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Royal Papworth Hospital NHS Foundation Trust

Quality Report 2021 / 2022

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Quality Report 2021/22

Contents

Part 1 Statement on quality from the Chief Executive

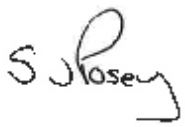
Providing high-quality, safe and effective care is at the heart of everything we do here at Royal Papworth Hospital. We are extremely proud to have gained an excellent reputation for quality in heart and lung medicine, but we know we must continually work to improve the care we provide to our patients. This Quality Account provides an overview of the quality of services that we have provided to patients during 2021/22 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. We recognise that we have areas of challenge and we have included updates in our report on M.Abscessus, surgical site infection rates, which have been elevated and we are working to reduce, and our performance with documentation of venous thromboembolism (VTE) which we are working on solutions with our staff through a dedicated task group to improve performance. 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 2022/23 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 2021/22 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
20 June 2022

Information about this Quality Report

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

Every NHS trust, including NHS foundation trusts, must 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 2021/22.

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 2022/23 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 2021/22 priorities

Our 2020/21 Quality Report set out our quality priorities for 2021/22 under the three quality domains of patient safety, clinical effectiveness and patient experience. *See our 2020/21 Quality Account for further detail: https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports*

The following section summarises the five quality improvement priorities identified for 2021/22 together with the outcomes. The tables below demonstrate achievements against the 2021/22 Goals.

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

2021/22 Priority 1: Safe

Objective: Build and develop Quality Improvement (QI) capability within the QI team and across the organisation

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can this be measured?	2021/22 Progress:
Continue to develop a QI road map to articulate the direction of travel and in particular how national, mandatory and local clinical audits, other clinical effectiveness assurance and reporting on patient experience outcomes will be prioritised in addition to the Trust's quality improvement priorities. 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	A draft road map was developed but paused due to Covid. This was not progressed further.
		BAU monitoring of Clinical Audit and QI programme status through minutes of Clinical Audit & Quality Improvement Steering group.	Meetings were paused during the pandemic, but clinical audit continued and was monitored through the Quality & Risk Management Group (QRMG). National mandated audits continued along with selected local audits to improve key service areas. Evidence is in QRMG Q2 21/22 report. Clinical audit and QI activity is now routinely reported into QRMG therefore the Quality Improvement Steering Group has been closed. Monthly reports have been received throughout Q4 evidencing completed audits.
		KPI: Number of projects registered under the QI programme evidencing the use of Institute for Healthcare Improvement (IHI) methodology	A formal QI programme has not commenced however several local QI projects/audits principles have been undertaken e.g. improvements in managing delirium in critical care
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 Eastern Academic Health Science Network (EAHSN) regarding re launching this Master Calls programme in 2021/22	Completion of the "Train the Trainer QI Masterclass" in 2021/22.	This remained on hold due to the pandemic and insufficient capacity within the team.
		KPI: Number of QI Trained Staff at RPH	Meeting with EAHSN in Feb 2022 with agreement to carry over the funding/agreement previously arranged and prepaid in 2019/20 for the provision of: • 6 half day sessions for the training and mentoring of 6-8 members of staff, focussing on key quality improvement techniques and methodologies (For QI leaders and champions).

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can this be measured?	2021/22 Progress:
			• Access to a series of beginner/intermediate level videos, to get colleagues to a position ready for the more advanced in person 6 session course above. We are working with EAHSN to develop the content of the on-line course content for 6-8 people that will be delivered in 22/23 [dates to be confirmed]. The target audience will be Clinical governance leads, medical / nursing / AHP (staff to be identified).
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 on line. During 2020/21 14 staff had accessed this online training. In addition, 18 staff had received face to face training delivered by the Clinical Audit and Quality Improvement team.	Refreshed intranet pages containing a comprehensive suite of reference materials to be launched by late FY 21/22.	**This was not** progressed and will now be part of the EAHSN package. Bronze QI training has continued to be available to staff throughout the year via the Clinical Governance intranet pages.
		Internal QI Curriculum to be developed and available for staff to book into by late FY21/22	There has been no further development with a QI curriculum, but this will be reviewed again when the Quality Strategy is refreshed in September 2022.
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	Meetings were paused during the pandemic, but clinical audit continued and was monitored via QRMG. Clinical audit and QI activity are now regularly reported into QRMG therefore the Quality Improvement Steering Group has been closed.
		Wider engagement with a focus on developing the quality improvement programme.	This has continued to be on a 1-1 basis responding to staff scoping QI programmes.
		Agreed Quality Improvement Management Plans in place with each division.	This had been on hold during the pandemic and there are currently no plans in place but this will be reviewed again when the Quality Strategy is refreshed in September 2022.

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?	2021/22 Progress Q4 Update
Objective 1: Patients with a diagnosis of diabetes to be easily identifiable using the electronic patient record (EPR).			
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	Various options have been investigated by the digital team over the last year however this type of clinical system development is no longer on offer; the supplier of the RPH EPR has taken a change in direction with Lorenzo and has therefore paused any amendments to the clinical platform. One of the advantages of making diabetes easily identifiable on EPR was for the purpose of audit, therefore alternative ways of more easily identifying patients with diabetes are being considered: • Self Service Analytics (SSA) is a tool to support extraction from RPH EPR • Retrospective audits can be done through the Data Warehouse
		Implement audit cycles to improve compliance by using the new identifier when in place.	New identifier not in place.
Objective 2: Diabetes update to be added to the e-discharge summary.			

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress Q4 Update
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	Diabetes has now been added to the e-discharge summary and this will be reinforced with Trust wide communication via the Message of the Week. A baseline audit of discharge will be undertaken against which to benchmark future audits to review compliance of patients' diabetes history on the e-discharge. This will be a vital transfer of additional information to patients' general practitioners on discharge from RPH.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress Q4 Update
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	The diabetes team have sourced appropriate training packages for RPH staff: • Safe use of Insulin on E-learning for Health • Bespoke local training package with interactive questions for launch on LearnZone The diabetes team are now investigating the options within E-learning for Health and will liaise with other specialist RPH teams (who have recently designed their bespoke LearnZone training) to learn what is needed for a LearnZone package. The advantages of the latter will include the ability to review and refresh the content reflecting national learning but also include local learning through investigation of recent incidents.
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 low. Exploring potential ways of offering training updates. Monthly score card in development.	• Refresher training identified • Fewer incidents reported on Datix • Diabetes monthly score card	

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

1. **Progress the implementation of the C&C leadership programme**
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?	2021/22 Progress
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 by end October 2021	**Quarter 1/2** • Final framework published and communicated across Trust. • Project lead appointed to embed values through delivery of training programme; all staff will attend. **Quarter 3** • Pilot sessions conduced at end of 2021 - 47 staff trained through 4 pilots. Programme was then on hold due to the Covid vaccination initiative. • Launched at briefing 31.01.2022. • Link to booking line • Campaigns in atrium to raise awareness. • Planning to train 229 staff per month over the next six months, i.e., 70% of staff. • Model of delivery has been extended to face to face as well as online learning. **Quarter 4** • 207 staff trained including 36 at the House. • Teams sessions in development and due to roll out home workers in May 2022. • V&B session designed for induction and will be offered to all new starters from 9/5/2022. • Bespoke sessions delivered directly to teams in some cases.
2. Line management development	Launch the programme at the end of April with session 1 and cohort 1.	E-learning to be built and rolled out across Q2/Q3. Integration with current induction programme.	**Quarter 1/2** • Content of e-learning and face to face programme of line management modules developed with SMEs. • Facilitators being appointed. **Quarter 3**

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
	Continue to build sessions for the programme and work with subject matter experts to develop content (this is an ongoing process) Dates for cohort 2 and 3 live so those interested can plan their participation in the programme	Roll out for existing managers as part of competence development Attendance levels and feedback forms monitored. Better management of staff experience should see improved Pulse and staff scores related to management and autonomy over work and increased role satisfaction. A reduction in sickness absence, and numbers of disciplinary processes is hoped for.	Content is almost complete. Plan to launch in April 2022. Facilitators in place. **Quarter 4** Programme launched to the Trust in March with applications open for the first cohort of 16 which will commence from April 2022. Further cohorts being planned for Q3&4 2022/23 Currently developing tools for evaluation including structured survey and assessment of impact.
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.	IPR policy and process including revised 360 feedback tool has been developed and has been approved by the senior workforce team. Presentation to Executive Directors and Joint Staff Committee due in April with roll out expected in May 2022.
Objective 2: Create an equitable, inclusive and healthy working environment.			
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.	**Quarter 1/2** • EDI Staff Network producing Strategic Plans. • New Women's Network Launch end of November • Embed Allyship Programme • Review and Update EDI Action Plan Pulse Survey will go out end Sept. **Quarter 3** • Review of Pulse Survey Results – improved response from 65% to 70%

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
		Improved survey response – greater %	• Review, update and evidence WDES and WRES action plans. • Review of Cultural Ambassadors Cohort 1 training, prepared for Cohort 2. • Commenced Module 1 of 18 month Reciprocal Mentoring for Inclusion Programme • Engaged with Heads of Nursing and Ops Managers to discuss Staff Survey WRES and WDES results. • Reviewed and updated EDI Action Plan • Created Engagement sessions with Staff (February LGBT+ History month, March International Women's Day 22 etc). • Cohort 2 Trans Awareness Training for leaders and staff within the organisation. • Reviewed and Implemented Fairer recruitment process (No more tick boxes) with Head of Recruitment and Recruiting managers. **Quarter 4** National survey results from 2021 issued at end of March 2022 – response rate was 70% - improvement from 65.1% in 2020 On track with WDES and WRES action plans; these are reported monthly to Quality & Risk Committee. Gender Pay gap action plan submitted to Q&R March 2022 and approved. Network meeting established for: LGBT+, BAME, Women's, DaD (Disability & Difference). Now all meet bi-monthly. Network chairs have completed a Network Chairs Development Programme. Two network chairs have won regional awards: Diversity Champions (Healthcare Financial Management Association) and BAME network chair shortlisted for the national BAME healthcare award nominated as a clinical champion (event in June).

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
2. Compliance management / governance and data collection analysis	Working with Workforces Information team to define data set needed for monitoring compliance, trend reporting and defining priorities.	Data sets agreed and provided Yearly Trend analysis available and reported 6 month-yearly with consequent action plans in place Compliance with Accessible Information Standards	Regular reporting continues to: • CCL Programme Board • EDI Steering Committee • Quality and Risk Committee Trend analyses for Workforce Race Equality, Workforce Disability Equality, Gender Pay Gap, Pulse Survey Results are analysed and reflected in action plans. Action plans are reviewed in line with published staff survey results. Compliance with Accessible Information Standards – funding awarded to support Sign Live (system used to communicate with deaf or hearing-impaired patients). Aim is to launch in June 2022.
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.	Changes in policies and procedures Changes in interviewing techniques Sense checking (staff survey) if they feel a shift	Goal paused as cultural competence training is being considered centrally through the C&P system so not being undertaken independently at RPH. RPH Director of Workforce and Organisational Development is the lead for EDI cultural change programme across the system.
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 WDES- Action Plan and Report WRES- Acton Plan and Report NHSE independent evaluation Staff Survey	Rollout of reciprocal mentoring achieved with recruitment to programme; currently 20 people to assign into partnerships. Race and disability focus. Four Reciprocal Mentoring modules planned for 22/23 with module 1 dates agreed for June 2022 commencement. RPH completed four modules of the Diversity and Inclusion (D&I) Partners Programme in March 2022.
Healthy 1. Safe at work – ongoing workplace and individual	Significant work on risk assessing work place for Covid 19 has occurred over	Staff Risk Assessment process reviewed and approved for 2021/22.	**Quarter 1/2** • Review of RA process is pending publication of latest guidance. Process for enabling staff to return to work is now embedded.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
risk management, PPE, access to rest spaces	past year. Need now to embed Covid RA and support for staff into BAU.		• A repeat RA is triggered when there are changes in circumstances for an individual • Lone worker policy under review. • Home working – safety issues being considered (ergonomic /equipment investment) **Quarter 3** • Completed the review process and implementation of RA7 at end of 2021. • Buddy system set up for 'safe route to work' scheme • Self-defence lessons and safety alarms - in discussions with police. • Continued updates to staff re Covid regulations **Quarter 4** • RA7 launched and 45.8% of staff have completed this to date. • OH compliant with timeline on level 5 assessments • IPC regularly monitoring and updating guidance on covid working arrangements in the light of general public lifting of restrictions.
		PPE available to all staff.	PPE has been available to all staff throughout the year.
		Rest areas available for all staff groups.	Rest areas are available for all staff.
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.	**Quarter 1/2** • Regional OH review (ICS wide) has been delayed. • Current OH staffing issues has made the servicing of contract challenging. **Quarter 3** • Service evaluation still under review. Weekly reviews in place with OH • Regular performance reports received. **Quarter 4** • Service improvements have been made with current provider.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
			• New OH nurse appointed and in place. • Reduction of timelines from referral to outcome. • ICS wide project for OH services initiating and likely to be progressed through 2022/23.
3. 90% compliance - staff Flu/Covid-19 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 for both vaccines.	HR Lead appointed to health surveillance and vaccination programmes (flu/TB screening/COVID booster). Flu and Covid booster vaccination programmes rolled out successfully. 75% of staff received the flu vaccination. The flu vaccination programme was stopped earlier than usual due to the national requirement to focus on covid vaccination. We achieved the following COVID19 vaccination rates (there were 3 vaccinations required) 97% first dose, 95% second dose, 89% booster. Covid Spring Booster made available to all in scope inpatients Preparations taking place for programme for autumn covid and flu booster from August 2022.
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 and PULSE surveys 2022 response in this area. Reduction in bullying and harassment percentages.	**Quarter 1/2** This remains on work plan. The EDI agenda, line management training and V&B training will hopefully support this. **Quarter 3/4** • All policy work has been on hold. • Dignity at Work policy due to be published at end of April 22 • Pulse Survey completed. • Staff Survey complete and results discussed and published to managers for their action planning. Action planning meetings being held with triumvirates.
5. Agile/Flexible Working	Much work has been undertaken to enable staff to work flexibly over the last year in response to Covid-19. Work is now underway to make flexible	Agile Task & Finish group to be established. Agile working to be considered as a default for all staff appointments.	**Quarter 1/2** • Agile Task and Finish group set up (will consider issues such as managing people at home / technology / hospital estates). • Draft a policy for conditions of home working. • Review of Lone worker policy underway.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
	working business as usual. New agile working policy in place.		**Quarter 3** • On hold due to Covid - will be picked up after work on the mandatory vaccines for health workers is complete. • Lone worker policy with Risk Manager. **Quarter 4** • 2021 survey results published. Hotspots identified and working up plans to address. • Planning for 2022 survey taking place.
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.	Number of staff using the service Improvement in longer term absence for mental health related issues. Improved response in staff survey	**Quarter 1/2** • Sleep pods in place • Health & Wellbeing (H&W) spaces established • Hardship fund agreed for further 2 years • Staff recognition schemes in place • Staff coaching introduced • Weight loss clinics/physical activity being considered • NED lead for H&W appointed • New intranet H&W site with a road map of things on offer to staff – published and advertised to staff through weekly briefing and Newsbites. Nominated HR leads for each area to be appointed. **Quarter 3** • Provided mini menopause sessions x 3 well attended • Health and well-being part of on boarding and induction training. • Revamped H&W hub. • Spotlight in Communications on H&W in January 22. • Monthly collaborative meeting of H&W facilitators set up • H&W coffee mornings in place. • H&W facilitator dedicated to home workers appointed. • Monthly diary of H&W events on intranet. • H&W pens with pull out of events signed off • Leadership support circles for H&W training and were promoted in Dec 21 • Food van at both sites • Running club set up

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
			• Mindfulness projects for 'Men's Minds Matter Too' under development. **Quarter 4** • Provided Menopause Library books for the Trust through support of women's network • Establishing the Trust as a menopause friendly workplace is under development • Maintaining contact with Frank Lee Centre to promote staff benefits and physical health • Carried out small surveys on areas H&W needs focus. Outcomes include – how to unwind to prevent burnout and physical health • Physical health/fitness classes internally under development after an ask for this • New intranet upcoming in May has allowed us to plan/revamp H&W Hub and make resources more clear for its launch – it will include recognising common themes that affect H&W such as sleep/burnout and materials on how to unwind after work • Keeping in touch with current Mental Health First Aiders and support them further with resources and upcoming refresher training • Continue to work more closely with Communications to reach others about H&B • Continue to work more closely with H&W Facilitators and promotion of roles • Spotlighting the H&W Hub and additions to it • Promotion of useful/trusted external webinars more frequently and share resources from them • Promotion of Trust Initiatives staff can engage in • 16 H&W wall mounted noticeboards were put up on all floors of the hospital and are updated/monitored • H&W posters designed and approved for awareness • H&W posters put up at the staff residential accommodation at Waterbeach showing what support we offer

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
			• Simple handout resource pack for those who may not have immediate access to intranet under development • A hospital departmental H&W distribution list under development to reach others further • Planned events/competitions in advance staff can be involved in with Communications and Charity • Working with external companies to benefit staff mental and physical health • Researched internal staff skills that could benefit other staff wellbeing • Wellbeing conversations for staff and line managers under development with Compassionate & Collective Leadership team • Departmental H&W awareness sessions lead by facilitators • H&W Hub and mental/physical support currently being incorporated into inductions • Keep in contact with collaborative members and departments regarding wellbeing promotion • Ran various Mini mindfulness sessions through Tiny Pause open to all members of the Trust on various themes that affect H&W

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
Objection 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?	2021/22 Progress
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 (Priority relates to the impact on business and no of users eg hospital wide/department/one user) 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	After re-evaluation of the digital estate 500 desktop machines were ordered to replace low spec machines. There is now a reduction in % of machines with lower specs with the replacement program underway and 200 PCs changed out The replacement programme continued and the entire estate will be under 5 years old and hence supported by warranties. A further 400 machines will then need capital funding for a replacement programme to maintain this position.
		No of incidents reduced by 25% (= reduction of 7.5 to 22.5)	There have been 25 P1/2 incidents in the year. Two of the systems are technically stable with no incidents in the last 6 months. The technical fix for Trust pagers is due at the end April 2022.
		Reduce time for all cause system recovery by 20%, (= reduction of 1.12 hrs to 4.8 hrs) through faster triage of problems and quicker escalation with suppliers.	Due to staff vaccines and sickness we saw this slip with an increase in recovery time in quarter three, however this did recover somewhat in Q4. Overall downtime post P1/2 incidents remains at an average of >5 hours.
		Ward rounds (target 3)	Digital teams have continued to walk the wards to proactively inspect for malfunctioning and/or broken kit and have maintained the target of 3 rounds per week throughout the year.
b. Ensure local network is robust and not contributing to system issues.	Continued monitoring shows improvement in performance. Local Virtual Private Network (VPN)	Reduce VPN line maximum usage to 75%	This has been achieved with increased line capacity and maximum usage has fallen to below the 75% target.

