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Royal Papworth Hospital

NHS Foundation Trust

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Royal Papworth Hospital NHS Foundation Trust

Quality Report 2023 / 2024

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Quality Accounts Report 2023/24

Contents

The Quality Account Annual Report

The quality account is an annual report published by providers of NHS healthcare about the quality of the services they provide. The report includes details of progress and achievements against the Trust's quality and safety priorities for the previous year and describes what the Trust will focus on in the year to come.

What should a quality account look like?

Some parts of the quality account are mandatory and set out in accordance with the NHS (quality Account) Regulations 2010 and Department of health- Quality accounts Toolkit 2010/2011.

The toolkit can be accessed via www.gov.uk/government/news/quality-accounts-toolkit.

The Quality Account must include:

Part one

- A statement from the trust board (or equivalent) summarising the quality of the NHS services provided

Part two

- A series of statements from the board, the format and content of which are prescribed in the regulations and toolkit.
- A review of Trust performance against the Quality Improvement Priorities for 2023/24 priorities

Part three

- A review of the Trust's 2023/24 performance presented against the 3 domains of patient safety, clinical effectiveness, and patient experience.

Part four

- A series of statements from stakeholders on the content of the Quality Account

Additional sections and information may be added; however, the Quality Account must have an introduction, a review of the previous year's performance, and a look forward at the priorities for the coming financial year.

Introduction

Welcome to Royal Papworth NHS Foundation Trust's Quality Account. We would like to thank everyone who contributed to our Quality Report and hope that you enjoy reading about the Trust and how it has performed in 2023/24 against the priorities set within the 2022/23 account.

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 2023/24.

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

Royal Papworth Hospital NHS Foundation Trust ("Royal Papworth Hospital" or "the Trust") is the UK's largest specialist cardiothoracic hospital and the country's main heart and lung transplant centre. We have an extraordinary commitment to delivering the highest levels of clinical quality and outcomes and for providing the best possible standards of personalised care to our patients. Royal Papworth Hospital was one of the first foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003 and came into existence in July 2004 as Papworth Hospital NHS Foundation Trust. Since then, it has been licenced by the Regulator (previously named Monitor, now NHS England). From 2018 we became Royal Papworth Hospital NHS Foundation Trust.

Whilst Royal Papworth Hospital is a regional centre for the diagnosis and treatment of cardiothoracic disease, it is also a national centre for a range of specialist services, including heart and lung transplantation, pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.

Royal Papworth Hospital is located on the Cambridge Biomedical Campus and offers cutting edge facilities for patients requiring heart and lung treatment in a bespoke building.

The facilities include:

- 290 beds, with virtually all being single rooms
- 36 commissioned-bedded Critical Care Area comprising of level 2 and level 3 beds.
- 6 state-of-the-art theatres • 5 Catheter Laboratories
- 6 inpatient wards and a 24-bed day ward including 4 coronary care beds
- A centrally located outpatient unit
- State-of-the-art imaging and diagnostic service

Information about the hospital can be found on the Trust's website: https://royalpapworth.nhs.uk.

Part 1 - Statement on quality from the Chief Executive

At Royal Papworth Hospital NHS Foundation Trust, our mission is to provide excellent, specialist care to patients suffering from heart and lung diseases, a mission underpinned by an ambition to be to the forefront of innovation, research and education. The word 'care' is critical in this statement – it is not just about treating people from the communities we serve but caring for them and their families throughout their treatment too. To be able to achieve this mission our care must be safe, effective and of the highest quality.

This Quality Account provides a summary of the quality of our services throughout 2023/24. Below I summarise some of the successes, improvements, and areas of priority focus for the year ahead.

We continue to be the UK's largest and leading centre for adult cardiothoracic transplants, carrying out more heart, lung, and heart-lung transplants than any other centre, with the shortest waiting times and the best outcomes.

According to the most recent NHS Blood and Transplant reports[1], we have the shortest waiting times for both heart transplantation and lung transplantation; patients at Royal Papworth Hospital get their heart or lung transplant far sooner than at any other hospital. We also have the best survival rate for patients one year after their heart transplant.

Other successes include our robotic thoracic surgery programme which launched in April 2023. Following an intense period of training for our theatre teams, the first patient was treated in May, and more than 100 people have now benefited from minimally invasive robotic surgery, improving outcomes, and reducing length of stay in hospital.

Our cardiology team continue to innovate with new treatments which are improving safety and quality for our patients. One example of this is our new laser procedure, excimer laser coronary atherectomy (ELCA), a minimally invasive way of cleaning and expanding stents which have narrowed over time. This means patients can avoid the need for heart bypass surgery, again reducing length of stay in hospital and improving quality of life.

Research trials are continuing to explore ways to better find, diagnose and treat heart and lung diseases. Our new research and development team is playing a pivotal role in trials focused on a new treatment for the lung condition sarcoidosis, early detection of lung cancer and much more in cardiovascular, respiratory and sleep medicine.

Staff engagement and morale is crucially important to maintain the highest quality of care. We have seen improvements in our vacancy rate, turnover, and NHS Staff Survey scores in 2023/24. Though there is work still to do, it has been pleasing to see this progress which helps to make our hospital safer for our patients.
Another way we make our hospital safer is through staff mandatory training and there have been two new training modules launched this year. One is focused on the Patient Safety Incident Response Framework (PSIRF) which has replaced the Serious Incident Framework. This represents a significant change in the way the NHS responds to patient safety incidents, focused on compassionate engagement, considered and proportionate responses to incidents and better supporting staff and patients through the process. The other is the Oliver McGowan Mandatory Training on Learning Disability and Autism, which aims to save lives by ensuring health and social care workers have the skills and knowledge to provide safe and compassionate care to people who are autistic and people with a learning disability.

[1] https://www.odt.nhs.uk/statistics-and-reports/organ-specific-reports/

Additionally, the Trust is considering the process for implementation of Martha's rule Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition.

Tackling the waiting list and backlog of appointments, procedures and operations remains the national focus. At Royal Papworth Hospital we have focused on treating our most urgent patients and those waiting the longest. We know that waiting for treatment, particularly for heart and lung conditions, can have a significant impact on people's physical and mental health. Being more unwell when they are then treated also then can impact the quality of their outcome. Continued industrial action has limited the amount of planned activity we have been able to do, but we are determined to constantly support our patients who are on our waiting lists. We hope to see a resolution to the consultant and junior doctor strikes as soon as possible.

The incidents of post-operative surgical site infections (SSI) have also improved, though our rates remain above the national benchmark set by the UK Health Security Agency. Our chief nurse – who is also the director of infection prevention and control – continues to expertly lead our teams to work together in new ways to bring the rates down. These improvements are continuously monitored, reviewed, and discussed by the Boad of Directors.

We have continued to see very low numbers of patients acquiring Mycobacterium abscessus, which is reassuring that our mitigations and the way staff are looking after these patients remain effective.

Recruitment and retention, hospital-acquired infections, and our waiting lists will continue to be a focus for us in the next 12 months to ensure we can continue to offer the highest quality care and the best outcomes for the patients we treat. Excellence in research and innovation will remain a priority, as will working closely with our partners in the Cambridgeshire and Peterborough Integrated Care Board, East of England region and nationally.

The information and data contained within this report have been subject to internal review and challenge 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 in 2023/24.

Eilish Midlane
Chief Executive Officer
18 April 2024

Trust vision, strategic aims, and values

Our Vision → **Bringing tomorrow's treatment to today's patients**

Which we deliver through...

Our Strategic Aims

Deliver clinical excellence We will build on our world-leading outcomes, investing effort and resources in developing and implementing innovative services and models of care, growing expertise and extending the frontiers of clinical practice.	**Grow pathways with partners** We will seek to develop services with partners and patients in local, regional, national, and international networks so that our specialist expertise can be accessed easily and where we can best add value to the patient's treatment
Offer a positive staff experience We will seek to offer the best staff experience in the NHS, enabling staff to fulfil their potential by providing a working environment where they can feel valued for what they bring to the Trust, achieve a work life balance and feel engaged in their work.	**Share and educate** We will establish a Royal Papworth School, enabling us to grow and develop not only our own staff but also share our expertise and learning for the benefit of national and international networks as well as our local stakeholders.
Research and innovate We will continue to develop the Trust as a centre for research and development, fully nurturing our expertise and creativity in a structured way for the benefit of patients.	**Achieve sustainability** We will establish a sustainable operational and financial position to ensure that we are making the most of Royal Papworth and applying all our resources in the most effective and efficient manner.

Our Trust Values

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

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

2.1 Priorities for improvement

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

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2024/25 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 2023/24 priorities

Our 2022/23 Quality Report set out our quality priorities for 2023/24 under the quality domains of patient safety, effectiveness, responsiveness and well led. See our 2022/23 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 2023/24. The tables below demonstrate achievements against the 2023/24 Goals.

Priority 1: Implementation of the Patient Safety Incident Response Framework

Priority 2: Increased action on prevention of health inequalities

Priority 3: Safe: Harm free care – Venous thromboembolism (VTE), Pressure Ulcers and falls

Priority 4: Reduce Surgical Site Infections

Priority 5: Improve Resourcing and Retention

Quality Account 2023/24 Priority 1

Objective: Implementation of the Patient Safety Incident Response Framework Executive Lead: Maura Screaton, Chief Nurse

To support the NHS to further improve patient safety, a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

Objectives 2023/24	Baseline position for April 2023	How will this be measured?	2023/24 Progress:
Complete the year one Implementation plan for the Patient Safety Incident Response Framework (PSIRF)	PSIRF Orientation stage (month 1-3) is at final stage of completion. Aiming to finalise in April 2023	Completion of the 12-month part of transition plan: • PSIRF Orientation (Months 1-3) • Diagnostic and discovery (Months 4-7) • Governance & quality monitoring (Months 6-9) • Patient safety incident response planning (Months 7-10) • Curation and agreement of the policy and plan (Months 9-12) • Transition (12 months +)	PSIRF went live at Royal Papworth on 1 January 2024 as per plan. We transitioned from the National Reporting and Learning Service to Learning from Patient Safety Events on 31 March 24. Our PSIRF Policy and the PSIRF Annual Plan for Jan 24-Mar 25 were published August 23.
Recruit Patient Safety Partners (PSPs) to be part of the governance structure as part of the PSIRF implementation in the Trust.	No PSPs currently recruited. In 22/23 we started the implementation plan; this was delayed as we required additional resource to support the implementation. Patient Safety Lead post started in Q4 and project support to start in Q1 23/24.	• Finalisation of role profile for PSPs in line with the national profile and joint ICS approach of these roles. • Recruitment of two PSPs for PSIRF. • PSPs to be part of governance and patient safety programmes of work by end 23/24. • Set up of a support and supervision system for the new roles.	Patient Safety Partner Procedure published 30 November 2023 outlining the role, objectives & expectations of the PSP role. Informal interviews for role of PSP arranged for April 2024.
Implement new patient safety mandatory training for all staff - level 1 and clinical staff and operational leads level 2.	No current training in place.	Implementation of the PSIRF required training: • **Level 1a:** Essentials of patient safety for all staff. • **Level 1b:** Essentials of patient safety for Board and Senior Leadership teams • **Level 2**: Access to Practice for all staff with a registration to practice, and managerial staff who will manage and support patient safety.	Mandatory national Patient Safety Syllabus Levels 1 and 2 via ESR commenced on 1st July 23. As of the 31/03/2024, we had a Trust compliance of Level 1 - 1718/2155 = **81%** and Level 2 - 1182/1830 = **66%** Compliance trajectory targets for 100% by July 2024.

Quality Account 2023/24 Priority 2

Objective: Increased action on prevention of health inequalities **Executive Lead: Dr Ian Smith, Medical Director**

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 2023/24	Baseline position for April 2023	How can this be measured?	2024/25 Progress
To participate in the new reviewed Equality Delivery System 2 for 23/24 This includes system changes and considers the new system architecture and through collaboration and co-production and taking into account the impact of COVID-19, the EDS has been updated and EDS 2022.	The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The Trust took part in this EDS2 annual review prior to the pandemic.	Completion of the EDS2 for 23/24 and graded and reported on to board. The EDS2 self-assessment comprises 4 stages: • Better Health Outcomes (1.1-1.5) • Improved Patient Access and Experience (2.1-2.4) • A representative and supported workforce (3.1-3.6) • Inclusive Leadership (4.1-4.3)	The EDS self-assessment and action plan was submitted and approved at Board in Jan 2024. Actions monitored via the EDI Steering Group.
We will redesign our inpatient services and increase the support we offer to people who are admitted to or attend Royal Papworth Hospital to help them to stop smoking, to reduce harm from tobacco and be smoke free during an inpatient admission. We will provide tobacco treatment advice and support to individuals and groups of people, who want to stop smoking, reduce their harm from tobacco or for temporary abstinence when in hospital.	The NHS Long Term Plan gives a commitment that all patients admitted to hospital that currently smoke cigarettes will be offered NHS-funded tobacco dependence treatment services by the end of 2023/24. This is currently not in place.	We will embed our new Health Inequalities Specialist role within our services to support this programme of work. Post holder due to start in June 2023.	Health Inequalities Specialist and Tobacco Advisor appointed on fixed term post until Sept 24. Additional investment will be scoped during 2024 for continuation for service.
		We will develop the service model, data flows and logistics within the organisation needed to achieve the commitment of all inpatient smokers at RPH being able to access dependency treatment serviced by March 2024.	Acute Inpatient Smokefree pathway in place with digital referral service fully established on all inpatient wards. Patients are referred to participating pharmacies for twelve weeks behavioural support and Nicotine replacement Therapy. Ongoing provision of on-line staff training and awareness on nicotine replacement products in place. Regular Trust representation at monthly regional meetings. Data sharing agreement between Royal Papworth and Health You (C&P local stop smoking organisation) in place.

Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/25 Progress
		We will monitor the uptake of the number of patients who engage with the tobacco dependency program	Data is evaluated against ICS metrics to monitor changes in smoking prevalence amongst patients and submitted to the ICS. The programme's success rate at Royal Papworth may be attributable to the compounding impact of the life event leading to their admission for care.

Quality Account 2023/24 Priority 3

Objective: To review our Harm free care process for Venous thromboembolism (VTE), Pressure Ulcers (PU) and falls

Executive Lead: Maura Screaton, Chief Nurse

Harm free care: VTE, PU and falls - linked to performance and required oversight and for focus on harm free care charting and trends.

Harm Free Care Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
Launch a Harm Free Care Panel (HFCP) that will have oversight of the Trust Quality Improvements required for Falls, VTE, Pressure Ulcers and Diabetes	No current panel in place	• Scope and launch a Harm Free Care panel that reports into QRMG. • Clear Governance Structure to support the Trust wide improvement for these 3 areas of harm free care.	Harm Free Care Panel established and embedded with clear governance structure in place.

FALLS Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
Re-establish a Falls Prevention group with multi-professional membership to strengthen trust wide learning from patient falls - focus will be on prevention of future harm and improvement.	• Previous prevention group was suspended during the pandemic and remains so. • Falls monitored monthly on PIPR and reported quarterly as part of quality report to QRMG/Q&R	• Group re-established with updated terms of reference and membership agreed and overseen by Harm Free Care panel reporting into QRMG. • Key Performance Indicators agreed for the year 23/24. • Progress of actions and learning from investigations monitored with quarterly reporting to QRMG	Falls Prevention & Management group established and embedded with clear governance structure in place. Medical Lead for Falls group identified.
Completion of the revision of the review of the existing falls and prevention Policy, with focus on the two main areas: • Prevention of Patient Falls. • Management of a Patient Following a Fall.	Current review of Falls Policy underway by Falls Task and Finish Group.	• Patient prevention and Falls Policy completed, approved, and launched. • Included in the policy compliance against policy as clear KPI's for the annual Falls audit. • Audit/Actions Plans monitored by Falls Prevention Group.	Falls Management and Prevention Policy reviewed and published in September 23 with new criteria for 23/24 falls audit added. Audit completed for 23/24.
Review trauma Pathway following a patients fall - Options appraisal of the resources and training	• Falls Task and Finish group set up in 22/23 has been reviewing current policy/Trauma process.	• Options appraisal completed and reported on to QRMG and onwards to Q&R.	Trauma pathway agreed within revised Falls Management and Prevention policy.

FALLS Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
requirements needed to undertake imaging of trauma patients at Royal Papworth Hospital	• Options appraisal currently being scoped	• As agreed, any new pathways (as required) to be further implemented in 23/24. • To work with our partner Acute hospital on the Bio-campus site (as required) for any new pathways, to support streamlines of care following a fall, with suspected trauma.	Ongoing cross campus work to take actions forward within Harm Free Care.

Pressure Ulcers Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
Promote Equality and Diversity in Pressure Ulcer Management –	This is not in place at RPH currently.	There is a growing UK wide evidence base recognising a lack of capability in recognising early onset and depth of pressure ulcer injury in BAME patients which increases the risk of deeper pressure ulcer development due to late recognition of skin injury. • Introduce a 'Darkly Pigmented Skin PU Assessment' programme of education	Darkly Pigmented Skin PU Assessment' programme of education introduced via varied pathways.
Introduce a Wound Care Tissue Viability education board to each main inpatient department. To include management of pressure ulcer and BAME considerations.	Currently 3S, 4NW and 5S thoracic surgery have education boards.	Wound Care Tissue Viability education boards to be in place on: • 5 North cardiac surgery. • Thoracic medicine wards • CCA and Theatre area to have a dedicated education board. All ward/CCA PU boards should highlight PU metrics and education on the specifics of pressure ulcer risk assessment, prevention and management of pressure ulcer and BAME considerations. To be used as dedicated resources to continue to education staff.	Education boards now in place in clinical areas and in use.
Integrate the Patient Pressure Ulcer Patient Leaflet into the discharge process to support patients who have become physically deconditioned during the admission, consequently, remain at risk of PU development at	• In 22/23 there have been documented instances failure to give adequate pressure ulcer advice at discharge.	• Preventing Pressure Ulcers leaflet to be updated. • Preventing Pressure Ulcers leaflet to be given on discharge in addition to verbal advice.	Preventing Pressure Ulcer leaflet reviewed, updated but awaiting publication.

home and to promote self-management of pressure areas post discharge with the support of community teams as necessary.	• Lack of information was identified as a contributing factor to the further deterioration at home.	• This will be overseen via the pressure ulcer scrutiny panel who engage with ward sisters. • Checking patient leaflets are being used - will form part of the annual PU audit to gain assurance the new updated process is in place and implemented.	

VTE Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
Sustained improved compliance with VTE assessments within 24 hours of admission. National target is 95%	• Average monthly compliance rate for period Oct 22- Mar 2023 was 88.22%. • Monthly audit of % compliance for VTE assessments on admission implemented. • VTE monitored monthly on PIPR and reported quarterly as part of quality report to QRMG/Q&R. • Consultant VTE champions identified across the Trust. • Lorenzo clinical indicator (dashboard) in place to optimise/ highlight patients in need of VTE risk assessments before 24h target breached	New VTE Medical Lead appointed.	Medical Lead commenced September 2023
		Medical VTE champion roles and responsibilities determined.	Role in development
		VTE oversight committee to be re-established (Quarterly), who will have oversight of performance and action plans, reporting into new Harm free care panel and reported into QRMG.	VTE Oversight Group re-established
		Medical VTE champions (bi-monthly), led by medical VTE lead, who will review ongoing VTE performance and updated ongoing action plans.	• Bi-monthly VTE Medical Champions meeting established. • Scoping under way to review weekly VTE audit reports, with the aim to establish causes and fluctuations in VTE assessments in real time to highlight causes of variability. In discussion: data to be disseminated to VTE Medical Champions to review practice in their area. • A planned Audit of patients who are do not have VTE assessments performed to be undertaken by junior doctors with cardiology/thoracic and potentially surgery in 24/25, to review improvement

VTE Objectives 2023/24	Baseline position for April 2023	How can this be measured?	2024/2025 Progress
		Bi-monthly VTE link nurse/AHP meeting led by Head of Nursing Cardiology to be in place with clear roles and responsibilities set.	Bi- monthly link nurses re-established.
		Investigation of further digital options to aid compliance of VTE assessment.	This is not achievable within existing electronic patient record (EPR) system however development of a future EPR will consider the inclusion of digital alert to aid VTE compliance.
Preparation for re-application of VTE exemplar status in 2024	• In 22/23 the Trust was unable to achieve the national target of 95%. • In recognition the Trust decided not to apply for revalidation as an exemplar site. • It was agreed that the focus would be on the informatics and engagement, both at a clinical and patient level in preparation for a re-application in 2024.	• VTE oversight committee to undertake review of this 2022/23 progress for revalidation status. • Benefit and consideration of Exemplar status to be reviewed by VTE oversight committee when VTE medical lead in place and details of criteria known. • Facilitate organisation self-assessment against Exemplar criteria when known.	Exemplar criteria not confirmed for 23/24. This area was not achieved in 23/24 - Facilitate organisation self-assessment against Exemplar criteria when known. However, the national returns are due to commence in 24/25 that the Trust will participate in.

Quality Account 2023/24 Priority 4

Objective: To Reduce Surgical Site Infections rates, post Coronary Artery Bypass Graft (CABG) and valve surgeries for patients
Executive Lead: Maura Screaton, Chief Nurse

Objectives 2023/24	Baseline position for April 2023	How will this be measured?	2024/2025 Progress
Continued theatre ventilation assurance work	• Compliance with national regulations has been confirmed but concern remains on design of air flow. • Practical changes have been made to practices within theatre to reduce perceived risk (change to area for gowning/gloving)	• Establish regular Ventilation Safety meetings. • Independent specialist review of ventilation	• Ventilation Safety Group established with clear governance structure in place. • External review undertaken by NHSE in June 23. • Independent ventilation expert recruited to commence April 24. Audit and Risk Assessment to be undertaken on commencement.
Develop assurance on decontamination and sterilisation of sterile instruments.	• Improved oversight on issues with instrument decontamination and sterilisation • All non-conformance events are recorded on Datix, and reports are now reviewed. • Instrument replacement programme in place. • Decontamination lead appointed	• Regular review of non-conformance reports • Decreased no of non-conformance reports on Datix. • Decontamination assurance report to be presented at monthly IPCC meeting.	• Regular decontamination monitoring has continued via appropriate the governance routes. • Trust Decontamination Lead appointed. • New decontamination service provider appointed from April 24.
Embedding of NICE guidelines for prevention of surgical site infections	• Theatre uniform policy reviewed in line with AFPP and NICE guidance. • Trial of antibiotic coated sutures • Trial of antibiotic impregnated dressings and minivac dressings	• Audit of compliance with theatre uniform policy • Introduce antibiotic coated sutures for all operative cases. • Introduce antibiotic coated dressings for at risk patients. • Embed mini-VAC dressings for high-risk patients	• Trust dress code reviewed, and compliance is monitored regularly. • Antibiotic coated sutures dressing introduced. • Prevena Incisional VAC dressings introduced in Q1 and now standard practice. • Data findings of VAC dressings evaluation in Q3 demonstrated a 3% improvement on SSI rates.
Improved theatre environment	• A new theatre schedule was implemented to ensure one theatre a month undergoes a complete deep clean. • A robust deep clean schedule for theatres is in place.	• Decreased footfall in theatres – evidenced through weekly footfall audits. • Theatre audits: (target in brackets) • Hand hygiene (>94%)	• Weekly footfall audits implemented against agreed indicators place across all 6 theatres. Further analysis of data required before conclusions can be drawn. • Theatre Audit standards achieved.

Objectives 2023/24	Baseline position for April 2023	How will this be measured?	2024/2025 Progress
	• Regular IPC rounds in place including all of the patient pathway.	• ANTT audit (>94%) • Cleaning & decontamination (>94%) • Cleaning QC (94%) • Compliance with administration of prophylactic antibiotics • Monthly deep cleans completed	• Deep Cleans Theatre schedule (one theatre a month) completed. • Compliance with Antibiotic Policy for Surgical Prophylaxis completed October 2023: 75% compliance. This is a 6 monthly audit and will continue to be monitored by the SSI Governnace oversight groups.
Continued focus on IPC audits	• Programme of IPC audits re-established throughout the year. • Oversight at IPCC and SSI stakeholder group • SSI assurance dashboard in place	• Focus on ANTT training and its implementation in practice to identify areas of non-compliance, and reasons why. • External review of audit process to enable learning and holistic approach to auditing patient pathway	• ANTT training compliance is 96% with audit evidencing 94% compliance. • External review undertaken by NHSE in June 23.
External review of practice	• NHSI/E IPC lead advice and guidance • External DIPC review requested	Consider all recommendations and reviews for learning and improvement through SSI stakeholder group	• Recommendations from NHSE visit in June 2023 monitored by SSI Stakeholder group, membership which includes external stakeholders from the ICB and NHSE. • SSI dashboard monitored and shared monthly at Board level.
Diabetic management pre and post operatively	• HBA1C preoperatively by GP • Improve education of staff in management of blood glucose	Audit practice in respect to compliance of completion of HbA1C and blood glucose management	• HbA1C reviewed at pre-assessment. • Pre-admission team undertakes weight management and maintains monthly contact whilst on waiting list. • Virtual diabetic pre-optimisation ward to be developed through 2024/2025 and monitored via the SSI Stakeholder Group • A variety of existing and new education opportunities continue to be offered.

