigations are ongoing by CCA & 5S and these have been reported on our incident management system (DATIX) and are for discussing at November 2021 VTE scrutiny panel. The last moderate harm reported in relation to VTE was 20/08/2019.

CCA compliance with VTE risk assessment within 24 hours is significantly below the 95% standard (as seen in Figure 4 below). In addition not all patients are having a risk assessment recorded within Metavision every 24 hours (as seen in Figure 5) in line with DN500 and NG89 best practice guidance. A new medical and nursing lead for VTE within CCA was appointed in June 2021 to lead some QI work to improve the risk assessment standards. Changes have also been made within Metavision to ensure visibility of VTE risk assessment on the daily ward round.

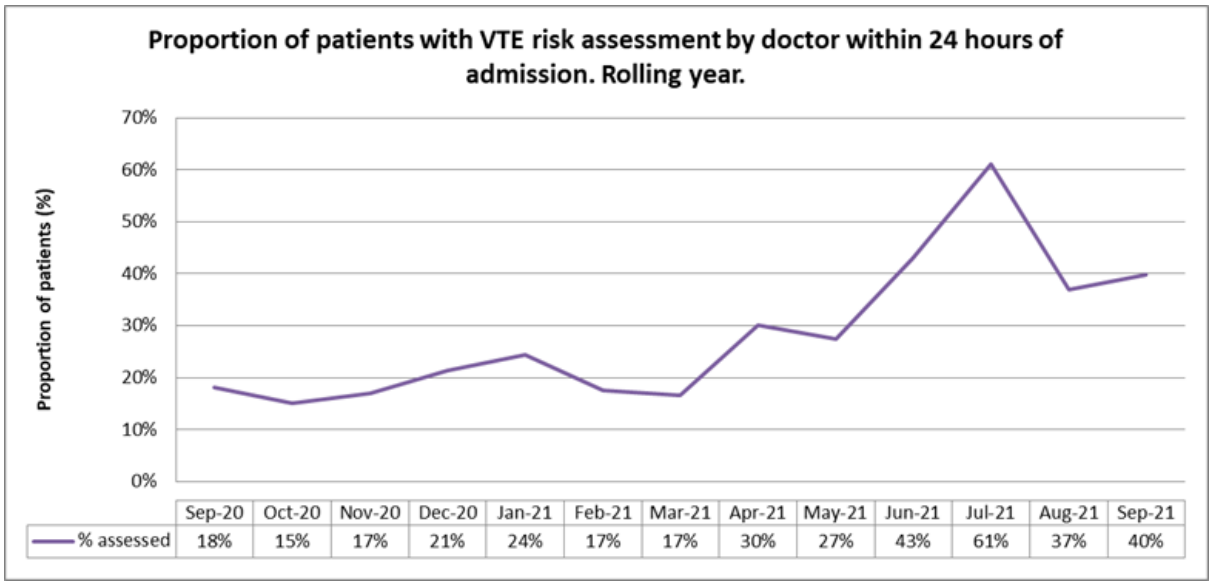



Figure 4: VTE Risk Assessment CCA (Sept 2020 - Sept 2021)

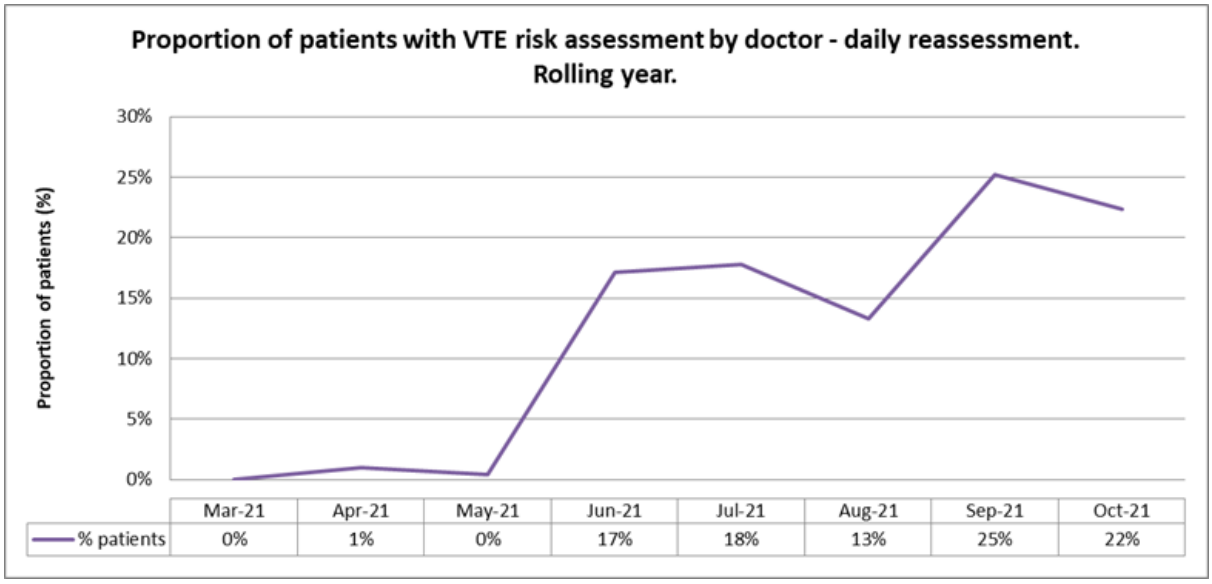



Figure 5: VTE Daily Risk Assessment CCA (March 2021-Oct 2021)

## VTE Risk Assessment by Wards

VTE risk assessment compliance with 95% standard continued to be a challenge on a monthly basis in 2020/21, particularly in August 2021 Due to a national digital issue on the day of induction in August 2021, the new intake of junior doctors were not able to have hands on training including accessing a VTE risk assessment form and ward clinical indicator tab on Lorenzo. A quick reference guide/e-learning was released to the new clinical teams to address this. We are working hard to increase monthly compliance with MDT teams.

| RPH - VTE Assessment Compliance | Month | | |
|---|---|---|---|
| | Jul | Aug | Sep |
| 3 North East Ward RPH | 86.3% | 57.3% | 78.6% |
| 3 South East Ward RPH | 82.1% | 73.7% | 84.1% |
| 3 South West Ward RPH | 87.4% | 83.2% | 86.0% |
| 4 North West Ward RPH | 73.7% | 80.3% | 67.7% |
| 4 South East Ward RPH | 58.3% | 62.5% | 68.8% |
| 4 South West Ward RPH | 72.3% | 59.5% | 72.8% |
| 5 North East Ward RPH | 95.0% | 78.4% | 97.2% |
| 5 North West Ward RPH | 73.6% | 80.9% | 79.3% |
| 5 South East Ward RPH | 94.5% | 89.4% | 91.8% |
| 5 South West Ward RPH | 75.0% | 92.9% | 97.1% |
| Day Ward RPH | 89.7% | 88.4% | 90.2% |
| **Grand Total** | **85.4%** | **80.4%** | **85.2%** |

Table 6: VTE Risk Assessment compliance by wards

The metric used previously was a random selection of 30 patients per month this gave a low confidence interval as our average monthly admissions are >1000. This has now changed to encompass all inpatient admissions and the data above outlines June 2021 baseline data.

The criteria for inclusion within the audit is the % of admissions for which a VTE Assessment was initiated within 24 hours of admission on either Lorenzo or Metavision or within the proceeding 7 days pre admission. All overnight stays are included. Same day admit/discharge on Day Ward are included unless there is an agreed cohort exemption (as per DN500). The audit system is being refined to capture appropriate day ward admissions.

This new methodology is being applied to all patients, rather than 30 randomly selected admissions and is also more in line with the recommended monitoring suggested by NICE. Following this change, we have seen an overall reduction in the measured compliance, but this is due to a more robust approach to monitoring rather than a sudden reduction in practice quality.

There is significant quality improvement work to undertake in several areas of the Trust. Staff should remain vigilant to ensure VTE risk assessments are completed in a timely manner on admission. When a risk assessment is missing or not completed despite request a DATIX should be completed.

There was a focus on Cardiology for August to continue to drive improvement closer to the 95% target. Within cardiology this has featured as the weekly 'Buzz Word' to engage MDT learning and raise awareness of the importance of VTE. Within Thoracic Medicine, a pilot QIP has been initiated in Oct 2021. The ward Sisters' administrator will check the VTE clinical indicators every morning, and give a list of non- compliance to the Nurse in Charge. The Nurse in charge will flag non-compliance to the appropriate medical teams.

VTE and bleeding risk assessments featured on new doctor's induction during August intake and going forward and the VTE link matrons/members will spot check VTE risk assessments. An interim VTE nursing lead took over in Sept 2021. A monthly speciality group and ward league table is being developed in conjunction with VTE leads and clinical audit team to help target areas for improvement.