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
	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	Maintain HSCN line maximum usage at or below 85%	This has been achieved with increased line capacity and maximum usage has fallen to below the 85% target.
		Network availability (target >98%)	Achieved
		Server availability (target >95%)	Achieved
c. Improve stability of core infrastructure systems (e.g. 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).	All systems show increased reliability, IEP is now much more stable with regular repeated failures. All have achieved no key system downtime in last 5 months
		Improved supplier management through increased meeting frequency and Terms of Reference for management with all suppliers (quarterly or where instability monthly).	Quarterly reviews with all suppliers are in place and on-going
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 RSSC (10 patients) to validate system upgrades. Expected expansion of users to improve patient experience and reduce the need to ask repeated questions	Expected expansion of users within RSSC and across Cardiology.	Expansion and rollout across other areas of the Trust initially stalled due to • pressure from other digital projects • lack of local admin time to support the system appropriately Following feedback version 2 of Patient Aide has necessitated a rewrite of the software. To implement version 2 across different areas of interested stakeholders across the Trust would require submission to the Investment group for funding

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
	Cardiology investigating opportunities for use of Patient Aide. Satisfaction survey with App and also numbers of patients enrolled		to support this. RSSC continue to support and administer version 1 locally despite the lack of admin time to support this. There are 716 registered RSSC users of the system.
		Patient experience / satisfaction metrics: – plan to survey patients using app at intervals to understand impact	Outcome of the two pilots undertaken in RSSC suggest that given the high number of 'did not attend' rates the Patient Aide platform in its current format is not suitable for a long-term use for virtual clinics in the sleep service. The main barrier for attendance was difficulties with logging on to the platform. The green statistic however was encouraging with a potential saving of 8.03 tonnes CO2e. The future of the project is being reviewed.
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.	This project has been further delayed due to issues with the pharmacy stock control system upgrade which would be required to implement this functionality. It was anticipated that a proof-of-concept implementation would have been in place by December 2021 with a fully featured implementation perhaps in place by the end of the financial year however this has seen further delays due to supplier problems. As we are waiting further software developments, we are unlikely to achieve full end to end barcode medication administration with Lorenzo. Partial checking has however commenced. Expected date of software delivery is May/Jun 2022 and an objective for the 2022/23 Quality Account will be to implement the scanning of patient wristbands to confirm patient identify prior to the administration of medicines in inpatient areas.
c. Engagement with Digital	% of user group meetings which were quorate: 3 meetings in last 48 months.	Improve quoracy to 6 per year.	There has been no improvement with internal stakeholder engagement despite a repositioning of the Lorenzo User Group to a Digital User Group. Improved Trust wide engagement with Digital will need to be reviewed and re-energised.
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 and medications from	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	GP connect, a new digital platform, was introduced in November 2021 and is a useful tool to further improve patient care. GP Connect allows, with appropriate consent in place, authorised RPH hospital staff to view a patients' full GP record from any practice in England via Lorenzo. An immediate benefit has been seen for example with Cystic Fibrosis patients

Goals 2021/22	Baseline position for April 2021 for target 21/22	How can progress be measured?	2021/22 Progress
the GP practice. Implementation of the Shared Health and Care Record (SHCR) enables visibility of patient history across the ICS, region and the wider community.			who require monitoring bloods after starting a new medication; RPH clinicians can easier track blood results over multiple counties thus saving time across the whole system.
b. Working with ICS partners towards development and implementation of a SHCR to enable system wide care.	In procurement for a SHCR at present, shortlisting for provider/supply commencing in Feb 2021 with an aim for a functional go-live Sept 2021.	There is a connection to and a minimum data set being shared through the Implementation of SHCR Minimum viable Solution by End Sept 2021	Phase 1 of the project, connecting GP systems to supplier (Orion) platform, is underway. The future Phase 2 to connect secondary providers to the SHCR will be of greater benefit to RPH when implemented.

Priorities for 2022/23

Our priorities for 2022/23 reflect the domains of quality: patient safety, clinical effectiveness, well led and patient experience. Our priorities are:

Quality Account 2022/23 Priority 1: Safe:

Objective: Patient Safety Incident Response Framework to include after action review academy.

Objectives 2022/23	Baseline position for April 2022	Our goals for 2022/23
To continue to scope and prepare for the implementation of the new Patient Safety Incident Response Framework (PSIRF)	Two named Patient Safety Specialist (PSS) roles in place for the Trust: Assistant Director for Quality and Risk Clinical Governance Manager Medical lead	To set up an internal working group in Q1 to lead the new PSIRF implementation project working towards the agreed date of implementation of the PSIRF, once released.
To implement and adopt the new PSIRF and launch in Spring 2022	The two PSS roles attend the monthly National Training Webinars which updates and supports the education and knowledge requirement for the pending implementation.	Develop an action plan to implement and adopt the PSIRF. This should align to the national programme of suggested implementation which we are awaiting publication, due to be spring 2022. This will be monitored by QRMG.
To recruit patient partners as required, to be part of the governance structure as part of the PSIRF	No patient partners currently recruited. We are awaiting the date of implementation of the PSIRF framework.	To scope the role and develop job descriptions in line with the national profile of these roles. Recruit the required numbers of patient safety partners as per the PSIRF. To set up a support/supervision system for the new roles.
To scope and implement a Trust wide after-action review (AAR) process to support staff with the outcome from incident management	There have been a small number of after actions review held within the year of 21/22. But no formal programme in place.	Develop a plan to introduce a formal Trust process for AARs. Scope and commission a training provider to deliver AAR training to 10-15 facilitators. Roll out a programme of AAR review sessions that provide structured reviews or a de-brief session for relevant staff/patient incidents. Monitor the number implemented and develop mechanisms to capture the feedback from the session for improvement.

Executive Lead: Maura Screaton, Chief Nurse
Implementation Lead: Louise Palmer, Assistant Director for Quality & Risk

Quality Account 2022/23 Priority 2: Safe/Effective:

Objective: Health Inequalities – increased action on prevention of health inequalities

For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan takes a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.

Objectives 2022/23	Baseline position for April 2022	Our goals for 2022/23
Reduce variation in access to or quality of services	The Trust holds large data base of patient demographics including addresses and post codes. The Trust seeks to understand further information on patient referrals depending on post code deprivation.	Correlate patient distribution from defined services with demographic database information and areas of deprivation.
Support healthy behaviours among individuals	Trust engagement and sign up with treating tobacco dependency national initiative 1. Implementation of new tobacco treatment pathways across inpatient and outpatient services	Development of plan to introduce initiative across defined inpatient and outpatient areas Record number of patients offered tobacco treatment and complete mandatory reporting Record number of patients who engage with programmes.
Partnership working and strategy development with local ICS on health inequalities	Trust engaged with local ICS inequalities group. Trust leading system cardiovascular care pathway. Inequalities considered as part of this.	Measurement of patient outcomes. Linking inequalities to patient safety agenda.

Executive Lead: Dr Ian Smith, Medical Director
Implementation Leads:
Dr Ian Smith, Medical Director
Maura Screaton Chief Nurse

Quality Account 2022/23 Priority 3: Safe:

Objective: Harm free care: VTE, Pressure Ulcers and falls - linked to performance and need for focus on harm free care charting and trends

Objectives 2022/23	Baseline position for April 2022	Our goals for 2022/23
VTE		
Improve compliance with VTE assessments	National target is 95%. There are an unknown number of VTE link nurses as many have moved around internally or left the Trust during the COVID base.	To continue to carry out monthly audit of compliance to review % of compliance and address areas achieving suboptimal performance. Local action plans to be created at divisional level to support improvement in compliance for areas not achieving 95%. Monitored at divisional level and reported into QRMG. To monitor compliance against national target. To re-refresh the role of the link nurse per division and increase the number of link nurses and attendance at link nurse meetings. To carry out a full scoping exercise Trust wide to review who requires regular education from medical trainees/ relevant Advanced Nurse Practitioners (ANP) re VTE.
Aim for compliance with the Exemplar status	Last Exemplar site approval was carried out in 2017. Exemplar renewal date was due 2020 - postponed due to COVID. We are expecting this review in 2022 (no date has been set yet by the governing body)	To carry out a self-assessment within Q1 against last known VTE Exemplar Criteria (to include RAG rating of current compliance). Create an action plan from self-assessment to review and work towards achieve revalidation as a VTE Exemplar Trust.
FALLS		
To introduce and undertake annual falls audits	Constant monitoring of number of falls and levels of harm with mini-RCAs undertaken following fall. Intentional rounding audits undertaken.	Annual audit of falls - aim to implement and complete by end Q2 Actions and learning from audit to be presented to Quality Risk Management Group (QRMG) in Q3
To review all staff groups are receiving the correct falls prevention and trauma information as part of mandatory and local induction to the Trust and areas of work	Falls awareness training is not delivered in a consistent way across all relevant staff groups.	Review content of Trust local induction and essential to job role training Scope and develop an awareness refresher training package for current staff in Q1 Roll out of refresher training in Q2/Q3 For new starters, develop and implement Learn Zone (or face to face) falls awareness package for role appropriate staff groups. Monitor compliance of falls awareness training for new starters and existing staff receiving refresher training via Learn Zone (or face to face).

Pressure Ulcers (PUs)		
A reduction by 20 % in pressure ulcers examined at pressure ulcer scrutiny panel where acts and omissions in care are associated with incomplete documentation found in the pressure ulcer SSKIN care plan document.	There were 11 pressure ulcers in the last reporting year where acts and omission in care were identified and were linked to gaps in documentation.	• Monitor the numbers of incomplete documentation of Lorenzo SSKIN care bundles • Carry out annual PU audit
A reduction by 10% in the number of medical device related pressure ulcers in Critical Care Area patients.	A CCA QI audit on the subject in 2021/22 found that with 10% reduction in this type of pressure ulcer was achievable when supported with local area, senior leadership and Wounds Care TVN team support.	• Monitor the numbers of PU associated with medical devices • To include medical device associated PUs in the annual PU audit
Establish 4 teaching sessions a year to be provided for the Wound Care Tissue Viability link nurse group	This programme is new for 2022/23	• Organise the 4 teaching sessions accessible through MS Teams. • Attendance will be monitored at PU scrutiny panel • Attendance reported in annual audit

Executive Lead: Maura Screaton, Chief Nurse
Implementation Leads:
Robert Gannon, Wound Care Nurse Consultant
Polly Gunsman, Falls Prevention Specialist Nurse
Sandra Mulrennan, Head of Nursing Cardiology

Quality Account 2021/22 Priority 4: Safe

Objective: Bar code medicines administration

Objectives	Baseline position at April 2022	Our goals for 2022/23:
To implement the scanning of patient wristbands to confirm patient identify prior to the administration of medicines in inpatient areas (excluding CCA)	Patient identify is currently confirmed verbally and by manually checking patient wristbands.	Progress against work package implementation plan. % of medicines administration actions where the requirement to scan the patient's wristband is overridden.
To investigate the requirements for a full closed-loop medicines administration workflow and create a high-level plan for the implement of this workflow.	There is an aspiration for the Trust to implement a complete closed-loop medicines administration workflow, however there is no specific plan to meet this objective.	Evidence of engagement with other organisations who have already implemented this workflow to gather 'lessons learnt'. Production and approval of a high-level strategic plan for the implementation of Barcode Medicines Administration (BCMA).

Executive Lead: Maura Screaton, Chief Nurse
Implementation Lead: Christopher McCorquodale, Deputy Chief Pharmacist

Quality Account 2022/23 Priority 5: Well Led:

Objective: Compassionate & Collective Leadership (CCL) and good staff engagement

Objectives	Baseline position at April 2022	Our goals for 2022/23:
Deliver three cohorts of the new Line Managers Compassionate and Collective Leadership Programme	Programme launched to the Trust in March 2022 with applications open for the first cohort of 16 which will commence from April 2022. Further cohorts planned for Q3&4 2022/23.	Attendee evaluation of the workshop Use the quarterly staff survey to assess impact on staff perception and line manager perception of impact on behaviours and introduce a structured survey and assessment of impact Improved management of staff experience should see improved Pulse and staff scores related to management and autonomy over work and increased role satisfaction. A reduction in sickness absence and numbers of formal disciplinary processes is also anticipated.
Continue the delivery of the Values and Behaviours workshops.	243 staff have attended workshops. Team sessions in development Home workers delivery of training due to commence May 2022 V&B session designed for induction and will be offered to all new starters from 9/5/2022.	Achieve 75% workshop attendance of all staff V&B session integrated into the corporate induction. V&B session delivered as part of the Line Managers Induction
Implement the Reciprocal Mentoring Programme	Four Reciprocal Mentoring modules planned for 22/23 with module 1 dates agreed for June 2022 commencement. RPH completed four modules of the Diversity and Inclusion (D&I) Partners Programme in March 2022.	Develop a process to monitor the outcome from concepts/projects developed between partners Annual staff survey results Pulse internal survey results (6 monthly) WRES and WDES annual reports including data on national compliance indicators

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

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 2021/22 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 2021/22 represents 100% of the total income generated from the provision of relevant health services by Royal Papworth Hospital NHS Foundation Trust for 2021/22.

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 2021/22, 21 national clinical audits and 1 national confidential enquiry covered relevant health services that Royal Papworth Hospital NHS Foundation Trust provides. During 2021/22, Royal Papworth Hospital NHS Foundation Trust participated in 20 of the 21 (95%) national clinical audits and 1 of the 1 (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 2021/22, 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 21/22 (95%)		
Audit Title	**Audit Source**	**Compliance with audit terms**
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	100
National Audit of Inpatient Falls[1]	Royal College of Physicians	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 on next page.
National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms [2]	NHS Digital	N/A
National Audit of Cardiac Rehabilitation	University of York	100
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	100
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	100
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	100
National Cardiac Audit Programme: Adult Cardiac Surgery	Barts Health NHS Trust	100
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management Devices and Ablation	Barts Health NHS Trust	100
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	100
National Cardiac Audit Programme: Coronary Angioplasty (Percutaneous Coronary Interventions)	Barts Health NHS Trust	100
National Cardiac Audit Programme: National Congenital Heart Disease Audit	Barts Health NHS Trust	100
National Lung Cancer Audit (NLCA)[3]	Royal College of Physicians	100
Sentinel Stroke National Audit programme (SSNAP)	King's College London	N/A [4]
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
National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	100

[1] Cambridge University Hospitals submits on behalf of RPH as the treatment provider/diagnosing trust for hip fractures as per the audit inclusion criteria.

[2] 2021/22 represents a pilot year for the National Diabetes Inpatient harms audit. In 2022/23 RPH will contribute to the programme, following the audits pilot in 2021/22.
[3] 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.
[4]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 and hence withdrew from the audit.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

Title	Cases Included	Cases Excluded	Clinical Q returned	Case Notes Returned	Organisational Questionnaire returned
Transition from child to adult services	10	76	In Progress	In Progress	1

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 2021/22. 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 16 local clinical audits were reviewed by the provider in 2021/22 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:

Prescribing of medicines for Secondary Prevention following bypass surgery

- To update the surgical discharge summary to include an option for In House Urgent Coronary Artery Bypass Graft (CABG) surgery post myocardial infarction with an option to add in information regarding the secondary prevention
- If secondary prevention is not prescribed on a TTO (to take out) due to a particular reason, pharmacists should be encouraged to write this in the discharge summary during the TTO screening process. This can also improve the communication to the GP with regards to the medication plan.
- Pharmacists should be present on ward rounds and question the use of appropriate secondary prevention.
- The medical team should be encouraged to document the plan with regards to medication treatment post-operatively.