Quality Account 2023/24 Priority 5:

Objective: To Improve Resourcing and Retention for the Trusts workforce

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

Objectives 2023/24	Baseline position for April 2023	How will this be measured?	2024/25 Progress updates
Develop talented people managers through our Compassionate and Collective Line (CCL) Managers Development Programme • Run four cohorts of the Programme. • Review the impact of the Programme.	• Two cohorts have been recruited to and further two are being promoted • Discussions have started on what measures could be used to review the impact of the programme	• 64 line managers to have completed the Line Managers Programme • Positive feedback from participants • Positive feedback from the participants' managers • Improvement in the responses to the questions in the Pulse Survey and National Staff Survey about line managers • Report produced, including recommendations for improvement, by the end of 23/24	We have now had 102 managers who have completed the CCL programme @ March 2024 with a further 80 currently engaged on it. Feedback collected after each module and is generally positive. In 2024/25 we will be undertaking a wider review and implementing a 360 to measure impact. Impact of this work on staff survey outcomes to form part of workforce committee report at its meeting in May 2024.
Effectively manage our talent, supporting development and succession planning across all services. • Develop a simple talent management process and supporting training material for line managers. • Develop a methodology for describing career /development pathways within the organisation and create material that describes an initial six career pathways for key roles	Revised appraisal policy launched in 22/23 that includes tool for career conversation	• A talent management process developed, piloted and launched for line managers to use as part of the appraisal process. • Monthly training sessions on talent management developed and timetabled. • Six career pathways developed and created across a range of professions. • Career Pathway material communicated and used in recruitment material	Progression our work on the talent programme was delayed in 2023/4 whilst we waited on the funding agreement to resource the Operational Directors capacity. This was agreed in Q3 and appointed in Q4. Work on this started in March. Career pathways programme commenced in the autumn 2023 with project management working through the design phase with a pilot of methodology due in Cardiology over June-July 2024 and outcome report by the end of September 2024. The aim is to scale up roll out the pathways assessment methodology to other staff groups across the organisation in Q3/4 2024/25
We will develop and implement further leadership development programmes and tools and techniques to support the development of capable, confident, and	Development gap analysis undertaken for the Triumvirate leadership in 22/23.	• Development and delivery of a leadership development programme for the triumvirate leaders that encompasses the accountability framework and team development and coaching.	We have used our leadership and management programme as the basis for the development of further bespoke programmes for senior leaders and matrons and we are currently engaging in a collaborative for matron's leadership development

Objectives 2023/24	Baseline position for April 2023	How will this be measured?	2024/25 Progress updates
compassionate leaders at all levels in the organisation.		• Develop and deliver sessions on key areas of leadership that are identified as gaps through the Line Managers Programme (LMDP)	with CUH. We have also developed a suite of skills works that complement the LMDP and we plan to continue to develop this in 2024/5

Priorities for 2024/25:

Our priorities for 2024/25 reflect the domains of quality: patient safety, clinical effectiveness, well led and patient experience. Our priorities are:

Priority 1: Diabetes
Priority 2: Nutrition and Hydration
Priority 3: Delirium and Dementia

Equality Delivery Statement: We will ensure patients have access to the right care at the right time through this quality improvement work our approach will focus on addressing any equality and health inequalities for patients.

To determine its Quality Priorities for the coming year the Trust reviewed clinical performance indicators and identified a long list of improvement proposals that were considered with input from clinical teams, our Patient & Public Involvement Committee and the Quality & Risk Committee before the final priorities were selected.

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

Quality Account Priorities for 2024/25 Priority 1 - Diabetes

Aim: Safe care and improvement in the management of patients with Diabetes

Background: Diabetes affects many of the patients we see at RPH who also have cardi-respiratory conditions. Optimising diabetes control and treatment leads to better patient outcomes – for example, reduced length of stay and reduction in risk of Surgical Site Infections.

Equality Delivery Statement: We will ensure patients have access to the right care at the right time for diabetes and through this quality improvement work our approach will focus on addressing any equality and health inequalities for patients.

Objectives 2024/25	Baseline position for April 2024	How will this be measured?
Review and update clinical Guidelines for the management of Type 1 and Type 2 Diabetes for staff caring for patients with diabetes or suspected diabetes.	The Trust currently has three standalone documents, which review a full review: 1. DN494 – Clinical Guidelines for the management of ward-based patients with hyperglycaemia. 2. DN511 – Clinical guidelines for the management if patients with diabetes who are undergoing minor procedures. 3. DN550 – Insulin – Management of patients who require a variable rate intravenous insulin infusions (VRIII) Clinical Guidelines.	• To create and publish two new clinical guidelines for Type 1 and Type 2 diabetes. These will include a clear monitoring and auditing section to audit compliance of implementation of updated ways of working. • The current documents are archived DN494, DN511 and DN550. • The creation of a new annual audit that will include monitoring of the new guidelines in practice is in place, with actions plans for improvement. • The oversight and outcome from the new guideline development and audit management is monitored by the newly developed diabetes focus group. Reporting into QRMG via Harm Free Care Panel.
Education and training for patients and staff for care and management of patients with diabetes. To include updates on the new published guidance.	Current guidance is out of date (DN494, DN511 and DN550). Ad hoc tea trolley training delivered by Diabetes Specialist Nurses. Local induction to role on diabetes within local clinical teams.	Completed trust wide launch of new clinical guidance via comms: • message of the week • newsbites • update intranet page • training and education events, e.g. tea trolley, local staff meetings • creation of an annual cycle of ongoing refresher training
Medical oversight role to be implemented to support clinical management of patients with complex diabetes.	No current dedicated medical support (via pa allocated time). Risk 2387 on corporate risk register – in relation to no dedicated Consultant Diabetologist time in the Trust.	• Dedicated medical role/or provision in place and aligned with diabetes specialist nursing team. • Corporate risk reduced/closed with medical role mitigation in place.
Create a new oversight of guidance and practice diabetes steering group to include medical representation to support the clinical	Group not in existence.	• Diabetes Steering group created with bimonthly meetings in place. • Diabetes focus group supported by dedicated medical role.

Objectives 2024/25	Baseline position for April 2024	How will this be measured?
governance and practice of diabetes management within the Trust.		• Governance structure set up and group reporting into QRMG via Harm Free Care Panel.
Review all patient referral pathways from point of referral to discharge, for early identification of undiagnosed patients with diabetes and optimal management of patients with established diabetes.	Pathways do not routinely optimise opportunities for early identification of patients with undiagnosed diabetes and optimise the management of patients with diabetes.	Mapping of patient pathway completed and opportunities for improvement identified. This mapping will include: • From referral to our hospital • Preadmission • During Inpatient admission • At discharge for ongoing care
To optimise diabetes diagnosis and management to improve treatment efficiencies, reduce delays in treatment and reduce length of stay. Focusing on three main clinical work streams: 1) SSI reduction from diabetes control prior to surgery. 2) Optimisation work for Diabetic patients on surgical waiting list. 3) Support for oncology patients who require PET scans which are dependent on blood glucose levels.	**SSI:** Ad hoc local medical clinical level support for diabetes, by specialist Diabetologist, but no dedicated support in place to support optimisation of all patients.	Patients with diabetes are optimised prior to surgery to improve blood glucose control, evidenced through length of stay, surgical site infection (SSI) rate reduction and patient outcomes. This will be monitored through the SSI Stakeholder Group, Patient Flow Programme and QRMG.
	Surgical waiting list: No specific specialised consultant support for patients with diabetes for other services e.g. cardiac surgery, cardiology patients, oncology.	To further review how we can expand the current optimisation work for patients on surgical waiting list e.g. weight management, smoking cessation (implemented in 2023/24). To review how we can enhance clinical work streams to utilise time on waiting lists to optimise blood glucose control. To reduce risk factors for further medical events. This will be monitored by newly formed diabetes oversight group reporting into QRMG.
	Oncology: Current practice is to sign post to GP for support if patients' diabetes is not controlled when they attend for PET scans at RPH. This can cause delays in PET scan reviews, as patient require further blood sugar control, often through GP services. Ultimately leading to delay of review and diagnosis through Oncology pathways.	Scope and review efficiencies and time to PET scanning by reviewing and monitoring internal resource (cancer pathway tracking information) to identify delays. Review completed on the potential implementation of hospital monitoring of blood sugar reviews for our patients as they attend other appointments. Data available by real time tracking and can be monitored through Thoracic Oncology Business Meeting / TAMG and Cancer Transformation Group.
To improve compliance as per NICE guidance (NG19) standards for the completion	The annual audit for 2023/24 against NG19 Diabetic Foot Problems standards results found 51% of patients did not have the recommended foot assessment completed.	• Dissemination of the recommended actions arising from the completed 2023/24 and local actions in place at ward level. • Audit 2024/25 to be completed with demonstrable improvement seen.

Objectives 2024/25	Baseline position for April 2024	How will this be measured?
of foot assessments for patients with diabetes to be undertaken within 24 hours of admission.		• Focussed quality improvement project for 2 wards completed. This project will have followed PDSA approach clearly identifying ongoing continuous improvement. • Sustained improvement demonstrated via yearly audit for focus project areas (2 wards) and wider roll out of this improvement work to other areas.
To improve compliance as per NICE guidance (NG28, NG 17) standards for diabetic care plan completion for patients with diabetes.	Annual audit for NICE guidance NG28, Type 2 diabetes in adults: management, and NG17 Type 1 diabetes in adults: diagnosis and management with 23/24 results 33% patients did not have a diabetic care plan.	• Dissemination of the recommended actions arising from the completed 2023/24 and local actions in place at ward level. • Audit 2024/25 to be completed with demonstrable improvement seen. • Focussed quality improvement project for 2 wards completed. This project will have followed PDSA approach clearly identifying ongoing continuous improvement. • Sustained improvement demonstrated via yearly audit for focus project areas (2 wards) and wider roll out of this improvement work to other areas.

Executive Lead: Maura Screaton, Chief Nurse

Implementation Leads:

- Jackie McDermott, Diabetes Specialist Nurse
- Jason Ali, Consultant in Cardiac and Transplant Medicine
- David Meek, Associate Medical Director for Clinical Governance
- Jacqui Wynn, Head of Quality Improvement and Transformation

Quality Account Priorities for 2024/25 Priority 2 – Food and Hydration

Aim: To improve patient experience with their nutrition and hydration needs while staying or visiting our hospital.

Background: The Trust is working on initiatives to improve access, quality, and delivery of food to patients. This is to continue our work regarding outstanding care and to meet the regulation needs of the Health and Social Care Act 2008 (regulated activity) Regulations 2014: Regulation 14 – Meeting nutritional and hydration needs. Which requires us to make sure that people who use services have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment.

Equality Delivery Statement: We will ensure patients have access to food and drink to meet their nutrition and hydration needs and through this quality improvement work our approach will focus on addressing any equality and health inequalities for patients.

Objectives 2024/25	Baseline position for April 2024	How can this be measured?
Continue to re-establish the Food and Nutrition group with multi-professional membership, to strengthen trust wide learning from patient experience and incidents, audits and inform improvement initiatives.	Food and Nutrition Group ceased May 2022 and have subsequently met once.	• Group re-established with regular meetings in place. • Terms of Reference fully reviewed with the agreed new governance reporting structure in place (via QRMG or CPAC Committee). • Progress of actions and learning from investigations monitored with quarterly reporting into a suitable governance meeting for oversight.
To continue to improve collaborative working between Estates, OCS and Dietetics Team on the provision, oversight and specialist advice of access to food and hydration needs for patients.	Monthly meeting between Dietetics, Estates and OCS. No food service dietitian.	• Improved collaborative working monitored through monthly Dietetics, Estates and OCS meeting. • Performance against the 8 National Standards for Healthcare Food and Drink (NHS England 2022). • Estates Returns Information Collection (ERIC) in place and shared. • Full scoping and review project completed on the potential for a Food service dietitian post (Standard 3) with main interface between Estates/OCS and clinical services and ensure compliance with the Nutrition & Hydration Digest (BDA 2023). • Full business plan completed for new Food service dietitian post or how this requirement could be added to 1 or 2 internal posts to support this ongoing collaboration.
Patients can access good quality food and hydration over 24-hour period that meets their personal and dietary needs.	Reduced access to food and snacks out of hours for patients returning from theatre/ procedures or to assist management of diabetes. Current provision of snack boxes ordered via switchboard after 19.00hrs.	• Improved access to food and hydration needs and this is monitored monthly via Food and Nutrition Group, with clear oversight of improvement plans in place. • Provision of sandwiches via ward pantry monitored monthly by Matron/Estates and reported to Food and Nutrition Group. • Monitored use of snack boxes by Estates/OCS and reported to Food and Nutrition Group. • Patient satisfaction survey in place (via FFT survey dedicated question or OCS feedback survey). With results being used to inform and support the co-deign of improvements.

Objectives 2024/25	Baseline position for April 2024	How can this be measured?
Increased food choices for patients, such as long stay and those with specific dietary needs including religious requirements.	Long term patients (defined as > 4 wks) flagged to Site Service Operations Manager by a matron or dietitian can arrange use of any patient menu or access to the restaurant menu.	• Gap analysis and thematic review of patient experience undertaken by Food and Nutrition Group and recommendation actions monitored through Food and Nutrition Group. • Options to increase food choices – such as food voucher for use in the canteen/café, implemented. • Improved patient experience received via Food and Nutrition Group monthly monitoring of QR code feedback.
Improvement in oral health in patients and associated reduction in poor nutritional intake.	Mouth care procedure (DN731) implemented.	• Create new annual audit that will include monitoring of the new procedure with actions plans for improvement to be monitored by Food and Nutrition Group.
Improved of nutrition communication and systems between clinical staff and housekeepers at ward level.	No consistent approach currently.	• Improvements and recommendations identified via completed Dietetic student leadership project May 24 with actions monitored via the Food and Nutrition Group.
Completion of guidance to review In House Urgent surgical pathways patients who experience delay in treatment and extended periods of fasting.	No existing guidance in place.	• Guidance for In House Urgent surgical patients completed. • Improvement of patient experience monitored via Matrons quality rounds, the Chief nurse visibility rounds. • Targeted question in the Trust Friends and Family Test (FFT) survey for the year, to review food and hydration and experience and this will be able to evidence if patient experience in relation to all food and hydration needs.
Implement the new mandatory regulations for management of food waste and splitting of food waste.	In place for ward regen kitchen and restaurant, but not a consistent approach.	• Compliance with new regulations achieved with monitoring via Estates and OCS. • Evidence in place to support CQC well led domain- which has a new reformed focus on environmental sustainability-sustainable development.

Executive Lead: Maura Screaton, Chief Nurse

Implementation Leads:

- All Matrons
- Dawn Stapleton, Site Services Operations Manager
- Gillian Gatiss, Clinical Lead for Dietetics

Quality Account Priorities for 2024/25 Priority 3 – Delirium and Dementia

Aim: To Improve outcomes for patients who experience delirium under our care or have dementia and care needs requirements.

Background: Linked to patient experience, the Trust currently does not have clear strategy or approach to how we are optimising the pathway for patients who experience Delirium and Dementia.

Equality Delivery Statement: We will ensure patients who experience delirium or have dementia have access to the right care at the right time and through this quality improvement work our approach will focus on addressing any equality and health inequalities for patients.

Objectives 2024/25	Baseline position for April 2024	How can this be measured?
Develop Trust guidance/policy and process for dementia and incorporate any guidance update from: 1. NICE Guideline 97 Dementia: assessment, management and support for people living with dementia and their carers (June 2018)	No current dementia guidance or policy.	• Completed new dementia guidance published and launched trust wide. Included in the guidelines a clear monitoring and auditing section to audit compliance. • Create new annual audit that will include monitoring of the new guidelines with actions plans for improvement to be monitored by the Dementia and Delirium Group.
Review and update of DN626 Guideline for the Prevention Recognition and Management of Delirium expiry Jan 23. To incorporate any guidance update from: 1. NICE Guideline 103 Delirium: prevention, diagnosis and management in hospital and long-term care (July 2010, updated Jan 23) 2. NICE Guideline 83 Rehabilitation after critical illness (Sept 2009, reviewed June 2018)	Current Policy DN626 out of date. Baseline audit for NICE re-completed Feb 24.	• Completed new delirium guidance published and launched trust wide. Included in the guidelines a clear monitoring and auditing section to audit compliance. • Create new annual audit that will include monitoring of the new guidelines with actions plans for improvement to be monitored by the Dementia and Delirium Group.
Develop a new dementia 3-year strategy or approach to include key strategic priorities, with the aim of improving the quality of life for people living with dementia and their carers while under our care.	No current strategy/approach. Last strategy was for the period 2015-2018, which is now archived.	• Scoping exercise that has included the voices of patents and or their carers as part of our newly developed Dementia approach while under our care. • Completed dementia strategy published and launched trust wide. • A 3-year implementation plan has been developed on how the strategy will be achieved and this will be monitored by the Trust Dementia and Delirium

Objectives 2024/25	Baseline position for April 2024	How can this be measured?
		Group, who in turn reports to the Safeguarding committee. • Audit/actions plans to be monitored by Dementia and Delirium Group. • Throughout the duration of the strategy qualitative feedback and patient/carers stories will be sought from our service users to continue to inform us on the lived experience of those using our services and their carers to aid our drive any future improvements.
Education and training for patients and staff for care and management of patients with Delirium and Dementia To include updates on the new published guidance and Trust strategy for Dementia.	Current guidance and strategy are out of date. Local induction to role on Delirium and Dementia within local clinical teams.	Completed trust wide launch of new guidance/policy and process for dementia and the newly updated Demetia strategy via comms: • message of the week • newsbites • update intranet page • training and education events, e.g. tea trolley, local staff meetings • creation of an annual cycle of ongoing refresher training • Ongoing awareness campaigns in place to strengthen awareness of these areas of patient/cares care.

Executive Lead: Maura Screaton, Chief Nurse

Implementation Leads:

- Andre Santos, Matron Surgery
- Corinne Mossey-Gaston, Speech and Language Therapy Team Lead
- Penny Martin and Afua Tobigah, Operational Safeguarding Leads
- Jennifer Whisken, Deputy Chief Nurse

2.2 Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by Royal Papworth Hospital (RPH) 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. NHSE 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 NHS Improvement (NHSI) and the Department of Health (DoH) 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.

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

Healthcare Quality Improvement Partnership (HQIP) is responsible for several national healthcare quality improvement programmes, including managing and commissioning the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England. NCAPOP covers the national clinical audit programme, which includes 28 National clinical audits and the clinical outcome review programmes, such as Maternal, Newborn and Infant Clinical Outcome Review Programme and Medical and Surgical Clinical Outcome Review Programme.

From June 2022, the National Cardiac Audit Programme (NCAP) transitioned from HQIP to NHS Arden & GEM Commissioning Support Unit. Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

In the financial year of 2023/24 there were 19 National clinical audits and 2 National Confidential Enquiry projects that were relevant to Royal Papworth Hospital NHS Foundation Trust. During 2023/24, Royal Papworth Hospital participated in 18 of the 19 (94.7%) National Clinical Audits and both National Confidential Enquiries (100%). We did not participate in the National Diabetes Inpatient Safety Audit (NDISA) due to a lack of data. However, the Clinical Audit Team are working with the Diabetic Nurse Specialists to ensure full support is provided to retrieve and submit the relevant data.

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 2023/24, 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 18/19 (94.7%)

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 Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)[1]	Royal College of Physicians	100
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	NHS England	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 Audit of Cardiac Rehabilitation	University of York	100
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	100

Audit Title	Audit Source	Compliance with audit terms
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)[2]	Royal College of Surgeons of England (RCS)	100
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	100
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcomes Research (NICOR)	100
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	National Institute for Cardiovascular Outcomes Research (NICOR)	100
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	100
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	100
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	100
National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	NHS Blood and Transplant	100
National Pulmonary Hypertension Audit	NHS England (formerly NHS Digital)	100
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	100
UK Renal Registry National Acute Kidney Injury Audit[3]	UK Kidney Association	100

Note 1: Cambridge University Hospitals submits on behalf of RPH as the treatment provider/diagnosing trust for hip fractures as per the audit inclusion criteria.
Note 2: 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.
Note 3: Cambridge University Hospitals uploads AKI data on behalf of RPH.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2023/24, Royal Papworth Hospital NHS Foundation Trust participated in two NCEPOD studies which were relevant to the Trust. The projects, which are detailed below, are due to be completed in Spring 2024.

1. End of Life Care, commissioned by Healthcare Quality Improvement Partnership (HQIP) as part of the Clinical Outcome Review Programme into Medical & Surgical care. The report for which is due to be published in Autumn 2024.
2. Rehabilitation following critical illness, commissioned by HQIP as part of the Clinical Outcome Review Programme into Medical & Surgical care. The report for which is due to be published in Spring 2025.

National Audits collect a large volume of data about local service delivery and achievement of compliance with standards, and provide information about attainment of outcomes, and they

produce national comparative data for individual healthcare professionals and teams to benchmark their practice and performance. The reports of 12 national clinical audits were reviewed by the relevant clinical teams at Royal Papworth Hospital NHS Foundation Trust in 2023/4. Below is a summary of the audits discussed at relevant divisional meetings.

Audit Title	Report Published
National Lung Cancer Audit (NLCA) – State of the nation report 2023	Y
National Audit of Percutaneous Coronary Interventions (NAPCI) Report	Y
National Adult Cardiac Surgery Audit (NACSA) Summary Report	Y
National Congenital Heart Disease Audit (NCHDA) Summary Report	Y
National Audit of Cardiac Rhythm Management (NACRM) Summary Report	Y
Management of Heart Attack (MINAP) Summary Report	Y
National Cardiac Audit Programme Summary Report	Y
The Inbetweeners – a review of the transition from CYP into adult health services	Y
National Audit of Care at the End of Life (NACEL) 2022/23 report	Y
National Hip Fracture Database (NHFD): 15 years of quality improvement	Y
National Diabetes Audit 2021-22, Type 1 Diabetes	Y
Inpatient falls and fractures – 2023 NAIF report on 2022 clinical data	Y

In addition, to participating in National Clinical Audits, Royal Papworth Hospital NHS Foundation Trust, completed 70 local clinical audits in 2023/24. Clinical Audit projects were undertaken across all divisions and focused on ensuring current practice was in line with guidelines for good practice, assessing whether our patients were receiving the best quality of care and identifying areas for improvement. A sample of the local audit activity and the actions resulting from these projects is listed below.

Consent Audit
This was a Trust-wide audit measuring adherence to the Trust policy for Consent to examination or treatment DN306. Following the audit, several actions were identified to improve compliance with the standards.

- Reminders to clinical staff completing forms to ensure that the procedure is written in full and not abbreviated.
- Reminders to clinical staff taking consent to ensure patients are completing all sections or assisting when needed.
- Surgery, Transplant and Anaesthetics division to agree that the use of stickers on Thoracic Surgery consent forms is acceptable and ensure this is reflected in the Trust consent policy.
- Ensure that the newly introduced consent forms are being fully utilised across the organisation.

Colorectal cancer screening in patients diagnosed with cystic fibrosis (CF): non-transplant versus transplant.
This was a thoracic medicine audit measuring practice at Royal Papworth Hospital against the clinical care standards outlined by the 2017 Cystic fibrosis foundation (US) guidelines. Several actions were identified to improve compliance with the care standards.

- People with Cystic Fibrosis to be advised of recommendations regarding referral for colonoscopy screening at the age of 40 (for non-transplant patients) or 30 (for transplant patients).
- Documentation of personal/ family history of cancer, and screening questions for red flag symptoms, at time of annual review
- To introduce the concept of colorectal screening to CF patients during their annual review before the age of 40

- No standardisation of bowel prep require, but each patient to be advised on a case-by-case basis as needed.