**VTE Action Plan:**

- Sisters/Team Leaders to share locally with staff the requirement to complete a VTE risk assessment on admission
- Matrons/HoN's to raise at all three divisional governance meetings the importance of completing VTE risk assessment on admission for all patients - completed
- Reminder to Sisters/Team Leaders how to access the quality indicators screen in Lorenzo – completed.
- Focus on VTE risk assessment in Cardiology during the month of August 2021 – ward daily visits, spot audit and divisional meeting discussion
- Focus on VTE risk assessment in Thoracic medicine from October 2021
- Quality improvement work continues within CCA to ensure all patients have a 24 hour risk assessment
- The Lorenzo team is in negotiation with Dedalus for a digital alert on clinical care activities in Lorenzo (eg prescribing) to be developed if a VTE risk assessments is overdue.

### 1.7 Inquests

During Q2 there were 5 inquest hearings; of these no representation from Royal Papworth Hospital was required. There was no further action required following conclusion of these 5 inquests.

The Trust attended 6 Pre Inquest Hearings in Q2, the purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest.

The Trust has been notified of 5 new Inquests/coroner's investigation in Q2 and statements have been requested. Any learning points identified at Inquest are discussed at QRMG in quarter.

The number of cases currently with the Trust under the Inquest process is 87 (as at 31/10/2021).

**Learning from Schedule 5s (prevention of future deaths)**
The prevention of future death reports are published on the Courts and Tribunals judiciary website. Any relevant reports or themes are forwarded to the relevant clinical leads and presented at the Quality Risk and Management Group for further dissemination and learning. The Trust has not received any prevention of future death reports in relation to Royal Papworth Hospital Inquests in Q2.

## 1.8 Clinical and Non Clinical Negligence Litigation

In Q2 2021/22 the Trust has received 6 new requests for disclosure of records and 2 cases were settled in Q2.

**Settled claims in Q2**

Claim 1: Q12021-01CL
Specialty – Cardiac Surgery (Joint claim with CUH - vascular)
Accepted - Delay of urgent outpatient appointment in 2016. Settlement in relation to above elbow amputation.

| | |
|---|---|
| Damages: | £59,155 |
| Claimant's costs: | £50,000 |
| Defence costs | £5,000 |
| Total cost | £114,155 |

Claim 2: Q12021-02CL
Specialty – Respiratory Medicine
Accepted - breach of duty secondary to an admin error processing the result of the Claimant's home oximetry study. This caused an approximate 11 month delay in initiating CPAP treatment.

| | |
|---|---|
| Damages: | £2,800 |
| Claimant costs | To be agreed |
| Defence costs | To be agreed |
| Total cost | To be agreed |

**Outstanding claims as at Q2 2021/22**

Table 7 below summarises the 18 clinical negligence claims that are currently open and being managed by NHS Resolution on behalf of the Trust. These costs represent the total claims cost if all these were accepted as breach of duty. *The Trust contributes to these costs via the Clinical Negligence Scheme for Trusts (CNST).*

| No. of claims | Damages reserve | Claimant costs reserve | Defence costs reserve | Total claim value if realised |
|---|---|---|---|---|
| 18 | £21,929,894 | £1,864,375 | £527,878 | £24,322,147 |

Table 7: The total costs of claims if were accepted as breach of duty - Data source: NHS Resolution 3/11/21.

**Average time in years for settlement/closure of claim**

Figure 6 (below) summarises the length of time clinical claims take before settlement is agreed. The time taken to close and settle claims from the time of reporting for Royal Papworth Hospital, is in line with the national and regional average.

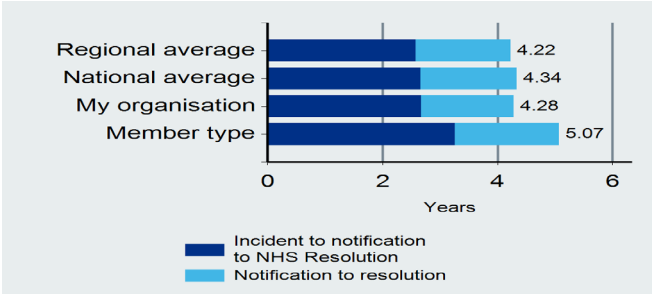



Figure 6: Average time in years for settled/closure of claims- Data Source: NHS Resolution 3/11/21.

**Non-clinical claims**
There were no new claims brought against the Trust during Q2. There are 2 ongoing claims which have been repudiated; one accident (WEB27780/M19LT006_002) and one violence & aggression (WEB33513/M19LT006_004). If no further contact is received by NHSR from the complainant's solicitors these will be closed when the statute of limitations has expired. All claims are shared with the local department, QRMG and Health & Safety Committee.

## 2.0 PATIENT EXPERIENCE

### 2.1 Formal and informal Complaints

We have received 7 formal complaints and 6 informal complaints (enquiries) for Q2. This is a decrease as seen in Figure 7 below, in the number of formal complaints received from the previous quarter (Q1; 15). Informal complaints (enquiries) are where the complaint requires an investigation and detailed response either in writing or verbally, but the complainant has expressly stated they do not wish to make a formal complaint. Informal complaints (enquiries) that can be responded to more informally are passed to the PALS Team for action.

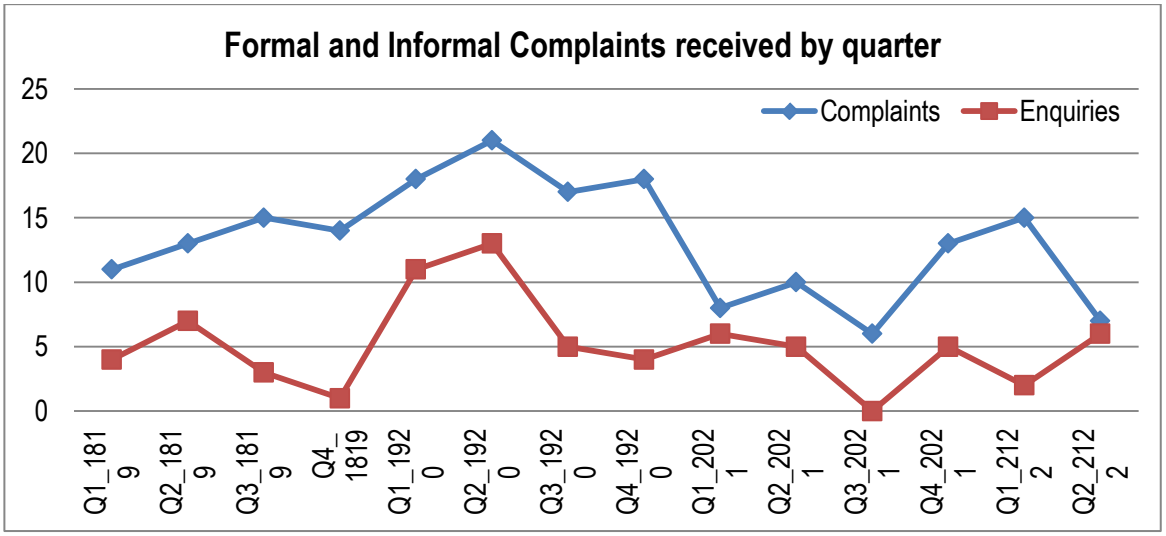



*Figure 7: Number of Formal and Informal Complaints received by quarter (source – Datix 14/10/2021)*

Of the 7 formal complaints received in Q2, 100% received a written acknowledgement from the Trust within three working days. Those that have been closed within the quarter have been responded to and of these there were as seen in Table 8 below 6 that have been partially upheld/upheld.

| Month | No. formal complaints received in Q2* (July - September 2021) | Upheld/Part Upheld | Enquiries for further information |
|---|---|---|---|
| July | 1 | 3 | 1 |
| August | 2 | 2 | 1 |
| September | 4 | 1 | 4 |
| **Total** | **7** | **6*** | **6*** |

*Table 8: Numbers of Formal and Informal Complaints (source: Datix 14/10/2021)*
**Not all complaints have been fully investigated at the time of this report so outcome has not been recorded.*

Formal complaints related to clinical care, communication and access to treatment was the highest primary subject captured during this quarter and consistently remains the highest categories for complaints within the Trust. Table 9 and Figure 8 show the primary subject of complaints comparing with the previous quarters.