Duty of Candour Re-Audit

- To ensure adherence to the Trust policy DN153 the results of this audit will be shared with the Quality and Risk Management Group and disseminated to the Divisional and clinical specialty Group meetings.
- The Clinical Governance Team to ensure any variance against standards is recorded on Datix. This should be clearly articulated on Datix with the reason for this variance
- Develop a process whereby the GP is notified of the patient safety incident causing harm to the patient.
- To aid the completion of the clinical audit, the standards need to be as an appendix within the Policy.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Annual Audit

- 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 (ReSPECT Procedure) 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

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 2021/22 that were recruited during that period to participate in research approved by a research ethics committee *was* 2,815. See table below:

Type of research project	No. of participants recruited per financial year			
	2018/19	2019/20	2020/21	2021/22
NIHR portfolio studies	1018	1,406	2246	1,061
Non-NIHR portfolio studies	33	124	186	81
Tissue bank studies	1987	1,867	968	1,673
Total	**3,038**	**3,397**	**3,400**	**2,815**

NIHR = National Institute for Health Research

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 60 studies of which 54 were portfolio studies (2020/21: 48 studies and 43 portfolio studies).

The Trust has responded well to restarting recruitment to studies following the pandemic, and although recruitment was lower than previous years, reflecting a lower amount of routine clinical activity going through the Trust, by the end of the year most studies were recruiting at expected rates. 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 was ranked as the top recruiting site in the UK for over 40% of the non-commercial interventional studies we supported and over 50% of the commercial studies we supported.

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 in 2021/22 and therefore no requirement for the Trust to achieve specific goals relating to quality improvement and innovation.

For 2022/23, CQUIN schemes have been re-established. As in previous years, the Trust has agreed to undertake national CQUIN schemes with both; NHSE Specialised Commissioning, and Cambridge and Peterborough CCG / ICB (acting for and on behalf of associate CCG / ICB commissioners). A summary of the schemes agreed for 2022/23 is provided below:

Commissioner Type	CQUIN Scheme
CCG	Flu vaccinations for frontline healthcare workers.
CCG	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.
CCG	Timely communication of changes to medicines to community pharmacists via the discharge medicines service.
NHSE Spec. Comm.	Achieving High quality Shared Decision Making (SDM) conversations
NHSE Spec. Comm.	Achieving priority Categorisation of patients within selected surgery and treatment pathways

As in previous years, the Trust has established a CQUIN Review Group. This group will ensure that CQUIN schemes are appropriately implemented and monitored.

The Trust will report CQUIN compliance / achievement in year via standard reporting as per the appropriate CQUIN timetable (noting that reporting milestones vary by scheme).

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 2021/22. Royal Papworth Hospital NHS Foundation Trust was invited to take part in a Provider Collaboration Review (PCR) for cancer, in March 2021. The interview was not related to any monitoring or inspection work and the outcomes were intended to be used to inform future CQC strategy.

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 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of completed records in the published data is as follows:

- *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 about 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 a Data Security and Protection (DS&P) Toolkit in June 2021, 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 March 2022.

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 2020/21.
- 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 2020/21

Royal Papworth Hospital NHS Foundation Trust is currently working on an action plan to address the Auditors recommendations for 2021/22. All recommendations for 2020/21have been actioned.

Learning from deaths

During April 2021 to March 2022, 182 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 52 in the first quarter; 55 in the second quarter; 41 in the third quarter; 34 in the fourth quarter.

By 06/05/2022, 13 retrospective case record reviews and 8 incident investigations have been carried out in relation to the 182 inpatient deaths. In 0 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:

5 in the first quarter; 6 in the second quarter; 7 in the third quarter; 3 in the fourth quarter.

No 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.

None 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; 0 representing 0% 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.

Lesson learnt from Medical Examiner Service:

- In 2021-22 the Medical Examiner service has been strengthened by the appointment of two new Medical Examiner Officers and four additional Medical Examiners. The service continues to be 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 provides additional support for bereaved families and works closely with the Bereavement Service provided by the Patient Advice & Liaison Service at Royal Papworth.
- The Medical Examiner Service at Royal Papworth has been complimented by Her Majesty's Coroners Service for its care for bereaved families and the attention to detail in referrals made to the Coroners service.
- Patients who die after transfer from Royal Papworth to another hospital are not easily captured using our existing processes. We will continue work with other organisations in the region to improve our ability to learn lessons from these patients.

Lessons learnt from Mortality & Morbidity Meetings:

- Speciality specific M&M meetings have been fully re-established post-pandemic providing a forum for analysis and debate of every death which occurs in Royal Papworth.
- 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:

- 14 retrospective case record reviews have been carried out in relation to 182 inpatient deaths in 2021-22.
- The Retrospective Case Record Review process is now well established and provides an additional safety net to identify patient safety concerns in the Trust. In 2021-22 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.
- Reviews were carried out on a range of patients who died in the Trust including patients undergoing cardiac surgery, thoracic surgery, transplantation and trans-catheter valve implantation.
- The majority of reviews did not identify any areas for improvement but rather acknowledged that a high-risk procedure had been performed with due care and attention but that the patient had succumbed to a recognised complication which could not have been prevented.

Lessons learnt from incident investigations:

- 7 incidents investigations have been carried out in relation to the 182 inpatient deaths in 2021-22.
- Of the 7 incidents reported none identified the patient's death as potentially avoidable.

Impact & Developments in 2021-22

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

- The weekly Serious Incident Executive Review Panel (SIERP) has become established as a blame-free, multi-professional forum at which potential moderate or severe harm incidents and deaths are discussed. This weekly meeting provides the patient safety focus for the Trust and a weekly rhythm for reporting and presentation has been embedded.
- The Medical Examiner Service at Royal Papworth continues to grow and develop - it is now providing an extended service beyond Royal Papworth for deaths in the community working closely with several GP practices.
- The Patient Advice and Liaison Service (PALS) has now fully established the Bereavement Follow-up Service for all in-hospital deaths.
- A thematic review of incidents relating to the transfer of patient from Cath Labs to Cardiology wards has identified some areas for improvement focusing on early communication with Critical Care, the correct use of NEWS scoring and the central role of the ALERT team (a team of Royal Papworth autonomous Advanced Nurse Practitioners who respond to, and care for, deteriorating patients outside of Critical Care).

0 case record reviews and 0 investigations were completed after 01/04/2021 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	2020/21 (or latest reporting period available)	2021/22 (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.	*This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.*			
The trust's responsiveness to personal needs of its patients during the reporting period In 2020-21 survey, changes have been made to the survey questions, and scoring regime. As a result, 2020-21 results are not comparable with those of previous years.	Trust Score was 79.8 in the 2019/20 survey. National average score was 67.1 National highest score was 84.2	Trust Score was 82.5 in the 2020/21 survey. National average score was 74.5 National highest score was 85.4	Our staff pride themselves on providing patients with safe, high-quality, and well-coordinated care treating our patients with respect and dignity. This level of care is reflected in the Trust achieving results in the top 10% of trusts in the inpatient survey.	We will continue to use data from the inpatient survey to identify areas for improvement.
The 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	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.	91.2% of the staff employed by, or under contract to, the trust in the 2021 staff survey would recommend the trust as a provider of care to their family or friends.	Our recommender score has reduced but remains above average for our peer group and significantly above the national average (67.8%). New indicators relating to burnout show us that our	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

Indicator	2020/21 (or latest reporting period available)	2021/22 (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…
(Data from National Staff Survey Benchmark report 2021)	Average for acute specialist trusts was 91.7%. The Highest scoring specialist trust was 95.5%. The Lowest scoring specialist trust was 82.0%.	Average for acute specialist trusts was 89.6%. The Highest scoring specialist trust was 94.0%. The Lowest scoring specialist trust was 69.1%.	staff are tired, and this is likely to have had an impact on how staff feel about our services. In year we have continued with implementation of the Compassionate and Collective Leadership Programme and launched our new values and behaviours framework to support our staff in delivering safe, high-quality care. As part of this we have focused on health and wellbeing support and developmental work with line managers and through our staff networks to maintain positive staff experience and engagement.	and Collective Leadership Programme will continue. Please see 2022/23 Quality Priorities. See also Annual Report – Staff Report section for other information on the 2021 Staff Survey.
Friends and Family Test – In Patient NOT STATUTORY REQUIREMENT	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. Monthly monitoring however, continued at Royal Papworth.	In March 2022 99.1% of our patients would recommend our service.	The Trust continues to promote the FFT test. The Trust achieved a 26.4% participation rate in the latest inpatient data (March 2022). The national response for the NHS was 17.7% (March 2022).	The Trust will continue to monitor and promote Friends and Family scores.
The percentage of patients who were admitted to	*The national VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID19 pandemic. Please see the VTE section for Trust performance figures.*			

Indicator	2020/21 (or latest reporting period available)	2021/22 (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…
hospital and were risk assessed for VTE during the reporting period				
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 case 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
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 (data unavailable). *Rate per 1000 bed days provided 2020-21.* (iii) Number and percentage resulting in severe harm/death Note 3	(i) Trust number for 2019/20 was 3399. The Acute Specialist Trust highest total was 5861, the lowest was 753 and the average was 3015. (ii) Rate per 100 admissions was not available. The highest, lowest and average Acute Specialist Trust rate per 100 admissions was not available. (iii) 5 resulted in severe harm/death equal to 0.15% of the number of patient safety incidents. The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 0.78%, the	(i) Trust number for 2020/21 was 2439. The Acute Specialist Trust highest total was 5411, the lowest was 761 and the average was 2566. (ii) Trust rate per 1000 bed days 48.7 for 2020/21. Acute Specialist Trust rate /1000 bed days 2020/21: highest 185.2, lowest 15.2 and average 71.9. (iii) 6 resulted in severe harm/death equal to 0.25% of the number of patient safety incidents. The highest Acute Specialist Trust % of incidents resulting in severe harm/death was 1.95%%,	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.

Indicator	2020/21 (or latest reporting period available)	2021/22 (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…
	lowest was 0% and the average was 0.13%.	the lowest was 0% and the average was 0.40%.		

Data Source: NHS Digital portal as at 27/05/22 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

2021/22 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 and the planned recovery of our services. The Hospital has treated 20,613 inpatient/day cases and 101,121 outpatient contacts from across the UK. For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2021/22. We have selected examples from the three domains of quality (clinical safety, patient experience and clinical effectiveness of care). These priorities 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 2021/22 where these have not been carried forward as key priorities for 2022/23.

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 Oxygenation (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. The Quality and Risk Committee have agreed a six-month extension of the current Quality Strategy whilst the organisation re balances following the COVID pandemic on business as usual and considers new initiatives e.g. patient safety framework. 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 and again in 2021/22 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. 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. As we now move to further recovery of services in 2022/23 we need to remain vigilant and agile to ensure continuous delivery of safe and effective care for our patients in these challenging times. Our Quality Strategy ambitions will continue, and evolve further, as we move through to the next full review due in 2023.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 20 which places a statutory Duty of Candour on all NHS organisations. The 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 2021 the Trust undertook an audit against the requirements of the Being Open and Duty of Candour Policy (DN153) for incidents graded as serious of moderate harm. This demonstrated overall good compliance with the Trust Policy and recommendations for improvement have been implemented by the Clinical Governance Department.

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 2021/22 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 2021/22 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).

MRSA bacteraemia and C. difficile trajectory infection rates*

During 2021/22 the total number of *Clostridiodies difficile* cases were 12 which was over our national threshold, which was 11. We had acknowledged our potential to go over our threshold this year, which is something that was recognised by the CCG as increase in C.Difficile has occurred across the region. There were zero cases of MRSA bacteraemia for 2021/22. The ceiling trajectory for MRSA bacteraemias remains 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 2 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 with the clinical teams. All C.diff cases reported 2 or more days into admission are now counted towards Royal Papworth Hospitals annual trajectory regardless of any lapses in care.

Goals 2019/20	Outcome 2019/20	Goals 2020/21	Outcome 2020/21	Goals 2021/22	Outcome 2021/22
No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia
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	No more than 11 C.difficile	Total for the year =12 we were one over our yearly target of 11.
Achieve 100% MRSA screening of patients according to agreed screening risk	95.5%	Achieve 100% MRSA screening of patients according to agreed screening risk	97.5%	Achieve 100% MRSA screening of patients according to the agreed screening risk.	98.6%

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.**

*All C.diff cases are now counted towards Royal Papworth Hospitals objective. Root cause analysis are completed and reviewed internally for any C.diff incidence that occur 2 or more days into admission. The Clinical Commissioning Group (CCG) are informed of all cases but, will only review a case if there are causes for concern or if an outbreak has been declared. They are always invited to, and regularly attend, our internal review meeting for each case.

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). This has been recently updated by the UK Health Security Agency (UKHSA) (formally known as PHE) and has been reviewed and our policy has been updated. There has been one case of CPE but there has not been any ongoing spread of CPE within the Trust in 2021/22.

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:
https://fingertips.phe.org.uk/search/ecoli#page/4/gid/1/pat/15/ati/118/are/RGM/iid/92193/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/tre-ao-0
E.coli rates are 28 per 100 000 compared with 132.9 in England, therefore, we remain low in comparison. In absolute numbers we had 9-Ecoli, 13-Klebsiella and 5-pseudomonas 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 for 2021/22. 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

During this reporting year, we have made changes to our governance structure in relation to M. abscessus. Three working groups focusing on clinical and research, estates and facilities and governance and communication are overseen by the M. abscessus steering group. The executive oversight group has membership from external stakeholders.

An epidemiological study has been commissioned by RPH on the advice of UKHSA to continue to investigate potential cause and thus far no single identifiable cause has been identified. In 2021/22, 10 patients have tested positive for M. abscessus. Additional treatments have been implemented to help further reduce mycobacterial counts. Regular testing of water continues. The Trust has implemented stringent measures to ensure that only filtered tap water is used for patient care for vulnerable groups and audit to monitoring compliance has been developed which began in April 2021.

Influenza

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for “frontline” staff 2021/22 was 73% and 79%% Trust wide.

In 2021/22, the Trust continued to admit flu related ECMO patients into the Critical Care Unit. However, the Trust noticed a significant decrease in ECMO admissions relating to flu throughout 2021/22. It is suspected that this decrease is related to the COVID-19 pandemic.

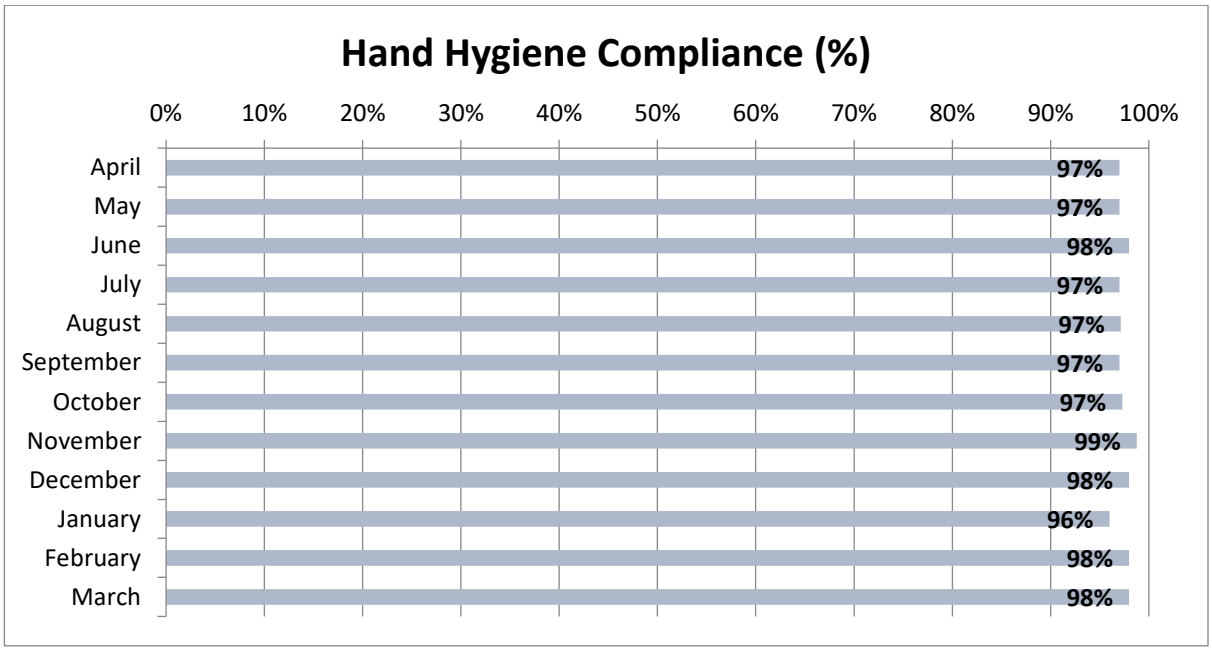
COVID-19 Pandemic

The Trust has continued to respond to the COVID-19 pandemic. There was an increase in COVID-19 positive patients admitted in Jan/Feb 2022 but less needing critical care support compared to previous surges. There were cases of nosocomial cases in 2021/22 with 2 cases in November and 6 nosocomial in March making it 5.5% total for the year. All these were fully investigated, and learning shared with the wider Trust.

We achieved the following staff uptake of COVID-19 vaccinations: (there were 3 vaccinations required) 97% first dose, 95% second dose, 89% booster.

The Trust continues to manage the COVID-19 pandemic as per Emergency Preparedness, Resilience and Response (EPRR) guidance with frequency of meetings tailored as necessary. The Clinical Decision Cell continues to meet regularly, with focus on actual and emerging clinical priorities.