Handling and Disposal of Linen Audit
This was an infection control audit measuring compliance with infection control measures for linen management, in line with DN789 Management of Used and Infected Linen Policy. Several actions were identified to improve compliance with the care standards.

- Reminder to all ward staff that any heavily stained linen should be placed in a white bag and labelled "rejected".
- Reminder to all ward staff that any 'rejected' linen should be stored away from used linen and the Estates team should be contacted to collect it.
- Ensure all linen bags are no more than 2/3rds full.
- Reminder to all matrons that during their regular matron rounds any issues with dust should be reported to OCS.
- Communicate to all ward staff that the linen room should be clear from clutter, and nothing should be stored on the floor to facilitate cleaning, which should be included in message of the week communications from the Chief Nurse.
- Remind all ward staff that used linen should be placed directly into the linen rounder and bags of used linen should not be left on the floor.

Local Safety Standard for Invasive Procedures (LocSSIP) audit on CCA
This was a critical care audit measuring compliance with Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) guidance around completing Local Safety Standards for Invasive Procedures (LocSSIP's) and ensuring safe practice through documentation. Several actions were identified to improve compliance with the care standards.

- A three-pronged approach to education alongside instructions to be provided to medical, nursing, and critical care staff regarding the use of LocSSIP forms.
- Increase the use of the LocSSIP forms within the clinical information system (CIS) focusing on the importance of clear documentation by medical staff, critical care scientists and nursing staff.
- Plan to re-audit following implementation of training and clear instructions regarding the use of LocSSIP forms.

Peri-operative antimicrobial prophylaxis in cardiac and thoracic surgery re-audit
This was a Pharmacy and Microbiology audit measuring compliance with the Trust's policy DN027 'Antibiotics for surgical prophylaxis procedure' and DN339 'MRSA procedure'. Several actions were identified to improve compliance across all the six standards assessed.

- Reminder to relevant staff that anaesthetic summaries should be completed for all patients in theatre and should include details for antibiotics administered as well as knife-to-skin/surgery start time.
- Ensure the MRSA status or risk needs to be assessed prior to administering antibiotics as it determines choice of antibiotic – DN339 has update guidance on risk assessing patients with unknown MRSA status.
- Ensure the dosage of antibiotics is based on patients' weight (or ideal body weight when appropriate).

This above Peri-operative antimicrobial prophylaxis audit is part of our ongoing monitoring and improvement plan for our Surgical Site Infection (SSI) work and is monitored on our central SSI dashboard for compliance.

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 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 1,868. See table below:

Type of research project	No. of participants recruited per financial year			
	2020/21	2021/22	2022/23	2023/24
NIHR portfolio studies	2246	1,061	1,192	772
Non-NIHR portfolio studies	186	81	63	86
Tissue bank studies	968	1,673	1,149	1010
Total	**3,400**	**2,815**	**2,404**	**1,868**

NIHR = National Institute for Health Research

By maintaining a high level of patient 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. The Trust has a very active research PPI panel which actively supports research design and management of Royal Papworth Sponsored research studies. They are co-applicants on a number of grants and members of Trial Steering Committees.

During 2023/24 the Trust recruited to 68 studies of which 58 were portfolio studies (2022/23: 71 studies and 60 portfolio studies).

The Trust has a balanced portfolio of observational and interventional studies across a range of specialities and patient populations including bronchiectasis, atrial fibrillation, cardiac surgery, and sleep medicine. The Trust continues to sponsor a number of single and multi-centre studies. Staff across the organisation are involved in research either directly involved in the research teams or by supporting research activity.

Quality is at the heart of all our research activities and Royal Papworth Hospital achieved global first recruitment on 2 studies as well as a number of UK first recruits.

All Royal Papworth publications can be found on our website on the Research and Development pages: https://royalpapworth.nhs.uk/research-and-development/publications This is maintained and updated regularly by our Knowledge and Library Services.

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 patients who participated in, and staff who supported, our research over the past year.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Royal Papworth Hospital NHS Foundation Trust's income is 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.

Following the suspension of CQUIN during the pandemic, CQUIN schemes were re-established in 2022/23. As in previous years, the Trust has agreed in 2023/24 to undertake national CQUIN schemes with both NHSE Specialised Commissioning, and Cambridge and Peterborough ICB (acting for and on behalf of associate ICB commissioners).

In 2023/24, CQUIN achievement was paid in advance through the application of 1.25% to the 2023/24 national tariff and this was reflected in the contract value. Submission of performance against CQUIN metrics takes place quarterly and any non-achievement, could be reclaimed by commissioners in line with the national CQUIN guidance. It is not expected that there will be any adjustment to CQUIN payments related to performance in 2023/24.

A summary of the 2023/24 schemes is provided below:

CQUIN Ref	CQUIN Name
CQUIN01	Flu Vaccinations for frontline healthcare workers
CQUIN02	Supporting patients to drink, eat and mobilise after surgery
CQUIN03	Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria
CQUIN10	Treatment of non-small-cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
CQUIN11	Improving the quality of shared decision-making (SDM) conversations

As in previous years, progress against CQUIN schemes has been monitored by the Trust through a CQUIN Review Group. This group ensures that CQUIN schemes are appropriately implemented and monitored. CQUIN subgroups have been in place in 2023/24 for CQUIN02 and CQUIN11.

The Trust reports CQUIN compliance / achievement in year to commissioners 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 issued enforcement action against Royal Papworth Hospital NHS Foundation Trust during 2022/23 regarding Ionising Radiation (Medical Exposure) Regulations 2017 (further details below).

Royal Papworth Hospital NHS Foundation Trust is subject to periodic review and was last inspected by the CQC in June & July 2019 when we received an overall rating of Outstanding.

We were 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. The report of this inspection is available on the CQC website at: https://www.cqc.org.uk/provider/RGM

Ionising Radiation (Medical Exposure) Regulations 2017 ('IR(ME)R')

CQC is the enforcing authority for IR(ME)R in England. Its powers of enforcement for IR(ME)R derive from the Health and Safety at Work etc. Act 1974 ('HSWA').

The last IR(ME)R inspection was in November 2022. All recommendations made as a result on this inspection were implemented to support future compliance with the regulations and signed off by the Fundamentals of Care Board in September 2023.

Clinical Research Facility (CRF) at the Heart Lung Research Institute (HLRI)

CQC registration of the HLRI was successfully achieved in September 2022. This relates to both the in and outpatient areas of the CRF.

Data Quality

It is essential that data about patient care is accurate and reliable. How the Trust 'codes' a particular operation or illness for example, is important as not only does it impact on income for the care and treatment that the Trust provide, but it also anonymously informs the wider health community about illness or disease trends.

Royal Papworth Hospital NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data as of January 2024 are:

- Which included the patient's valid NHS number was 100% (national average 99.6%) for admitted patient care and 100% (national average 99.9%) 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 99.8%).

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 2023, 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 is carried out by CHKS Ltd, with Jane Wonnacott ACC (Dis) TAP accredited Auditor leading the audit.

The 2023/24 annual independent clinical coding audit was carried out the week beginning 8 April 2024. The draft report received at the time of writing confirms that the levels achieved in 2022/23 have been maintained. The final audit report when received, will inform any actions to be put in place as a result of auditor recommendations.

All recommendations for 2022/23 have been actioned. Royal Papworth Hospital NHS Foundation Trust will devise an action plan to address any recommendations from the 2023/24 audit as required.

Learning from deaths

During April 2023 to March 2024, 194 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 47 in the first quarter; 48 in the second quarter; 46 in the third quarter; 53 in the fourth quarter.

By 20/05/2023, 18 retrospective case record reviews and 9 incident investigations have been carried out in relation to the 194 inpatient deaths. In 1 case 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:

7 in the first quarter; 8 in the second quarter; 4 in the third quarter; 8 in the fourth quarter.

Two patient deaths during the reporting period were 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; 1 representing 2% for the second quarter; 0 representing 0% for the third quarter; 1 representing 1.9% 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 Associate Medical Director for Clinical Governance.

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.

Lessons learnt from Retrospective Care Record Reviews:
There are now several processes which work in parallel to comprehensively review all deaths at Royal Papworth to identify issues and improve quality and safety for patients. These processes include:

- All deaths in the previous week are presented at the weekly Safety Incident Executive Review Panel (SIERP)
- Medical Examiner (ME) Scrutiny Review
- Retrospective Case Record Review (RCR)
- Morbidity & Mortality Meeting (M&M) case discussion
- Incident Investigation (grading and investigation response agreed at SIERP)

Two patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

- One identified that elective surgery would have been high risk, in retrospect, this may have extended the patient's life and the risk of undertaking surgery would have been lower than in the deteriorating condition after transfer.
- One identified potential delays in the referral/treatment pathway which is currently still under investigation.

Lessons learnt from incident investigations:
9 incident investigations have been carried out in relation to the 194 inpatient deaths in 2023-24. Of the 9 incidents reported, a summary of the learning is summarised below:

- Utilising different strategies to optimise peri-operative care for high-risk patients.
- Challenge of early warning scores for complex patients with "chronically" abnormal physiology.
- Importance of timely and up-to-date documentation
- Improving knowledge and tools to identify possible arterial cannulation for nurses in critical care.
- Use of correct early warning scale on ward highlighted and to be part of deteriorating patient workstream.

Impact & Developments in 2023-24
An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

- Improvement work is underway, to review how to increase compliance and train further medical colleagues to be able to support the required RCR completions.
- In conjunction with the Associate Medical Director for Clinical Governance, Medical Examiner and Clinical Governance Manager, the Trust Medical Examiner Scrutiny Procedure (DN792) has been merged with Mortality Case Record Procedure (DN682).
- All other procedures which relate to in-patient deaths are being reviewed and collated to further merge with DN682 to create a single trust Learning from Death Policy.
- As part of the completion of the Learning from Deaths Policy, we will plan an increased medical awareness campaign around the statutory requirements and internal learning opportunities from the review of all inpatient deaths.

The Patient Safety Incident Response Framework (PSIRF) was introduced at Royal Papworth Hospital from January 2024. This is a system-based approach to learning. A learning response will no longer be defined by the incident grading alone following a patient safety incident, a summary of learning response outcomes for patients who have died will still be summarised in the LFD report with associated continuous improvement as required.

0 case record reviews and 0 investigations were completed after 01/04/2024 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 2022/23 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

The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing.

Following the merger of NHS Digital and NHS England on 1st February 2023 NHSE are reviewing the future presentation of the NHS Outcomes Framework indicators. Proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. While the results of this consultation are considered, the update on 5 of the NHS OF indicators that are definitely expected to continue in future regardless of the results of the consultation, do not apply to Royal Papworth Hospital NHS FT.

The following core set of indicators applicable to Royal Papworth Hospital on data made available to Royal Papworth Hospital by NHSE and data sources are required to be included in the Quality Accounts.

Indicator[1]	**2022/23 (or latest reporting period available)**	**2023/24 (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...**
Statistic: the percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital after admission.[2]	Trust score percentage was 11.1 in 2021/22. The national average score was 14.7	N/A	This is previously reported data as the annual publication of this dataset is on hold while the results of consultations are considered.	The Trust recognises the impact of readmissions on patient experience and continues to identify areas for improvement.
The trust's responsiveness to personal needs of its patients during the reporting period[3]	Trust Score was 82.5 in the 2020/21 survey. National average score was 74.5. National highest score was 85.4.	N/A	This is previously reported data as the annual publication of this dataset is on hold while the results of consultations are considered.	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	85.7% of the staff employed by, or under contract to, the trust in the 2022 staff survey would recommend the trust	88% of the staff employed by, or under contract to, the trust in the 2023 staff survey would recommend the trust	This data has improved as the Trust continues to recover from the pandemic which, as a respiratory virus,	Survey results have been share with Divisions/ Directorates and with staff through our normal

Indicator[1]	2022/23 (or latest reporting period available)	2023/24 (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...
would recommend the trust as a provider of care to their family or friends (Data from National Staff Survey Benchmark report 2023)	as a provider of care to their family or friends. Average for acute specialist trusts was 86.5%. The Highest scoring specialist trust was 93.5%. The Lowest scoring specialist trust was 71.6%.	as a provider of care to their family or friends. Average for acute specialist trusts was 87.8%. The Highest scoring specialist trust was 94%. The Lowest scoring specialist trust was 73.9%.	had a significantly greater impact of the hospital's operations and staff compared to our specialist Trust peers.,. Additionally, we have continued to improve on our vacancy rates through 2023/24 which has improved the outlook of staff on their jobs so they do not feel overworked and are better t able to provide the level of care/service they want to. We continue to see high levels of staff reporting bullying and discrimination from patients and from colleagues which is disheartening to see.	communication channels. They are also shared and discussed with Staff Networks. They inform the work of the Compassionate and Collective Leadership Programme and the Resourcing and Retention Improvement Programme. At the end of 2022/23 we finalised a revised Workforce Strategy which set clear priorities for the next two years. See also Annual Report – Staff Report section for other information on the 2022 Staff Survey.
Friends and Family Test – In Patient	In March 2023 98.6% of our inpatients and 96.4% of our outpatients would recommend our services. National (Feb 23): 94.6% of inpatients and 93.7% of outpatients.	In March 2024 98.5% of our inpatients and 97.2% of our outpatients would recommend our services. National (March 2024): 94% of inpatients and 94% of outpatients.	The Trust continues to promote the FFT test.	The Trust will continue to monitor and promote Friends and Family scores. Please see our update on a listening organisation for further information.
The percentage of patients who were admitted to hospital and were risk	The national VTE data collection and publication was suspended to release capacity in providers and commissioners to manage the COVID19 pandemic remained suspended in 2023/24. Please see the VTE section for Trust performance figures.			

Indicator[1]	2022/23 (or latest reporting period available)	2023/24 (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…
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.[4]	Trust rate was 21.8 in 2021/22. The national rate for 2021/22 was 25.2	Trust rate was 17.9 in 2022/23. The national rate for 2022/23 was NA	The change in definition of cases attributed to the Trust occurred in 2020/21 this increased the rates reported.[4]	Infection prevention and control is a key priority for the Trust. For further information see our update on 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 4	(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%%,	NA	This is previously reported data as the annual publication of this dataset is on hold while the results of consultations are considered.	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. For further information please see our update on Patient Safety Incidents.

Indicator[1]	2022/23 (or latest reporting period available)	2023/24 (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 lowest was 0% and the average was 0.40%.			

Information Source: NHS Digital portal as at 21/05/2024 unless otherwise indicated.

Note 1 The coronavirus pandemic began to have an impact on Hospital Episode Statistics (HES) data late in the 2019/20 and continued into the 2020/21 financial year. This means different patterns were seen in the nationally submitted data, for example, fewer patients being admitted to hospital, Statistics which contain data from this period should be interpreted with care..

Note 2 These are experimental statistics. The data set includes indirectly standardised percent with 95% and 99.8% confidence intervals.

Note 3 In 2020-21 survey, changes were made to the survey questions, and scoring regime. As a result, 2020-21 results are not comparable with those of previous years.

Note 4 Data shows annual counts and rates (per 100,000 overnight bed days) of CDI by acute trust. Rate information, using rate calculations as currently defined, is not appropriate for comparison. The counts of infections have not been adjusted to give a standardised rate considering factors such as organisational demographics or case mix. Rate information is of use for comparison of an individual organisation over time https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Note 5 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 2023/24

2023/24 has been another busy year for Royal Papworth Hospital and its staff. We have seen significant challenges relating to impact of industrial action affecting delays in some patient treatments and hence patient experience. Staff have worked hard going over and above in providing support for patient safety initiative activity to treat as many patients as possible thereby reducing the time patients wait for our services. We have continued to plan the recovery of our services and undertake some transformational programmes of change to support that recovery and the optimisation of our hospital. We have also seen excellence in innovation and working with our system partners supporting winter pressures across our system and maintaining excellent outcomes for our patients. The Hospital has treated 23,666 inpatient / day cases and 110,221 outpatients contacts from across the UK, an increase from 22/23 (20,797 inpatient/day cases and 103,284 outpatient). For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2023/24. 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 2023/24 where these are not reported elsewhere.

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.

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

Our Quality Strategy was published in 2019 and set our quality ambitions and direction for the three years to 2022 this was extended to March 2023 with the agreement of the Quality and Risk Committee. This was further extended for a further 6 months to September 2023. We are currently drafting the updated strategy, alongside reviewing the published update from NHS Impact (Improving Patient Care Together). This review and consideration of the completion of the NHS Impact Self-Assessment tool, will support the shaping the new Trust Quality strategy for 2024/25.

We want quality improvement and continuous 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.

From 1st April 2024, commissioning functions of the 59 delegated acute specialised services becomes the responsibility of the Integrated Care Board (ICB). They will exercise these responsibilities through the Joint Commissioning Consortium (JCC) and the Specialised

Commissioning Team will continue to work on their behalf with retained specialised services remain NHSE's responsibility.

Alongside strengthening our relationship with our Commissioners we will implement and embed the new Patient Safety Incident response framework, reporting incidents as required ensuring that quality improvement projects focus on the areas identified with our patient safety plan for 2024/25. We will also participate and support any system wide projects that are identified by us or system partners.

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 requires 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

A verbal duty of candour conversation will take place with the patient/relative/carer as soon as reasonably practical after an incident is known and to offer an apology. This is followed up in writing, which includes a named family liaison member of staff who is responsible for maintaining contact with the patient and or family throughout the investigation period. Their 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 experiences of being involved in this process.

For incidents that meet the threshold for duty of candour, this 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 Safety 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.

In 2023 the Trust undertook an audit against the requirements of the Being Open and Duty of Candour Policy (DN153) for incidents graded as serious or moderate harm during the period of 2022/23. This demonstrated overall good compliance with the verbal duty of candour conversation happening in a timely way after the incident occurred. One of the areas for improvement is the written duty of candour letter being sent or given to the patient/family/carer. This has continued to be the focus of improvement in 2023/24 for the Trust and the annual audit of compliance is planned for early 2024/25. Any improvements will be overseen by QRMG.

Patient safety domain

Safer Staffing Initiatives

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Trust Board corporate accountability for quality and safety.

Developing workforce safeguards (NHS England, 2019) state that effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high-quality care to patients and service users.

At RPH the setting of nursing establishments should triangulate from different sources using evidence-based tools where possible. Establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient needs-based information using an acuity and dependency scoring evidence-based tool such as Safer Nursing Care tool (SNCT, 2023).
- Professional judgement
- Activity levels including seasonal variation in service demand.
- Service developments and any changes to delivery.
- Contract commissioning.
- Staff supply and experience issues.
- Where Temporary Staff has been required above the set planned establishment
- Patient and staff outcome measures
- Benchmarking with other 'like' organisations

The annual nursing inpatient establishment review for 2024/2025 was undertaken (December 2023) in line with national policy and regulation, with due process followed as detailed in the Trust's Nursing Establishment Setting Policy (2022).

This annual staffing establishment review has considered and analysed the data relating to staffing metrics in line with safer staffing guidance. Triangulation of data was undertaken with acuity and dependency scoring using the Safer Nursing Care Tool and Professional Judgement.

The following conclusions were agreed:

- There would be no changes to whole time equivalent (WTE's) in nursing establishments, however there are some changes to skill mix - but not overall numbers.
- Registered nurses and unregistered nurses are maintained in terms of balance for skill mix and number of posts.

The following recommendations were noted:

- Ward/ unit establishments are to remain the same.
- These recommendations have been shared and agreed at the Clinical Practice Advisory Committee and the Workforce Committee (March2024)
- Undertake further SNCT data collections in May and November 2024 and agree the percentage for the side room calculation uplift.
- Streamline rosters ensuring templates match the budgeted and worked WTE for transparency and correct reporting.

- Optimise SafeCare Live for daily staffing reviews utilising professional judgement
- Arrange refresher training for the new SafeCare Acuity tool to the SNCT for consistency and benchmarking.
- Utilise the SafeCare system for non-ward-based areas such as Theatres which has recently been introduced to capture professional judgements and red flag events.
- Plan to utilise the SafeCare system for Cath Laboratories
- Continue monthly staffing reviews and Roster key performance indicators (KPI) monitoring.

The Safer Staffing Working Group continues in 2024/25 to provide advice and direction to nursing teams in the monitoring of SafeCare and ensuring delivery and evaluation of safer staffing for 'ward to board' assurance.

Visibility inclusive nursing rounds

Weekly inclusive visibility rounds, led by the Chief Nursing Office will continue in 2024/25. The schedule of these rounds covers varied themes across quality, environment, patient safety, safeguarding, staff health and well-being. All staff groups and grades of staff including patient governors and students are invited to attend to shadow and participate in the rounds.

Patient Safety Rounds have included: Visibility rounds/ Integrated Care Board rounds/ 15 Steps/ In your shoes/ and Fundamentals of Care Board peer reviews.

We have designed and established an inpatient nursing safe staffing report which was cascaded to the teams and presented monthly at the Clinical Practice Advisory Committee. Furthermore, we have developed a new operational lead role for safer staffing which is covered one day per week by the Cardiology Matron which supports the safer staffing portfolio of the Deputy Chief Nurse.

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 2023/24 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 2023/24 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 2023/24 there were a total number 19 cases of *Clostridiodies difficile (C.diff)*, with 17 of these being within the criteria for inclusion being positive cases confirmed after 2 days

admission or within 28 days of discharge. The threshold is set by UKHSA and we were above our national threshold, of 7 but despite this, we did not identify any outbreaks. Although our numbers were higher than national threshold, we achieved low numbers when compared to national and regional cases which have seen a dramatic increase in 2023/24, which is something that was recognised by the Integrated Care Board (ICB).

There were 2 cases of MRSA bacteraemia for 2023/24 against our ceiling threshold of zero for 2023/24, indicating that we were above our threshold for the year. All MRSA bacteraemia's and *C. difficile cases* are reported to our integrated care board (ICB), and we conduct post infection reviews (PIR) for on each case where MRSA bacteraemia or C.difficile, is reported two or more days into a patient's admission, to review the events and enable continuous improvement of practice. Any lessons learned are shared with the clinical teams within the trust and we ensure that the ICB are involved throughout the process. Of note, all C.diff cases reported 2 or more days into admission are now counted towards Royal Papworth Hospitals annual threshold regardless of any lapses in care.

Goals 2020/21	Outcome 2021/22	Goals 2022/23	Outcome 2022/23	Goals 2023/24	Outcome 2023/24
No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	2 MRSA bacteraemia
No more than 11 C. difficile (C.diff).	12 cases for the year = we were one over our yearly target of 11.	No more than 12 C. difficile.	8 cases of C. diff for the year = 4 cases below the threshold.	No more than 7 C. difficile.	19 cases of C.diff for the year = 10 over threshold. (< 2 exclusions)
Achieve 100% MRSA screening of patients according to agreed screening risk	98.6%	Achieve 100% MRSA screening of patients according to agreed screening risk	96.7%	Achieve 100% MRSA screening of patients according to agreed screening risk	94%

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 bacteraemia attributed to the Trust and added to our trajectory/ yearly threshold.

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, and Carbapenems are a powerful group of broad spectrum beta-lactam (penicillin-related) antibiotics. In many cases, these are our last effective defence against infections caused by multi-resistant bacteria. 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. Guidance was recently updated by the

UK Health Security Agency (UKHSA) in September 2022 which was reviewed and incorporated into our trust policy in support this guidance.

During 2023/24 there were 4 cases of CPE that were identified from screening but no ongoing spread of CPE within the Trust in 2023/24.

Escherichia coli (E.coli)

Data collection for *E.coli, Klebsiella* spp. and *Pseudomonas aeruginosa* BSI has been provided via the Public health England (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

In 2023/24 the trust E.coli rates were recorded as 19.1 cases per 100 000 compared with 115.6 in England, showing that we have a low number of cases in comparison to the national levels. This equates to 11 cases of E.coli, 11 cases of Klebsiella and 3 cases of-pseudomonas in 2023/24, and the annual audit will be carried during the coming year.

Mycobacterium Abscessus

Following routine testing in 2019, we launched an investigation into some cases of patients acquiring M. abscessus. This is a rare infection which can cause problems for people with specific underlying respiratory conditions or who are immunosuppressed.

We immediately put in place safety measures and regular reviews of their effectiveness. Since implementing these additional and robust water safety measures, alongside continued education for staff and patients, we have significantly reduced the counts of mycobacteria in the water. In 2023/24, two new cases of M. abscessus have been identified but further investigation has found a potential risk of contamination.