| Subject | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 |
|---|---|---|---|---|---|
| Clinical Care/Clinical Treatment - General Medicine Group | 3 | 2 | 2 | 7 | 2 |
| Clinical Care/Clinical Treatment - Surgical | 1 | 0 | 3 | 4 | 1 |
| Clinical Care/Clinical Treatment - Radiology | 0 | 0 | 1 | 0 | 0 |
| Communication / Information | 4 | 3 | 2 | 2 | 1 |
| Delay in Diagnosis / Treatment or Referral | 0 | 0 | 0 | 1 | 0 |
| Appointments | 0 | 0 | 0 | 0 | 0 |
| Environment - Internal | 0 | 0 | 0 | 1 | 0 |
| Privacy, Dignity and Wellbeing | 0 | 0 | 1 | 0 | 0 |
| Medication Issues | 0 | 0 | 0 | 0 | 1 |
| Nursing Care | 0 | 0 | 0 | 0 | 1 |
| Parking/Transport/Facilities | 0 | 0 | 2 | 0 | 0 |
| Other | 2 | 1 | 2 | 0 | 1 |
| **Total** | **10** | **6** | **13** | **15** | **7** |

*Table 9: Primary subject of Formal Complaints by Quarter (source: Datix 14/10/2021)*

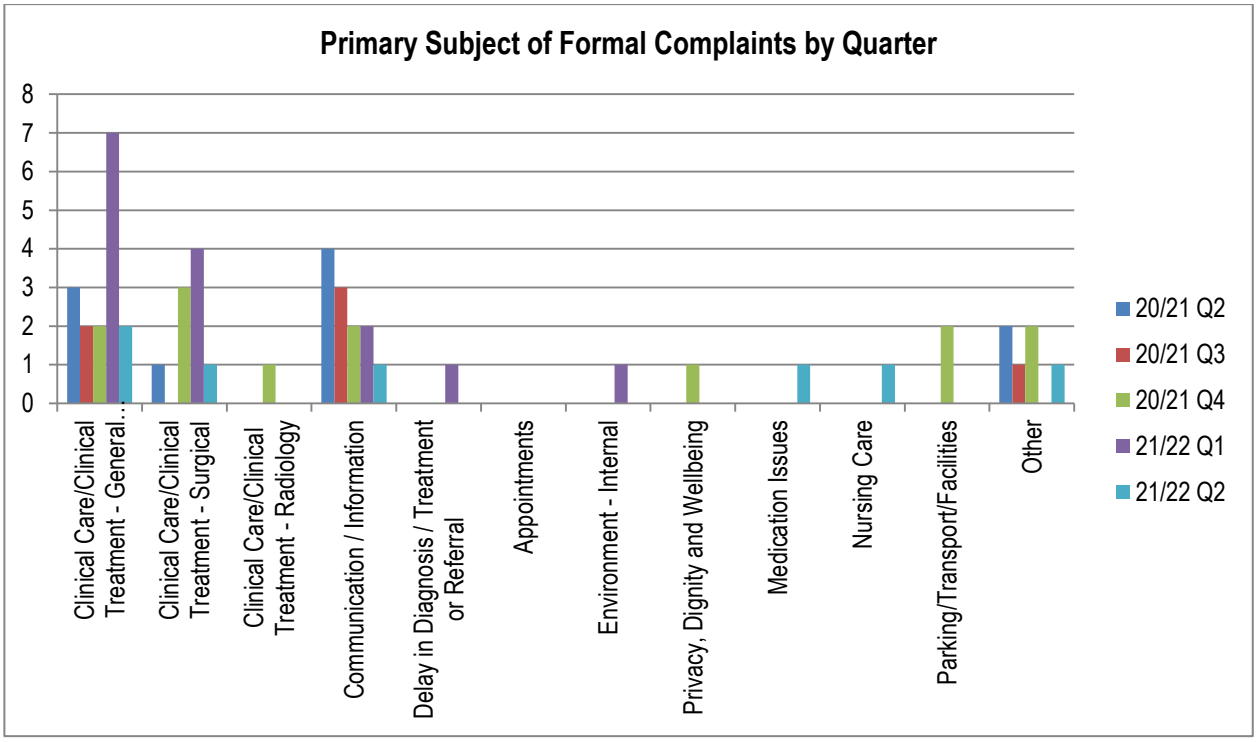



*Figure 8: Primary subject of complaints compared with previous quarters (source: Datix 14/10/2021)*

The directorates/specialities receiving complaints during Quarter 2 are shown in Table 10 below. The number of complaints received per clinical speciality/directorate is highlighted through quarterly reporting. There has been a slight increase in the number of complaints received in Q2 relating to Thoracic Services including the Respiratory Support and Sleep Centre (RSSC).

| Clinical Speciality/Directorate | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 |
|---|---|---|---|---|---|
| NPH Cardiac Surgery | 0 | 1 | 0 | 2 | 2 |
| NPH Cardiology | 1 | 1 | 3 | 6 | 2 |
| NPH Cath Labs | 0 | 0 | 0 | 0 | 0 |
| NPH Critical Care | 2 | 1 | 0 | 1 | 0 |
| NPH Interventional Cardiology | 0 | 0 | 0 | 0 | 0 |
| NPH Lung Defence | 1 | 0 | 0 | 0 | 0 |
| NPH Oncology | 0 | 0 | 0 | 0 | 0 |
| NPH Outpatients | 3 | 1 | 2 | 1 | 0 |

| Clinical Speciality/Directorate | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 |
|---|---|---|---|---|---|
| NPH Thoracic Services | 0 | 0 | 0 | 0 | 2 |
| NPH PVDU | 0 | 1 | 0 | 0 | 0 |
| NPH Respiratory Physiology | 0 | 0 | 0 | 0 | 0 |
| NPH Royal Papworth Private Care | 0 | 1 | 1 | 0 | 0 |
| NPH RSSC | 0 | 0 | 0 | 3 | 1 |
| NPH Thoracic Surgery | 0 | 0 | 3 | 0 | 0 |
| NPH Surgical/Transplant | 3 | 0 | 4 | 2 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 |
| **Total** | **10** | **6** | **13** | **15** | **7** |

*Table 10: Complaints by Directorate and Speciality (Source Datix 14/10/2021)*

All formal complaints in Q2 were closed within the designated timeframe which had been agreed with the complainant (as seen in Table 11). In total 13 complaints were closed in Quarter 2, of which 8 were closed within the standard 25 working days, 4 were closed within 45 working days following a more complex investigation and 1 had been extended beyond 60 working days due to extenuating circumstances which had been discussed with the patient. There were no Parliamentary and Health Service Ombudsman (PHSO) referrals in this quarter.

| Quality Dashboard Monitoring – Q2 | | |
|---|---|---|
| Number of complaints responded to within 25 day timeframe | 8 | 100%** |
| Number of complaints responded to within 45 day timeframe | 4 | 100%** |
| Extenuating circumstances-extendted timeline agreed with comaplinant | 1 | 100%** |
| Number of PSHO referrals in quarter | 0 | 0 |
| Number of PHSO referrals returned upheld with recommendations and action plans | 0 | 0 |

*Table 11: Quality Dashboard monitoring (** 100% of complaints responded to at the time of reporting within timescales agreed with the complainant)*

### 2.2 Informal Complaints (Enquiries) Details of Those Received and Outcome in Q2 20/21

In Quarter 2 we received 6 informal complaints as seen in Table 12. Informal Complaints (Enquiries) are defined as issues which may require further enquiry, advice or information in order to resolve them; this can be at a local level or by the service in which the concern originated.

| Reference/ Date Received | Location | Description | Subject | Outcome |
|---|---|---|---|---|
| Q22122-18 14351<br><br>19/07/2021 | 5 North Ward/CCA (Cardiac Surgery)<br><br>Inpatient | Family member raised some concerns about her late father's care and treatment at RPH. Family are concerned that the procedure delay resulted in the sad outcome. | Access to treatment and drugs | Apology given and a resolution meeting held with the family. At this meeting the feedback was reviewed and the outcome of the investigation explained.<br>The learning from the feedback was agreed and a number of actions were identified as a result of the patient's feedback, these included:<br>- Remind clinical teams that both NHS and private can be booked for weekday theatre slot if the surgeon identified a clinical need or urgency.<br>- Provide family with feedback regarding the outcome of the next M&M meeting when patient is discussed.<br>- To review pre-surgery patient |