Trust Hand hygiene compliance figures 2021-22 (April-Mar)



Surgical Site Surveillance

Surgical Site Infections

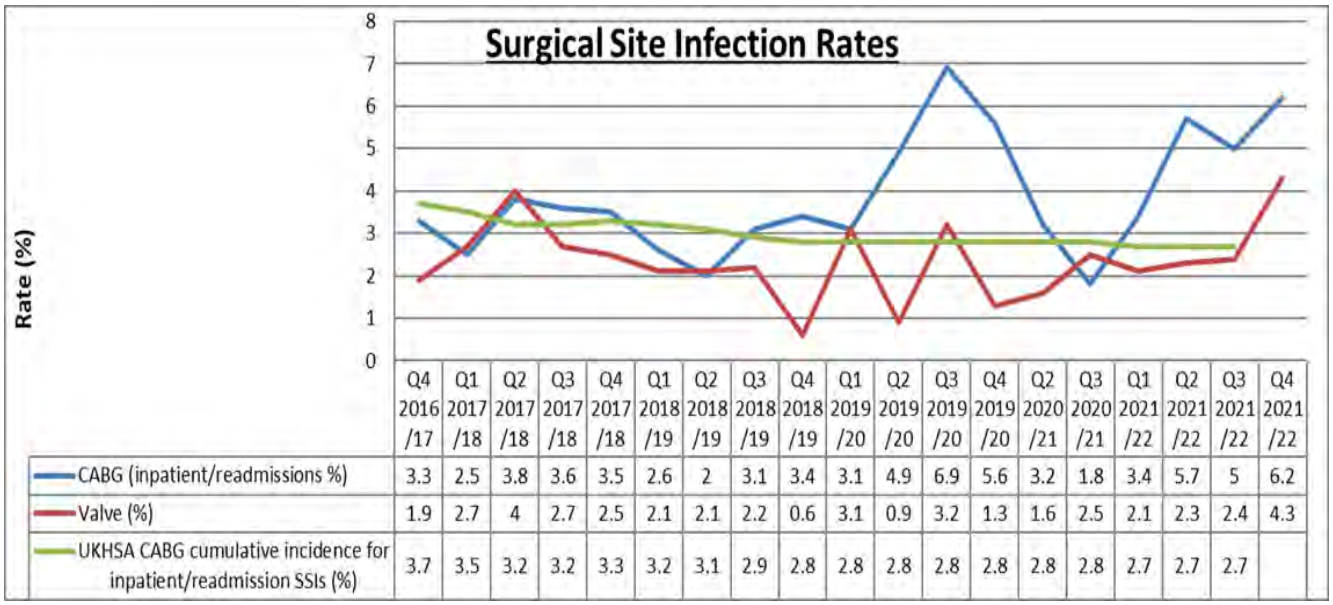
Surgical Site Infection (SSI) reporting (internally and to UKHSA) consists of identifying coronary artery bypass graft (CABG) patients with a surgical wound infection that meet defined SSI criteria. As part of reporting, patients are grouped in terms of when their infections are identified

- Inpatient (during current surgical admission) or readmission due to wound infection
- Other post discharge follow-up e.g., outpatients/ community team
- Self-reported by patients

UKHSA produce quarterly SSI summary reports comparing RPH rates to all hospitals that submit their CABG SSI rates. The UKHSA benchmark comprises of inpatient and readmission data for CABG patients only. RPH do however report on all categories of surveillance i.e. post discharge presentations and patient reporting. This is encouraged by UKHSA, to allow Trusts to understand their true infection rates however, for the purpose of benchmarking only inpatient and readmission data is used.

Since moving to the Cambridge Biomedical Campus in May 2019, RPH has seen rise in SSI rates. In addition, Q4 2021, surveillance indicates a spike in SSI in particular in respect to deep and wound infections.

Surgical Site Surveillance monitors patients for one year post surgery. This means that identification of SSIs can still occur quite some time after the original operation. Due to this, figures that are reported are subject to change. The data in this report is current as of 9th June 2022.



	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 2019/20	Q4 2019/20	Q2 2020/21	Q3 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
CABG (inpatient/readmissions %)	3.3	2.5	3.8	3.6	3.5	2.6	2	3.1	3.4	3.1	4.9	6.9	5.6	3.2	1.8	3.4	5.7	5	6.2
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	2.1	2.3	2.4	4.3
UKHSA CABG cumulative incidence for inpatient/readmission SSIs (%)	3.7	3.5	3.2	3.2	3.3	3.2	3.1	2.9	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.7	2.7	2.7	

SSI rates 2021-2022

2021-2022 has seen a significant increase in surgical site wound infections at Royal Papworth Hospital. Since reporting has recommenced post Covid surges, we are seeing higher numbers of patients being identified with wound infections and this is being reflected in the number of patients requiring care by the Wound Care Tissue Viability team. Our annual figures show that following CABG surgery the rate of surgical wound infection is 7.5% (64 infections out of 856 surgeries) and for valve surgery it is 2.8% (15 infections out of 537 operations).

Our inpatient/readmission CABG infection rate has increased over the year from 3.4% to 5.7%. The annual national benchmark has remained at 2.7%. The run chart represents the inpatient/readmission CABG rates from 2016 to 2022 with UKHSA benchmarks.

Note that the benchmark figure for Q4 (2021/22) is not yet available until this data is submitted to UKHSA in June 2022. This graph also shows valve infection rates for the same period. Valve infection rates have historically remained around 2 – 3%, with occasional spikes, however in quarter 4 2021/22 we saw an incline to 4.3%. This is the highest valve rate we have seen since SSI surveillance began at Royal Papworth. There is no national surveillance of valve SSI therefore, valve rates are for internal reporting only

SSI Stakeholder Group

The SSI stakeholder group was established in 2019 following the increase in SSI's rates following the move to new Royal Papworth Hospital. The stakeholder group has representation from the multi-disciplinary team involved in the patient's surgical pathway.

Due to the increase in surgical site infections that we are seeing within the Trust this year, the SSI Stakeholder Group have increased frequency of meetings to address actions and review learning. No one cause has been identified for the increase in infection rates however we continue to closely monitor and assess any potential contributing factors. We are engaging with our regulators e.g. CCG, UKHSA and the CQC keeping them informed of actions taken.

Reducing the incidence of SSI's is a priority for the clinical decision cell and the group are supporting implementation of appropriate recommendations.

Following year end the Trust has reported a serious incident in respect to surgical site infections due to the continued increased incidence especially in deep wound infections. This is to ensure transparency to internal and external stakeholders and allow further scrutiny and learning to improve performance.

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 treatment can be critical to the chances of survival. Since 2015, the UK Sepsis Trust has collaborated with a number of organisations to produce operational clinical screening tools such as the Sepsis 6 care bundle. The Sepsis 6 care bundle is designed to promote early identification of sepsis. In addition, using the bundle ensures 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 this 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.

1.1 Aims and Objectives

To ensure that all indicated investigations and treatments are performed 100% of the time within the first six hours of identification of symptoms. To ensure that the care bundle is used until symptoms are resolved

1.2 Standards

	Aspects to be measured	Expected standard
1	Sepsis 6 care bundle to be present in the electronic records of all patients who were identified as having had Sepsis	100%
2	Sepsis 6 care bundle documentation is fully completed	100%
3	Blood cultures to be taken within one hour of referral	100%
4	ABG/Lactate measured within one hour of referral	100%
5	FBC/Catheterisation commenced	100%
6	Fluid challenge administered within one hour of referral	100%
7	IV antibiotics to be commenced within one hour of referral	100%
8	High Flow Oxygen administered within one hour of referral	100%
9	Sepsis 6 care bundle used until resolved	100%

1.3 Methodology

This audit focuses on the accurate use of the Sepsis 6 care bundle which is recorded in the Patient electronic notes system (Lorenzo), for all retrospective patients who were identified as having Sepsis symptoms during the period April 2021 – March 2022.

1.4 Sample

A total of 171 electronic notes for patients identified with Sepsis symptoms, were eligible to be included in this audit.

2.0 Results
2.1 Achievement against criteria

>=95%	76 – 94%	<=75%

	Standard	Expected Standard	Achieved Standard 2020-2021	Achieved Standard 2021-2022	Numbers
1	Sepsis 6 care bundle to be present in patient notes	100%	99%	96%	165/171
2	Sepsis 6 care bundle documentation is fully completed	100%	97%	75%	124/165 6 N/A
3	Blood cultures to be taken within one hour of referral	100%	99%	96%	143/149 9 N/A 1 blank
4	ABG/Lactate measured within one hour of referral	100%	99%	100%	162/162 6 N/A 3 blank
5	FBC/Catheterisation commenced	100%	98%	99%	150/151 20 N/A
6	Fluid challenge administered within one hour of referral	100%	87%	99%	92/93 46 N/A 32 blank
7	IV antibiotics to be commenced within one hour of referral	100%	98%	95%	142/149 13 N/A 9 blank
8	High Flow Oxygen administered within one hour of referral	100%	99%	99%	148/149 8 N/A 14 blank
9	Sepsis 6 care bundle used until resolved	100%	96%	99%	163/165 6 N/A

Sepsis 6 care bundle present and utilised

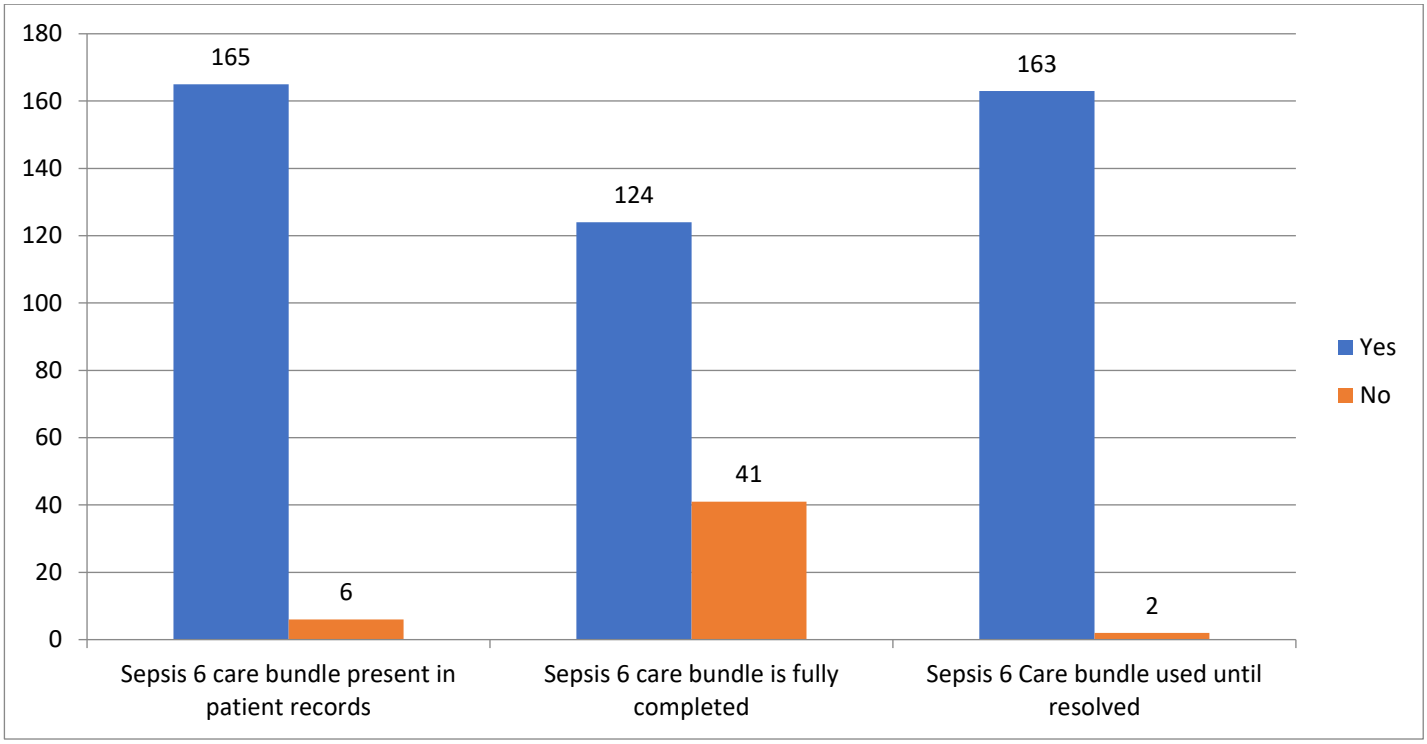
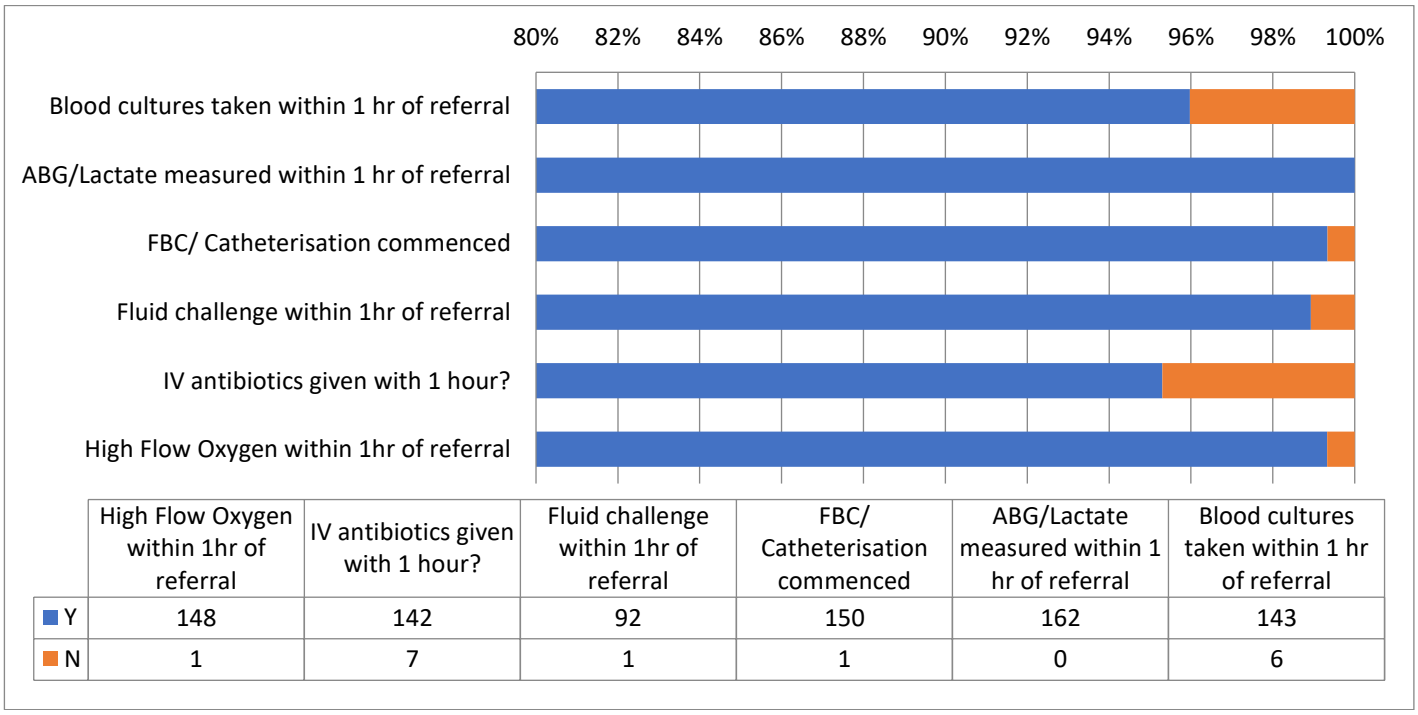


Figure 1: 96% of patient records checked on Lorenzo had a Sepsis 6 care bundle form present. 75% of patient records checked fully completed the Sepsis 6 care bundle. 99% used the Sepsis 6 care bundle until resolved.

Actions taken within one hour of referral



	High Flow Oxygen within 1hr of referral	IV antibiotics given with 1 hour?	Fluid challenge within 1hr of referral	FBC/ Catheterisation commenced	ABG/Lactate measured within 1 hr of referral	Blood cultures taken within 1 hr of referral
Y	148	142	92	150	162	143
N	1	7	1	1	0	6

Figure 2: >95% of patient's records showed that Blood cultures, ABG/Lactate, FBC, Fluid challenge, IV abx, & highflow oxygen were checked within 1 hour of referral.

Conclusion

The current guidance from the updated Surviving Sepsis Campaign (2021) highlights the importance of implementation of all the components of the Sepsis bundle to ensure effective

management of patients. The result of this audit continues to show positive results with 8/9 standards reaching above 95% compliance.

Standard 6 (*Fluid challenge administered within one hour of referral)*, was an action in the last audit and has risen in compliance from 87% to 99% in this audit.

Standard 2 *(Sepsis 6 care bundle documentation is fully completed),* has declined in compliance since the last audit from 97% to 75% in this audit. The Sepsis group are responding to this with a review of the Sepsis bundle and a review of staff training during 2022/23.