Influenza (flu)

The Trust continues to be committed to providing a comprehensive flu vaccination programme for all staff. The uptake for "frontline" staff in 2023/24 was 46.9%, and 50.3% for Trust wide staff. Uptake was lower this year but reflects trends seen in the national picture.

In 2023/24, the Trust continued to admit influenza related extracorporeal membrane oxygenation (ECMO) patients into Critical Care. This showed an average of 5 patients per year relating to flu, needing ECMO support.

COVID-19

The Trust has continued to respond to the worldwide COVID-19 pandemic. There was a small increase in COVID-19 positive patients admitted in October to December 2023. However, none of these patients required critical care support and we saw a reduction in the numbers of patients needing to come into hospital due to COVID-19 infection. There were 14 nosocomial cases in 2023/24 periodically with a spike in October and December where we also saw more COVID-19 cases within the trust. All nosocomial were fully investigated and the learning was shared trust wide.

Table of COVID-19 Figures for 2023-24:

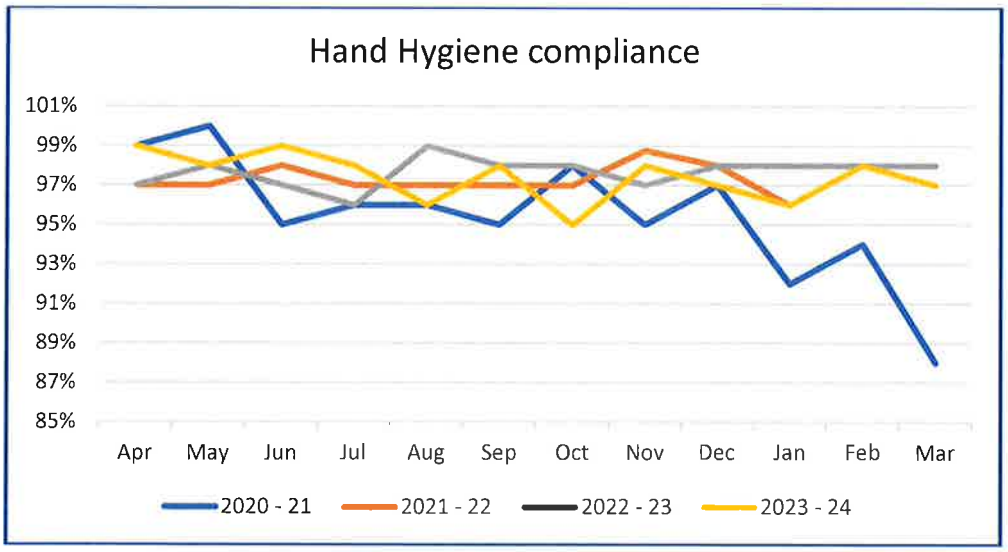
Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Year Total
New positive patient	8	1	6	3	1	6	12	7	18	9	9	1	79
Nosocomial 8+ days	2	0	1	0	0	0	1	0	1	0	1	0	6
Nosocomial 14+ days	0	0	0	1	0	0	2	1	3	1	0	0	8
Total new nosocomial	2	0	1	1	0	0	3	1	4	1	1	0	14

During 2023/34 we achieved 41.6% uptake of the COVID-19 vaccinations booster programme for frontline start and 44.8% for trust-wide staff.

All positive organisms, outbreaks or nosocomial are managed by the Infection Prevention & Control team through the Infection Control, Pre and Peri-operative Care Committee (ICPPCC).

Trust Hand hygiene compliance figures 2022-23 (April-Mar)

Results for 2023/24 are consistent compared to the previous year, with the occasional month of lower compliance. IPC have raised the awareness on the importance of Hand Hygiene which has seen a higher number of audit episodes this year compared to last. The audit process, narrative behind the non-compliance and action plan have much improved this year meaning a more robust audit cycle.



Surgical Site Surveillance

Surgical Site Surveillance at Royal Papworth Hospital (RPH) consists of identifying cardiothoracic surgery patients that develop a surgical wound infection. Historically we have only monitored Coronary Artery Bypass Graft (CABG) and valve surgeries, however in 2023-2024 we also introduced surveillance for Pulmonary Thromboendarterectomy (PTE) surgeries, heart and lung transplantations and other cardiac surgeries that require a sternotomy wound.

To be classified as a surgical site infection (SSI), cases must meet the SSI criteria set by the UK Health Security Agency (UKHSA), and at RPH we report our CABG infection rates to UKHSA quarterly. Currently we do not submit our valve and other surgery infection rates but use this data for internal monitoring only. The aim is however, in 2024 to report our non-CABG infection rates (note this will not include PTEs and transplants as UKHSA do not report these categories).

As part of the CABG reporting, SSI patients are grouped in terms of how they are identified, as follows:

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

From this data we can compare our hospital rates to all other hospitals that submit their CABG SSI rates by gaining a benchmark figure. However, it should be noted that this benchmark figure consists only of those identified in the inpatient or readmission group. As per the UKHSA, "the benchmark comprises inpatient and readmission data only, as it is mandatory for all hospitals to use these two detection methods. Not all hospitals have the resources to undertake other forms of post discharge surveillance; hence we currently use inpatient and readmission data only for benchmarking". However, RPH continues to identify patients via the other methods, as they remain important that they are recorded and taken into consideration for internal monitoring.

The Surgical Site Surveillance programme monitors patients for one year post surgery, meaning that the identification of an SSIs can still occur within that time frame post following surgery. Therefore, figures are constantly updated and subject to change. The data in this report is correct as of 13th March 2024.

Surgical Sites Infection rates 2022-2023

2023-2024 has continued to see a high rate of surgical site wound infections at Royal Papworth Hospital. Our annual figures show that following CABG surgery the rate of surgical wound infection is 8.3% (69 infections out of 831 surgeries) and for valve surgery it is 3% (16 infections out of 534 operations). This, however, is a decrease from 2022-2023 where our CABG SSI rate was 10% and our valve SSI rate was 3.6%.
For PTE, transplant and other cardiac surgeries, surveillance started in October 2023, therefore annual data is not available. Based on 6 months of data there were 4 infections out of 80 PTE operations (PTE only – excluding in addition to CABG or valve) = 5% infection rate. There were 2 infections out of 38 transplant operations = 5.3%, and 1 infection out of 52 other cardiac surgery procedures = 1.9%. Infection rates appear high due to the smaller number of patients in these categories. Further data on trends in these surgery groups will be presented when a bigger data sample has been collected.

In March 2024, we submitted our first quarter of data for valve and other cardiac surgery procedures (non-CABG UKHSA reporting category). A benchmark is not provided for valve

surgery as it is not available for valve surgery alone. The reporting category consists of valve and all other cardiac surgery (non-CABG and non-valve), and a benchmark is given for all collectively. Going forward into 2024/2025 with continued quarterly submissions, we will begin to present this data, as we do with CABG surgery.

Our SSI rates are broken down into categories for reporting to UKHSA. The following table demonstrates the quarterly CABG rates for each identification group. As can be seen our overall infection rate has ranged from 6.9% - 10% throughout the year 2023-24. Most of our infections are identified when patients are still an inpatient post procedure, or if they are readmitted with a wound complication. The other categories however do contribute significantly to the overall CABG SSI rate.

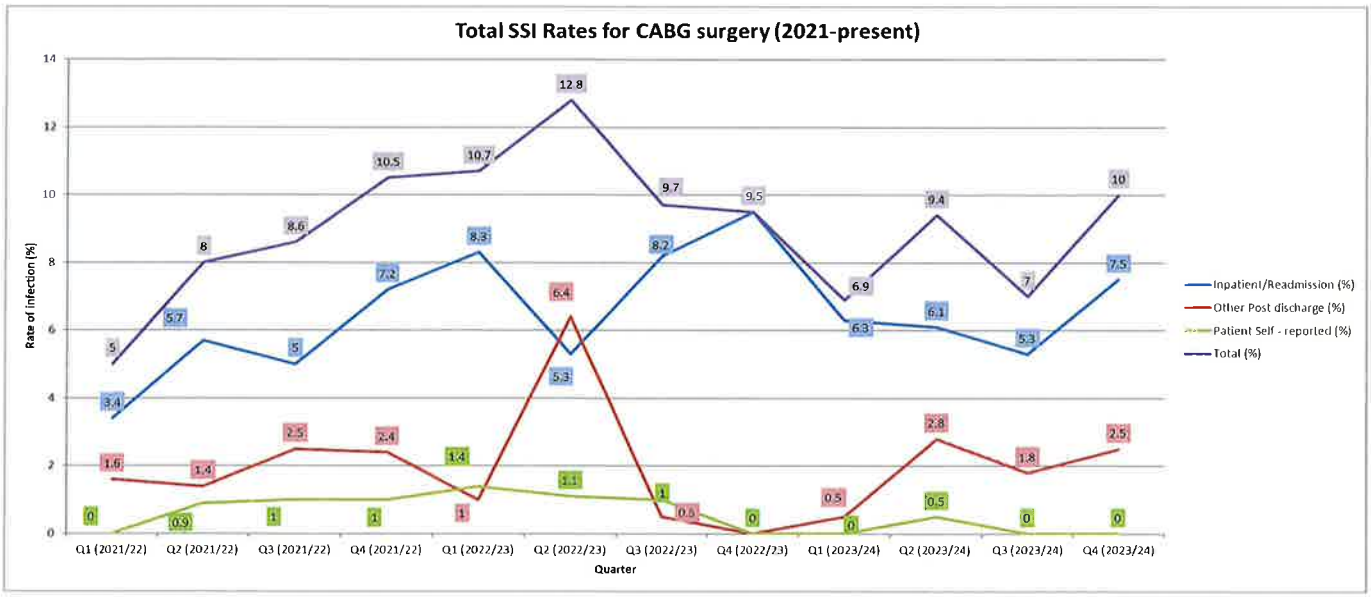
	Q1 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
INPATIENT/READMISSION	12 (6.3%)	13 (6.1%)	12 (5.3%)	15 (7.5%)
POST DISCHARGE	1 (0.5%)	6 (2.8%)	4 (1.8%)	5 (2.5%)
SELF REPORTED	0 (0%)	1 (0.5%)	0 (0%)	0 (0%)
TOTAL	13 (6.9%)	20 (9.4%)	16 (7%)	20 (10%)

CABG SSI Rates 2023-2024 *(No. of patients and infection rate %)*

The following graph shows the breakdown of CABG SSI category reporting from 2021 – 2024. As can be seen, our overall infection rates are slightly lower than 2022-2023, however quarter 4 (January - March 2024) has seen a peak again at 10%.

Our inpatient/readmission rate has continued to be on an incline since 2021. Although these rates have decreased slightly in comparison to 2022-2023, the UKHSA national benchmark for this category has remained at 2.6-2.7% throughout the year.

Total SSI rates for CABG surgery 2021 – present



SSI Stakeholder Group 2023-2024

The SSI stakeholder group was originally established in 2019 to deliberate over the rise in deep wound infection rates following the move to the new Royal Papworth Hospital. The stakeholder group gathers representatives from the multi-disciplinary team involved in the patient's surgical pathway.

Following on from the actions commenced in 2022, May 2023 saw the introduction of five task and finish groups implemented by clinical governance in response to the continued high rate of SSIs. The five groups are as follows:

- **Clinical Practice Group**: Focuses on reviewing and scrutinising all aspects of clinical care; make recommendations for change in the clinical management of patients; ensure there is sufficient focus on risk assessment; review the outcomes and recommendations from clinical reviews of SSIs; and provide evidence-based advice and guidance based on the latest research for the management of SSIs.
- **Communications and Engagement:** Supports the development and delivery of all external communication to stakeholders, media and public with SSI; support clinical teams in critically appraising all patient communication in relation to SSI i.e. patient letters, leaflets, and consent information; and providing updated staff communication regarding SSI i.e. frequently asked questions and staff messages.
- **Staff Engagement:** To support clinical teams to consider the impact of human factors and behaviour and develop staff awareness and engagement in activities related to SSI such as uniform, clinical standards and environment; to support a quality improvement culture and consistent application of required practice standards.
- **Environmental and Decontamination:** To maintain infection prevention and control (IPC) standards; to provide expertise and guidance on IPC measures in relation to SSI; to monitor and oversee ventilation safety, decontamination subcommittee, estates meetings with theatres, CCA and level 5, cleaning standards of environment and medical devices, and water safety; and to provide expertise for training and information in relation to the environment including cleaning of equipment.
- **SSI Patient Scrutiny Panel:** To ensure root cause analyses (RCAs) are completed for all patients with a deep or organ space SSI; to identify any omissions in care and review practice; to present all RCAs to the surgical mortality and morbidity (M&M) meeting to ensure multi-professional review; to identify any harm/risk and escalate a summary of harm reviews to the Safety Incident Executive Review Panel (SIERP) if required.

Each group has its own actions aimed at reducing SSIs as well as communicating the correct information to staff and patients. Each group reports directly to the SSI Stakeholder Group which is the senior decision-making group for the organisation regarding the current, ongoing, and future management of SSIs.

The task and finish groups have continued into 2024, following the reporting structure.

Royal Papworth Hospital has also sought external assistance in our surgical site infection rates, including a visit from NHS England who gave some observations and informal recommendations to assist our work in reducing SSIs. This included recommendations around adopting EVH as the routine method of vein harvesting, pre-op optimisation of HbA1c and weight loss management in diabetic patients, and the number of staff required in theatres being risk assessed. They also gave recommendations regarding the environment such as a process to ensure cleaning standards are met, ventilation review by an independent authorised engineer and observations for best practice within the building design.

Root Cause Analyses (RCAs) of deep and organ space SSIs

The SSI and wound care team have completed the full RCAs of all deep and organ space infections throughout 2023-2024 which have been reviewed at the scrutiny panel weekly. The RCAs look at the patients whole surgical pathway, to identify any factors that could be causative to the development of the SSI. Each RCA has been discussed at the meeting and sent to the individual consultant and surgical team involved in the patient's operation for comments. All findings have been acted upon in clinical practice.

Wound Care/Tissue Viability Team 2023-2024

The Wound Care team have been actively involved in supporting SSI patients through inpatient care on the wards as well as in outpatients wound clinic, working closely with parent surgical teams.

2023/2024 has shown that SSI rates at RPH remain elevated but are reducing and it remains a high priority within the trust. Additional surgical site surveillance that commenced this year has enabled us to monitor all cardiac surgeries and identify any trends and themes that may also occur in these groups.

The task and finish groups continue to progress with the actions set and report to the SSI stakeholder group fortnightly. The established RCA process for all deep and organ space infections continues to enable a thorough review of any potential causes and practice is changed from lessons learnt.

Sepsis

Sepsis in patients remains a potentially life-threatening condition and one that can be fatal if it is not appropriately recognised or if timely treatment is not instigated, and it is often reported that the first few hours are critical to the chances of survival.

The **Sepsis Six** bundle was originally developed by the UK Sepsis Trust (2005) as an operational solution to a set of complex, yet robust guidelines developed by the International Surviving Sepsis Campaign. It was revised in 2019 to reflect the latest evidence in the management of Sepsis and ensure that antimicrobials are used promptly, effectively, and efficiently. The bundle aims to provide a safe, standardised approach to assessing patients with potential sepsis and their subsequent management within the ward setting. It is also envisaged that by using the sepsis bundle, medical, nursing and the wider members of the entire multi-disciplinary team will have the required knowledge and understanding to recognise, treat and improve the outcomes for patients with severe sepsis.

As recommend by the NICE guideline (NG51) on Sepsis: Recognition, Diagnosis and Early Management published 2016, updated in March 2024 sepsis should be monitored locally and nationally. This is monitored through our Papworth Integrated Performance Report (PIPR) on a quarterly basis. As there is no Emergency Department (ED) within the Trust, our numbers of patients with Sepsis are small. Therefore, while the national quality requirement is 'based on a standard of 50 service users each quarter', we report on every patient confirmed with sepsis, alongside our quarterly audit data of compliance.

This report covers data for patients admitted into our ward areas and critical care area for the period 1st April 2023 – March 31st, 2024, as validated by the Lead Nurse(s) for the ALERT/ surgical ward ANP teams and CCA matron. The standards measured are below in the table.

Standards

	Aspect to be measured	Expected standard
1	Sepsis screening required	100%
2	Screening completed	100%
3	Sepsis 6 care bundle documentation completed	100%
4	IV antibiotics are given within 1 hour (excluding pts already on antibiotics)	100%

Sepsis audit analysis data

A detailed breakdown of Q1-Q4 data of those suspected to have sepsis and the compliance of completion of the standards from our quarterly audits against the Sepsis 6 bundle is shown below.

Q1	Q2	Q3	Q4
92%	74%	95.3%	94.2%

Whilst still above the Trust target of 90% during Quarter 1, 3 and 4, seven patients did not have a full septic screen completed, however all patients received antibiotics.

For Q2 we had a 74% compliance for full sepsis screening. This is lower than our target of 90%. From a review of this data there appeared to be potential suspected sepsis triggering staff to open the sepsis assessment bundle on the wards for patients, however not completed as not required, as other factors confirmed that it was not sepsis. No patients on the wards developed sepsis in this quarter and all patients received required antibiotics to prevent and potential sepsis devolving (as required). All CCA patients received antibiotics and potential sepsis was manged well.

Improvement updates and implemented in 2023-24:

- Working group is now in progress to fully implement (as applicable to our setting) the required changes to NICE guideline (NG51) Suspected sepsis: recognition, diagnosis, and early management (published 2016, updated in March 2024) and to incorporate these changes within our own hospital guidelines (DN598 Management of Sepsis).
- UK standards for microbiology investigations have been updated.
- In recognition of the wider roles undertaking by Advanced Clinical Practitioners (ACPs) a 'clinician' may be a non-medical prescriber who has responsibilities that include the prescribing of antibiotics.
- Emphasis is now clearly placed on using and interpreting NEWS2 scores within the context of the person's underlying physiology and comorbidities.
  - If a single parameter contributes 3 points to their NEWS2 score, a request for a high-priority clinical review by a clinician with core competencies in the care of acutely ill patients (FY2 or above) must be undertaken.
  - Furthermore, if there is a deterioration or an unexpected change in the person's condition, the NEWS2 score should be re-calculated and then a re-review.
- When the source of infection is confirmed or microbiological results are available then the antibiotic must be reviewed and if appropriate, changed to a narrow spectrum one.
- Sepsis recognition and management training during preceptorship and deteriorating patient study days.

- Ad hoc sepsis recognition and training for all staff using the tea trolley concept (taking education ward to ward, as an engagement event).
- Face to face sepsis training with all Doctors entering the trust on induction.
- There has been further work on the sepsis bundle template to aid documentation to be completed to improve compliance.

Acute Kidney Injury (AKI)

Acute kidney injury (AKI) is a common complication in hospitalised patients and is associated with increased risk of morbidity and mortality, and early detection and intervention to correct reversible causes is pivotal to patient safety. The number of patients who develop acute kidney injury continues to fluctuate as the incidence can depend on patient acuity & planned procedures. This report covers data for patients admitted to Royal Papworth Hospital who have had an acute kidney injury. The data has been validated by the Lead Nurse for ALERT and Surgical Ward ANP teams.

It is imperative that 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 - Acute kidney injury: prevention, detection, and management (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 within the guidance, is the AKI bundle, which is available on Lorenzo to ensure a safe, standardised approach to the assessment & management of patients with AKI within the ward setting. It includes staging of AKI, evidence of medicines review & daily creatinine level, and fluid balance & daily weights. 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.

Annual as part of our oversight and assurance we review AKI compliance against the Trusts Acute Kidney Injury Guidance (DN622). A summary of the outcome of this audit and our recommendation for improvement is detailed below.

Aims and Objectives

- To identify the total number of patients who develop AKI while at RPH.
- To ensure that the care bundle is used until symptoms are resolved.

Methodology

This audit focuses on the accurate use of the AKI care bundle which is recorded in the Patient electronic notes system (Lorenzo), for all retrospective patients who were identified as having AKI during the period April 2023 – December 2024.

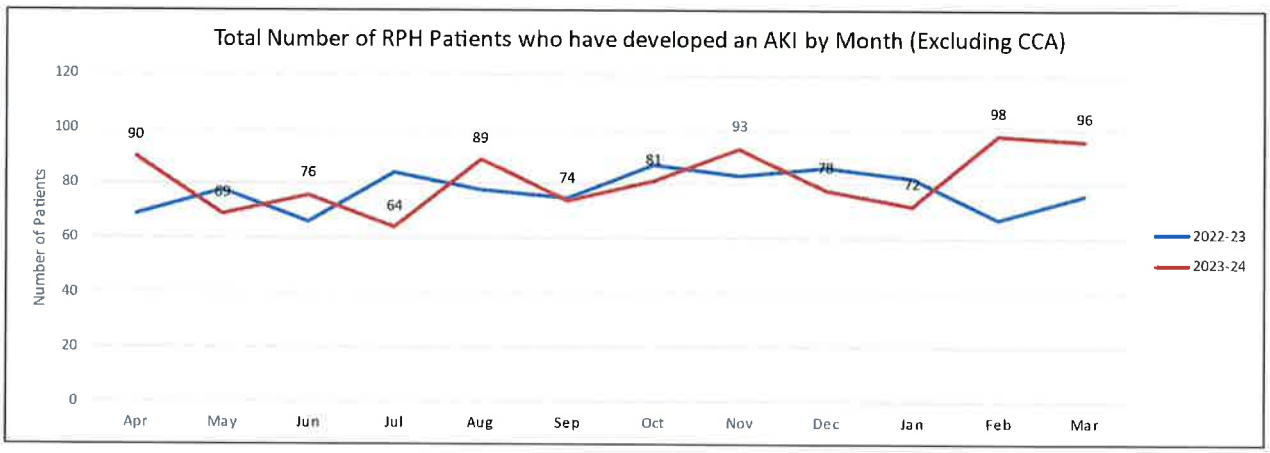
Sample

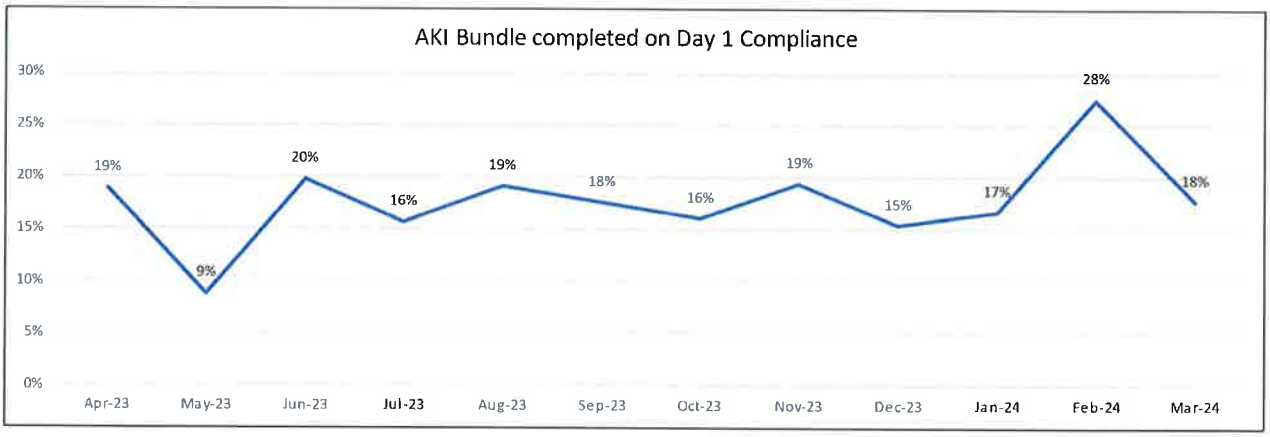
A total of 714 electronic notes for patients identified with AKI, were eligible to be included in this audit.

Criteria for assessing compliance with the AKI bundle:

Completed	AKI bundle is fully completed for every day of AKI
Partially started	AKI bundle is fully completed for 50% of total amount of days with AKI
Not started	No AKI pathway/ less than 50% of total amount of days fully completed
Excluded	CCA

Results:





Conclusion:

The current Acute kidney injury: prevention, detection, and management (2019) NICE guidance highlight the importance of early detection and management of AKI. The result of this audit highlights poor compliance of documented evidence of the AKI bundle.

Recommendation and action plan

- Improve documentation and compliance with the AKI bundle
- To raise awareness within the trust by including in Spotlight of the month by the education team –February 2024, and Message of the week, trust wide.
- Ongoing prompting from ALERT and surgical ANP's when reviewing patients on the wards to either complete or maintain bundle.
- Medical teams to highlight AKI to the ward staff when reviewing the bloods.