| | | | | |
|---|---|---|---|---|
| | | | | leaflets to make sure the risk of death is clear, look at gaining support from patients in developing these leaflets.<br>- Share family feedback within the division at the next divisional meeting.<br>Family confirmed they were satisfied with the response provided.<br>**Informal complaint closed.** |
| Q22122-20 14396<br><br>16/08/2021 | Respiratory Physiology<br><br>Inpatient | MP has raised concern on behalf of his constituent over PCR Covid tests and the rules when he visits our hospital. Require explanation of process followed at RPH. | Clinical Treatment | Apology given and in response to patient feedback the Infection Control team are reviewing guidance in relation to shielding patients and the need for PCR testing prior to their admission.<br>**Informal complaint closed** |
| Q22122-24 14473<br><br>13/09/2021 | 3 South West<br><br>Inpatient | Request received from CUH to provide information regarding the patient's referral for an angiogram in April 2021 and the reasons why RPH requested for this be undertaken at CUH. | Clinical Treatment | Details of discussions with Consultant Interventional Cardiologist and decision making process shared with CUH to assist in responding to family concerns.<br>**Informal complaint closed** |
| Q22122-25 14474<br><br>13/09/2021 | RSSC<br><br>Outpatient | Enquiry received from MP via PALS regarding a concern from the patient relating to an appointment with RSSC and a medication review. | Clinical Treatment | Apology given and details of patient appointments and review by RSSC Physician shared. Patient advised to contact PALS should they have any further enquiries.<br>**Informal complaint closed** |
| Q22122-26 14481<br><br>14/09/2021 | Cardiac Day Ward<br><br>Outpatient | Patient has asked some clinical questions of her Consultant regarding the symptoms experienced since an ablation procedure in December 2018. | Clinical Treatment | Apology given and response provided to patient's specific questions regarding symptoms which appear unrelated to the ablation procedure. Patient feedback noted, and shared with the team for their reflection and learning.<br>**Informal complaint closed** |
| Q22122-30 14535<br><br>30/09/2021 | 3 South West Ward<br><br>Inpatient | Patient has contacted MP for support as following a telephone is growing considerably anxious waiting to see what is going to happen following a telephone consultation in June 2021 | Access to treatment and drugs | Details of outcome of appointments with Consultant Cardiologist shared. Informed patient they remain under the follow up care of RPH. Patient advised to contact PALS should they have any further enquiries.<br>**Informal complaint closed** |

*Table 12: Informal Complaints (Enquiries) received in Q2 2021/22 (Source Datix 14/10/2021)*

### 2.3 Formal Complaints; Details of Those Closed and the Outcomes in Q2 20/21

We closed six formal complaints within the quarter that had an outcome of being upheld or part upheld. All complaints receive a full explanation and an appropriate apology and the lessons learned and action are agreed. Table 13 below shows the outcome and actions agreed.

| Trust Reference | Summary of Complaint | Outcome | Lessons learnt/ Action(s) identified – Highlighted actions are outstanding and monitored via the Quality and Risk Management group for completion |
|---|---|---|---|
| Q42021-53F 14397 | Patient had raised a formal complaint regarding a member of staff conduct during an overnight sleep study. | Upheld | Apologies were given. A resolution meeting was held as arranged with patient as a reflection and learning from the feedback received. At this meeting the patient's feedback/experience was reviewed and the outcome of the formal complaint investigation explained.<br><br>The learning from the feedback was agreed and a number of actions were identified as a result of the patient's feedback, these included:<br>- An upskill programme for staff.<br>- Chaperone poster being put up.<br>- Development of a patient leaflet to support awareness of the unit before admission, to be co-produced with patients who have used the unit.<br>- Development of a patient video to showcase the sleep unit and what happens on admission. This will be co-designed with patients to help address common misconceptions from being a patient on the unit.<br>- Improved patient information available on the Trust website including details of the sleep unit, pictures of the unit, the patient information leaflet and video.<br>- New signage in the bedroom areas on the unit, to help with patient expectation and increase awareness of recording and sound equipment.<br>- Review care documentation to support staff in recording care offered e.g. offering of a chaperone during provision of care.<br>- An agreed patient story was developed and was shared to aid wider learning and feedback from this experience.<br><br>This action plan was developed and agreed with the patient. The meeting closed the complaint and the patient was satisfied with the response. They agreed they would like to be part of the co-design of the leaflet and video.<br>**Complaint closed.** |
| Q12122-06F 14077 | Patient has raised some concerns regarding her care following recently being made aware of a nodule present after scan. | Upheld | Apology given and incident reported on Datix and investigation undertaken. The learning was the process in place for the review of incidental findings was not followed and resulted in the alert being missed.<br>Patient received further follow up and review.<br>Pathway is currently being developed to ensure the alerted lung nodule is sent to the patient's Consultant and automatically sent to the |

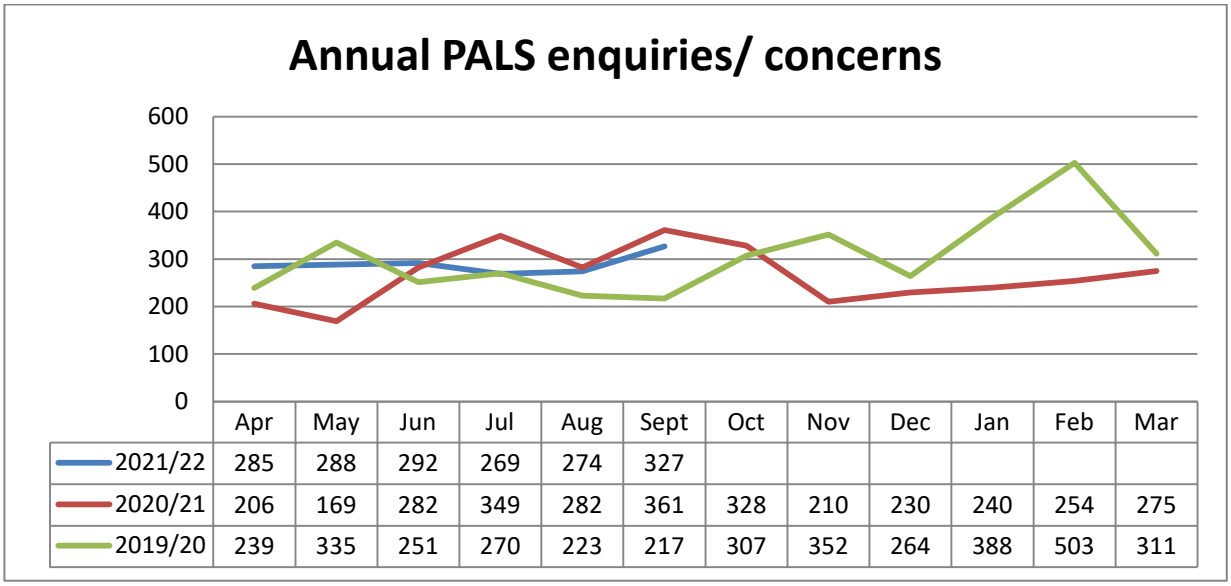
| Trust Reference | Summary of Complaint | Outcome | Lessons learnt/ Action(s) identified – Highlighted actions are outstanding and monitored via the Quality and Risk Management group for completion |
|---|---|---|---|
| | | | Consultant Respiratory Physicians.<br>**Complaint closed.** |
| Q12122-09F 14159 | Patient transferred to RPH for heart surgery, advised to have loose teeth extracted prior to surgery. Surgery was unable to proceed due to calcium deposits in heart valve, patient is concerned this was not identified earlier and could have avoided having teeth removed. | Upheld | Apology given. The learning was we did not identify earlier that CT images had not been received from the referring hospital and were not available at the MDT meeting which would have precluded the patient from open heart surgery. Patient feedback was shared with the clinical team and all staff reminded about checking to ensure scans are requested and obtained (where possible) in a timely way for MDT meetings.<br>**Complaint closed.** |
| Q12122-13F 14218 | Complaint received from sister and family of deceased patient after family members were refused access to the hospital facilities and additional visitors were restricted while awaiting access to see their relative when they were on CCA. | Partially Upheld | Apology given. The learning was there was miscommunication between the ward to security staff. There was a large family unit who had not all planned access in line with COVID Infection control guidance. During the wait to see the patient, some family members were refused access to use the hospital facilities by security staff. This was reviewed and OCS staff were reminded that visitors can use hospital facilities (in the outpatient area). Staff supported all the relatives at the time to see the patient.<br>The complainant experience was shared with the OCS Team for their learning and reflection.<br>**Complaint closed.** |
| Q12122-14F 14219 | Complaint received from patient regarding poor communication and experience with contacting the Devices Team for clarification regarding follow up appointment. | Upheld | Follow up appointment arranged with patient and apology given for the lack of communication. The learning was staff shortages resulted in a delay responding to patient enquiries in a timely manner. Patient experience shared with clinical team and at directorate meeting.<br>**Complaint closed.** |
| Q12122-16F 14263 | Patient attended for TOE, procedure subsequently cancelled as no COVID test was available, patient informed tests were being held for emergency admissions only. | Upheld | Apology given. There was a miscommunication of when rapid COVID tests could be used. This patient was a planned elective, so was not appropriate to use the SAMBA machine.<br>Learning and actions agreed:<br>- All SAMBA COVID test requests to go through Microbiology (DN 814) as this is a limited resource for specific uses.<br>- Pathology to explore the potential of recording requests which have been declined as currently there is not a formal mechanism.<br>**Complaint closed** |

*Table 13: Identified actions arising from complaints upheld or partially upheld in Q2 21/22 (Source Datix 14/10/2021)*

## 3 PATIENT ADVICE AND LIASION SERVICE

3.1 During Q2 2021/2022, the PALS Service received a total of 870 contacts (as seen in Figure 9). In this quarter we separated the enquiries into immediate resolutions and PALS concerns / enquiries. Out of the total of 870 contacts 633 were immediate resolutions which are

straightforward enquiries that the PALS team either responded to directly or signposted to the correct department. These are no longer recorded on Datix. Alongside the immediate resolution enquiries the PALS team also supported 237 concerns / enquiries from patients, families and carers. These are more complex enquiries where the PALS team needed to contact the relevant team(s) for information/ feedback. These continue to be recorded on Datix.