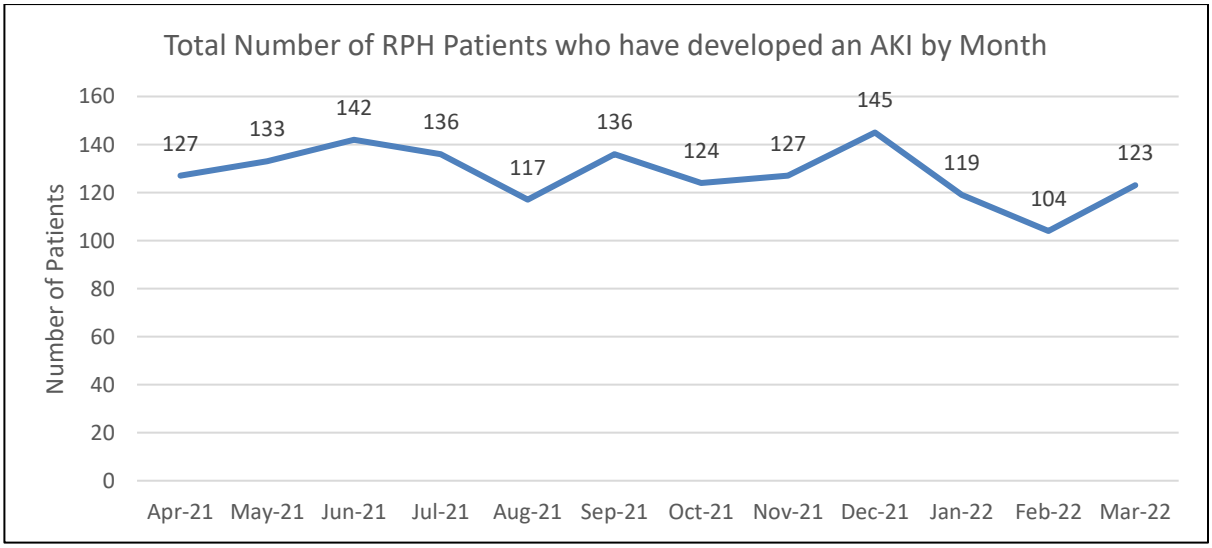
Acute Kidney Injury (AKI)

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 and 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). Acute Kidney Injury Guidance (DN622) is 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.

The following data identifies the total number of AKI incidents at RPH (Critical Care and the ward areas).

Total number of patients with AKI 1/4/2021 – 31/3/2022
1533 patients



This report identifies the number of incidents of AKI at RPH. This includes both patients in ward areas and Critical Care. Compliance with the AKI bundle has not been included in this report due to the issues outlined below.

Pressure Ulcer Report: April 2021-March 2022

Background and standards

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 (National Pressure Ulcer Advisory Panel (NPUAP), 2016). In their detailing of how trusts should report pressure ulcers, NHSE and NHSI (2018, appendix 1) describe eight principal 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. For the purposes of simplicity and greater situational awareness, we report all categories of pressure ulcers.

The Wound Care / Tissue Viability Nurse (TVN) team 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 is further examined in detail by the relevant clinical area who conduct this examination through a root cause analysis (RCA) of the incident. The RCA is reviewed at the Pressure Ulcer Scrutiny Panel who meet quarterly. The panel, made up of trust wide nursing representation, review the RCAs and concludes whether all care was in place and the ulcer could not be prevented or if there were acts and/or 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 robustness and triangulation of monitoring of pressure ulcers. In this reporting year, we reported the patient's experience of pressure ulcers through these differing methodologies to gain reliable and valid data in support of patient care and to inform us where to direct our resources.

Pressure ulcer rates and outcomes

Datix incident reporting system

Table 1 describes the number and grade of pressure ulcers acquired at RPH throughout 2021/22. In addition to this, 106 patients were admitted to RPH with an established pressure ulcer.

Of the 236 acquired at RPH, 23 pressure ulcers were classed as deep pressure ulcers – DTI=20 (low harm), Category three=2 (moderate harm), Category four=1 (serious harm).
Of the category 3 pressure ulcers, both were medical device related pressure ulcers (MDRPU) in long term COVID-19 CCA VV ECMO patients.

There were identified omissions of care following RCA in one case and actions and education put in place.

In the previous reporting year, 272 pressure ulcers were captured through reporting systems inside the hospital. This year's reduction in pressure ulcer acquisition was despite the annual period covering two further surge periods of admissions of COVID-19 CCA ECMO patients.

MASD	Category 1	Category 2	Category 3	Category 4	DTI	Unstageable	Other	MDRPU	Total
74	39	10	2	1	20	1	35	54	236

Table 1: Pressure ulcers report through Datix 2021-22

(MASD: Moisture associate skin damage; DTI: deep tissue injury; MDRPU: Medical device related pressure ulcers)

Prevalence audit reported the following

The biannual prevalence audit findings were consistent with Datix finding low levels of deep pressure ulcers. The audit did not uncover any deep pressure ulcers (category 3, 4, DTI) that were not already identified through Datix (table 2 & 3).

Ward	No. Patients	No. PU	No. Cat 1	No. Cat 2	No. Cat 3	No. Cat 4	No. Ungradable	DTI	MDR PU	% PU	No. MASD	%MASD
5NE	19	0								0%	3	16%
5NW	14	0								0%	3	21%
5SW	12	1						1		8%	0	0%
5SE	18	1		1						6%	2	11%
4SE	14	0								0%	0	0%
4SW	18	0								0%	1	6%
4NW	18	0								0%	0	0%
3SW	18	1			1 - transfer from QEH					6%	0	0%
3NE	7	0								0%	0	0%
3NW	6	0								0%	0	0%
Day Ward	23	0								0%	0	0%
CCA	34	5	1		1				3	15%	6	18%

Table 2: Pressure Ulcer Prevalence Audit June 23, 2021

Ward	No. Patients	Ski injury no.	Cat 1	Cat 2	Cat 3	Cat 4	Ungradable	DTI	MDR PU	% PU	MASD	%MASD
5NE	19	3	friction, elbow							5%	2	22%
5NW	9	1								0%	1	11%
5SW	18	5		1 (friction, elbow)						6%	4	22%
5SE	17	1						1 (sacral)	0	6%	0	0%
4SE	15	2								0%	2	13%
4SW	11	0								0%		0%
4NE	Closed	Closed								0%		0%
4NW	11	0								0%		0%
3SW	19	1								0%	1	5%
3SE	19	0						0		0%	0	0%
3NE	13	4						1 (heel)	1 (NGT)	15%	2	15%
3NW	2	0								0%		0%
Day Ward	19	0								0%		0%
CCA	30	13		2 * (buttocks)				2 (heel, sacral)	1 (ETT)	17%	8	27%

Table 3: Pressure Ulcer Prevalence Audit March 1, 2022

Pressure Ulcer Scrutiny Panel Outcomes

In this reporting year, it was determined that 11 incidents had acts and/or ommissions in care that may have contribute towards pressure ulcer formation. In the majority of cases, the act and/or ommission in care was associated with documentation issues. See table 4. These outcomes are consistent with previous reporting years despite a significant increase in acuity levels of patients this year with COVID-19.

	Category 2	Category 3	Category 4	DTI	Unstagable	Total
2021/22	5	1	0	5	0	11
2020/21	6	1	0	5	0	12
2019/20	3	1	0	8	2	14

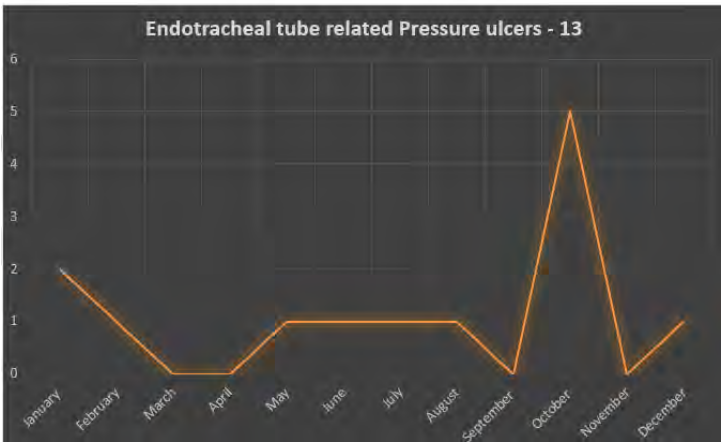
Table 4: Pressure ulcers associated with acts or ommissions in care

It is likely that recent investment in increasing the number of dynamic mattress systems available to patients including one in every bed space on CCA and the introduction of simplified pressure ulcer management strategies we developed in COVID-19 surge to the rest of the trust, led to an overall reduction in pressure ulcer incidents and marginally reducing the number of pressure ulcers where acts and/or omissions in care were a factor. This was achieved in the face an unprecedented rise in the number of high and very high risk patients admitted to CCA and the respiratory ward due to COVID-19.

Actions: Many of the pressure ulcers associated with acts and/or omissions in care reached this conclusion due to gaps in documentation. Medical device related pressure ulcers (MDRPU) and moisture associate skin damage (MASD) remain a challenge.

Action1: Supporting documentation standards
There is now a standard document for Surface, Skin inspection, Keep moving, Incontinence/moisture and Nutrition (SSKIN) care across the Trust to help consistency of documentation and reduce opportunity for error.

Action 2: MDRPU reduction project in CCA
In response to a rise in MDRPU in CCA, CCA introduced a project known as the 'Two Birds Campaign' in winter 2021. This was a simple approach to protecting lips and mouth from endotracheal tube injuries which were the source of the majority of MDRPU on CCA and thus across the trust. The outcome with a strong educational and leadership effort in support, was very encouraging, leading to a reduction in MDRPU. See outline and results below.



Two Birds Campaign and follow up Audit, CCA Winter 2022

Action 3: Implementation of the 'Simple Safety for Skin' project
This project simplifies down to 3 tasks the core management interventions required to prevent and treat MASD and pressure ulcers. The approach has been finalised and the with implementation expected to be completed by summer 2022.

Action 4: Engaging with corporate trainers to support education

- Key products and kit used to prevent and manage pressure ulcers. Company trainers are currently on site supporting the implementation of the 'Simple Safety for Skin Project'.

2022/23 Quality account targets

- A reduction in the number of pressure ulcers associated with acts and/or omissions in care due to incomplete documentation findings in the ward based SSKIN care bundle.
- A reduction in the number of medical device related pressure ulcers in CCA patients.
- Establishing a quarterly education update about prevention and management of pressure ulcers and moisture associated skin damage, targeted at registered and non-registered staff caring for patients at risk of pressure ulcer development.

Ongoing strategies and initiatives for 2022/23

- The Scrutiny Panel continues to examine all category 2, 3, 4, DTI, or unstageable pressure ulcers developed within the Trust to identify lessons learnt and share good practice.
- Biannual pressure ulcer prevalence audits and annual mattresses surface audit continue along with new spot check audits by matrons.

- Continue Datix incident reporting for all MASDs and category 1, 2, 3, 4, DTI, and unstageable pressure ulcers developed within the Trust and all MASDs and category 1, 2, 3, 4, DTI, and unstageable pressure ulcers admitted/transferred into the Trust.
- Maintain a standing agenda item in the Quality and Risk Management meeting to report pressure ulcer rates.
- Continue with educational efforts focusing on pressure ulcer prevention, identification, reporting and management across the trust.
- Working with wound care industry partners to support training in pressure ulcer management.

Challenges

- The trust is currently supporting a robust action plan to reduce a rise in surgical site infections. This is having a resource impact on the Wound Care TVN team however, the team are being supported temporarily by additional hours from a wound care specialist.
- The role of the tissue viability link nurse is being re-energised as part of returning to normal Trust activities to ensure education and training of staff in the area of tissue viability is supported.

Conclusion

- There is a strong and robust reporting culture in place to record pressure ulcers using a multi-modal monitoring strategy. This was demonstrated in incident reported rates of pressure ulcer acquisition consistent with prevalence inspection rates.
- There were low rates of deep category 3 and category 4 ulcers acquired in the trust.
- It is likely that investment in increasing the number of dynamic mattress systems available to patients including one in every bed space on CCA and the introduction of simplified pressure ulcer management strategies we learned in COVID-19 surge to the rest of the Trust, led to an overall reduction in pressure ulcer incidents and marginally reducing the number of pressure ulcers where acts and omissions in care were a factor.
- MASD and MDRPU remain a challenge in respect to prevention however innovative improvements have been put in place by departments e.g. critical care that are demonstrating effectiveness.
- There are strong quality account targets set to support areas where we deliver a good standard of care and enhance the standard of care where challenges have been identified.
- There are plans in place to further develop capability of staff through the education of local link practitioners. This will allow the Tissue Viability specialist team to focus on complex issues and continuous scrutiny and improvements.

Patient Safety Incidents – Severity

Incidents by Severity	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total*
Near Miss	90	112	93	39	334
No harm	423	442	375	388	1628
Low harm	205	206	225	296	932
Moderate harm	12	5	5	4	26
Severe harm	2	0	0	1	3
Death UNRELATED to the incident	1	4	4	1	10
Total	733	769	702	729	2933

Patient Safety Incidents by Severity (Data source: DATIX 21/04/21)
*Correct at the time of production. Some incidents may be downgraded in severity following investigation.

Over 700 patient safety incidents have consistently been reported during the financial year despite a second wave 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 CQC requirements to

report under the Key Lines of Enquiry (KLOE).

Those graded as near miss (11%), no/low harm over the last 12 months (88%) 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. 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 21/04/2022. 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 reported one Never Event during 2021/22 where a misplaced nasogastric tube was not checked prior to administering medication (there was no harm to the patient). Immediate actions were taken, investigation completed and recommendations implemented. 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. 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 Falls Prevention Lead.

2021-2022 has again proved an unusual and challenging year due to COVID-19. As services return to pre pandemic activity, the wards and departments are caring for increasing numbers of frail patients.

Throughout the 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 2021-2022 but there were 5 moderate harm incidents.

Themes arising from falls overall, were patient frailty, trailing ECG cables and association with mobilising to bathrooms. The majority of falls were unwitnessed including the moderate harm falls.

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

- Introduction of alarm units for bathrooms across Level 5 Surgery to alert staff to patient movement
- Further emphasis on training provided for all clinical staff on falls prevention
- Promotion of frailty scoring to highlight patients at risk of falls.
- Promote role of Falls Link Nurse to strengthen teaching on the wards
- Promotion of the use of clips to help prevent cables trailing and causing trip hazards
- Review and promote use of falls alarms when appropriate
- Explore the introduction of telemetry where necessary to avoid the hazard of trailing cables.
- Investigate how lessons and themes are being shared to ensure change in practise and learning

The table below demonstrates the number of actual falls per quarter across the year. 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
2021/22	34	47	44	43	168

Source DATIX 15.06.2022

Prevention of venous thromboembolism (VTE)

Indicator: The percentage of patients who were admitted to hospital and were risk assessed for VTE during the reporting period

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
20/21	100%	93%	97%	**97%**	97%	100%	100%	**99%**	97%	97%	97%	**97%**	97%	97%	97%	**97%**
21/22	93%	97%	86%	**92%**	85%	80%	85%	**84%**	84%	86%	83%	**84%**	83%	83%	87%	**85%**

Data source: NHS Digital database as reported in Quality and Risk Management Group Report
National reporting for VTE is currently suspended.

Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons:

The Trust made significant changes to its methodology in June 2021/22. The previous year (2020/2021) reporting represented a move from a random selection of 30 patients each month, to whole hospital monitoring. The methodology until May 2021 involved sampling 30 random patients out of all admissions. Pre Covid, the trust would often see 1500-1700 admissions a month. In assuming a 93% compliance rate as frequently observed, the confidence interval on

this would be approximately 93% ± 9.1%. The methodology from June 2021 onwards samples all applicable patients, for July this was 1300 admissions. As our sample size now equals our population size, our confidence interval is 85% ± 0%.

Royal Papworth Hospital NHS Foundation Trust intends has taken the following actions to improve this score or rate and so the quality of its services:

Summary:
Circulation of more targeted and tailored reporting e.g., quality reports, monthly ward scorecards, speciality group reports and divisional levels to facilitate identification and implementation of local improvement measures.

Scrutiny provided through RPH governance and performance structures to review and address areas achieving suboptimal performance. VTE risk assessments is included in the divisional performance review meetings. The VTE oversight group will monitor VTE assessments across divisions and help identify improvements in compliance and share learning.

Development of a new policy and further refinement of our monitoring for 2022/23 to facilitate a better understanding of our current position and support our improvement efforts and closer align to policy.

Identify appropriate internal clinical audit quality standards for audit to allow bench-marking against other VTE exemplar sites and NICE guidelines NG89.

Education/Workforce: Investigation of the feasibility of increasing non-medical prescribers' involvement in VTE assessment. Circulation of quick digital reference guides and educational reminders sent out to doctors and trainees rotating from Critical Care areas and following induction.

Delay in the build and delivery of a Lorenzo clinical prompt for outstanding VTE assessments remains on the risk register and is under review by the Trust.

Inclusive visibility rounds

In October 2021 weekly inclusive visibility rounds, led by the chief nursing office, were introduced. The schedule of these rounds has varied themes e.g. quality, environment, patient safety, shadowing and well-being. All staff groups and grades of staff including students are invited to attend. These rounds will continue through 2022/23.

Patient experience domain

Patient Stories at Board

Patient stories have continued to form an integral element of capturing the patient experience throughout 2021/22. Members of staff representing a variety of professions have presented at the Board of Directors and at professional meetings such as the Clinical Professional Advisory Committee (CPAC), Sister / Charge Nurse meeting, Management Executive and the Patient Experience and Safeguarding groups. Patient stories are also included in monthly Matron reports for the Clinical 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 2022/23.