- Re-audit compliance with AKI bundle in June 2024 following implementation of action plan and disseminate results to all ward areas.

In February 2024, the detection and management of AKI featured in the trust's 'Message of the Week', and the teaching teams promoted AKI as the monthly topic for the wards. This was primarily done to underpin the expected standard of care in line with local and national guidance. Included in this was a guide to accessing and completing the AKI bundle on Lorenzo.

Pressure Ulcer Report: April 2023-24

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 which include patient co-morbidities and external factors such as shear and skin moisture (NPUAP 2019).

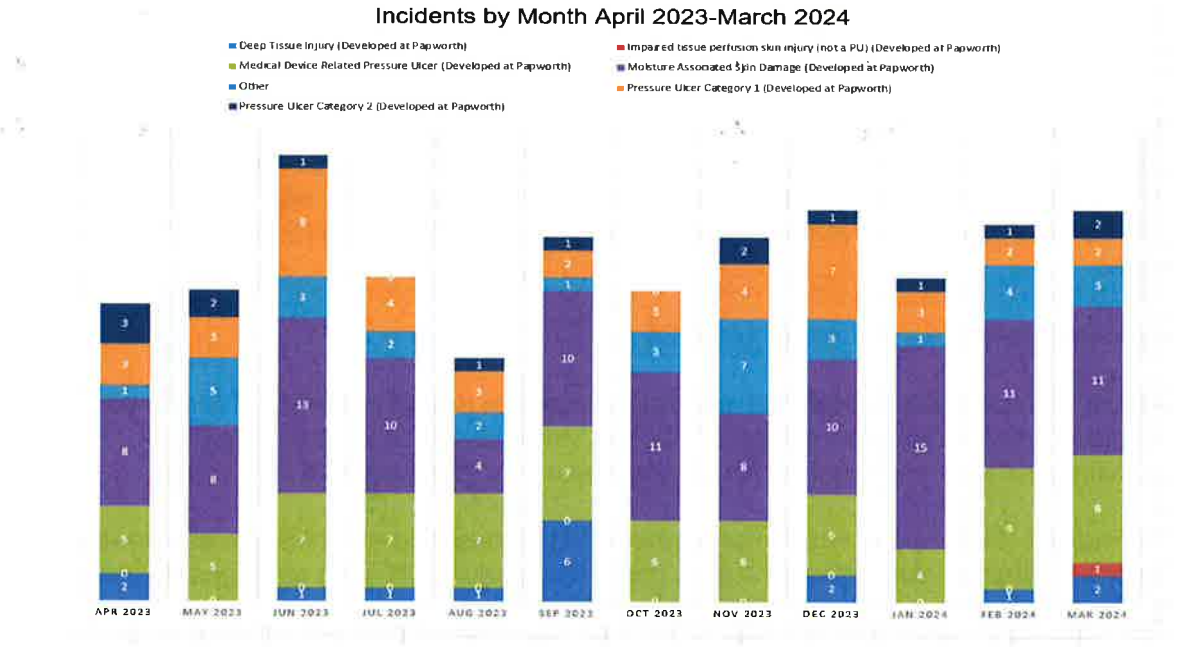
NHS England (NHSE) and NHS Improvement (NHSI) describe eight main pressure ulcer categories, ranging from category 1 to 4, deep tissue injury (DTI), an unstageable category, medical device related skin pressure ulcers (MDRPU) and moisture associated skin damage (MASD) (NHSI & NHSE 2018, appendix 1). The paper states that all pressure ulcers should be reported through local reporting systems with the exception of category 1 ulcers. However, at RPH, we agreed through scrutiny panel that for the purposes of clarity, greater situational awareness, and learning, we will report all categories of pressure ulcers and MASD.

Category 2 pressure ulcers or deeper are confirmed where possible, in person, by the Tissue Viability Nursing (TVN) team or an experienced TVN link nurse once an incident report has been raised. In keeping with the NHSE and NHSI guidance, all category 2 ulcers or deeper, are subject to a root cause analysis (RCA) of the incident.

In total, there were 307 pressure ulcers, medical device related pressure ulcers (MDRPU), or moisture associated skin damages (MASD) reported during 2023/24 that developed at Royal Papworth Hospital (see table below) This represents a slight increase from 2022/23 when 288 were reported. Of those reported in 2023/24:

- 111 were pressure damage over bony prominences.
- 119 were skin injuries caused by moisture exposure.
- 77 were related to the placement of medical devices.

Of the 307 reported, 15 were category 2 superficial depth pressure ulcers and 16 were deep tissue injuries. There were no deep category 3 or 4 pressure ulcers reported.



Pressure ulcers, MDRPU and MASD by month

Whilst there has been a small increase in overall numbers reported this year, 307 vs 288 for 2022/23, there has been a significant reduction in deep tissue injuries (no break in skin but suspicion of deeper than superficial damage) from 24 in 2022/23 to 16 in this reporting year.

The TVN team undertake a biannual point prevalence audit where they inspect the skin of all inpatients on two set dates, and the results from the audits undertaken in January and March 2024 found rates of pressure ulcer development to be low. During the audit, it was assuring to note comparability between pressure ulcers reported through incident reporting and those seen on bedside audit were consistent.

The sustained low rate of deep pressure ulcers and the reductions in deep tissue pressure ulcers can be linked to two initiatives that were undertaken during the year:

- Embedding the Simple Safety for Skin (SSS) campaign into practice. This is an ongoing project that focuses on the prevention, identification, and management of Moisture Associated Skin Damage (MASD) which is a superficial skin injury which if not identified early can lead to deep pressure ulcers development. This project also explains the relatively high number of superficial depth MASDs identified (119) and the low number of deep pressure ulcers, as early identification at the superficial stage enabled clinical areas to put in place further preventive measures.
- The introduction of a Managed Air Mattress trial has seen a significant increase in dynamic mattress availability.

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 (Gannon et. al., 2021, Fletcher and Hall 2018, Smith et. al., 2017). For example, the trust uses Datix as our primary reporting system which is reliant on clinicians recognising

and identifying the correct category of pressure ulcer and then reporting it appropriately following training in how to use the system.

The trust biannual point prevalence audits record the numbers of pressure ulcers on a set date and are extremely useful in validating the trends that are identified through Datix reporting.

A strong clinical presence by the Wound Care TVN team is a vital part of our monitoring strategy as visibility and availability plays an invaluable role in the correct identification and grading of pressure ulcers. This expert clinical presence supports NHSE and NHSI standards regarding confirming the category of ulcers before they are reported formally.

Pressure Ulcer Scrutiny Panel Outcomes
As described previously, a root cause analysis (RCA) investigation is conducted for all pressure ulcers of category 2 and above. The RCA is reviewed at the trust Pressure Ulcer Scrutiny Panel which meets quarterly. The panel is made up of trust wide nursing representation and reviews each RCAs and then concludes whether all appropriate care was in place and whether the pressure ulcer could have been prevented. The panel also identifies learning and agree action plans with the clinical teams and monitor trend in pressure ulcer development and has oversight on the performance of current preventive and management projects.

Below is the number of pressure ulcers reviewed at scrutiny panel associated with acts and omissions in care.

	Cat 2	Cat 3	Cat 4	DTI	Unstageable	Total
2023/24	5	0	0	5	0	10
2022/23	3	1	0	11	0	15
2021/22	5	1	0	5	0	11
2020/21	6	1	0	5	0	12
2019/20	3	1	0	8	2	14

In all incidences where acts and/or omissions in care were noted, the trend conclusion was linked to the standard of documentation in the Lorenzo EPR. This was a trend not seen in Metavison (Electronic Patient Record used on Critical Care). Overall, there has been some improvement in the overall number of acts/and omissions in care compared to previous years. This coincides with significant education initiatives provided by industry partners in pressure ulcer care and our team focusing on reporting standards at ward handover, simplification of the SSKIN care bundle document within Lorenzo, the role out of the Simple Safety for Skin project to the general ward areas and the introduction of the Dynamic Air Managed Mattress Service to all ward areas. A reduction in staffing vacancies across the Trust towards the end of the reporting year may also have impacted positively on outcomes.

Action highlights from 23/24

1. **Documentation**
   Pressure ulcers associated with acts and or ommissions in care were linked to the standard of documentation in the Lorenzo EPR system where patients may have had the care needed but this was not documented.

- The SSKIN care bundle form on Lorenzo where pressure area care is documented has been simplified and consolidated.
- Implementation of one standardised SSKIN care bundle to be used across the hospital.

2. **Simple safety for skin project**
During the COVID-19 pandemic the need for critical care increased, and the introduction of this simplified system led to a significant reduction in MASD's which our data indicated was the most common skin injury.

This project was extended beyond the Critial Care Area and launched in September 2023 on the wards. It simplified pressure ulcer and MASD hygiene to one single type of skin friendly wash, with one long-acting skin protectant product, and a focus on repositioning schedules and use of the dynamic mattress system for high-risk patients.

This system was accepted for publication in the journal Wounds UK in 2021, is currently the subject of a national industry supported education roadshow and was presented as a plenary talk at the 2023 Tissue Viability Society conference before been presented to a pan-European expert panel in June of this reporting year.

Conclusion:

- The rate of deep pressure ulcers has reduced in 2023/24 in comparison to 2022/23.
- There is a strong and robust reporting culture in place to record pressure ulcers using a multi-modal monitoring strategy. This was demonstrated in the consistency of reported rates of pressure ulcer formation with those identified during prevalence inspection audits.
- MASD and MDRPU remain a principal challenge in respect to prevention.
- There are challenges in the documentation with the architecture of the Lorenzo EPR systems despite support from our IT team to simplify the relevant forms.
- The appointment of a Wound Care TVN nurse educator (currently 1 day per week) represents a wise trust investment in preventative care going forward.

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Patient Safety Incidents

There were 3017 patient safety incidents and near misses reported on the Trust's incident management system (Datix) that occurred in the financial year 2023/24. This is within our expected variations for incidents reported in year and 5 more than last year when 3012 were reported. There continues to be a healthy safety culture within the Trust and an understanding of the importance of learning from incidents and the CQC requirements to report all incidents under the Safe Domain.

Those graded as near miss, no/low harm over the last 12 months (99%) demonstrate 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.

The table below displays the number of incidents by severity reported for each year.

Incidents by Severity	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024*
Near Miss	511	375	305	153	166
No harm	2349	1500	1722	1553	1517
Low harm	724	704	916	1261	1297
Moderate harm	11	21	24	28	13
Severe harm	5	7	3	3	5
Death caused by the incident	1	0	0	1	1
Death UNRELATED to the incident	11	11	11	13	18
Total	3612	2618	2981	3012	3017

Patient Safety Incidents by Severity (Data source: DATIX 18/04/24)
*Correct at the time of production. Some incidents may be regraded in severity following investigation.

The level of investigation carried out after a patient safety incident is determined by the level of severity, with moderate harm incidents and above being reviewed at the Trust's Serious Incident Executive Review Panel (SIERP). 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.

Patient Safety Incident Response Framework (PSIRF)
PSIRF went live in the Trust in January 2024. It changes how the NHS responds to incidents and how we learn from them. PSIRF is about creating a supportive culture that prioritises safety by avoiding inappropriate blame of individuals and provides the tools to create a culture of learning and improvement. It helps us to look beyond the actions of people and at the systems we work in. It allows us to identify our key safety priorities and take a proactive proportionate approach to patient safety events.

Under PSIRF all NHS Providers are required to start using the new national system called Learning from Patient Safety Events (LfPSE). We have successfully migrated the new LfPSE template into our Datix system for incident/event reporting and we went live in the Trust on the 19th March 2024. The new LfPSE template captures information on patient safety in healthcare, which automatically uploads into the national system.

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 2023/24 linked to a retained item found after surgery. The retained item was not on the formal swab count, however, was used as an alternative for an item which is on the formal swab count in theatres. Therefore, in recognition of the potential patient safety implications and Trust learning, the incident was classified as a Never Event. The incident did not cause harm to the patient and was investigated as an organisational incident.

Reducing falls and reducing harm from falls

With an ongoing focus on Harm Free Care within the Trust, reducing the number of falls sustained by patients and reducing the ensuing harm remains a high priority. Monitoring of numbers of falls is achieved through Datix incident reporting system and feeds into the Ward Scorecard and forms a core focus of the Falls Prevention and Management Group and the work of the Falls Prevention Specialist Nurse.

Under the Management of Health and Safety at Work Regulations and CQC Regulation 17, the Trust has a responsibility to protect all patients from harm and "so far as is reasonably practicable" carry out "suitable and sufficient" patient and health & safety risk assessments to that ensure they remain safe.

PSIRF (Patient Safety Incident Response Framework), renews the focus of listening to patients, carers and staff and informs action to improve patient safety. Harm Free Care is defined as an absence of four common harms: pressure ulcers, harm from falls, urine infections in patients with a catheter, and venous thromboembolism (VTE).

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 building premises health & safety, and to ensure that appropriate action is undertaken. All falls are reviewed by the Falls Prevention Lead.

In 2023-2024 a total of 151 falls were reported. This is compared to 146 the previous year. It is notable that patients being admitted to our services are overall increasing in age and becoming frailer. Challenges to waiting list times have been seen due to industrial action and backlogs arising from the pandemic.

Throughout the year there have been regular occurrences of, patients being lowered to the ground, no and low harm falls and a moderate harm fall. 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 for falls are reviewed at QRMG and at the Band 7 ward sister and charge nurses' meetings.

There were no serious incidents from falls in the financial year 2023-2024. There was 1 moderate harm incident, while in the previous year 2022-2023 there were 5 moderate harm falls.

Themes arising from falls overall, were patient frailty, trailing ECG cables and association with mobilising to bathrooms. Delirium/ confusion was noted in 11 falls. 115 of the 162 falls were unwitnessed.

Concerning the moderate harm fall and continuing from previous work, several actions have been put in place:

- Ongoing promotion 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.
- Link Nurse Roles generally have been harder to promote due to low staffing levels. Ward Managers are raising falls issues at the ward meetings.
- Promotion of the use of clips to help prevent cables trailing and causing trip hazards.
- Review and promote use of falls alarms when appropriate, including when patients are stepped down from one-to-one care.
- Telemetry to be introduced where necessary to avoid the hazard of trailing cables.
- Implementation of training for PSIRF in order to identify themes for falls prevention and harm minimisation.

The table below demonstrates the number of actual falls per quarter across the year. The learning from falls incidents is shared at the Quality & Risk Management Group and among various clinical and nursing forums.

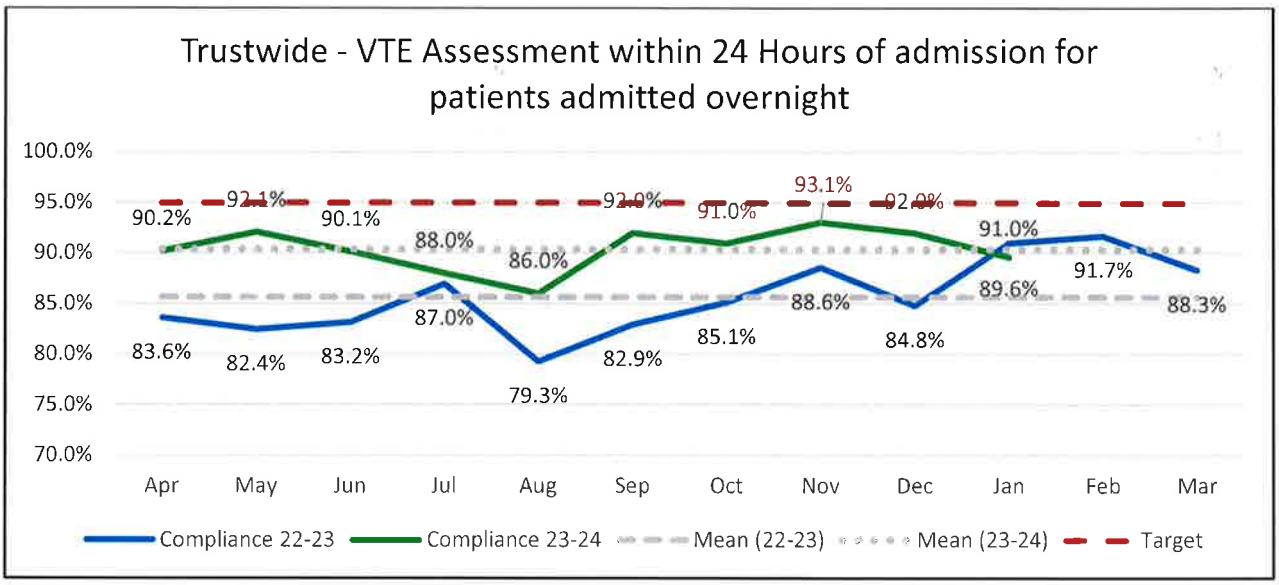
Financial Year	Q1	Q2	Q3	Q4	Total
2019/2020	31	25	44	37	137
2020/2021	25	39	53	28	145
2021/2022	29	45	34	42	150
2022/2023	35	38	38	35	146
2023/2024	37	32	38	44	151

Source DATIX 20/04/2023

Prevention of venous thromboembolism (VTE)

Venous Thromboembolism (VTE) Assessment on Admission is mandated by Trust procedure for all overnight admissions at RPH.

VTE Trust procedure utilises national guidance from NICE and the Department of Health (DoH) as its foundation. The criteria for the VTE Assessment on Admission Monthly audit are the % of patients, who stayed overnight, who had a VTE risk assessment completed within the first 24 hours of their admission, for patients who had a length of stay of greater than 24 hours. The trend over the last rolling 12 months of compliance can be seen below in the graph, the target is 95%.



VTE remains an area of particular focus and continues to be monitored through monthly Trust quality & risk meetings and divisional performance meetings.

We continue to work with the clinical teams to support improvement with VTE assessment compliance. Consultant VTE medical lead took up post end of September, and medical champion roles in place across divisions and VTE link nurses and AHPs meet bi-monthly.

Digital options for a clinical prompt for outstanding VTE assessments reviewed and unlikely within the current EPR system, and considerations to be taken forward with any new EPR system. Internal VTE clinical indicator view within the current electronic patient record reviewed and optimized to highlight patients in need of VTE risk assessment before the 24h target.

A communication strategy implemented with the support of digital teams, to deliver new initiatives to raise awareness of VTE risk amongst clinical staff and patients. A focus to empower and increase patient VTE awareness further in 2024. As well as planned education and training for junior doctors.

A continued focus on the informatics and engagement, both at a clinical and patient level for 2024/25 planned.

There were no solely hospital attributable thrombosis events and no harms occurred from incidents reported.

Patient Experience Domain

Patient Stories

Patient stories continued to form an integral element of capturing the patient experience throughout 2023/24. Members of staff representing a variety of professions have presented at the Board of Directors, Quality & Risk Committee, and at professional meetings such as the Clinical Professional Advisory Committee, Band 7 meeting, Management Executive, Patient and Public Involvement Committee, and the Patient Experience and Safeguarding groups.

Patient stories are also included in monthly Matron reports for the Clinical Divisions which provide a valuable opportunity for discussion directly with the senior multidisciplinary team and reports are circulated to teams for further learning. This practice has continued during 2023/4. Quarterly divisional quality reports to the Quality and Risk Management Group now include examples of patient stories, if available, for sharing of learning.

Learning from patient stories

Royal Papworth Hospital recognise that patient stories are another important contribution to improving the quality of the services we provide. Patient stories offer a fantastic opportunity to obtain detailed feedback from individuals on the care they receive. It is therefore important that the individual sharing their story understands the process for capturing patient stories and how their story will be used.

In 2022/23 the Patient Experience Manager working in collaboration with staff from across the organisation (Matrons, Allied Health Professionals and Support Staff) undertook a review of the current process for collecting patient stories and developed a consent form and patient information leaflet. The consent form will be used to obtain a patient's consent to use their story to understand more about the health and care services we provide to our patients, their families, and carers. These documents are the initial phase of developing an agreed process for obtaining and sharing patient stories. In 2023/24, we will be developing a range of methods to support staff in capturing patient stories and for presenting these stories at Board Level, whilst ensuring this feedback is used for instigating positive change and improvements.

The Board have heard stories patients that bring the experience of our patients to life with reports from across the organisation that share the challenges, successes and learning from each individual story. The following seven stories provide information from our patients and staff to illustrate this:

- A patient that joined the Board of Trustees meeting with her husband and members of the Critical Care and Allied Health Professionals teams to tell her story of spending 113 days on ECMO and 130 days in the critical care unit. The patient thanked all at the hospital for the care she had received and shared a video of how staff had helped her and worked with her. The video showed how staff helped her to exercise and improve hand her coordination by using handheld shakers to play in time with members of staff who were playing guitar in her room to encourage her rehabilitation. The patient also explained how she had appreciated being pampered during her stay as staff provided her with a foot spa and applied face masks and she really appreciated the kindness and the time that staff spent with her. They arranged a visit outside for her which required a doctor, a perfusionist, a critical care nurse and a

care assistant, but it meant that she could see and enjoy the sunshine and allowed for some visitors to come together to see her for a few minutes. The story was a showcase for increasing the level of intervention for long stay patients on critical care, offering treatments and going back to the roots of care.

- A member of the Cardiothoracic Support Team who was the first point of contact for patients having elective cardiac procedures and those in the thoracic benign (non-cancerous) service. This story related to a patient who had attended a nurse led clinic prior to admission for an angiogram and detailed the support that they required from the team about stopping smoking and the correct diet. The patient has specific communication needs as English was their second language. After the procedure , when the patient was reflecting on their journey, they said that they felt well informed about the procedure and were appreciative of the information that had been given to them at their pre-admission appointment. The story demonstrated the importance of the preadmission process and the time and vital information that can be given to patients at this time to help with lifestyle advise as well as helping our patients understand what to expect from the procedure.

- In May, the Trust held an event entitled 'Death Matters' in the hospital atrium. The Trust Consultant in Supportive and Palliative Care shared the journey of a patient who was being supported by the Supportive and Palliative Care Team with the Board about the continuity of care that they received within the hospital and outside of the hospital at both the new RPH site and the previous site. The team provided emotional support to the patient, most importantly listening to them to try and make sense of previous losses that had had a profound effect on them. The patient feedback from this experience was that they said that the hospital team were exceptional and was glad to see that the special and unique atmosphere at the previous hospital site had transitioned to the new one, which was immensely reassuring.

- A Ward Sister from the Respiratory Sleep and Support Centre (RSSC) presented a story concerning a patient that was transferred from a district general hospital (DGH) following a recent heart attack who had also a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The Trust's Respiratory Sleep and Support Centre receives many referrals from critical care units around the region due to its expertise and skills in being able to wean patients from invasive ventilation. The story followed the patient's journey as they were gradually weaned from their ventilation system which included having their tracheostomy removed. The patient and their partner praised the staff from the Respiratory Sleep and Support Centre saying for their specialist knowledge which made them feel safe also gave them confidence. The patient also recalled their concern regarding their first arrival at RPH as they could not communicate verbally and understandably found this difficult but said that it was really reassuring to know that at all times they were treated with dignity by staff.

- The Board of Trustees also heard a story regarding a patient with non-specific learning disabilities who was on the urgent transplant list and had been waiting five months on the list as a patient in the hospital. Unfortunately, the patient needed to return to theatre and critical care a further four times due to recognised clinical issues that occurred following their transplant. However, despite this, the patient provided really positive feedback and said how appreciative they had been of all the treatment that they received saying that they felt safe in the hospital, even if they did

miss playing their games and watching the television streaming services that they were able to access at home.

- The Board also heard about the importance of the dietician service to our patients, especially to those patients who, for whatever reason, had a long stay at the hospital, and those patients who have been diagnosed with eating disorders

- Finaly the Board heard an uplifting story regarding the organ donation pathway from the Specialist Nursing team for Organ Donation and the support that they provide to potential donor families. When the team work with them, it is naturally a devasting and very vulnerable time for them and by the nature of the work it can also be quite time critical. It was therefore pleasing to hear the team describe their recent communication training has helped them to improve the service that they are able to provide to families at this particularly sad time.

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning.

There are many different causes of dementia and many different types. People often get confused about the difference between Alzheimer's disease and dementia. Alzheimer's disease is a type of dementia and, together with vascular dementia, makes up the majority of cases. Dementia symptoms may include problems with:

- Memory loss
- Thinking speed
- Mental sharpness and quickness
- Language, such as using works incorrectly, or trouble speaking
- Understanding
- Judgement
- Mood
- Movement
- Difficulties doing daily activities

People with dementia can lose interest in their usual activities and may have problems managing their behaviour or emotions. They may also find social situations difficult and lose interest in relationships and socialising. Aspects of their personality may change, and they may lose empathy (understanding and compassion). A person with dementia may see or hear things that other people do not (hallucinations).