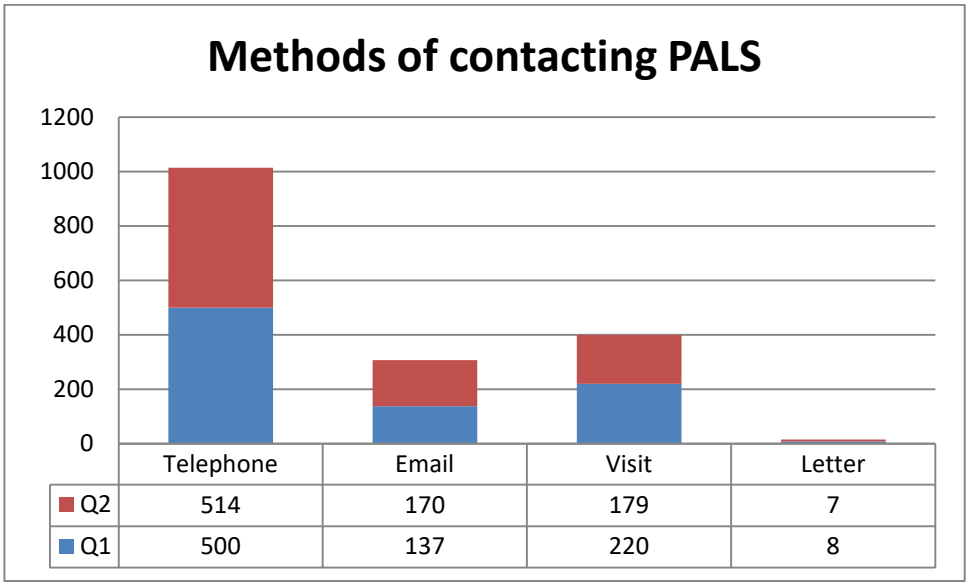



| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 | 285 | 288 | 292 | 269 | 274 | 327 | | | | | | |
| 2020/21 | 206 | 169 | 282 | 349 | 282 | 361 | 328 | 210 | 230 | 240 | 254 | 275 |
| 2019/20 | 239 | 335 | 251 | 270 | 223 | 217 | 307 | 352 | 264 | 388 | 503 | 311 |

*Figure 9: Total PALS contacts incl. immediate resolutions, enquiries, concerns (Source Datix 05/11/2021)*

## 3.2 Method of Contacting PALS

How the PALS team were contacted in quarter two continued to be the similar to quarter 1 as seen below in Figure 10. There were 514 enquiries received by telephone, 179 by in person visit, 170 by email and 7 by letter.




| | Telephone | Email | Visit | Letter |
|---|---|---|---|---|
| Q2 | 514 | 170 | 179 | 7 |
| Q1 | 500 | 137 | 220 | 8 |

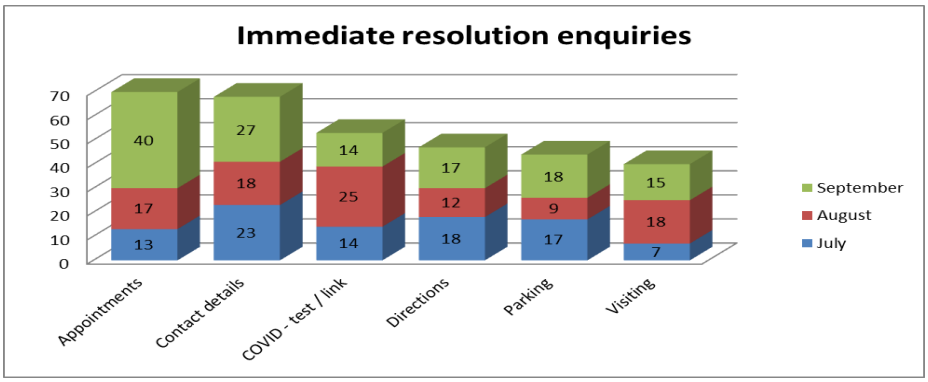
*Figure 10: Methods of contacting PALS (Source Datix 05/11/2021)*

## 3.3 Immediate resolution

Of the 870 contacts to PALS the 633 immediate resolution enquiries in Q2 that the PALS team supported (as shown in Figure 11) the three main themes of the top three were:

1. Appointments – enquiries regarding accompanying patient to outpatient appointment
2. Contact details – contact details of wards, clinics, secretaries

3. COVID-test / link – enquiries regarding COVID swab tests prior to coming to hospital, text




messages including link in text message, self-isolation.

*Figure 11: Immediate resolution enquiries –main themes (Source Datix 05/11/2021)*

Areas to highlight from the main contacts this quarter are enquiries regarding coming to the hospital: visiting inpatients (the number of enquiries are in the "visiting" column) and accompanying outpatients for their appointments (the number of these enquiries are in the "appointments" column, together with other appointment-related queries) – approximately 80 enquiries in total. Still many patients turn up at the entrance being accompanied by someone who is not on security's list. The reasons for possible breakdowns in communication are being investigated. Members of the security team have been verbally assaulted by visitors and patients. The entrance to the hospital and concerns relate to this are being reviewed by OCS and the Trusts estates team.

There were a number of enquiries about the Med10 forms received from wards regarding these and staff have been advised and reminded that the PALS team are not able to provide these forms; they need to be requested from the government's website.

### 3.4 PALS Enquires/Concerns

The PALS team supported 237 concerns (out of the 870 total contacts) being raised by patients or their relatives (as shown in Figure 12 below).

Of the concerns supported by the PALS team the top themes were communication, information and advice requests. We have received a total of 180 enquiries/ concerns regarding these. The main sub-subjects within these were:

1. Clarification of medical information – information in clinic letter, discharge summary, results enquiry, medication enquiry
2. Appointment queries – chasing outpatient appointment, chasing procedure, rearranging / cancelling appointment, requesting clarification
3. Telephone number enquiries.

Two PALS enquiries were escalated to formal complaints.

Four enquiries were signposted to an organisation external to the Trust: three to GP surgeries, one to NHS England.