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

- Recovery for long stay patients under the additional restrictions of COVID illustrated how much of a patient's recovery was dependent on their psychological wellbeing, and how important it was for them to be supported particularly in managing their expectations.
- Some of the positive actions that we sometimes take for granted in how we support our patients which saw transplant patients enabled to hold their weddings and our critical care patients being taken to the duck pond.
- The impact of the virtual rehabilitation programme in cardiology. This story highlighted that communication with patients was vital to their recovery, outcome and experience of services, especially with the added stress and difficulties of the pandemic. It showed how staff felt empowered to tailor services to meet individual needs with a highly professional service where the staff went above and beyond, thinking 'outside the box' and making a difference to Royal Papworth patients.
- The impact of our therapy staff who had been eager to support and to motivate their patient and get them stronger and ensure that everything was in place to support their discharge.
- The impact of our ECMO service for a patient transferred to us as part of the COVID-19 pandemic surge load levelling that was coordinated through the Regional Critical Care Network. The patient had been delivered of twins a few days before she was transferred to RPH. She was on ECMO for 20 days and at day 12 she was up and awake. She wanted her care to be transferred back to local services so that she could be as close to her family as possible which took place two days after decannulation (which is part of stepping down from her Critical Care treatment). Her family were supported by the compassion and care shown by the Family Liaison Team (a team set up specifically as part of the Trust COVID-19 response) who supported in a very difficult situation.
- How we support vulnerable patients and the drive to create a safe environment for patients with learning difficulties. One patient had lengthy wait for cardiac surgery because of the COVID pandemic. We needed to ensure that we made proper adjustments and that we get it right for these patients as that would bring benefits to the wider patient population.
- Patients who had experienced delays in our In-House Urgent (IHU) MDT and how we could improve their experience of care. Whether we could have involved them earlier in decisions, and how we manage cancellations where patients were not fit or because of lack of theatre time or critical care beds. These issues were being addressed through multidisciplinary work to improve the pathway and preparation of care plans for individuals.

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. This has been particularly true during the Covid-19 pandemic where visiting restrictions and use of face masks and other PPE makes the experience even more disorientating and frightening

Alzheimer's research published in November 2020 show that dementia continues to have huge implications for the NHS, with the addition of COVID-19 exacerbating existing challenges for the health service, people living with dementia and their families. According to the Office of National Statistics (ONS); dementia was the most common main pre-existing medical condition among COVID-19 deaths between March and June this year, with a quarter of all COVID-19 deaths linked to dementia during this period.

During the pandemic the revised Dementia-Friendly Hospital Charter was published in October 2020 as a result of the COVID-19 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.

Royal Papworth Hospital Dementia strategy was created in 2015 to enhance the experience of patients and carers living with Dementia. Our aims are that 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. The review of the strategy has been extended to allow time for the move to the New Hospital and the NHS's response to COVID-19 pandemic. The strategy for Dementia is now going to be included in a new Strategy for Vulnerable patients including Dementia, learning Disability, Autism and those with acute mental health problems.

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.

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 during the daily board rounds and reasonable adjustments as required by good practice and underpinned by legislation are made by senior nurses as necessary and this has become embedded during previous years.

During the Pandemic visiting was suspended at Royal Papworth Hospital and over the last 12 months has varied according to the stage of the pandemic. However during the whole of 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 arrangements.

Progress to improve the experience of 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.
    - There is the ability to create alerts for confirmed and suspected Dementia but these are not always used. Work has been ongoing to make the needs of this patient group much more visible on the electronic system. (Links in with the work with Learning Disabilities and Autism)
    - The use of alerts is not yet embedded in service and training needs to be established to promote better understanding of this functionality within Lorenzo. This will provide better data regards dementia patients at RPH.

2. Due to personnel changes we currently do not have a named nurse for Dementia; the support for this patient group is being provided by the Falls prevention specialist nurse as well as the Safeguarding and Psychological medicine teams.
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. A Patient and Carer Experience Strategy which will acknowledge our vulnerable patients including Dementia, Learning Disability and Autism and those with acute mental health problems is being developed to consider the needs of these groups and help us identify the steps needed to achieve this.
5. 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, however there is a need to extend this training.
6. 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.
7. The Changes brought in by the Mental Capacity Amendment Act 2019 with the introduction of the Liberty Protection Safeguards to protect those who are most vulnerable has been delayed nationally. The draft code of practice is out for comment and the date for implementation is still awaited.
8. Training is required by the introduction of the Liberty Protection Safeguards. This has started with members of the Safeguarding team and needs to be widened as Deprivation of Liberties is everyone's business.

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 2021/22 see the figures are below

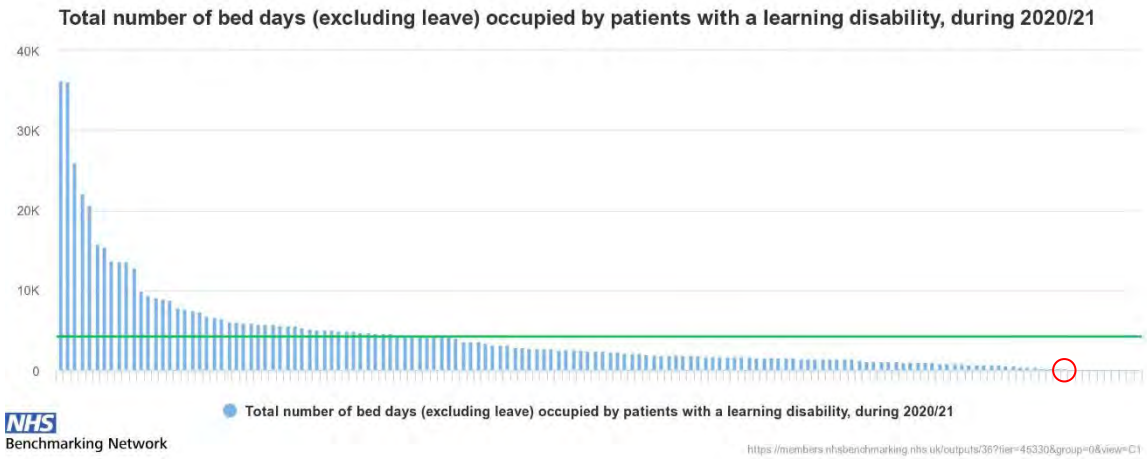
	Contacts	Unique patients
Learning Disabilities	236	84
Autism	14	6

The numbers show a 129% increase from last year. The increase for patients with Autism is 75% This appears to indicate an increasing recognition of patients with Learning Disability & Autism by the staff.

Royal Papworth Hospital participated for the fourth year running in NHSEI Learning Disability Improvement Standards self-assessment to better understand the experience of our patients.

Data submission occurred in Jan 2022 for the reporting year 2020 to 2021 (which is the most recent reporting year). Chart 1 below shows the 'Total number of bed days (excluding leave) occupied by patients with a learning disability during 2021/21' (there were 148 national responses from NHS Trusts). Royal Papworth Hospital is close to the far right of the chart (highlighted by small red circle; the green line represents sample mean).

Chart 1
Total number of bed days (excluding leave) occupied by patients with a learning disability during 2021/21



Sample Information

Sample Mean	Sample Median
4,221.8	2,437.0

Total National responses: **148**

Your Response

Submission	Response
Royal Papworth Hospital NHS Foundation Trust	211.0

Our action plan has again been updated with the progress that is being made to improve the experience of patients and carers 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 DN825 Resource allocation in a critically resource constraint environment (including CRITCON-4 guidance) and to the Consent Guidance 011G

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 over the last 12 months has varied according to the stage of the pandemic. However during the whole of the pandemic period, the Trust made reasonable adjustments to allow family members or carers to support patients with Learning Disabilities and Autism. 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 to protect those who are most vulnerable has been delayed nationally. The draft code of practice is out for comment and the date for the implementation is still awaited.

Progress to improve the experience for patients with Learning Disability and Autism

1. 2 staff members have been trained as LeDeR (Learning from Deaths Review) reviewers and 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. As a trust we have committed to hear the voice of our patients with Learning Disability & Autism through patient stories and to embed that learning within the trust. One story was shared at a joint Safeguarding committee, at a board meeting and wider through the in-house newsletter. As a result of the story we are working with the communications team to create a virtual tour of the hospital to replicate the tour that was shared by use of a laptop for a patient with Learning Disabilities who was unable to visit the hospital and this reduced her anxiety especially as she lacked any support while an inpatient. The staff team supported her well.
4. We have developed some communication resources for patients with Learning Disabilities which are available for staff use.
5. The Trust has established a system to monitor incidents reported through Datix affecting people with Learning Disabilities. Lessons and themes from this are reported through the Joint Safeguarding Committee.
6. We monitor patients with a learning disability and autism on a waiting list for our services and report quarterly to the Joint Safeguarding committee
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 to protect those who are most vulnerable has been delayed nationally. The draft code of practice is out for comment and the date for implementation is still awaited. Training has started for the safeguarding team and will need to be escalated across the trust as Deprivation of Liberties is everyone's business.
9. Continued Work with Digital colleagues to create an alert icon on Lorenzo for Learning Disability and/or Autism patients.
10. Agreement to investigate the creation of a low stimulus environment has been given and we are looking at appropriate locations.

Patient Led Assessments of the Care Environment (PLACE) Programme

PLACE assessments have been suspended since 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 2021/22 Royal Papworth Hospital received 40 formal complaints from patients and or their families (compared to 37 of the previous year). Of the 40 complaints reported (28 inpatient and 12 outpatient complaints) 39 were relating to NHS provided services with 1 complaint related to private patient services at Royal Papworth Hospital.

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 an informal complaint. Investigation of the issues raised follows the same robust process as a formal complaint, but a response is provided to the complainant either via email or telephone, this will also include providing details of any actions identified as a result of raising their concern. The Trust received 35 informal complaints in 2021/22, compared to 16 in the previous year (2020/21). We are unable to benchmark this to previous years as this is a new way of classing these types of complaints.

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 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	March 2022
2.4	2.9	7.4	7.4	5.9	3.4	7.4	6.9	6.0	2.5	3.0	4.5

The overall Trust value remains 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.

Royal Papworth Hospital continues to take 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 an investigation and the table below shows the number of complaints received and of those, the numbers upheld or part upheld. Out of the 40 complaints

received in 2021/22, 38% were upheld or partly upheld following investigation, a small increase of 3% from 2020/21 (35%).

Quarter	Number of complaints received (including private patients)	Complaints upheld/ Part upheld
Q1 2021/22	15	6
Q2 2021/22	7	3
Q3 2021/22	11 (1 Private Patient)	4
Q4 2021/22	7*	2*

*Not all complaints for Q4 have been closed

Overall, the primary subject of complaints received at Royal Papworth Hospital remains clinical care and communication, although we have noticed an increase in the number of concerns relating to discharge and follow up care following discharge from RPH. In 2021/22, 38% of complaints received related to clinical care and 23% relate to communication, an increase from 2020/21 (35% clinical care; 22% 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	2021/22	2020/21	2019/20	2018/19	2017/18
Clinical Administration and Appointments	0	2	3	0	0
Staff attitude	3	0	0	1	2
Clinical Care/Clinical Treatment	15	13	28	12	8
Patient Care (including nutrition and hydration)	5	5	0	0	0
Nursing Care	2	0	1	0	5
Catering	0	0	0	1	0
Patient Charges	0	0	0	0	0
Communication/Information	9	8	27	28	41
Delay in diagnosis/treatment or referral	2	0	7	10	9
Admissions, discharge and transfers	2	2	1	1	2
Consent	0	1	0	0	0
Equipment Issues	0	0	0	0	1
Privacy and Dignity	0	1	1	0	1
Environment - Internal	0	0	3	0	0
Medication issues	0	0	2	1	0
Facilities including Parking and Transport	1	4	1	0	1
Other	1	1	0	0	0
Totals	40*	37*	74*	53*	70

Complaints by primary subject (Data source DATIX 22/04/2022

*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 – 2021/22
A patient video was developed to showcase the sleep unit/ what happens on admission. This was co-designed and produced with patients to help address common misconceptions from being a patient of the unit.
We reviewed the assessment paperwork and recording of patients while on the sleep unit. In line with other nursing notes/documentation to support staff being able to record care offered e.g. offering of chaperone and being able to document this.
We have explored how to gain a wider patient story development for quality assurance e.g., at a Trust board or sub board level meeting to share the experience and learning from patient experiences.

Selection of actions taken as a result of upheld and part upheld complaints – 2021/22
We have reminded the nursing staff about communication around pain management and to recheck using pain scores before discharge to check about pain and any concerns relating to ongoing pain management and what to expect
We have had several complaints linked to access to our hospital due to Covid restriction being in place. Access to the hospital has been supported by our security team and we have worked with this team to develop our processes and how we communicate the restricted access, to aid better public/patient experience when accessing for visiting etc.

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

Care Quality Commission (CQC) Inspections

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

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

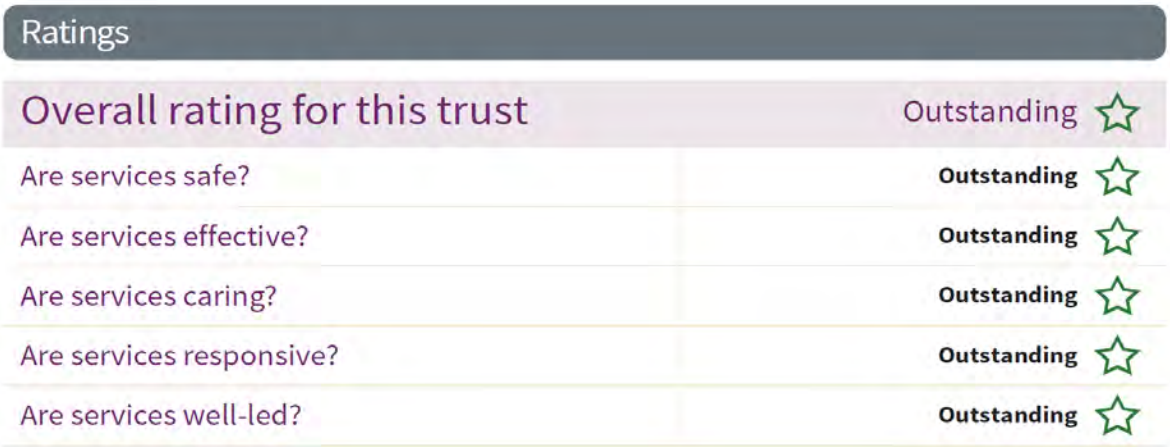
The aggregated rating for well-led at core service level was outstanding and the CQC rated well-led at trust-wide level as outstanding. When aggregated with the core services, this gave a rating of outstanding for the overall trust.

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

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

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

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



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

CQC Internal Mock Inspections

The Trust undertook a self-assessment of the end of life services in July 2021. In summary, the inspection identified an improvement in four out of the five domains (see table below); Safe and Effective rising from 'requires improvement' to 'good', Caring rising from 'good' to 'outstanding' and Well Led rising from 'requires improvement' to 'outstanding'. The domain of Responsiveness remained 'good'. In line with the CQC rating process, the overall rating was therefore rated as 'outstanding'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
July 2021 (mock)	**Good**	**Good**	**Outstanding**	**Good**	**Outstanding**	**Outstanding**
Oct 2020 (mock)	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Feb 2020 (mock)	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
2015	Good	Good	Good	Good	Good	Good

The Trust has also continued with its schedule of CQC Fundamental Standards reviews 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.

External Well Led Developmental Review

The Trust undertook an external Well Led developmental review which commenced in January 2022 and was reported to the Board in May 2022. The key themes identified included:

- Continuing to develop leaders to maintain the high-quality leadership of the Trust.
- To develop and strengthen leaders' capabilities in external stakeholder relationship to enable them to drive the system changes that are on the horizon

An action plan is being developed to respond to the recommendations and that will be used to support the Trust development through 2022/23 and beyond.

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, has continued 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

.

Planning for recovery and preparation for subsequent waves of COVID19 was managed and all possible opportunities to deliver the business-as-usual activity and go beyond pre COVID19 activity levels were pursued along with planning to deliver the system performance standard of 104% of our 2019 baseline activity in 2022/23. In subsequent COVID19 waves our approach has been to maximise our BAU activity alongside delivery of COVID19 service lines.

Cardiovascular Outcomes – NICOR report 2017-2020

Royal Papworth Hospital is one of the better performing NHS hospitals in the UK for cardiac surgery survival, according to the latest NICOR annual report. Over a three-year period, the hospital had a risk adjusted survival rate of >98%, and was above the national average. During that time, Royal Papworth performed the 4967 elective and urgent procedures, one of the largest case volumes in the UK. The data comes from the National Institute for Cardiovascular Outcomes Research (NICOR) report, published on the SCTS website, which looked at hospital performance between 2017 and 2020.

Royal Papworth leads in Transplant Survival Rates

Royal Papworth Hospital has some of the UK's best survival rates for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in November 2021.