Because people with dementia may lose the ability to remember events, or not fully understand their environment or situations, it can seem as if they are not telling the truth or are wilfully ignoring problems. As dementia affects a person's mental abilities, they may find planning and organising difficult.

Maintaining their independence may also become a problem. A person with dementia will usually need help from friends or relatives, including help with making decisions. The symptoms of dementia usually become worse over time. In the late stage of dementia, people will not be able to take care of themselves and may lose their ability to communicate.

The NICE guidelines for Dementia: assessment, management and support for people living with dementia and their carers. NICE states providing care and support is very complex, because of the number of people living with dementia and the variation in the symptoms each person faces. This has led to considerable variation in practice. Areas that pose particular challenges for services and practitioners may include:

- coordinating care and support between different services
- what support carers need, and how this should be provided
- staff training

This guideline makes evidence-based recommendations aiming to support these areas of practice.

Dementia also has significant costs for health and social care services. Because of this, it is important to ensure that people living with dementia can get the care and support they need, and that services provide this in an efficient and cost-effective way.

In addition, new methods for diagnosing and assessing dementia have been developed. Amyloid imaging techniques have been licensed for use in the UK, and new evidence is available for cerebrospinal fluid examination. There is also evidence on different approaches to assess and diagnose dementia subtypes. The guideline makes new recommendations on dementia diagnosis, based on a review of the latest evidence.
This guideline addresses how dementia should be assessed and diagnosed. It covers person-centred care and support, tailored to the specific needs of each person living with dementia. As part of this, it can help professionals involve people living with dementia and their carers in decision-making, so they can get the care and support they need. It also addresses care coordination and staff training, and how dementia may impact on the care offered for other conditions.

NICE guidelines does not cover every aspect of dementia care or support, or areas where recommendations would be the same for people with or without dementia. It focuses on areas where:

- there is variation in practice, and enough evidence is available to identify what works best
- people living with dementia need different care and support to people in the same situation who do not have dementia.

The Trust is currently compliant with these guidelines

NHS Dementia Guide (2020)
People who are living with dementia are entitled to be free from abuse and neglect and where abuse is experienced, and action should be taken to stop and prevent it. The Care Act (2014) provides Local Authorities with a duty to safeguard adults.

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.

We seek to offer our patients and their carers with dementia safe individualised care, and to be treated with respect, and well informed whilst in our care.

The first Royal Papworth Hospital Dementia strategy was created in 2015 to enhance the experience of patients and carers living with Dementia. Work has commenced to create a combined strategy for vulnerable patients which will encompass those with learning disabilities, autism, acute mental health problems as well as dementia.

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 are put into practice.

The dementia audit undertaken early Feb 24 reviewed the completion of The Kings Fund EHE Environmental Assessment Tool looking at 'Is you ward dementia friendly?'

The audit was undertaken by 5 hospital volunteers on all wards. This will provide data on whether the care environment is appropriate for patients with Dementia and identify areas for improvement. This data can be used to inform Trust strategy and policy with regards to the management of patients with Dementia.

Currently, we are still waiting for our clinical team to divulge the data. We will analyse and develop further plans. The trust is developing a strategy to combine the work with delirium, through our delirium workgroup with sponsorship of Deputy Chief Nurse.

Learning Disabilities and Autism

Definitions

Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities.

Learning disability is defined by Mencap as *'a reduced intellectual ability and difficulty with everyday activities, for example household tasks, socialising or managing money which affects someone for their whole life.'*

Autism is defined by the National Autistic Society as *'a lifelong developmental disability which affects how people communicate and interact with the world. More than one in 100 people are on the autism spectrum and there are around 700, 000 autistic adults and children in the UK.'*

Statutory and regulatory requirements

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 Health and Care Act (2022) introduced a requirement that all regulated health and social care service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role.

The Government Mandate (2022-23) to NHS England focused on improving services for people with learning disabilities and on supporting them in the community to reduce reliance on mental health inpatient care. This was felt to be particularly important given the impact of COVID-19 on access to NHS services.

The Disability Rights Commission (DRC) have one key goal 'a society where all disabled people can participate fully as equal citizens (2022). 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 (DRC, 2022).

The NHS Long Term Plan published in 2019 pledged that over the next five years, the national learning disability improvement standards will be implemented by all services funded by the NHS to ensure people with learning disabilities and/or autistic people can receive high quality, personalised and safe care when they use the NHS. The plan aims to improve people's health by making sure they receive timely and appropriate health checks, while improving the level of awareness and understanding across the NHS of how best to support them as patients.

Performance against the learning disability improvement standards

The four improvement standards against which NHS Trust performance is measured cover:

1. Respecting and protecting rights.
2. Inclusion and engagement
3. Workforce
4. Specialist learning and disability services

The first three 'universal standards' apply to all NHS Trusts and the fourth 'specialist standard' applies specifically to Trusts that provide services commissioned exclusively for people with a learning disability and/or autistic people.

A Trust's compliance with these standards demonstrates it has the right structures, processes, workforce, and skills to deliver the outcomes that people with a learning disability, autistic people, their families, and carers expect and deserve as well as commitment to sustainable quality improvement.

Royal Papworth Hospital participated for the sixth year running in the NHSEI Learning Disability Improvement Standards self-assessment to better understand the experience of our patients. The results will be published later in 2024 for Year 6.

Progress to improve the experience for patients with learning disabilities and/or autism at Royal Papworth Hospital.

1. Respecting and protecting rights

- Royal Papworth Hospital takes its responsibilities to respect and protect the rights of those patients who are vulnerable. It is important to ensure that patients who are vulnerable have their rights protected and respected.

- This is undertaken in a variety of way through consistent and responsive individualised care planning. Patients who have a learning disability or who have autism are supported through this process by ensuring staff recognise and respond to the patients' individual requirements on admission to its services. These reasonable adjustments are required by law and are frequently made but not consistently recorded.
- Providing reasonable adjustments by working closely with the patient and their nominated carer/guardian/significant other to enable the person to feel safe and empowered to make decisions about their care wherever possible. Recognising the family and carers expertise in managing the person in the hospital environment can be empowering and this featured as a patient story at the Safeguarding Committee
- The use of hospital passports is encouraged as these patients held records can significantly improve communication between the patient, significant other (where deemed appropriate and consented for) and care staff. Learning from a local Safeguarding Adut Review (SAR)- "Mark" published by Cambridgeshire and Peterborough Safeguarding Adult Partnership Board in December 2022, noted that '*It is important that documents such as hospital passports are kept up to date for informing health professionals about patients with complex social and health needs'.*
- While the passport is a patient held record – staff need to check that the information is up to date. We are creating a staff guide to prompt staff re checking that they are up to date. The Royal Papworth version of the passport has been updated to include information any Dols / court of protection order and lasting power of attorney welfare involved as well as contact details for professional involved.

Inclusion and engagement

- There are communication resources for patients with Learning Disabilities which are available for staff use: https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/5-good-comms-standards-easy-read.pdf
- The Trust recognises that a low stimulus area for patients with learning disabilities and/or autism is recommended however it has been challenging to identify a dedicated space whilst remaining sensitive to requirements versus the availability of suitable space. The Trust can support individuals on a case-by-case basis if patients' needs are identified earlier in the patient pathway.
- A quiet area offering lower stimulus is provided on the Day Ward.
- As a regional and national centre we recognise the financial impact for families of people with learning Disability or Autism. The use of charitable funds to provide financial to support families to allow them to stay locally to provide support, reduce stress and anxiety has been invaluable.

Workforce

- The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for staff training and is the Government's preferred and recommended training for health and social care staff to undertake. It is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the only training with permission to include Paula McGowan OBE, telling Oliver's story and explaining why the training is taking place.
- HEE is working with partners to arrange trainers' training that will prepare people with a learning disability and autistic people to co-deliver the online interactive and face to face sessions of The Oliver McGowan Mandatory Training on Learning Disability and Autism. Each Integrated Care Board (ICB) is being supported to develop training capacity. The ICB and its partners are currently working on the details of how this will be delivered.

- The eLearning package is the first part of both Tier 1 and Tier 2 of the Oliver McGowan Mandatory Training was launched 6 Nov 2023 at Royal Papworth Hospitals and our compliance as of the 31/03/2024 was 55.94%.
- The 2nd part of the training (either a live one hour online interactive session for those needing Tier 1, or, a 1-day face to face training for people who require Tier 2) is yet to be rolled out at Royal Papworth. The details of how this is to be delivered is still being discussed at the ICB. It is expected that the ICB will start rolling out the Online version of tier 2 (60 mins) in later Spring/ early summer.

2022-2023 Data for patients with learning disabilities and autism

The numbers of patients attending RPH with Learning Disabilities and Autism are low. Data submitted for the most recent NHS England Learning Disability Improvement Standards has not yet been published.

Inpatient data April 2023- March 2024

55 admissions out of 24,213 admissions were for patients with learning disabilities/autism. That equates to 32 unique patients with learning disabilities/autism were admitted out of 17,684 unique patients.

Outpatient Data April 2023- March 2024

264 attended outpatient appointments out of 123,304 attended outpatient appointments were for patients with learning disabilities/autism.
83 unique patients with learning disabilities/autism attended an outpatient appointment out of 46,268 unique patients.

Reasonable Adjustments in period

15 patients were recorded as Reasonable Adjustments being "needed". Only 9 patients were recorded as having been "made".

Future planning for patients with learning disabilities and autism

- The first part of The Oliver McGowan training was rolled out across the trust on 6th November 2023. In common with the rest of the ICB we have not yet started the delivery of the 2nd part of this training. This is expected to start this year as part of a wider ICB collaboration.
- We remain committed to hear the voice of our patients with learning disabilities and/or autism through patient stories. There is clear need for a continued proactive approach to make accessible these stories and to embed that learning across the Trust.
- We monitor patients with a learning disability and autism on 'Access Plan' waiting lists and report quarterly to the Joint Safeguarding Committee. There is however a need to review the patient referral pathway to ensure patients with a learning disability and/or autism are identified *as standard* to allow for the adequate provision of appropriate support on admission, e.g. allocation of low stimulus area.
- The development of an icon for Learning Disability and Autism has been ruled out by the provider of our current electronic patient record Lorenzo as the developer Dedalus is no longer supporting the development. The contract for Lorenzo expires in June 2027. The ability to easily flag presence of patients with additional needs is an important function to be included in any new electronic patient record.
- The ICB is rolling out Learning Disability Alerts across the system which will help provide a more seamless service for patients from within the region.
- A virtual hospital tour is already available on the public facing website; however the Communication Team are supporting plans to develop a virtual tour for patients with

learning disabilities and/or autism on the website (* will also apply to dementia) to support a positive patient experience when attending and/or visiting the hospital. This will supplement our easy read "getting ready for hospital".

- The use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for patients with Learning Disability or Autism is being audited this year. The results will be shared with the safeguarding committee along with the ReSPECT steering group.
- The Trust will consider the contribution of patients with a learning disability and/or autism to the Patient Experience Strategy which is currently being reviewed.

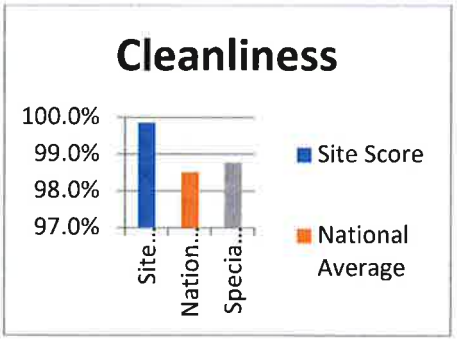
Patient Led Assessments of the Care Environment (PLACE) Programme 2023

All healthcare providers are required to take part in the national Patient-Led Assessment of the Care Environment (PLACE) annual inspections. PLACE is a national self-assessment tool designed to measure standards of:

- Cleanliness,
- Food comprising Organisation Food and Ward Food
- Privacy, Dignity & Wellbeing,
- Building Condition, appearance & maintenance,
- Dementia friendly environment
- Disability friendly environment
-

The Health & Social Care Information Centre (HSCIC) provide comprehensive guidance on the organisation and conduct of assessments and separate guidance documents for staff assessors and patient assessors. PLACE assessments are carried out by internal and external assessors within inpatient facilities and the surrounding patients assessed environment. Assessors include Governors, Volunteers, Trust members and representatives from the Trust's facilities contractors. Staff areas and clinical treatments are excluded from this assessment.

The tables demonstrate the Trust performance against the national average. The Trust has scored above the national average in the following areas: cleanliness; food including organisation food and ward food; condition, maintenance and appearance, dementia and disability, demonstrating that the new site is of an exceptional standard.


Cleanliness
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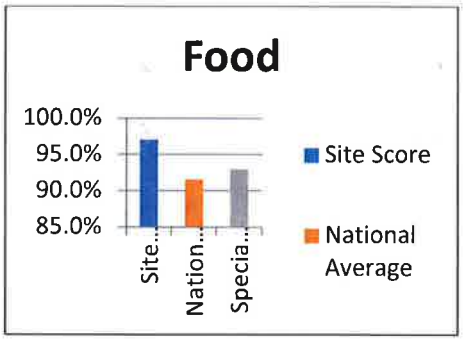
99.0%
98.0%
97.0%
Site...
Nation...
Specia...
Site Score
National Average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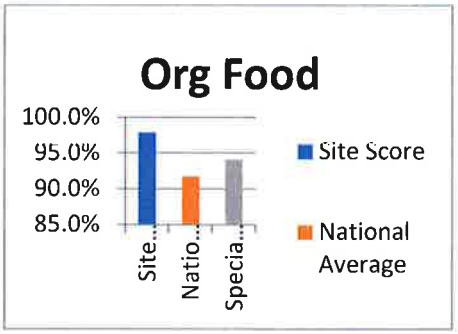
90.0%
85.0%
Site...
Nation...
Specia...
Site Score
National Average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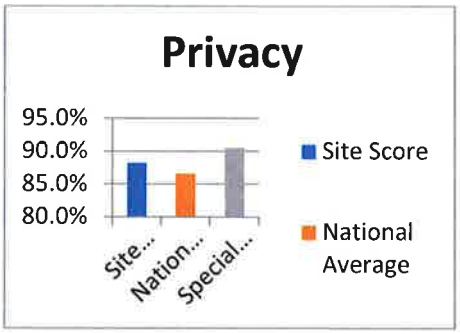
Site...
Natio...
Specia...
Site Score
National Average


Privacy
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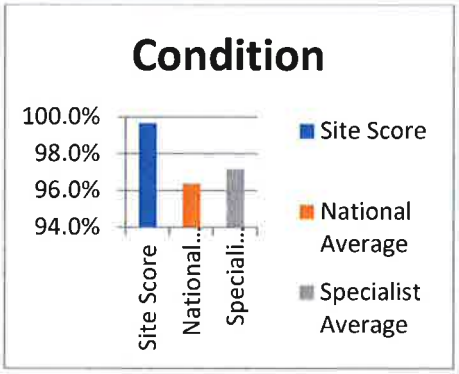
90.0%
85.0%
80.0%
Site...
Nation...
Special...
Site Score
National Average


Condition
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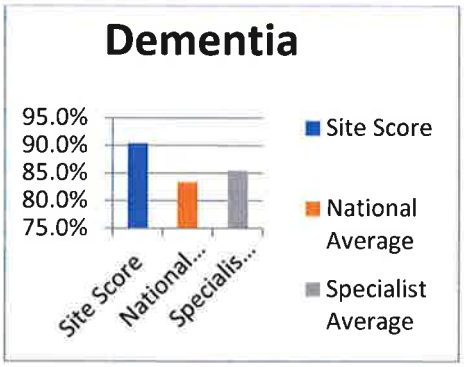
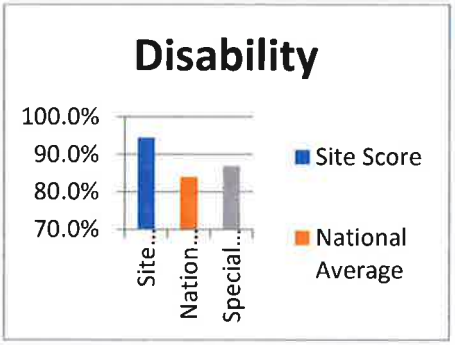
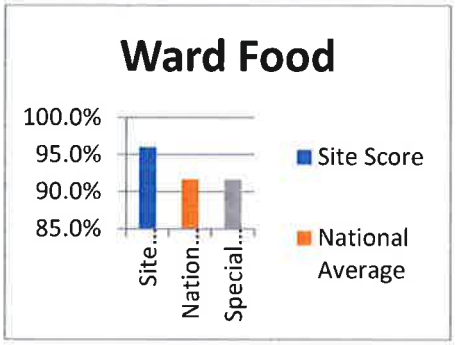
98.0%
96.0%
94.0%
Site Score
National...
Speciali...
Site Score
National Average
Specialist Average


Dementia
95.0%
90.0%
85.0%
80.0%
75.0%
Site Score
National...
Specialis...
Site Score
National Average
Specialist Average


Disability
100.0%
90.0%
80.0%
70.0%
Site...
Nation...
Special...
Site Score
National Average


Ward Food
100.0%
95.0%
90.0%
85.0%
Site...
Nation...
Special...
Site Score
National Average

Area	2023 Site Scores	2023 National Average	Comments
Cleanliness	99.86%	98.52%	The Trust's cleaning service OCS are continuing to uphold the levels of site cleanliness and managed to maintained staff numbers throughout the year. The audit results show that cleaning has scored above the national average and also improved on previous year's score.
Food (comprising Organisation and Ward Food)	97.1%	91.6%	It is very pleasing to see the food score for this year which reflects a significant level of work between Trust and OCS teams to ensure patient food quality is of a high level. They have spent time improving the training, education and leadership for the Housekeepers, and the Trust employs a Patient Catering Manager to ensure standards are constantly maintained. The role of the Manager aims to assist with development of our housekeeping staff's skills such as presentation, understanding of allergies and service times to maintain an effective housekeeping relationship, which in turn allows us to deliver a more efficient food service to our patients.
Organisation Food	97.9%	91.8%	
Ward Food	96.1%	91.%	
Privacy, Dignity & Wellbeing	88.2%	86.7%	This year's score has improved on previous years and although it remains above national average, it is below that of other specialist hospitals. The provision of single ensuite rooms, enhanced patient entertainment systems and a more patient focused care environment has helped the improved score.
Condition, Appearance & Maintenance	99.7%	96.4%	This is an area that the Trust continues to focus on with our Private Finance Initiative (PFI) partners to ensure we maintain the condition and maintenance of the site, with particular focus placed on the clinical areas. It is essential and remains a priority for the Estates and Facilities team who should be congratulated on this high score demonstrating that we continue to deliver a safe and well-maintained environment for our patients and visitors.
Dementia	90.4%	83.4%	It is particularly pleasing to see that the Trust has improved on our previous years' scores in these areas, for our most vulnerable patients. The trust works with Disability and Dementia-friendly advisors who are able to help us review and improve the environment where opportunities exist.
Disability	94.4%	84.1%	

Action Plan
A few minor issues relating to cleaning and maintenance were brought up in the feedback session. Due to the regular Patient Environmental rounds the issues identified during the PLACE audit were successfully captured and completed.

Summary
The Patient-Led Assessments of the Care Environment (PLACE) are an annual assessment of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g.

disability or dementia. The PLACE assessment tool provides a framework for assessing quality against common guidelines and standards defined by professional healthcare service delivery organisations and field experts.

This is the eight year the PLACE assessment programme that has run nationally, allowing us to benchmark against national averages. We will continue to carry out the assessments with a greater number of smaller teams over the forthcoming years.

We are grateful for the continuing support of Governors, volunteers and past patients who have participated in the assessments.

Once again, the outcome shows that while we have a diverse spread of inpatient environments, the quality of the cleanliness and condition, appearance and maintenance remain at a high standard across the whole Trust. This is reflected in the Trust score being above the national average in all categories.

Patient Assessors Feedback
The Governors and staff assessors who spoke to patients reiterated the excellent standards to which the Hospital is being maintained.

Listening to Patient Experience and Complaints

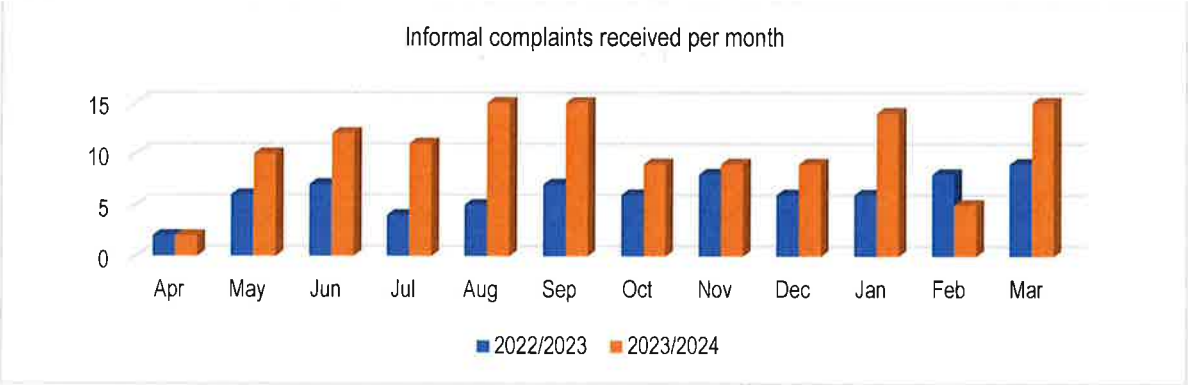
Listening to the patient experience and taking action following investigation of concerns and complaints is an important part of our Quality Improvement framework and provides an opportunity for the Trust to learn from valuable patient feedback to improve the services we provide.

The patient experience team set some local goals to be achieved during the period 2023/24.

The first was to embed the changes made in 2022/23 relating to how we process enquiries of concern made through our Patient Advice and Liaison Service (PALS) as informal complaints. This aims to ensure that these are resolved through local resolution, are accurately recorded and reported, and the themes are reported within the quality reporting to support future service improvement.

Informal Complaints
We have achieved embedding and capturing the informal complaints process and in turn we were able to capture 127 Informal complaints that were dealt with and resolved at a local level in in 2023/24. In the previous year those captured through PALS were 73 in 2022/23. We are unable to benchmark this year's data against the previous year 2022/23 as the recording was in a different format, with many local resolve issues not captured on the Trust Datix system. Going forward we will continue to monitor our informal complaints data and the themes that are captured through the new robust process.

The graph below shows informal complaint by month over the last 2 years.



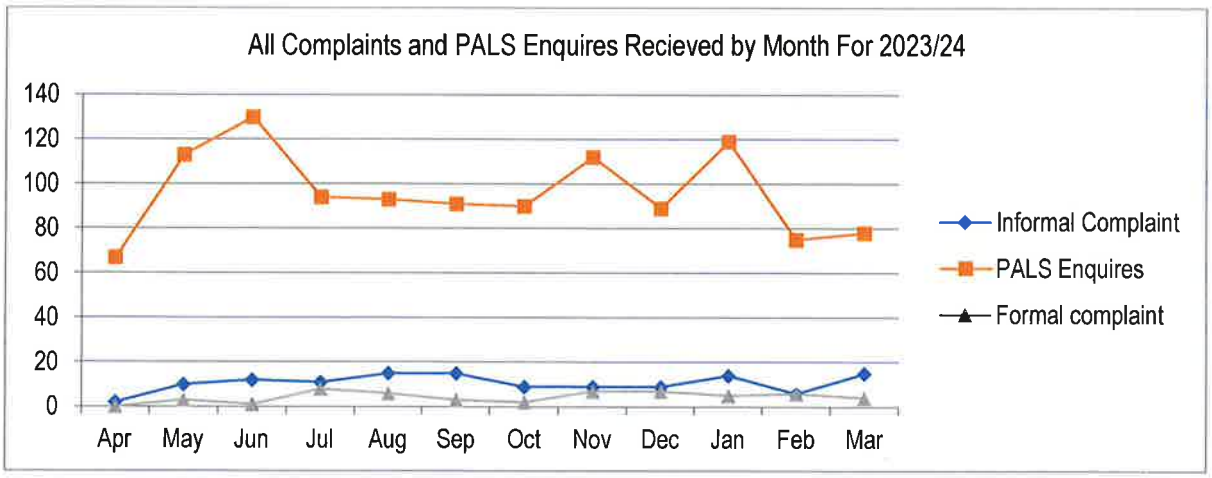
Source Datix 15/04/2024.