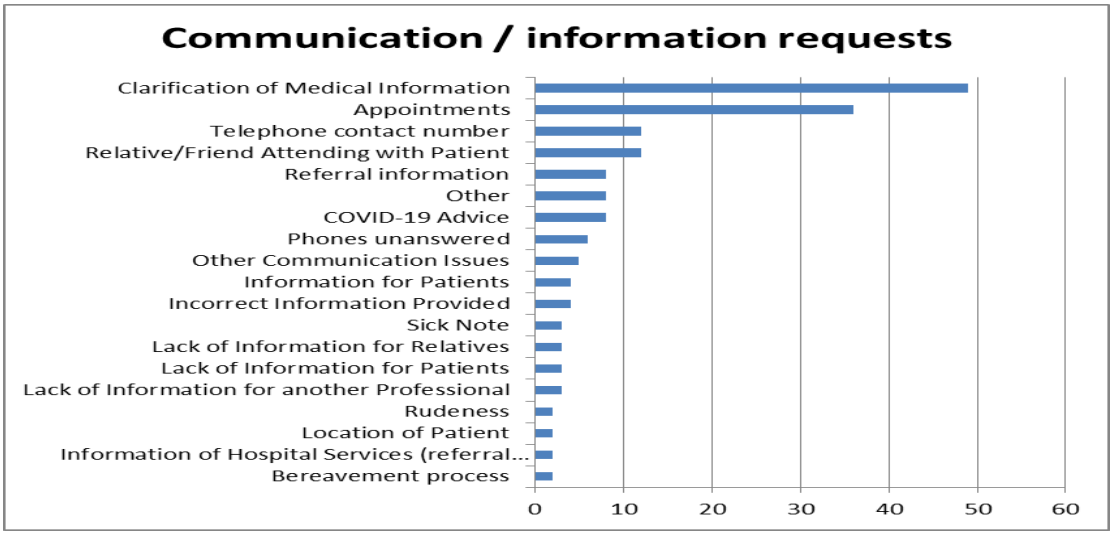
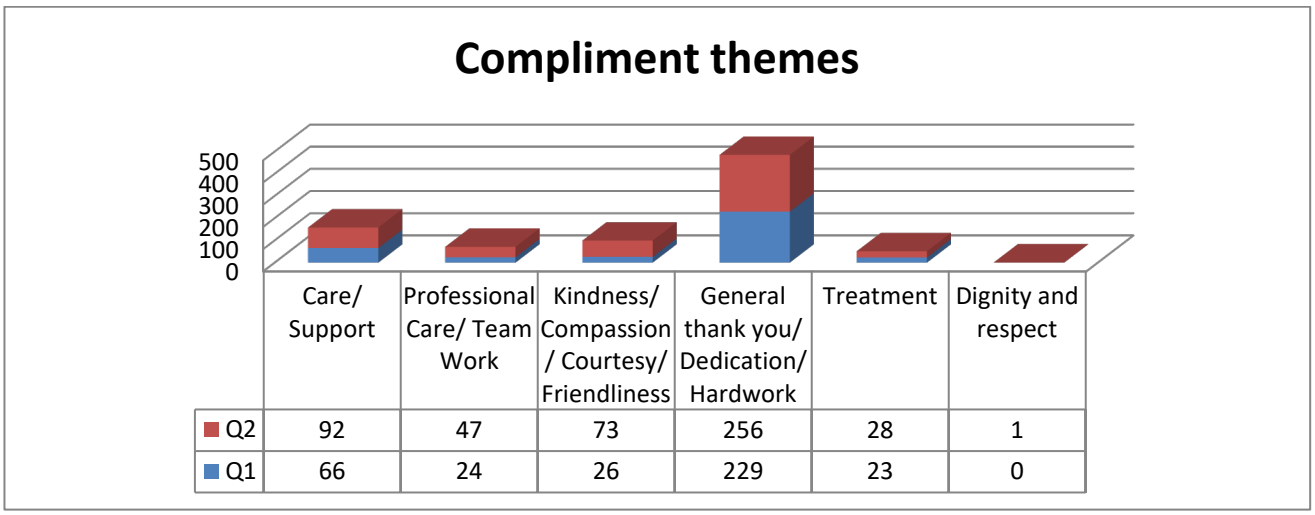



*Figure 12: Sub-subjects within communication, information and advice requests (Source Datix 05/11/2021)*

### 3.5 Compliments

In Q2 we received a total of 4072 compliments, of these 3757 compliments were received via the Friends and Family Test (FFT) Survey and 315 were received via cards/letters/emails/verbally. This is an increase of 2529 on the same time last year (Q2 2020/ 2021). As seen in Figure 13, the main themes from the compliments received cards/letters/emails/verbally were general thanks, hard work, care, kindness.




| | Care/ Support | Professional Care/ Team Work | Kindness/ Compassion / Courtesy/ Friendliness | General thank you/ Dedication/ Hardwork | Treatment | Dignity and respect |
|---|---|---|---|---|---|---|
| Q2 | 92 | 47 | 73 | 256 | 28 | 1 |
| Q1 | 66 | 24 | 26 | 229 | 23 | 0 |

*Figure 13: Main compliment themes*

**Examples of feedback:**

"The whole experience was excellent from the skills of the surgeons to the compassionate care of all staff in Critical Care and on the ward."

"I just want to say a massive thank you for all your help and support during and after my transplant and giving me this second chance of life."

"Thank you from bottom of my new heart for all your first class care. Extra special thanks to my nurses, you kept me laughing, motivated, informed."
"The CPAP Practitioners were amazingly prompt, friendly and professional all at once."

"As a senior nurse myself it is hard to place yourself in the patient's position and I am grateful for the empathy and support I was shown."

### 3.6 Bereavement and Bereavement Follow up Services

- 55 patients passed away in Q2. In this quarter we have started recording the amount of patients who required rapid release. Of 55 deceased patients 4 were rapid release in Q2.

- 20 referrals were made to the coroners, 11 of these resulted in post mortem and 9 in 100A.
- PALS continued to provide all clinical areas with the relevant and up-to-date paperwork for when a patient dies.
- Supported the mortuary team at CUH with chasing outstanding paperwork and completion of the bereavement process.
- PALS sent out 39 follow up letters and 9 of the NOKs made enquiries.

### 3.7 Volunteers

In Q2 the number of volunteer hours was 397 which is a decrease of 131 hours compared to Q1 (528). This decrease is due to support with vaccination clinics and weekend visiting support not being required.

The amount of volunteer hours in Q2 can be seen in Figure 14.

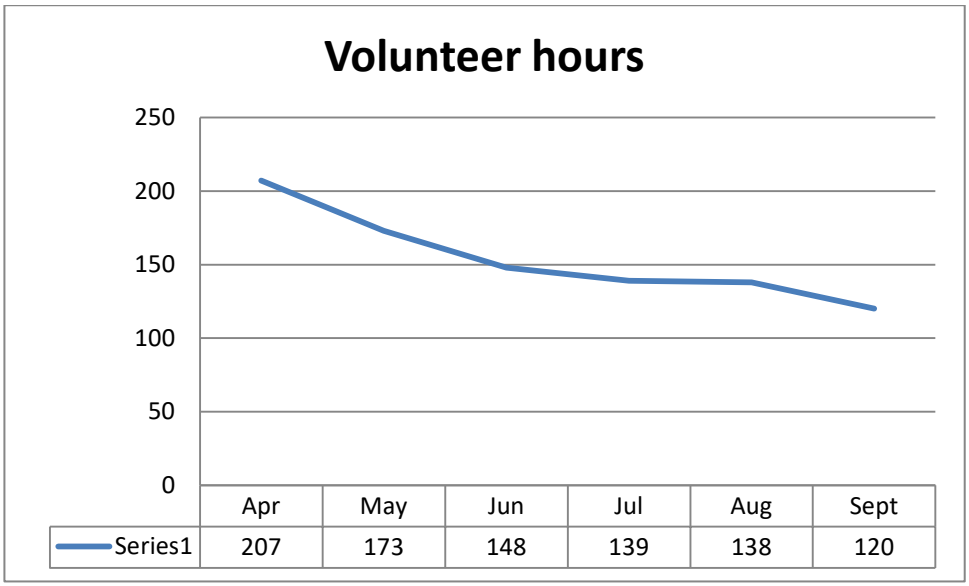



*Figure 14: Volunteer hours in Q1 and Q2 (Source Datix 05/11/2021)*

The recruitment process and volunteering roles are still being reviewed.

- Currently we only have 4 volunteers on site: 3 helping in pharmacy and 1 assisting with the staff flu and COVID vaccination clinic.
- 46 of the existing volunteers have indicated that they would like to return when possible.
- 51 new people have expressed interest in joining us as volunteers.

### 3.8 Patient Carer Experience Group (PCEG) Meeting

There was a virtual meeting in October 2021. This meeting is organised by the Nursing Management Administrator and chaired by the acting Chief Nurse. The agenda includes a patient story, current issues, updates regarding volunteers, patient representatives on committees, support groups, friends and family survey information and Healthwatch.

## 4.0 Incident and Risk Management

### 4.1 Non Clinical Accidents/Incidents

During quarter 2 there have been 324 accidents/incidents (including near misses) which have involved staff/contractors/organisation or visitors (Table 14). Figures remain almost the same compared to the previous quarters (n=330). The most common type of incident continues to be organisational issues/staffing (n=63) when comparing to Q1; insufficient numbers of healthcare professionals and inadequate check on equipment / supplies were two main categories reported.