The report identified that the national 30-day rate of survival following adult heart transplantation (risk-adjusted) was 91.4%, which ranged from 81.8% to 95.6% across centres (RPH 89.8%). The national 90-day survival rate (risk adjusted) was 88.3%, ranging from 77.2% to 91.5% across centres (RPH 87.5%). The national 1-year survival rate was 84.3%, ranging from 77.7% to 88.9% across centres (risk adjusted), RPH 85.6% risk-adjusted. The national 5-year survival rate was 70.0%, ranging from 63.3% to 79.1% across centres (RPH 79.1%) (risk-adjusted). At 5 years, there was some evidence of a significantly higher rate at Papworth in comparison to the national rate.

Whilst most rates were statistically consistent with the national rate of survival the report noted that Royal Papworth's survival rates were above the upper 99.8% confidence limits at five years, indicating significantly high survival from listing at that time point.

For lung transplant the 90-day post-transplant Papworth had a risk adjusted rate of 90.5%. This was statistically consistent with the national rate of survival which was 89.9% which ranged from 86.0% to 97.4%. The national risk-adjusted 1-year survival rate was 81.3%, ranging from 76.4% to 86.7% across centres (RPH 80.9%, with no significant outliers. The national 5-year survival rate was 56.2%, ranging from 31.0% to 62.8% across centres. The risk adjusted 5-year survival rate at Papworth was 60.7%.

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.

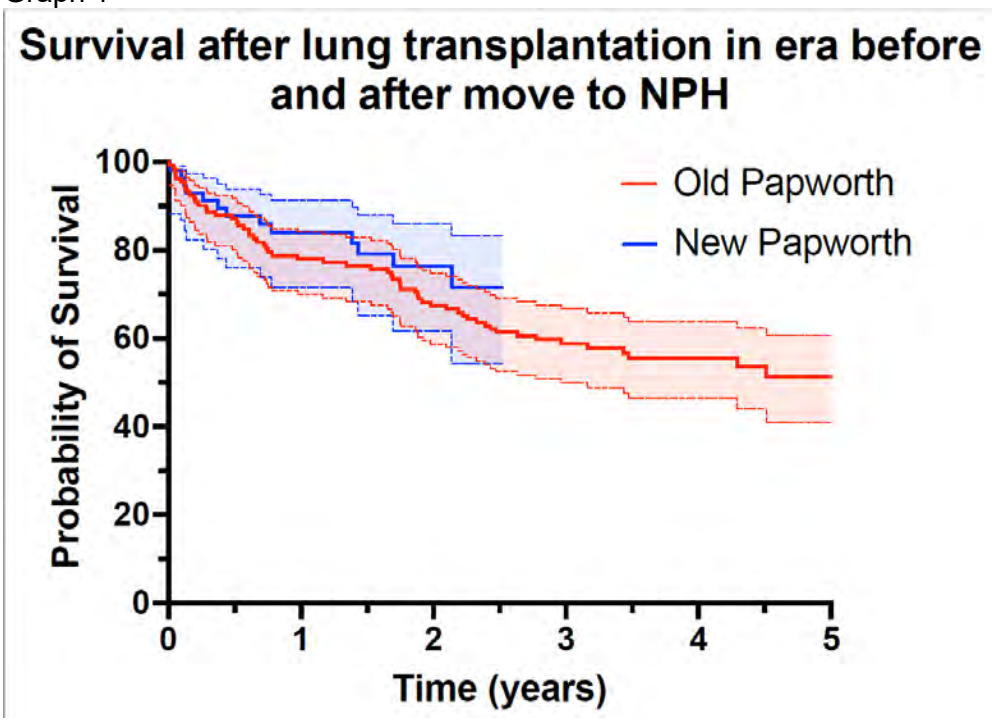
M. abscessus and lung transplantation outcomes

In response to the continued observation of new cases of M. abscessus clustering to the outbreak strain we have reviewed the outcome data for lung transplantation at RPH comparing the cases performed at the old hospital and the new hospital (Graph 1 below). There has been no deterioration in outcomes to date. We have also reviewed our outcome data compared to the UK returns and find that we remain with similar outcomes to the other main centres (Graph 2 below). Given the observation of M. abscessus in the lung transplant service, a fully informed and enhanced consent process is performed for all patients undergoing lung transplant and to date no patient has requested to have their surgery at another centre.

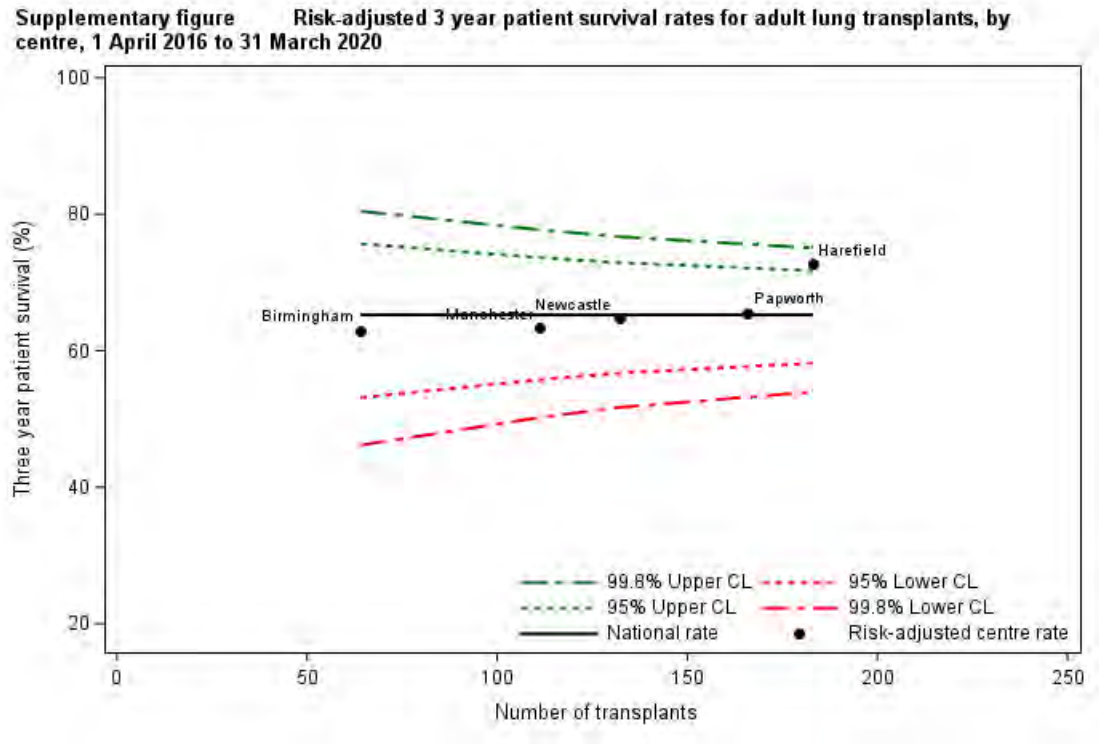
Consideration was also given to what other options would be open to any patient if Royal Papworth Hospital's transplant programme was put on hold. It was agreed that this would have a unsustainable impact on the four remaining centres; there would be a high likelihood that patients would not receive a transplant; and potential diminution of staff knowledge and expertise within the specialist field unless transferred to other units.

We will review the position on a 6 monthly basis and should either of these measures move beyond the confidence intervals we would undertake a further risk benefit analysis of the service with NHSBT.

Graph 1



Graph 2



Annual Report on Cardiothoracic Organ Transplantation 2020/2021, NHS Blood and Transplant November 2021

Respiratory Extra Corporeal Membrane Oxygenation (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. In 2021/22 the average length of time on ECMO Support was 44 days.

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. After a 2-year hiatus due to the global pandemic the Royal Papworth ECMO Course recommenced in November 2021. The multidisciplinary team has contributed to multiple scientific communications and articles published in the medical literature.

From December 2011, the service provided by RPH became part of the national network of services that provide a year-round ECMO service to all hospitals in the country. This includes the retrieval on ECMO of patients from the referring hospital by a dedicated highly specialised team. 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 the ECMO/CCA 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.

2021/22 has been a 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 with Severe Respiratory failure.

Due to this unprecedented demand on the National Service and a prolonged need for support, St Bartholomew’s Hospital (SBH) in London was recruited as a surge centre to support RPH. Seven 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.

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 April 2022 a survival of 58% 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 2022

Year	Referrals	Accepted	Supported with ECMO	ECMO bed days	Survival to discharge* (ECMO)	Survival to discharge* (all accepted)	30 day survival (ECMO)	30 day survival (all accepted)
Dec 2011/12	25	15	10	134	50%	66%	50%	66%
2012/13	111	28	22	443	68%	75%	64%	71%
2013/14	116	35	32	348	75%	77%	71%	71%
2014/15	152	40	37	490	76%	75%	76%	75%
2015/16	202	54	50	736	70%	70%	68%	68%
2016/17	149	36	35	406	86%	83%	83%	80%
2017/18	177	50	46	633	78%	78%	68%	62%
2018/19	201	54	54	959	76%	76%	76%	76%
2019/20	192	42	42	707	71%	69%	69%	69%
2020/21	1012	106	104	4063	64%**	64%**	63%	64%
2021/22	507	46	45	2162	61%**	63%**	61%**	63%

*discharge from Royal Papworth ** 1 inpatients

Royal Papworth (RPH) Critical Care Transfer Service

The Royal Papworth (RPH) Critical Care transfer service commenced on 4th January 2021 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 East of England Critical care Transfer Service commenced a service in December 2021 with RPH requested to support until 31 March 2022.

The RPH service provided 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 used an electronic referral and communication platform (Refer a Patient). From 1 April 2021, transfers were coordinated through the RPH CCA.

Between 1 April 2021 – 31 March 2022, the service safely transferred 174 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.

Royal Papworth Hospital has been commissioned to provide this surgery for the UK since 2000, and since 2001 has 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 continues to ensure the promotion of a freedom to speak up culture, building on the work developed by the Freedom to Speak Up Guardian (FTSUG) and the Trusts leadership team. Several initiatives across the year have been undertaken to support the Trust in becoming an open and transparent place to work and which enable staff to speak up safely and with confidence that their matters are taken seriously.

2021/2022 saw the increase in the number of Freedom to Speak Up (FTSU) champions, from a base of 16 to its current number of 26. This role continues to support the FTSU Guardian in:

- Raising the profile of speaking up on issues of concern
- Signposting staff on options for raising concerns in line with the Trusts Whistleblowing/Raising Concerns Policy
- Providing confidential advice and support to staff in relation to concerns staff may have about patient safety
- Providing confidential advice and support to staff in relation to the way their concerns have been handled
- Monitoring actions undertaken where staff identify a concern with trust processes.

Internal and external governance

The Trust is fully engaged with the National Guardian Office and support the Trusts FTSU Guardians engagement with local and regional networks of Guardians to enable the development of best practice.

Internal and external governance processes are established and oversee the reporting and monitoring of incidents raised through the Trusts FTSU Guardian. This involves:

- Independently reporting to the Board on frequency of incidents reported per quarter (numerical) as well as providing thematic narrative as categories of concerns reported for each period.
- Reporting quarterly to the FTSU National Office

- Independent anonymised incident scrutiny of quarterly submission data against national office categories
- Anonymised case review within FTSU champion trust business meetings to assist champion role and development (Bi-monthly)
- Quarterly FTSU champion business meetings
- Meeting regularly with executive and non-executive board directors

National trend comparators
The Trust has continued to enhance its position in the FTSU national index report which provides one of the indicators that help build a picture of what a speaking up culture feels like for workers (Dr H Hughes, National Guardian for the NHS, 2021/22). This provides a metric drawn from four questions taken from the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident. It is pleasing to report a continued upward trajectory in comparison to the previous year in relation to its national position as well as in relation to Q18f which were analysed by ethnicity; % of staff "agreeing" or "strongly agreeing" that they feel safe to speak up about anything that concerns them in their organisation". The national index continues to show a strong correlation with CQC ratings.

The Trust came 46th out 218 (up from 59th) with a score of 82.1% (up from 80.7). Against the Q18F section, the Trust compares well against the national mean of 65.6% (The Trust – 68.2%).

Although recognising progress, there is still work to do. The investment and increase in the number of FTSU Champions and the establishment of the role of the FTSU Guardian will continue to improve the drive for a more open and transparent place to work.

Actions going forward 2022/23
The Whistle-blowing procedure (Raising Issues of Concern) is to be reviewed during 2022/23 in line with the Trusts quality monitoring procedures. This provides guidance to staff on how they can raise any matters of concern which may affect them adversely on the safety and/or well-being of our patients/our staff or the public at large or which may be detrimental to the Trust as a whole. Our whistle-blowing policy is consistent with *Freedom to Speak Up* Report published by Sir Robert Francis QC.

All concerns raised are treated seriously and investigated thoroughly. Efforts are made to ensure reporting remain confidential and feedback provided to those reporting issues/concerns. All staff have the right to contact the Freedom to Speak Up Guardian and/or other senior officers of the Trust as listed in the procedure.

The work to promote the role of the FTSU Guardian, supported by FTSU Champions continues in to 2022/23. This includes regular engagement with staff through such activities and within both Trust sites; Trust walkabouts, drop in/by clinics; attendance at clinical and non-clinical business meetings; membership of Trust network forums; meeting new staff during Trust inductions and promoting the role and the action of speaking up in staff development programmes.

In 2021/22 the FTSU Guardian reported 105 concerns, an increase from 84 (2020/21). Although changes to the way National Covid pandemic strategies appeared during this period, staffing establishments to support clinical services across the country was proving challenging. The context was not dissimilar for the Trust. The nature of reporting reflects the workload pressures alongside leadership challenges where at times this was demonstrated through non compassionate styles adopted.

Bullying, harassment and methods of leadership provided the core themes across the reporting cycles for 2021/22. More particularly, and indicative of WRES reporting also, staff from a black, ethnic and minority background experienced these more frequently than their

non-BAME colleagues. This has informed several of the initiatives currently being undertaken by the Trust and which are supported and endorsed by the FTSU Guardian.

The coming year's actions will also accommodate a review of the FTSU strategy and roll-out further learning as proposed by the national guardian office that of the e-learning modules, developed with Health Education England, Speak *Up; Listen Up; Follow 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.

During 2021/22 we implemented the second phase of our Compassionate and Collective Leadership Programme to continue to progress our journey to build a high-quality care culture. We launched our revised Trust values in July 2021 which reflect the feedback from staff on what mattered to them, and to our patients. These are:

Compassion

Recognises and responds to the needs of patients and colleagues

Excellence

Makes a difference with each small improvement and by being open to new ways of working

Collaboration

We achieve more together

Our values are underpinned by a behaviour framework that guides staff on how we can ensure that all staff have a positive experience at work. All staff are expected to participate in a Values and Behaviours Workshop which encourages them to reflect on how they role model and promote the values and behaviours and helps them develop practical skills in giving and receiving feedback.

We have also launched our Compassionate and Collective Line Managers Development Programme which will improve the skills and confidence of line managers to be compassionate and inclusive leaders. We continue to work with system partners, on a range of priorities for example, Anti-Racism Strategy, development of apprenticeship opportunities and engagement with schools and colleges on work experience programmes and promoting the NHS as an employer of choice and systemwide workforce planning.

Further information on our Compassionate and Collective programme is included in our Quality Priorities 2021/22 and 2022/23.

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

Throughout 2021/22 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-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	80.00%	83.55%	86.73%	86.26%	86.95%	86.13%	85.99%	86.54%	85.38%	84.25%	81.32%	79.62%	79.62%
62 day cancer wait *	>85%	75.00%	63.60%	78.60%	100.00%	38.50%	50.00%	66.70%	46.20%	54.50%	42.90%	57.10%	50.00%	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%	86.91%	87.09%	94.29%	92.21%	90.78%	96.03%	97.32%	97.86%	97.93%	93.04%	96.68%	97.20%	93.94%
Monitoring C.Diff (toxin positive)	Less than 8	1	2	2	2	1	1	0	1	0	0	1	1	12
Number of patients assessed for VTE on admission**	>95%	93.30%	96.60%	86.10%	85.00%	80.40%	85.20%	84.10%	86.00%	82.90%	83.10%	83.20%	87.40%	87.40%

In 2021/22 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 2022).
**In 2021/22 the reporting of VTE risk assessment has been revised to follow the national data census approach rather than an audit of a sample number of case notes.

A listening organisation

What our patients say about us

2021 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 2021 results demonstrated:

- 63% of patients who were invited to take part completed the inpatient survey in 2021
- Royal Papworth response rate compared favourably, benchmarked against an average of 39% for other organisations
- Royal Papworth's overall positive patient experience score remains in the top quartile when compared to other Trusts

The top 5 scoring questions were in respect to

- Upholding patients' privacy and dignity
- Ability to achieve a good quality of sleep
- Flexible availability of meals
- Quality of meals
- Length of time waiting for a ward bed

At the time of publishing this Quality Account the full Adult Inpatient survey results were embargoed awaiting publication by the CQC, however the full results of for 2021 will be available in due course on the CQC website.