The second goal was to proactively engage with service users to resolve PALS enquiries at point of contact and to provide assurance that issues are dealt with appropriately. This has been achieved with 1151 PALS enquiries being received and addressed in 2023/24, compared to 651 enquiries recorded in 2022/23.

Formal Complaints

Every year the trust must make a statement under the NHS Health & Social care Act 2009 about how many complaints it has received, their subject, the issues they raise, whether or not they were well founded, and any actions taken. During the year we received 52 complaints in the period 2023/24. This compares to 58 complaints in the previous year 2022/23.

The graph below show All Complaints (Informal and formal) and Pals enquires received per month 2023/24.



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

Subjects of complaints
The most frequently occurring themes from Formal and Informal complaints were communication/Information (25%), delay in diagnosis/treatment or referral (19%) and clinical care/clinical treatment (10%)

Sub subjects of complaints
The five most frequently occurring sub subjects, specific issues raised within complaints about communication/information, delay in diagnosis/treatment or referral, or clinical care/clinical treatment were: dissatisfied with medical care/treatment/diagnosis outcome (12%), delay in diagnosis (7%), cancellation of treatment (6%), lack of information for patients (6%), and other communication issues (6%)

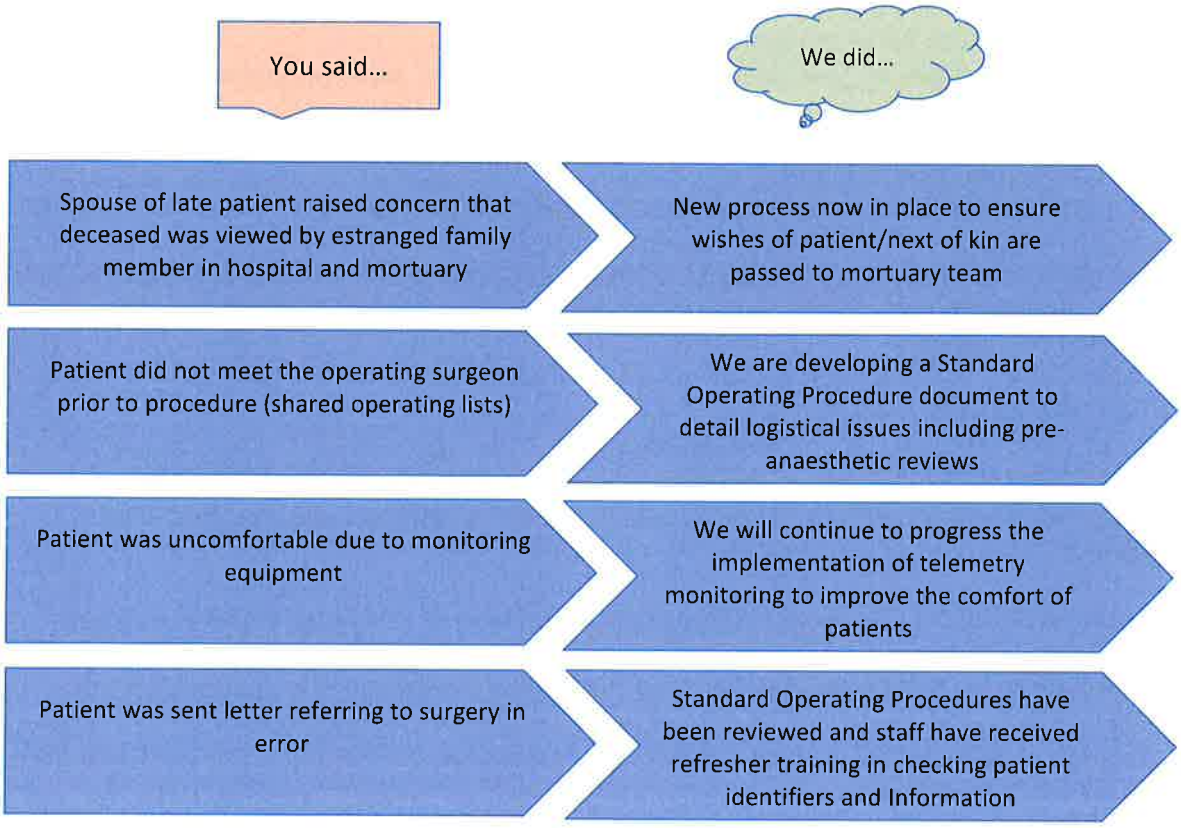
National benchmarking
The Trust uses the Model Hospital Metric to benchmark the number of formal complaints we receive against the total number upheld. Model Hospital reports the percentage of formal complaints upheld and provides a common basis for comparing the rate of upholding complaints, between organisations. This is monitored monthly as part of the Papworth Integrated Performance Report (PIPR) and quality and risk reporting. Of the 52 formal complaints received in 2023/24, 12 were fully upheld. A breakdown of the number of complaints upheld per month in 2023/24 is shown below:

April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	Total upheld
1	0	0	0	0	2	0	0	1	4	4	0	12

For the year of 2023/24 the Trust's average % of formal complaints upheld is 23% (12/52), this is 5.2% above our last year's figure of 17.8%, as calculated by Model Hospital from 22/23 (updated in September 2023), as shown below. Comparing this to 22/23 data we remain in the second quartile for the number of complaints upheld (as seen in graph below) and the peer median last year (26%) and 0.9% above the national provider median from last year figures (22.1%), based on the national comparative data. The below model hospital will be updated again in October 2024 for all Trusts, so we will be able to compare this year's annual figure further at this point.

How many formal complaints were well founded?
In the language of the complaint's services, the terminology used states whether or not the complaints are upheld. Just over half of all complaints received (57%) were concluded as being fully upheld or partially upheld. By this we mean that at least one of the concerns raised by the complainant required concerted action on the part of the hospital to address the issue. Of the 52 received there were 12 that were recorded as partially upheld, 12 classed as upheld and 11 that were agreed to be not upheld of those closed by the end of the financial year.

Actions are taken over the year and should demonstrate a clear connection from the concern raised to the change the organisation has made. Below are some of the quality improvements to our services we have made from the actions agreed and implemented from the complaint received in year:



All Complaints are detailed in the Quarterly Quality and Risk report available on our public website and reviewed at the relevant Business Units and divisional meetings 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

The last CQC inspection was undertaken in June & July 2019 (refer to page 32). The CQC looked at all of the Trust's core services (with the exception of end-of-life care) and its overall assessment was outstanding. The report of this inspection is available on the CQC website at: Download full inspection report for Royal Papworth Hospital NHS Foundation Trust - PDF - (opens in new window)

Internal reviews of CQC Fundamental Standards

The Trust has continued to develop and implement its schedule of routine self-assessments against the CQC Fundamental Standards in 2022/23. The fundamental standards are the, standards below which our care must never fall so these are an integral part of our internal monitoring process. Each review is undertaken by 3-4 multidisciplinary team members, and we have included volunteers in our review teams this year for the first time.

We undertake internal peer reviews to:

- ensure a programme of a continuous self- assessment providing assurance of safe and effective patient care.
- create an open and transparent programme of self-reflection and self-assessment
- celebrate areas of excellent practice
- identify areas for improvement.
- evidence areas of good practice and maintenance of improvement for future CQC inspections
- offer opportunity for individual personal and professional development for members of the peer review team.
- develop the Trust governance around quality compliance

Action plans are created as a result of the review's recommendations and are monitored by subject appropriate committees; the Fundamentals of Care Board is responsible for oversight of all reviews.

Relationship with the CQC

Royal Papworth Hospital has an excellent working relationship with the CQC Relationship Manager with quarterly meetings. Additional queries and requests are attended to as needed.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) Inspection

This took place on 6th November 2022 – further details can be found on page 32 of this report.

Clinical effectiveness of care domain

Cardiovascular Outcomes

Royal Papworth Hospital continues to contribute to the National Cardiac Audit Programme (NCAP) which aims to drive quality improvement in the design and delivery of cardiovascular services.

For the latest data period published this April by the national cardiac audit (NICOR), 1/4/20-31/3/23, and from our internal audit data, Royal Papworth hospital performed a total of 3581 cardiac surgical procedures, with an estimated recalibrated EuroSCORE predicted mortality of 2.3% and a significantly lower actual mortality of 1.7% (95% CI 1.3-2.1%). In total, during this period (including all emergencies and cases excluded by NICOR), we performed 4040 cardiac operations with a EuroSCORE II predicted mortality of 4.5% and a significantly lower actual mortality of 2.6% (95% CI 2.1-3.2%).

National comparisons from NICOR demonstrate that we performed the third highest volume of cardiac surgery in the UK (national average 757 cases per annum), and that the majority of hospitals had not returned to pre COVID pandemic levels of activity in this period (in 22/23 the average was 85% of 19/20 activity), and this was exactly our activity. We performed the second highest volume of aortic and mitral valve surgery, and the second highest volume of emergency aortic surgery (over double the national average). For the process outcomes, our waiting times were similar to the national average in 22/23, and we had the third highest day of surgery admission rate, and average length of stay. For the morbidity outcomes we compared much better than average with low rates of post operative bleeding, lower than average rate of intervention for deep sternal wound infection, average stroke rate, but higher than average requirement for post operative renal support.

Royal Papworth leads in Transplant Survival Rates

Royal Papworth Hospital continues to be one of the UK's top-performing hospitals for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in August 2023.

According to NHSBT's Annual Report on Cardiothoracic Organ Transplantation, RPH performed more cardiothoracic transplants in 2022/23 than any other hospital in the UK. It also had the lowest decline rate for donor organs, meaning that we accept a higher proportion of organs offered for transplantation than any other UK centre.

The data within the report showed that:

- Our patients have a shorter waiting for their transplant than in any other UK cardiothoracic transplant centre.
- The median wait time for a heart transplant is 133 days on the routine list compared to the national waiting times of 900 days (RPH 133 days), and 20 days on the urgent vs 48 for national waiting times, and 12 days on the super-urgent list compared to 18 for national lists.
- And the median waiting time for a lung transplant is 280 days compared to 584 days nationally.

The report also demonstrates that survival rates following heart transplantation are excellent at RPH.

- The national 30-day survival after adult donor after brain death (DBD) heart transplantation is 92.1% and ranged from 81.4% to 97.1% between centres and the result for RPH is 95.9% (risk adjusted 92.1%).
- The national 90-day survival is 89.4% and ranged from 77.1% to 94.5% between centres, and the result for RPH is 92.9% (risk adjusted 88.3%).
- The national 1-year survival is 84.9% and ranged from 72.9% to 90.8% between centres, and the RPH rate is 90.8% (86.9% risk-adjusted).
- The national 5-year survival is 71.4% and ranged from 65.6% to 77.3% between centres and the RPH rate is 74.3% (75% risk-adjusted).

For Lung transplantation results are equally impressive showing that:

- The national 90-day survival rate after adult lung transplantation is 90.6% and ranged from 87.6% to 93.4% between centres, and the RPH rate is RPH 93.3% (risk adjusted 92.6%).
- The national 1-year survival is 81.7% and ranged from 78% to 86% between centres, and the RPH rate is 82.7% (risk adjusted 81.5%).
- The national 5-year survival was 54.4% and ranged from 43.2% to 65% between centres, and the RPH rate is 54.6% (risk adjusted 49.9%).

Further information can be found about the report and the Trust results and Source data at https://www.odt.nhs.uk/statistics-and-reports/organ-specific-reports/, and Organ specific reports which provide statistics about organ donors, organ offers and declines, transplant waiting lists, transplant activity and survival rates after transplantation to relevant healthcare professionals and public and patient groups can be found at www.odt.nhs.uk

Respiratory Extra Corporeal Membrane Oxygenation (ECMO)

Royal Papworth Hospital is one of eight centres in England and Scotland that provide the highly specialised Respiratory Extra-Corporeal Membrane Oxygenation (ECMO) Service, including specialised advice and 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.

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.

The multi-professional team has contributed to multiple scientific communications and articles published in the medical literature, and some of RPH ECMO multi-professional team members sit on National and International Committees sharing experiences and knowledge to inform future practice.

From December 2011, the service provided by RPH became part of the national service that provide a year-round ECMO service for adult patients with acute respiratory failure 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 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 national centres providing ECMO in England & Scotland meet at least twice a year to review practices and outcomes and have weekly phone conferences when required to ensure that access to the service is maintained.

Whilst difficult to compare due to the multiple conditions treated and the absence of risk stratification, survival rates are in keeping with international figures. This is remarkable in patients who were referred because of their high likelihood of death.

Summary of activity for ECMO for adult patients with severe respiratory failure at Royal Papworth Hospital since December 2011 - March 2024

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%

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)
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	63%	64%	62%	63%
2021/22	507	46	45	2162	62%	63%	62%	63%
2022/23	241	37	35	717	63%**	65%**	63%**	65%**
2022/23	241	37	36	861	68.75%	70.6%	62.5%	64.7%
2023/24	289	35	35	1133	79.4%	79.4%♦	75%♦♦	75%♦♦♦

*discharge from Royal Papworth includes 6 inpatients on ECMO

**

♦ 1 inpatient now on ECMO, therefore not included in the calculation
♦♦ 3 survivors of ECMO not at 30d yet, therefore not included in the calculation
♦♦♦ 3 survivors of ECMO not at 30d yet & 1 inpatient now on ECMO, therefore not included in the calculation

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.

'Royal Papworth hospital has the second largest series of PTE operations in the world. In the 23/24 year we performed 155 operations with an in-hospital mortality of 1.9 %. Members of the RPH team will take part as task force chairs in the upcoming World Symposium in Pulmonary Hypertension in July 2024.'

Seven Day Services

In 2013, the Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. A focus on four priority standards was identified in 2015, reviewed in 2021 and remain relevant and important:-

- Standard 2 Time to initial consultant review
- Standard 5 Access to diagnostics
- Standard 6 Access to consultant-led interventions
- Standard 8 Ongoing daily consultant-directed review.

Following the pandemic, further review and guidance was provided to Trusts in February 2022 to incorporate where necessary, review of

- Daily Sitrep
- Consultant Job Plans
- Deep Dives – if required into areas of concern
- Wider performance and experience measures to include patient experience data, GMC trainee doctor survey data and audits of staffing levels and activity related to 7DS.

The daily hospital sitrep does not show significant variation in length of stay (LOS) associated with the day of the week when patients are admitted. There is also no significant variation in the number of discharges by day of the week. Job plans for all our acute specialist consultants provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty. The template below shows the level of compliance with Standard 5 regarding 24/7 access to emergency diagnostic tests:

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
USS	YES		
CT	YES		
MRI	NO [1]		
Endoscopy	YES		
Echocardiography	YES		
Microbiology	YES		

[1] *No radiographer to provide cardiothoracic MRI at weekends but this is not a service which is clinically necessary. If there is a need for non-cardiothoracic MRI, then this can be done at Addenbrooke's Hospital under the existing SLA agreement for emergency services.*

The following template outlines the level of compliance with Standard 6 regarding 24/7 access to emergency consultant-led interventions:-

Emergency intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive care	YES		
Interventional radiology		YES	
Interventional endoscopy		YES	
Surgery	YES		
Renal replacement therapy	YES		
Radiotherapy		YES	
Stroke thrombolysis		YES	
Stroke thrombectomy		YES	
PCI for MI	YES		
Cardiac Pacing	YES		

Performance of Trust

Throughout 2023/24 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-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	71.0%	71.8%	71.7%	72.0%	71.3%	70.5%	70.3%	68.8%	67.5%	68.1%	67.7%	67.0%	67.0%
62 day wait for 1st Treatment from urgent referral	>85%	16.7%	33.3%	20.0%	0.0%	11.0%	20.0%	28.6%	50.0%	11.1%	66.7%	0.0%	12.5%	22.5%
62 day wait for 1st Treatment from consultant upgrade	>85%	66.7%	57.1%	50.0%	0.0%	33.3%	58.0%	40.0%	62.5%	53.3%	85.2%	50.0%	48.0%	50.3%
31 day cancer wait	>96%	96.0%	97.0%	100.0%	89.0%	94.0%	100.0%	96.2%	97.0%	88.9%	92.6%	100.0%	97.0%	95.6%
6 week wait for diagnostic	>99%	98.5%	94.9%	94.6%	96.8%	91.8%	94.0%	90.5%	90.8%	92.0%	90.3%	94.8%	95.7%	93.7%
Monitoring C.Diff (toxin positive)	Less than 7	2	2	1	2	0	1	0	2	1	1	2	3	17
Number of patients assessed for VTE on admission	>95%	90.2%	92.1%	90.1%	88.0%	86.0%	92.0%	91.0%	93.1%	92.0%	89.6%	91.4%	93.1%	90.7%

*The definition of this indicator can be found in Annex 3 of this report.

Freedom to Speak Up

The Trust continues to be instrumental in driving several developments which directly or indirectly enhance the value of speaking up. Some have emerged because of NHS policy initiatives. For example, NHS sexual safety charter (Sept 2023), a set of principles seeking to eradicate sexual harassment in NHS work settings has been adopted. The national guardian's office NHS speak up policy template was launched and used to develop a revised speak up policy which both updates and reinforces the continuing commitment to speaking up across the trust.

Masterclass provisions were added to the Trust's line management programme with the aims to enable middle and senior leaders to understand the scope and responsibilities more fully in supporting a speak up culture. It is pleasing to update that speaking up continues to maintain an established leadership structure which supports speaking up, building on the work developed by the Freedom to Speak Up Guardian (FTSUG) and the Trust's leadership team. This provides strong messaging for staff that the Trust values speaking up, that staff can speak with confidence because it takes raising concerns by staff seriously.

Communicating the importance and support for speaking was enhanced through an increasing membership of freedom to speak up champions in 2023/24. An additional ten staff have been nominated to attend the national guardian online training for champions/ambassadors in preparation of this role. This is an effective role where each act to support staff by listening and signposting colleagues towards resolution. It is a highly valued role which attracts significant membership interest year on year since its inception at Royal Papworth Hospital.

The main endeavours by the FTSUG, supported by the champions during the period of reporting were:

- continued to maintain the important profile of speaking up on issues of concern.
- provided guidance through signposting to workers on speaking up in line with the Trust's speaking up processes and policies.
- Worked as a network in providing confidential advice and support to workers in relation to patient safety concerns.
- Contributed to identifying themes of concern for service areas for reporting.
- Monitored actions undertaken where staff identify a concern with Trust processes.
- Contributed to training and development opportunities regarding incivility.
- Ensured all new staff across all staff groups received speak up induction guidance.

Internal and external governance

The Trust has been fully engaged with the National Guardian Office and supports the FTSUG's engagement with national, regional, and local network of Guardians. This has provided the opportunity to explore and apply best practice.

Established internal and external governance processes have been effective in overseeing the reporting and monitoring of incidents raised through the Trust's FTSUG. As with the previous year, governance process has included:

- The Trust board has been regularly sighted on the frequency of incidents reported per quarter (numerical and categorical in line with National Guardian Office (NGO) guidance), with thematic narrative as explanatory considerations.
- Reported quarterly to the FTSU National Office and Trust board.
- Independent anonymised incident scrutiny of quarterly submission data against national office categories – undertaken by FTSU champions (process of internal validation).
- Anonymised incident case review discussion with FTSU champions for learning and development purposes (quarterly as part of FTSU champion business meeting)
- Quarterly FTSU champion business meetings to provide network support and for planning speak up initiatives.
- Reporting issues of concern as themes into service operational meetings.
- Communicating issues of concern as themes to operational and clinical leaders
- Meeting regularly with executive directors, non-executive director lead for speaking up, and engaging with relevant senior and operational clinical and non-clinical leads.
- Provided thematic narratives of issues of concerns into business meetings and EDI network forums.

National Guardian Office (NGO) reporting

Unfortunately, the FTSU national index report by the National Guardian was not produced by the national office for 2022/23, thereby removing the opportunity to compare both against benchmarked NHS Trusts and progression indices. However, quarterly, with annual incident reporting provided sufficient overview to enable the Trust to report that progress is being maintained on its work in making speaking up business as usual. Triangulation of incident reporting has correlated with NHS survey outcomes where confidence in speaking continues to be strong, of further note is that most staff reporting to the FTSUG indicated a positive score for speaking up again if there was need to.

Pleasing to report also that all Trust quarter and annual reports were submitted to the NGO on time. All submitted Trust reports for this period have contributed to the development of the NGO annual report to parliament in January 2024 by the Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy.

Trust FTSUG reporting and speaking up initiatives.

The Trust confirms an uplift of incidents from previous year. The FTSUG reported 131 incidents (2022/23). At time of writing, incidents reported to the national office (up to and including quarter 3 and midway Q4 -2023/24) is 129, projecting an increase of incidents for 2023/24 at year end. Of further interest, the Trust has experienced an increasing number of staff indicating they would speak up again. Of the 129 incidents, 76 would or are likely to speak up again. Unfortunately, national indicators through

NHS survey results suggest workers have a reducing confidence in speaking up, believing that speaking up does not result in demonstrable positive changes.

Strategies in supporting staff through wellbeing initiatives continued to be available, with enhanced opportunities for staff to access timetabled speak up drop ins alongside

conventional methods. In 2023/24, another initiative was launched to support staff develop a better understanding of microaggression and incivility-based behaviours.

Launched on the back of NHS Staff Survey and WRES/WDES outcomes, resulting workshop evaluations suggested attendees found these to be effective in defining such behaviours and increasing their confidence in either developing strategies in responding or in reporting through the Trust's range of policy processes. Other initiatives have included continued investment in mental health first aid training, the completion of a first cohort of reciprocal mentoring programme where a proposal to seek a smarter method of speak up reporting through a reporting App was instigated.

The FTSUG office has also maintained action on the eight principles as identified within the National Guardian Office reflection tool. Developed and agreed with both the trusts executive lead for workforce and organisational development and non-executive designated member (November 2022-November 2024)

The FTSUG has enjoyed the provision of a set of part-time hours of administrative support in undertaking their duties, responsibilities, and tasks of the role. It is anticipated that this will continue into 2024/25. This is coupled with a case to extend working capacity of the guardian from a dual split post towards full hours. The outcomes of this will be reported in 2024/25.

The FTSUG activities across 2023/24 have included a wide range of engagements in assisting the promotion and development of a just culture, in line with the Freedom to Speak Up publication guidance - A guide for leaders in the NHS and organisations delivering NHS services (collaboration between NHS England and National Guardians Office, 2022).

These have included:

- Regular visibility walk-by into clinical and non-clinical areas at both working sites (Hospital and Kingfisher House – Huntingdon).
- Communication of key speaking up messages through Trust briefing mechanisms
- Periodic drop-in surgeries
- Celebration of NGO speaking up month (October 2023)
- Engagement with network and operational committees
- Staff inductions to profile speaking up (corporate/junior doctor and non-medical and medical students)
- Involvement with senior staff selection and appointment processes
- Supporting oversight and engagement in policy developments with implementations.
- Engagement with all trust corporate, medical and non-medical student inductions.

Actions going forward 2024/25:

- National Guardian Office self-assessment (Freedom to speak up: A reflection and planning tool NGO 2022) was completed in 2022/23 with agreement to accommodate eight key principles as actions. Included and updated as part of the trust annual report for 2022/23, it appears for 2023/24 and into 2024/25 as actions cut across planning cycles.
- Extending the delivery and provision of microaggression and civility training into bespoke arrangements where staff release was proven to be difficult during 2023/24.

- Engagement with the range of forums to continue to profile speaking up, service business meetings, all staff briefings, EDI network committees, Joint Staff consultative committee.
- Continue to promote speak up access mechanisms, particularly for ethnic minority workers who find this more difficult. For example, anonymity reporting through alternative conventional reporting modes.
- Plan and develop quarterly masterclass speak up sessions for middle and senior managers undertaking the line managers development programme.
- Plan and develop regular time-tabled weekly speak up drop-in sessions alongside conventional access to the FTSU Guardian and champions.

Several of the actions identified for 2024/25 either build on existing provisions or are new initiatives. This is because the key principle of a speaking up is to ensure all staff and workers know how to speak up and feel safe and encouraged to do so. The FTSUG, supported by our champions, will continue to promote the importance of speaking up through established communication initiatives and networks to ensure good access to FTSUG and champions are maintained and communicated. This will include continuing to extend the number of FTSU champions. The Trust, like other NHS providers, celebrated speak up month in October 2023. This year's theme was *Breaking Barriers*. This, we anticipate, through the continued or additional actions listed, will help to break down barriers which some staff and workers experience when considering speaking up about a concern or issue.