Table 14 shows the incidents by type. Other types of commonly recorded incidents include Infection control (n=45), Security incidents (n=33), Behaviour/Violence Aggression (n=36) and Accidents (n=29).

| Type | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| Accidents | 24 | 27 | 18 | 32 | 29 | 130 |
| Administration - admission/discharge/transfer/waiting list | 23 | 15 | 11 | 11 | 11 | 71 |
| Anaesthetics | 0 | 2 | 0 | 2 | 2 | 6 |
| Behaviour/Violence Aggression | 18 | 26 | 23 | 12 | 36 | 115 |
| Blood Plasma Products | 5 | 7 | 0 | 3 | 2 | 17 |
| Communication/Consent | 20 | 14 | 12 | 11 | 10 | 67 |
| Data protection | 10 | 16 | 28 | 16 | 18 | 88 |
| Diagnosis Process/Procedures | 3 | 4 | 3 | 4 | 0 | 14 |
| Documentation | 20 | 13 | 7 | 12 | 6 | 58 |
| Environmental Hazards/Issues | 27 | 21 | 15 | 32 | 11 | 106 |
| Fire Incidents | 7 | 3 | 3 | 2 | 3 | 18 |
| Infection Control | 35 | 70 | 34 | 31 | 45 | 215 |
| Information Technology | 14 | 19 | 30 | 42 | 18 | 123 |
| Medical Devices | 30 | 27 | 9 | 23 | 19 | 108 |
| Medication/Medical Gases/Nutrition | 31 | 21 | 12 | 17 | 12 | 93 |
| Nutritional Feeding (Prescribed Feeds) | 0 | 1 | 0 | 2 | 0 | 3 |
| Organisational Issues/Staffing | 50 | 66 | 38 | 56 | 63 | 273 |
| Pressure Ulcers | 0 | 6 | 5 | 1 | 1 | 13 |
| Radiology | 3 | 2 | 1 | 1 | 0 | 7 |
| Security incidents | 12 | 19 | 19 | 14 | 33 | 97 |
| Treatment/Procedures | 5 | 8 | 5 | 6 | 5 | 29 |
| Total | 337 | 387 | 273 | 330 | 324 | 1651 |

Table 14: Non-clinical Incidents Reported for 2021/22 (Data source: DATIX 21/10/21)

### 4.2 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)

During quarter 2 there have been six new RIDDOR reportable incidents (see Table 15) which required reporting to the Health & Safety Executive (HSE); WEB39929, WEB40361, WEB40590, WEB40221, WEB40626, WEB40173. Three out of the six incidents were related to moving and handling issues. Staff members with injuries due to moving and handling are being referred to the Occupational Health department who continue to support these individuals throughout their recovery process. The incident information is also shared with the Moving and Handling Lead to aid learning and where necessary changes to policy and practice. Workforce continues to review all reported COVID sickness absence to confirm, using a decision tree, if COVID could have been contracted at work or in the community.

| | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | 21/22 Q2 | Total |
|---|---|---|---|---|---|---|
| Collision/Impact with object (not vehicle) | 0 | 1 | 0 | 0 | 1 | 2 |
| Contact with pot. infectious material | 2 | 1 | 1 | 0 | 0 | 4 |
| Infection | 0 | 0 | 2 | 0 | 1 | 3 |
| Moving and handling | 2 | 3 | 2 | 4 | 3 | 14 |
| Other type of accident | 1 | 0 | 0 | 0 | 1 | 2 |
| Slip, Trip or Fall | 1 | 0 | 0 | 1 | 0 | 2 |
| Total | 6 | 5 | 5 | 5 | 6 | 27 |

Table 15: – RIDDOR Incidents Reported for 2021/22 (Data source: DATIX 21/10/21)

### 4.3 Risk Register

There are currently a total of 607 open BAF corporate, H&S, charity and safety alert risks (as of 03/11/2021); compared with 580 in the previous month which demonstrates active recording of risks across the organisation and at all levels. However, 112 are overdue compared with 140 in the

previous month; which equates to 18% of the risk being out-of-date with an average of 62 days overdue (ranging from 2 days overdue to 794 days).

A monthly reminder is sent for both overdue corporate extreme risks to the handlers. It is the responsibility of the Divisions to update all risks and to report those 12 and above in their monthly reports; escalation of these risks are noted at QRMG. All new risks graded 12 and above are shared at QRMG & Q&R in addition to Divisional meetings. All departments have access to their risk register information via the Datix Risk Management dashboards. Corporate and Board level risks are presented to the Trust Audit Committee. A Risk Maturity Review was completed by external auditors BDO in September 2021. As a result the Risk Team is developing an action plan which will be shared with QRMG in due course.

### 4.4 Safety Alerts

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

Throughout Q2 2021/22 the Trust has received 26 formal Safety Alerts and Field Safety Notices, raised by manufacturers. These figures do not account for medication safety alerts which are managed by the pharmacy team or Estates/Security alerts managed by Estates. All 26 alerts have been actioned and are monitored at QRMG in line with the individual safety alert requirements. The Trust is fully compliant with national guidelines in Q2.

## 5.0 Effectiveness of Care

### 5.1 Quality and Safety Measures

The Summary Hospital-level Mortality Indicator (SHMI) is not applicable to Royal Papworth Hospital, therefore crude mortality is monitored and full details of this monitoring can be seen in Appendix 1.

### 5.2 Clinical Audit

**National Audits**

In Q2, one National Audit relevant to RPH was disseminated and reviewed at QRMG (NCEPOD – Hard To Swallow). An action plan is being drafted by the SALT lead.

In Q2, the datasets for last financial year (20/21) have been validated and locked down for the National Adult Cardiac Surgery Audit (NACSA) and Cardiac Rhythm Management audits. The team anticipates the audit reports to be published in Q3 21/22.

### 5.3 Local audit

Local audit capacity continues to be developed in line with the ongoing pandemic. The Clinical Audit and Effectiveness team is updating the Trust'clinical audit plan held with the team for 21/22, to review all the planned audits from e.g. serious incidents, safety alerts, Quality Accounts.

There have been 6 trust wide local audits completed and reported on in Q2:

- Alcohol Gel at point of care Audit (Infection control) (see Appendix 2)
- Environment Audit (Infection control) (see Appendix 2)
- Resuscitation Equipment Audit Report (Alert Team) (see Appendix 2)
- Attendance & completion of cardiac rehabilitation following heart transplantation (PSS Team) (see Appendix 2)
- ReSPECT Audit – Completed - see Appendix 4
- Consent Audit – Completed (see 6.a in QRMG file)

The Clinical Audit and Effectiveness team has improved a number of reporting processes in Q2. These have included a move to "whole hospital monitoring" for VTE Assessment on Admission and an updated methodology for surgical WHO checklist monitoring. The team has also started routine monitoring of the compliance for usage of the AKI bundle on Lorenzo.

### 5.4 NICE Guidance

In quarter two there were 60 NICE Guidance published and disseminated to Royal Papworth Hospital NHS Trust during Quarter 2 of 2021/2022, 22 of which have been deemed relevant to the services provided at RPH. Please see Appendix 4 for a list of applicable guidance and compliance ratings.

### 5.5 Quality Improvement

The Clinical Audit and Effectiveness team has appointed to the vacant 'Clinical Audit and Quality Improvement Coordinator Post' – the successful candidate to commence in Q3. This post will help to build capacity to start to develop again QI capacity.

## Quality and Safety Measures – ongoing monitoring

### Mortality monitoring

The Summary Hospital-level Mortality Indicator (SHMI) is not applicable to Royal Papworth Hospital, therefore crude mortality is monitored and the quarterly figure is presented below by speciality.

| Specialty | Cumulative discharges | Cumulative deaths | Cumulative crude mortality | Q2 2021/22 crude mortality | Q1 2021/22 crude mortality | Q4 2020/21 crude mortality | Q3 2020/21 crude mortality |
|---|---|---|---|---|---|---|---|
| Cardiac Surgery | 1624 | 47 | 2.89% | 2.32% | 2.00% | 5.91% | 3.02% |
| Cardiology | 7901 | 82 | 1.04% | 0.98% | 1.02% | 1.35% | 0.89% |
| Cystic Fibrosis | 273 | 1 | 0.37% | 1.14% | 0.00% | 0.00% | 0.00% |
| ECMO | 133 | 57 | 42.86% | 52.17% | 33.33% | 41.18% | 45.83% |
| Lung Defence | 367 | 3 | 0.82% | 0.00% | 0.00% | 5.56% | 0.00% |
| Oncology | 766 | 0 | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| PTE | 124 | 4 | 3.23% | 0.00% | 8.57% | 0.00% | 2.22% |
| PVDU | 1211 | 2 | 0.17% | 0.27% | 0.00% | 0.70% | 0.00% |
| Respiratory Medicine (inc ILD) | 436 | 2 | 0.46% | 1.32% | 0.00% | 0.00% | 0.00% |
| RSSC | 5429 | 9 | 0.17% | 0.07% | 0.12% | 0.38% | 0.19% |
| Thoracic Surgery | 711 | 7 | 0.98% | 1.59% | 0.00% | 1.20% | 1.09% |
| Transplant | 501 | 17 | 3.39% | 1.97% | 7.32% | 1.06% | 3.03% |
| **Grand Total** | **19476** | **231** | **1.19%** | **1.03%** | **2.87%** | **2.15%** | **1.00%** |

*Hospital coding data

All deaths are considered at the Serious Incident Executive Review Panel (SIERP) where decisions regarding the need for further review/investigation are discussed. The Medical Examiner also reviews all deaths and highlights those that require Rapid Case Note Review (RCR). All deaths are also discussed in further detail at the specialty M&M meetings