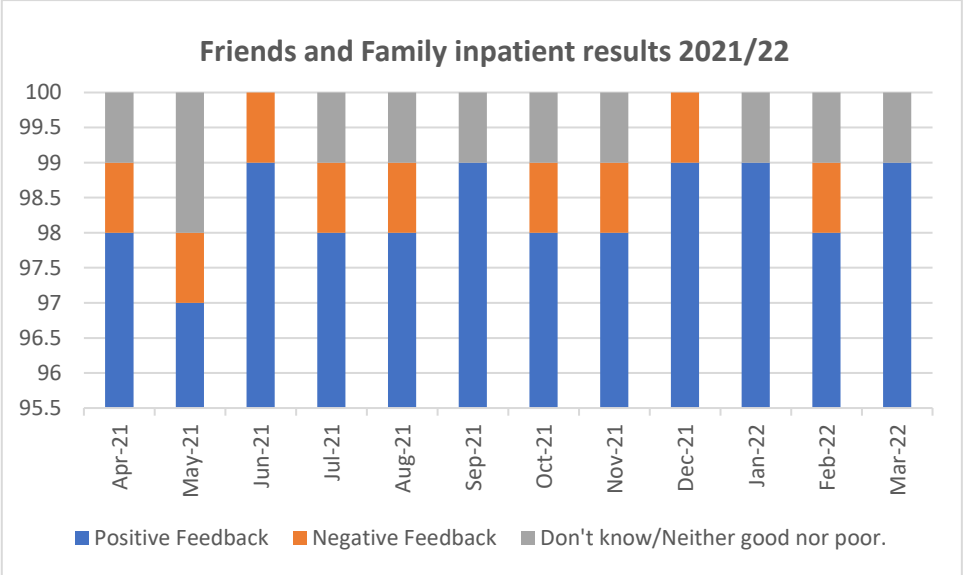
NHS "Friends and Family" test to improve patient experience and care in hospital

Since December 2020, the Trust updated the Friends and Family test questions 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 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.

At Royal Papworth Hospital NHS Foundation Trust, the responses are reviewed by the Trusts Matrons who receive a weekly report that details the number of patients who have participated in the survey and the recommendation scores. Alongside this they review all the free text feedback from patients noting and celebrating with their teams the compliments received. For any negative comments left these are reviewed and actions and improvement made, using the Wards '*You said - We did*' display boards to keep patients updated on how their feedback matters and what improvement have been made.

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



Detail of the Friends and Family Performance for 2021/22 is in include in the summary of performance against 2021/22 Priority 4: Communications – to improve patient experience at RPH.

Patient Support Groups

Royal Papworth has several patient support groups for patients which includes:

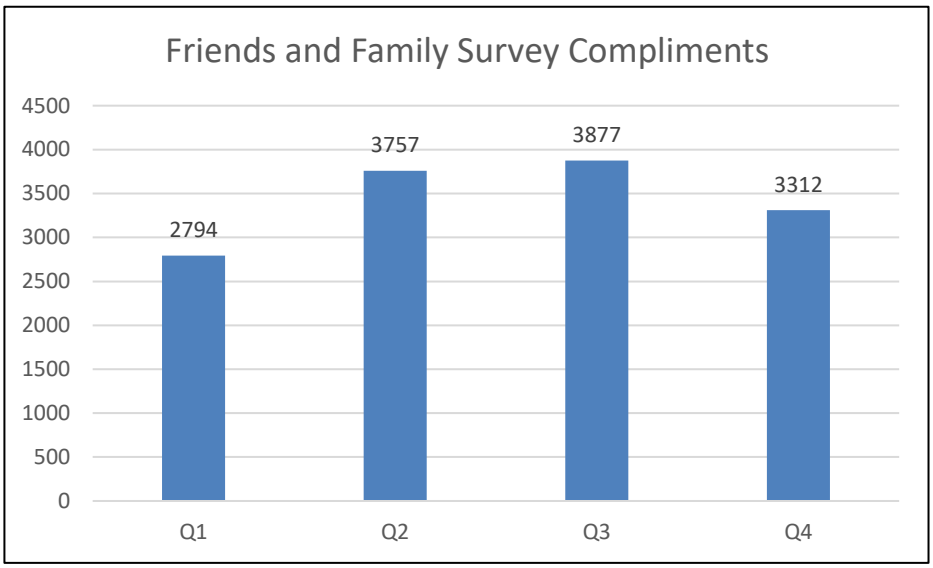
- The Mesothelioma Social Group
- Royal Papworth Pulmonary Hypertension Patient Support Group
- The Royal Papworth Pulmonary Fibrosis Support Group
- The Transplant Patient Support Group

Our website provides links to these and a wide range of independent organisations and groups offering advice and support to patients, families and carers. Details of these are available at: Patient support groups :: Royal Papworth Hospital

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.

In 2021/22 a total of 13740 positive feedback was recorded through the Friends and Family Survey. A breakdown of the number received per quarter is shown below, due to the change in process and the high volumes received these are no longer categorised by themes.



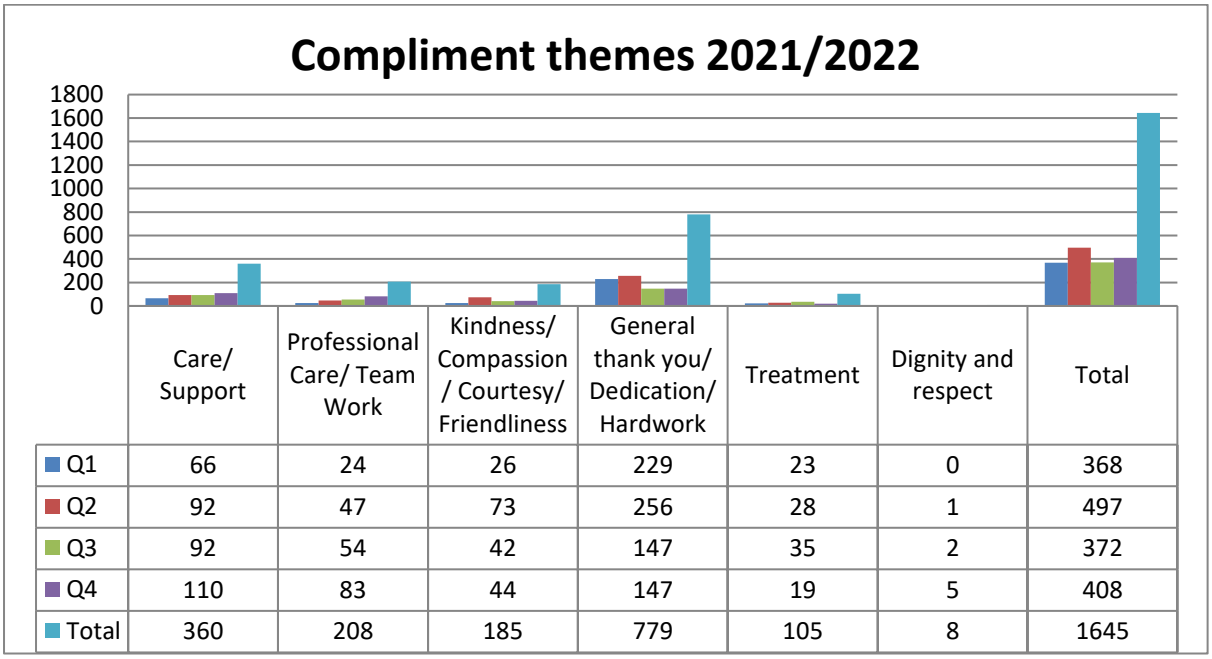
Examples of positive feedback received.

- *"A very big thank you for all your patience, kindness and care".*
- *"Words cannot express our gratitude, for the excellent, kind, caring and friendly treatment".*
- *"We have been so impressed and grateful for the exemplary care you have given. You made such an incredible impact on our lives through your dedication and care".*

During 2021/22 a total of 1645 compliments across the Trust were received through the PALS team. 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, hard work of staff
- Care and support provided
- Professional care provided and teamwork of staff across the Trust.



	Care/ Support	Professional Care/ Team Work	Kindness/ Compassion / Courtesy/ Friendliness	General thank you/ Dedication/ Hardwork	Treatment	Dignity and respect	Total
Q1	66	24	26	229	23	0	368
Q2	92	47	73	256	28	1	497
Q3	92	54	42	147	35	2	372
Q4	110	83	44	147	19	5	408
Total	360	208	185	779	105	8	1645

What our staff say about us

Staff Survey 2021

NHSI's requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2021 and these were included in the Staff Report section of the Annual Report.

Valuing Volunteers

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.

We were successful as a Trust to bid for and receive in Autumn of 2021 funding through the NHS England and Improvement Volunteering Services. As a part of this funding, we were able to employee a volunteer co-ordinator to be able to support the Trusts volunteer recovery programme over the winter period.

With this additional role we have been able to support the PALS Team to be able to maintain contact with all volunteers via email throughout the pandemic and together they are working to ensure volunteers can return to the organisation safely. We have developed and refreshed 5 new and existing roles within the Trust that volunteers can start to return to once all mandatory training and other risk assessments have been completed.

During December 2021, with the support of our additional volunteer coordinator post, we were able to recruit and return some of our existing volunteers to support the Trusts Covid Booster campaign programme in line with the NHS response. These volunteers were a core part of the success of the running of the vaccination hub.

Throughout the year we have had a small team of volunteers working in the Trust and the hours that all volunteers have worked are detailed in the below table. We had a total of 1974 worked by our volunteer workforce.

We currently have 36 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.

We have also procured the Better Impact database and with the additional capacity of the volunteer coordinator, employed through this project, we have been able to scope, update and implement a full refresh off all our volunteers' forms/policies and processes. We are now in the process of adding our volunteer data and training our PALS staff on the new system.

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 Clinical Commissioning Group (CCG) has reviewed the Quality Account produced by Royal Papworth Hospital (RPH) for 2021/22.

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 following the Covid19 pandemic.

The Quality Account is transparent to all and demonstrates the excellent work that the organisation has carried out during another 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 in 21/22 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 during the planned recovery phase following 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. Quality Improvement strategy time frames have been extended by the Trust in recognition of significant volume of work required and the need to ensure balance and restoration following the pandemic. Key area of Quality focus in 22/23 is aligned to the implementation of Patient Safety and Incident Response Framework (PSIRF).

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 has maintained high levels of MRSA decolonisation among patients, with high standards of practice ensuring that no patient was identified with MRSA bacteraemia. The trust is responsive, timely and thorough with investigations of any infection by the wider infection control team and in reporting them to the CCG. The Trust are closely monitoring Mycobacterium Abscessus and have implemented an executive oversight group to monitor and investigate identifiable causes.

RPH have maintained the 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 21/22 with the quality ambitions; Safe; Effective and Responsive and Patient Experience being at the core of care delivery. Further commitment to leadership has been demonstrated through phase 2 implementation of the Compassion and Collective Leadership Programme.

The CCG would like to commend RPH on all their success stories including the patient stories presented, care of patients with dementia, learning disability and cardiac and transplant survival rates.

The CCG would like to thank all 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 2021/22.

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

27 June 2022

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru | Welsh Health Specialised Services Committee

Welsh Health Specialised Services Committee commission services from Papworth on behalf of the seven Welsh Health Boards. We welcome the opportunity to contribute to the report and congratulate Trust on the hard work that has been undertaken not only to maintain the delivery of a significant volume of core workload alongside the response to the COVID19 pandemic but also the planned recovery of services that is in place. WHSSC is committed to commissioning high-quality, safe, and effective care from our providers and this report demonstrates the commitment that Papworth have in working worth ourselves in achieving that goal.

Carole Bell
Cyfarwyddwr Nyrsio ac Ansawdd
Director of Nursing and Quality Assurance

17 June 2022

Healthwatch Cambridgeshire and Peterborough

Royal Papworth Hospital Quality Account Statement 2021/22

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 care for patients and staff.

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

We acknowledge the continuing efforts and dedication of teams working across the Trust during and after the Covid-19 pandemic and note the significant role the Trust played in the provision of ECMO support (Extra Corporeal Membrane Oxygenator).
The Trust has continued to build upon providing positive mental and physical 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 attend Trust Board meetings.

In the past year we are pleased to have seen improvements made for people with additional communications needs. The introduction of Sign Live, June 2022 will provide welcome support to the deaf community.

The eventual rollout 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.
The planned strategy for vulnerable patients including Dementia, Learning Difficulties, Autism, and those with acute mental health problems will help improve patient care with special requirements.

We support Partnership working and strategy development with local ICS on health inequalities.

The introduction of delayed technology improvement for drug prescriptions between Lorenzo and the pharmacy stock control system will reduce the risk of errors, support clinical effectiveness and improve patient safety.

The planned working with ICS partners towards development and implementation of a Shared Health and Care Record (SHCR) to enable system wide care should improve patient experience. It will reduce the need for people to continually explain to health care providers their medical history.

The coming year

We look forward to continuing our positive relationship with the Trust over the next year and welcome their contributions toward the developing Integrated Care System for Cambridgeshire and Peterborough.

8 June 2022

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

For the second year running, the ongoing Covid pandemic meant that Governor activities were extremely limited as access to the hospital was not possible. This is where virtual meetings came to the rescue and after a rapid learning phase for both old and new public Governors committee meetings continued using 'Teams'. We also welcomed new staff and appointed Governors and their input has been most welcome.

We sadly lost two Public Governors, both representing the Rest of England, during the year – Janet Atkins had been both Governor and Volunteer for some years and David Gibbs was one of our newer Governors. One Staff Governor resigned on taking up a post at another hospital and one Appointed Governor on losing her seat on the County Council. Two other Governors resigned during the year for personal reasons.

The excellent NHS Providers Induction programme provided a valuable introduction to new Governors on their role and especially their relationship to the Board and the NEDs (Non-Executive Directors).

It was encouraging that Governor attendance at the monthly Board meetings increased with up to 10 Governors observing the Part 1 proceedings.

Governors chaired the PPI (Patient & Public Involvement), Forward Planning, Access and Facilities and Appointments committees. Other Governors sat on these committees and also observed/participated in Q&R (Quality & Risk), Performance, Nominations, Governor's Assurance, Audit, Fundraising, End of Life, Emergency Preparedness, Digital Strategy Board, PCEG (Patient and Carer Experience Group) and the Ethics committee.

Dr Richard Hodder
Lead Governor
6 June 2022

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 2021/22 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:

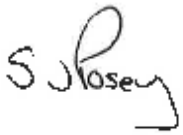
  - Board minutes and papers for the period April 2021 to 9 June 2022
  - Papers relating to quality reported to the Board over the period April 2021 to 9 June 2022
  - Feedback from Cambridge and Peterborough Clinical Commissioning Group which incorporates feedback from NHS Specialised Commissioning East of England dated 27 June 2022 (added pre-publication)
  - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated 6 June 2022
  - Feedback from Healthwatch Cambridgeshire dated 8 June 2022
  - Feedback from Cambridgeshire Health Committee (*feedback awaited*)
  - The Trust's "Quality and Risk Report: Quarter 4 and annual Summary 2021/22"
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2021 National Inpatient Survey
  - The 2021 National Staff Survey
  - The Trust's Annual Governance Statement 2021/22
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated 07 June 2022
  - 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: 20 June 2022 Chairman



Date: 20 June 2022 Chief Executive

Annex 3: 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 4 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

LearnZone	An internal e-Learning platform for Royal Papworth Hospital staff
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.
NEWS2	National Early Warning Score (version 2) – a nationally used early warning score designed to help detect and respond to clinical deterioration in adult patients.
NHS Improvement (NHSI)	NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHSI offers the support these providers need to give patients consistently safe, high-quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHSI help the NHS to meet its short-term challenges and secure its future. From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together: • Monitor • NHS Trust Development Authority • Patient Safety, including the National Reporting and Learning System • Advancing Change Team • Intensive Support Teams NHSI builds on the best of what these organisations did, but with a change of emphasis. Its priority is to offer support to providers and local health systems to help them improve.
NHS Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. From July 2012 data collected using the NHS Safety Thermometer is part of the Commissioning for Quality and Innovation (CQUIN) payment programme.
NHS number	A 10 digit number that is unique to an individual. It can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NMC	Nursing and Midwifery Council
NSTEMI	Non-ST-elevation myocardial infarction
P	
PALS	The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Patient and Public Involvement Committee (PPI)	**A Committee of the Council of Governors that provides oversight and assurance on patient and public involvement.**
PEA (formally PTE)	Pulmonary Thromboendarterectomy or Pulmonary Endarterectomy.
PHE	Public Health England
PLACE	Patient-led assessments of the care environment (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013.
Pressure ulcer (PU)	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Percutaneous coronary intervention (PCI)	The term percutaneous coronary intervention (sometimes called angioplasty or stenting) describes a range of procedures that treat narrowing or blockages in coronary arteries supplying blood to the heart.
Primary percutaneous coronary intervention (PPCI)	As above, but the procedure is urgent and the patient is admitted to hospital by ambulance as an emergency.
Priorities for improvement	There is a national requirement for trusts to select three to five priorities for quality improvement each year. These must reflect the three key areas of patient safety, patient experience and clinical effectiveness.

Q

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

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 behaviour, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.
Royal Papworth Hospital or Royal Papworth	**Royal Papworth Hospital NHS Foundation Trust.**

S

Safeguarding	Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.
SDTIs	Suspected deep tissue injuries
Serious incidents (SIs)	There is no definitive list of events/incidents that constitute a serious incident but they are incidents requiring investigation. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Sign up to Safety	A national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of Sign up to Safety is the philosophy of locally-led, self-directed safety improvement.
Systematic Inflammatory Response Syndrome (SIRS)	An inflammatory state affecting the whole body, frequently a response of the immune system to ischemia, inflammation, trauma, infection, or several insults combined.

U

UNIFY (Now NHS 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

WDES	NHS Workforce Disability Equality Standard
WRES	NHS Workforce Race Equality Standard

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