We recognise the challenge of addressing the specific concerns of bullying and the various harassments and incivilities across successive years within the Trust. Unfortunately, this is a mirrored concern, indicative of a national trend across all NHS Trusts. As concerning and which invites more targeted attention is the support for staff and workers from an ethnic minority background. WRES reporting indicates a concern that this group of staff are less likely to speak up in comparison to non-ethnically diverse colleagues. This is an ongoing need which will continue to inform actions for 2024/25 by the FTSUG and Trust's workforce strategy.

The Director of Workforce and Organisational Development is the responsible executive director for raising concerns, with the identified Non-Executive Director lead in support, with additional reporting to the board and other executive leads including the chief executive officer.

Staff Survey 2023

NHSI's requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2023 and these were included in the Staff Report section of the Annual Report.

Compassionate and Collective Leadership programme

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

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

We launched our revised Trust values in July 2021 and we continue to embed this at induction, through our 1-1 meetings with staff, and through our development and line managers courses. The following values were chosen as a result of reflections and feedback from staff on what mattered most to them, and to our patients:

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 to help them develop practical skills in giving and receiving feedback.

Further information on our Compassionate and Collective programme is included in our update on our Quality Priorities for 2023/24.

A listening organisation

What our patients say about us

NHS Adult Inpatient Survey

The National inpatient survey looks at the experiences of adults who have been an inpatient at NHS hospitals during the month of November 2023 however this was extended and only finished at the end of April 2024.

Royal Papworth Hospital has used the CQC approved contractor and a comparison of results will only be made with those Trusts who used the same facilitator. The number of respondents was 789 (65%) which is slightly higher than 2022 which was 62%. Results include every question where Royal Papworth Hospital received at least 30 responses which is the minimum required. At the time of writing this report the results of the survey are still embargoed.

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

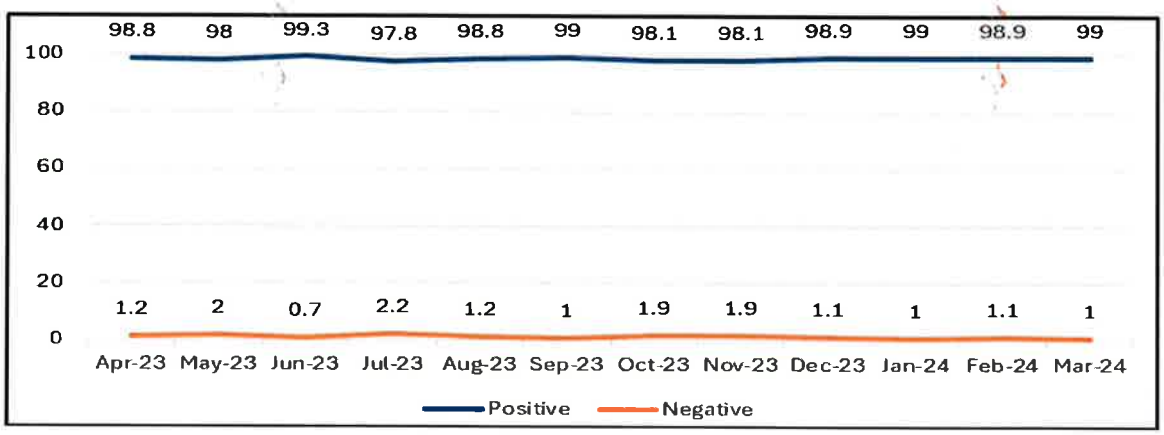
We want our patients to have the best possible experience of our care. The Friends and Family Test is a way of gathering patient feedback so we can learn about our patient's experiences of our services and make improvements wherever possible.

Since December 2020, the Trust has had a digital data collection process which enables all our patients (inpatients, outpatients, and day cases) to complete the survey and let us know about their experience. The survey is accessible and easy to use, utilising digital surveys via tablet onsite and a text messaging service for all outpatients.

Within Royal Papworth Hospital NHS Foundation Trust, the responses are reviewed by the Trusts ward Matrons' who receive a monthly 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. 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.

Throughout the last year from April 2023 to March 2024, we have continued to be well above our Trust target of 95% recommendation score for our inpatient and outpatient scores collected from our FFT surveys. Our scores from the Friends and Family inpatient survey for 2023/24 are shown in the figure below.

Friends and Family inpatient results 2023/24



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

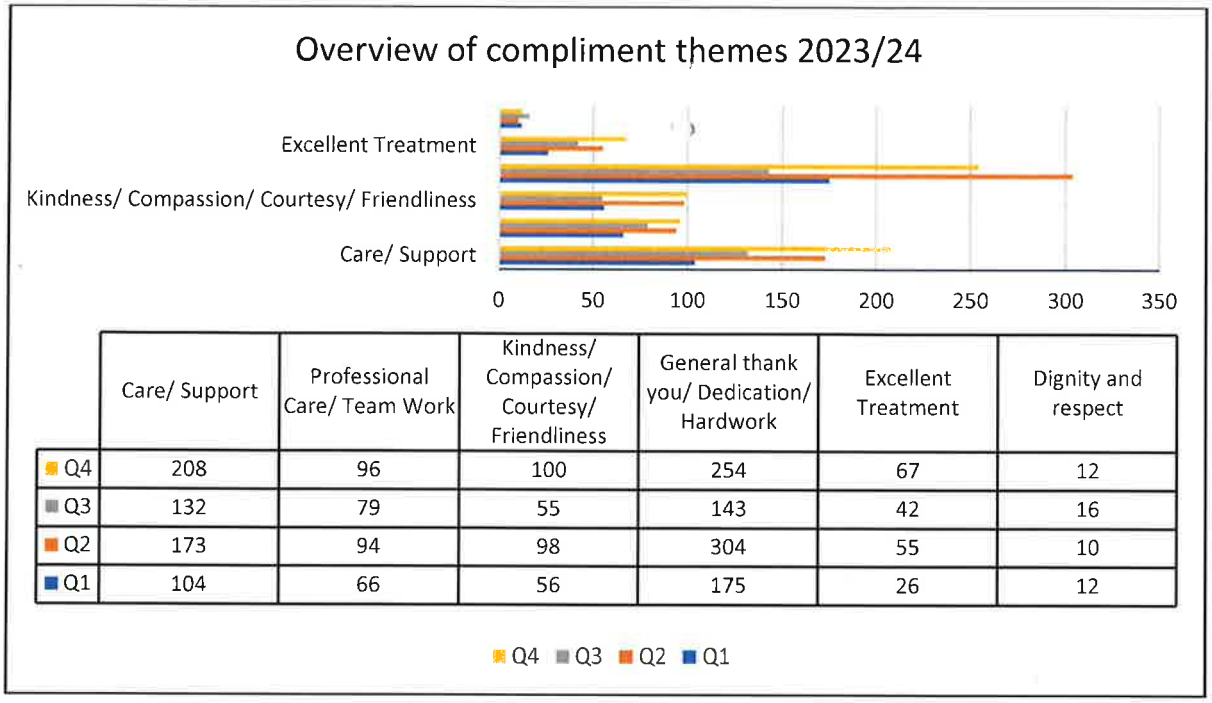
Compliments from patients and families

Compliments are received in two ways, through our Friends and Family Test (FFT) surveys and through verbal feedback, letters, thank you cards, and e-mail correspondence received via our Patient Advice and Liaison service (PALS). PALS record on a monthly basis the number of compliments received by our patients and their families relating to their experience at Royal Papworth Hospital NHS Foundation Trust.

There were 1056 compliments across the Trust received through the PALS team during 2023/24 and a total of 19,852 recorded through the Friends and Family surveys. Each quarter we review the compliments that have been captured from all feedback from our patients and from their families/carers through either our FFT surveys or feedback received via PALS. We are currently unable to theme our FFT surveys as this is captured through an electronic form and there is no ability to filter or theme the feedback left, due to the high numbers of surveys. However, all feedback is shared with our teams for ongoing service feedback and improvement.

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	Excellent Treatment	Dignity and respect
Q4	208	96	100	254	67	12
Q3	132	79	55	143	42	16
Q2	173	94	98	304	55	10
Q1	104	66	56	175	26	12

Patient Support Groups

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

Valuing Volunteers

Royal Papworth Hospital NHS Foundation Trust recognises the contribution of volunteers is invaluable. The Trust believes volunteering is integral to delivering and supporting a diverse range of services and activities that enrich the organisation.

Our volunteer policy demonstrates the Trust's commitment to the development of a volunteer service that improves patient experience by making a difference to service delivery or by being an advocate for positive change. That promotes and gives opportunities for people to volunteer and develops partnership and networking with national, charitable and third sector organisations including volunteer support groups.

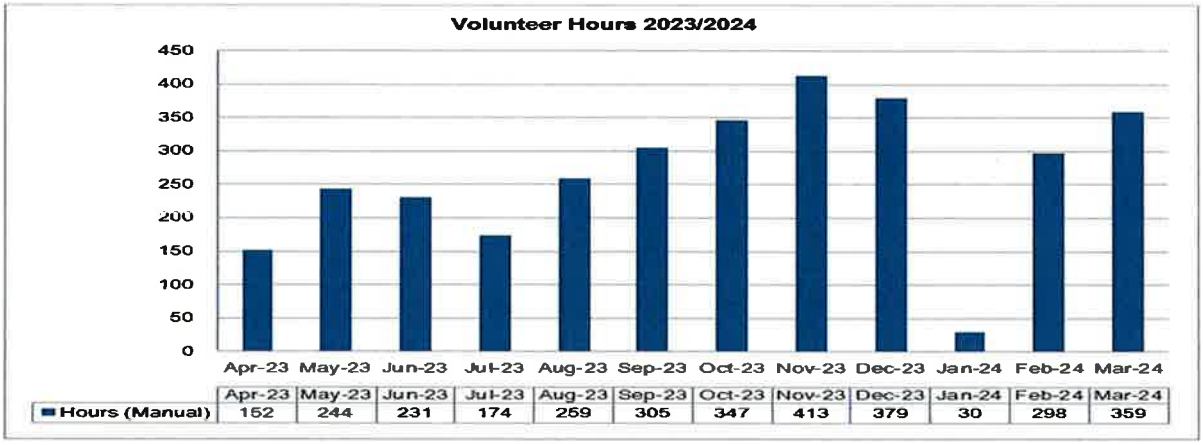
In 2021/22 following a successful bid through the NHS England and Improvement Volunteering Services Fund we were able to employ a volunteer coordinator to support the Trusts volunteer recovery programme. Since this time further additional funding has been secured through Charity funding (2022/23 and 2023/24) and with this additional role we have been able to support the Patient Advice and Liaison Service (PALS) Team in enabling the return of some of our previous volunteers and launched a recruitment campaign to gain new volunteers. At the end of March 2024, we now have a total of 65 active volunteers now supporting various roles, with another 19 progressing through the recruitment process. This compares to 14 at the time of reporting at the end of 2022/23.

Our volunteers support a range of roles across the Trust such as Ward Visitor, Meet and Greet, Chaplaincy support, Research Ambassador, Pharmacy Support, Ward Admin

Support, Reading Panel, Charity Ambassador, Charity Community Ambassador, Charity Tin Collectors and being part of our Quality Peer Review Assurance process on our wards.

Since April 2023, our amazing volunteers have contributed a total of 3,200 hours in supporting our staff make a real difference to our patients, their families, friends, and relatives. This compares to 2,135 hours in 2022/23.

The figure below shows the total number of Volunteer hours for each month in 2022/23.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Hours (Manual)	152	244	231	174	259	305	347	413	379	30	298	359

The volunteer coordinator continues to support the PALS team and our volunteers by providing regular support and feedback whilst ensuring our policies and procedures are up to date and fit for purpose.

We have continued to utilise and develop our volunteer database, Better Impact. Throughout the year the volunteer coordinator has been populating and developing this all in-one platform to enable the effective recruitment, screening, onboarding of new volunteers. We continue to develop the Better Impact database to aid and assist the PALS team in communicating, scheduling and the time logging of all our volunteers whilst enabling the team to report meaningful data regarding our volunteer hours and feedback.

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

Royal Papworth Staff Awards and Long Service Awards

In October 2023 we held our annual Long Service Awards in the Heart and Lung Research Institute (HLRI), next to our hospital. The event recognises and gives thanks to long-serving members of staff who have worked at our hospital for either 15, 20, 25, 30 or 35 years.

In December 2023 we held our annual Staff Awards, and for the second year running this took place at Homerton College in Cambridge. More than 200 colleagues, guests, and volunteers were in attendance to celebrate some of the outstanding achievements of our people throughout the past year. Hosted by former BBC Look East presenter Stewart White, there were 15 awards given out on the night from a shortlist of 45 nominees.

There was a special, 16th award on the night – a Lifetime Achievement Award - for Professor John Wallwork CBE in recognition of his 42 years of service to Royal Papworth Hospital ahead of his retirement as chairman. The event was generously sponsored by Gamma, with support from CMR Surgical and Royal Papworth Charity.

Annex 1: What others say about us:

Cambridgeshire County Council

Royal Papworth Hospital NHS Foundation Trust
Quality Account 2023/24
Statement by Cambridgeshire County Council Adults and Health Committee

The Adults and Health Committee received the draft Quality Account for Royal Papworth Hospital NHS Foundation Trust (RPH) on 26th April 2024. A Working Group made up of the councillors appointed to the RPH Liaison Group and the Council's Partner Governor at RPH was established to consider the draft under the committee's statutory health scrutiny function.

Royal Papworth Hospital was last inspected by the Care Quality Commission in summer 2019). It was rated as Outstanding.

The Committee found the draft Quality Account to be clear and accessible, and we want to praise the Trust's record in relation to patient safety and care. We also want to highlight the candour evidenced in the data and narrative around patient safety incidents and never events. Identifying and learning from events of this type is fundamental to a culture of openness and continuous improvement, and the Committee commends the Trust for this.

We also commend the Trust's continued commitment to excellence through research, and to sharing the benefits of this locally as well as with national and international partners. This includes the pioneering work taking place on new technology, including artificial intelligence. We do though emphasise the importance of patients and the public being kept informed about this, and the need to establish robust governance processes which include assessing the ethical dimension of such work.

We are very much aware of the unprecedented pressures which the NHS is facing and the impact this has on both service users and staff. This includes an increasing demand for services, the impact of industrial action and the high levels of burnout and exhaustion reported amongst RPH staff in the wake of the covid pandemic. We recognise the impact which these and other pressures have on treatment backlogs, but public concern about waiting times remains high. We share this concern and encourage the Trust to continue to make every effort to address this.

Royal Papworth Hospital's international reputation enables it to attract staff from around the world. This is a real strength, and supporting this cohort is key to retaining their expertise and skills. It would be useful to know what measures the Trust has in place to do this, and for that learning to be made available to local system partners. We share the concern expressed in the report about the high levels of staff reporting bullying and discrimination from patients and colleagues. The report links this to a decrease in kindness, and we were struck by how this contrasts with the heartfelt expressions of public support for NHS workers we saw on the Cambridge Biomedical Campus and across Cambridgeshire during the covid pandemic. We would see value in creating spaces for staff to come together and support each other, to renew the positive links with local communities which grew up during covid and to celebrate the contribution made by the growing number of volunteers supporting the work of RPH. We will follow this up through our Liaison Group meetings this year.

The Committee is conscious that people from some cultures might find it less easy to voice concerns about practices or behaviours they see or experience. Initiatives like Freedom to Speak Up, the National Staff Survey and the Pulse Survey all help address this, but we feel that enabling peer support networks and encouraging staff to advocate on behalf of colleagues

who might find it harder to speak up also have an important role to play.

We welcome the establishment of an Acute Inpatient Smokefree Pathway and the digital referral service now available on all inpatient wards to support service-users who want to stop smoking. We would like to understand the Trust's ambition in this area, and whether there is any learning that could be shared with system partners. We also encourage a synergy with our Public Health team's smoking cessation initiatives.

The Committee welcomes the aspiration to establish a Royal Papworth School to grow and develop its own staff and to share its expertise with local stakeholders as well as national and international partners. We would welcome the opportunity to discuss how this might link with our own Social Care Academy.

Staying in hospital is a stressful time for anyone, but for people with additional needs the challenge is even greater. We warmly endorse the work being done to make RPH a dementia-friendly environment and its planning to support service users with learning disabilities and autism, including through the roll-out of the Oliver McGowan training programme. We would encourage learning from these initiatives being shared with system partners.

We note that Eilish Midlane, the Trust's chief executive, serves as a Partner Member on the Cambridgeshire and Peterborough Integrated Care Board representing Provider Trusts. We welcome this demonstration of the Trust's commitment to being an active participant in our local Integrated Care System.

Beyond the Adult and Health Committee's health scrutiny role the County Council has a wider interest in the Cambridge Biomedical Campus. This includes its role as a significant local employer, its transport and connectivity needs and the importance of encouraging water management to reduce its impact on the local aquifer. We look forward to positive discussions across all these areas and more in the year ahead.

Healthwatch Cambridgeshire and Peterborough

healthwatch Peterborough healthwatch Cambridgeshire

Healthwatch Cambridgeshire and Peterborough

Royal Papworth Hospital Quality Account Statement 2023/24

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 continue to enjoy a positive relationship with the Trust. We find the Trust is always responsive to feedback and we welcome the commitment to learning from feedback to improve care for patients and the experience of staff.

Healthwatch continues to hear largely very positive feedback from patients and their families regarding treatment at the Royal Papworth Hospital. Where issues need to be raised we have found the Trust to be responsive.

Healthwatch welcomes opportunities to communicate with the Trust through representation on the Patient and Carer Experience Group and the Patient and Public involvement meetings. We also attend Trust Board meetings.

We support Partnership working and strategic development with local ICS on health inequalities and are pleased to note that RPH clinicians and staff actively participate in, and reporting back to, the various system quality assurance meetings which meet regularly.

The coming year

We welcome the Trust's contributions toward the ongoing development of the Integrated Care System for Cambridgeshire and Peterborough, and to continuing our positive relationship with the Trust over the next year.

Healthwatch plans to include attendance at Royal Papworth Hospital in in its programme of engagement in the coming year, allowing Healthwatch staff and trained volunteers to engage with patients and their families and hear their experiences of using Royal Papworth Hospital.

20 June 2024

Council of Governors

The Governors are pleased to note that Royal Papworth Hospital has had another good year as shown through this quality account.

In January 2024 the hospital said goodbye to chairperson Professor John Wallwork, and the Governors thank him for his many years of hard work. The Council of Governors appointed Dr Jag Ahluwahlia as the new hospital chair and are pleased to be working with him.

The council of Governors have been able to gain assurance from the Non-Executive Directors about the Trust's response to challenges through quarterly council meetings and regular Governor-led and board committees. The Governor-led committees are Patient and Public Involvement, Access and Facilities, Appointments and Forward Planning. Governors are also observers on the board committees Quality and Risk, Performance, Audit, Fundraising, End of Life Care, Emergency Preparedness, Workforce and Digital Strategy. Two Governors also act as lay person members of the Ethics committee.

Governors also attended 15 steps and Patient safety audit rounds across the hospital.

The Quality Account has highlighted successes as well as challenges and I believe the report to be accurate.

The areas of focus for the Governors this year are as follows:

Staff engagement and welfare has been a priority following the staff survey results of 2023. The Governors note the improved results of this year and congratulate everyone for their hard work in achieving these. However, reports of bullying persist, and the Council hope to see the Trust continue to tackle this.

Patient feedback and survey results are excellent across the trust, but the Governors have noted there may be gaps in the feedback gathered from patients under the hospital for long term care as both outpatient and inpatient. The council are satisfied work has begun to address this and will continue to seek assurance that the patient experience at RPH is positive.

Abigail Halstead, Lead Governor RPH
17th May 2024

Patient and Public Involvement Committee (PPI) Committee

Quality Account received and reviewed. Nothing more to add.
20 June 2024

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru | Welsh Health

Specialised Services Committee

Quality Account received. Nothing more to add.

Carole Bell
Cyfarwyddwr Nyrsio ac Ansawdd
Director of Nursing and Quality Assurance
20 June 2024

Cambridgeshire & Peterborough Integrated Care Board

Stakeholder Feedback – RPH Quality Account 2023/24

Cambridgeshire and Peterborough Integrated Care Board (the ICB) has reviewed the Quality Account produced by Royal Papworth Hospital Trust (RPH) for 2023/24.

Royal Papworth Hospital is a tertiary hospital offering specialist services in Cardiology and Respiratory. Royal Papworth is jointly commissioned between Cambridgeshire & Peterborough ICB and NHS England specialist commissioning team.

The Trust continued to report serious incidents in line with the serious incident framework up until end of December 2023. RPH participated in the system wide Community of Practice that successfully implemented the Patient Safety Incident Response Framework (PSIRF) from 1st January 2024. They have a new PSIRF policy and plan in place approved by the ICB, with the plan due to be reviewed in preparation for 2025/26. The Trust has embraced the improvement methodology through implementing PSIRF mid-year and started using a variety of patient safety investigating tools to gain identified learning.

The Trust is congratulated on having the shortest waiting times for both heart and lung transplantation and having the best survival rate for patients one year after their heart transplant.

The report contains a section on Learning from Deaths which details the number of deaths for which retrospective case record reviews and incident investigations have been carried out and the learning that has occurred from these investigations. The Trust has also used patient stories from across the Trust to enhance this learning and formulate recommendations to improve care.

The Infection, Prevention and Control (IPC) team were fully engaged with the collaborative work streams across the system through the Operational Group, a sub-group of the IPC Board. Throughout the year, the Trust had experienced challenges with surgical site infection (SSIs) rates above the national benchmark and they continue to fluctuate, and whilst early days SSI are on a downward trajectory. The Trust also had an outbreak of Mycobacteroides Abscessus (M.Abscessus), however this is not mentioned in detail in the report.

The Trust held stakeholder meetings to address the infection issues above and the ICB were fully engaged in supporting the Trust to identify learning and implementing actions to reduce infection rates.

RPH research activity has been strong, with recruitment of nearly 800 patients to a total of 68 different research studies, of which 58 were National Institute for Health and Care Research (NIHR) portfolio studies and 10 non-portfolio research. Two achieved global first recruitment status, which is a significant achievement and the ICB congratulate the Trust on this achievement. The hospital also participated in 18 of a potential 19 relevant national clinical audits (95% compliance) but were unable to participate in the two relevant national confidential inquiries due to a lack of data.

Recruitment numbers are around a third lower than in the preceding year, but this is attributed to the inclusion of more complex studies that do indeed typically attract fewer recruits. There is no mention of patient participation in research design or delivery (beyond a general expression of thanks), nor of staff engagement to support involvement in research, which are significant omissions given the level of research activity and the hospital's specialistnature.

The ICB would like to thank all staff working for Royal Papworth Hospital for their dedication, professionalism, hard work and commitment to patient care throughout the year and looks forward to continuing to work with RPH as part of the Cambridgeshire & Peterborough Integrated Care System.

Overall Cambridgeshire and Peterborough ICB agree the RPH Quality Account is a true representation of quality during 2023/24.

Carol Anderson
Chief Nursing
Officer
Cambridgeshire & Peterborough ICB

17 June 2024

Specialised Commissioning - East of England

Quality Account received. Nothing more to add.

Head of Nursing – Quality
20 June 2024

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 2023/24 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 2023 to 1 June 2024
    - Papers relating to quality reported to the Board over the period April 2023 to 1 June 2024
    - Feedback from NHS England - East of England, which incorporates feedback from Cambridgeshire and Peterborough ICB dated 22 May 2024
    - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated xxxx
    - Feedback from Healthwatch Cambridgeshire dated xxxx
    - Feedback from Cambridgeshire Health Committee dated 20 May 2023
    - The Trust's "Quality and Risk Report: Quarter 4 and annual Summary 2023/24"
    - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The 2023 National Inpatient Survey
    - The 2023 National Staff Survey
    - The Trust's Annual Governance Statement 2023/24
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 17 May 2024
    - 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

Dr Jag Ahluwalia

Chairman

Date: 28 June 2024

Eilish Midlane

Chief Executive

Date: 28 June 2024

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 das from GP referral to first treat 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	
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.
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 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
PSIRF	Patient Safety Incident Response Framework (PSIRF), which has replaced the Serious Incident Framework. Implemented into the Trust from 2024.
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.
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)	Serious incident but they are incidents requiring investigation. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
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.

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