**Appendix 2**

**Local Clinical Audit Summary**

The table below illustrates the completed clinical audit & effectiveness projects for quarter 2.

| | |
|---|---|
| **INFECTION CONTROL** | |
| **Alcohol Gel at point of care Audit** | **Findings:** Overall, the compliance rates of the Alcohol Gel at point of care audit have declined, with only 2/15 wards, (Theatres and Day Ward) achieving 100% compliance and 13/15 Wards achieving below 95%.<br><br>**Recommendations/Actions:** Hand pumps to be replaced in 4 NW, 4SE, 4 SW, 5S,outpatients, Radiology, Res Phys |
| **Environment Audit** | **Findings:** This Audit shows extremely positive results with 4 out of 4 of the Criteria scoring above 95% overall compliance. The only areas of concern which equates to one location only (IPC/ Bronchoscopy) is providing hand hygiene facilities in the clinical room and keeping the floors clean and free from spillage.<br><br>**Recommendations/Actions:** IPC to identify whether clinical room is for clinical procedures or storage and whether the use of alcohol gel is appropriate and floor to be cleaned by OCS. Room is monitored regularly by QC auditing: IPC/ Bronchoscopy |
| **ALERT** | |
| **Resuscitation Equipment Audit Report** | **Findings:** All Resuscitation Trolleys will be checked Weekly according to the Resuscitation procedure: 96.9%<br><br>All Resuscitation Trolleys will be checked Daily according to the Resuscitation procedure: 95.3%<br><br>The defibrillator will have been checked by Clinical Engineering within the last year:100%<br><br>Clinical Area Compliance with Audit Categories (Audit Tool Questions 2-21): 97%<br><br>**Recommendations/Actions:** Following publication of this report a member of the Resuscitation Service will meet with individual area/department managers whose clinical areas have a recurring monthly percentage compliance of less than 95% in order to develop a collaborative action plan to improve compliance. Monthly Resuscitation Service quality rounds to monitor compliance and provide more timely feedback to individual area/department managers and Matrons/Heads of Nursing/AHP Leads on a quarterly basis. |
| **PSS** | |
| **Attendance & completion of cardiac rehabilitation following heart transplantation** | **Findings:** At six months post discharge from hospital only 32% (N=7) of heart transplant patients operated on at RPH between January – July 2019 had attended and completed CR.<br><br>**Recommendations/Actions:** Further information is required over a longer period of time to ascertain whether 30% is an acceptable attendance rate for this patient cohort and if so, what can we implement to improve this. As a result of this information we have implemented a telephone follow-up service at six weeks and six months post discharge to review exercise routines and support further with referrals. Further data is being collected to see whether this is sufficient or whether face to face or virtual follow up meetings would provide better adherence and outcomes. |

**Appendix 3**

## ReSPECT audit 2020-2021 (Q3-Q4) Summary report

Background: The purpose of the audit is to establish if our current Trust procedure DN751 is being followed and to assess completeness of data on the forms. The audit process at RPH takes place monthly in the form of face to face spot checks in each clinical area to monitor compliance of Trust procedure and completeness of documentation.

The audit takes place across all clinical in-patient areas, auditing both the paper and digital forms. The data is collated by one of the Resuscitation Officers in a digital tool and reported on annually; this was discussed and approved at the ReSPECT Steering Group. The auditor will also compare the amount of forms communicated in the Ward Safety briefing against what has been found at the time of audit to report on effectiveness of ReSPECT decision communication within the Trust. The ReSPECT Steering Group was officially formed and approved by Quality and Risk Management Group, in response to audit findings from June/July 2020.

Summary of Findings:

- 88% of the time there was under reporting of ReSPECT documents at the daily Ward Safety Briefing when compared with the number for forms found.
- 97% of staff questioned were aware of ReSPECT decisions in place for patients at the time of audit.
- Paper forms are still being used within the Trust but the situation is improving from 14% in Q3 to 9% in Q4, as ReSPECT becomes more embedded in clinical practice.
- No East of England DNACPR forms were recorded as being used in clinical practice in Q4 of 2021.
- Compliance has improved across all of the following audit criteria; legibility, demographics, date of conversation, focus for treatment, CPR status and documented clinician details, from Q3 2020 to Q4 2021.
- There has been a slight decrease in compliance for the documentation of clinical guidance. This has decreased from 92% in Q3 to 83% in Q4.
- There has been a slight decrease in compliance for the documentation of summary of relevant information including diagnosis from 84% in Q3 to 75% in Q4.
- Compliance for the section documenting patient involvement in making the plan has remained the same over both quarters at 96%.

Recommendations:

- Feedback all positive findings to clinical groups to demonstrate that improvement is occurring and encourage further commitment to the ReSPECT process.
- Encourage further engagement and learning via the forums, sessions and Learn Zone to improve compliance of documentation.
- Further promotion of the e-learning packages that are available to provide staff with support for completing the ReSPECT form, with specific focus on areas that are not 100% compliant.
- Enhance the training packages and sessions available to highlight the importance of fully completing the ReSPECT form and offer guidance on content for the sections with use of example currently available.
- Revision to DN751 to include audit criteria summary so that clinicians are aware of the requirement to fully complete sections of the form.
- Explore options to improve communication of ReSPECT forms to the daily Ward Safety Brief.
- Evolution of the audit tool with additional questions around section 6 of the ReSPECT form, allowing more data collation for further service evaluation

**Appendix 4**

**NEWLY PUBLISHED NICE GUIDANCE AND QUALITY STANDARDS**

60 NICE Guidance published and disseminated to Papworth Hospital NHS Trust during Quarter 2 of 2021/2022, 22 of which have been deemed relevant to the services provided at RPH. These are listed below with their status of being reviewed.

| Title | Guidance Last updated | Distributed on | Status |
|---|---|---|---|
| Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Apixaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Acumen IQ sensor for predicting hypotension risk | July 2021 | September 2021 | Awaiting confirmation whether device in use at RPH to determine relevance (Clinical Engineering) |
| Nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| ENDURALIFE powered CRT-D devices for treating heart failure | July 2021 | September 2021 | Awaiting confirmation whether device in use at RPH to determine relevance (Clinical Engineering) |
| Clostridioides difficile infection: antimicrobial prescribing | July 2021 | September 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Inducing and maintaining normothermia using temperature modulation devices to improve outcomes after stroke or subarachnoid haemorrhage | July 2021 | September 2021 | Complete - Procedure not Performed at RPH , No Further Action required |
| COVID-19 rapid guideline: vaccine-induced immune thrombocytopenia and thrombosis (VITT) | July 2021 | September 2021 | Distributed to Clinical Leads |
| Antimicrobial prescribing: delafloxacin for community-acquired pneumonia | August 2021 | September 2021 | Complete - Not in use at RPH (Not within Formulary) |
| Patient Status Engine for wireless monitoring of vital signs | August 2021 | September 2021 | Complete - Distributed to Digital/Thoracic Med Leads, No further action required |
| Lung texture analysis for measuring interstitial lung diseases | August 2021 | September 2021 | Complete - Distributed to |

| Title | Guidance Last updated | Distributed on | Status |
|---|---|---|---|
| | | | Digital/Thoracic Med Leads, No further action required |
| Venous thromboembolism in adults | August 2021 | September 2021 | Updated Guidance Under Review by VTE Oversight Group |
| Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome | August 2021 | October 2021 | Distributed to Clinical Leads for Initial Review |
| Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s | August 2021 | October 2021 | Distributed to Clinical Leads for Initial Review |
| End of life care for adults | September 2021 | Not Yet Distributed | Clinical Audit to add to End Of Life Steering Group Agenda for Completion of Baseline Assessment |
| Workplace health: long-term sickness absence and capability to work | September 2021 | Not Yet Distributed | Clinical Audit to Liaise with Workforce to complete baseline assessment |
| Nivolumab with ipilimumab and chemotherapy for untreated metastatic non-small-cell lung cancer | September 2021 | October 2021 | Complete - Reviewed at drugs and therapeutics - No further action |
| Carnation Ambulatory Monitor for ambulatory detection of cardiac arrythmias | September 2021 | October 2021 | Awaiting confirmation whether device in use at RPH to determine relevance (Clinical Engineering) |
| Transapical transcatheter mitral valve-in-valve implantation for a failed surgically implanted mitral valve bioprosthesis | September 2021 | October 2021 | Distributed for Initial Review by Structural/TAVI Clinical Leads |
| Transapical transcatheter mitral valve-in-ring implantation after failed annuloplasty for mitral valve repair | September 2021 | October 2021 | Distributed for Initial Review by Structural/TAVI Clinical Leads |