## Contents

<table>
<thead>
<tr>
<th>Part 1</th>
<th>Statement of Quality from the Chief Executive</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 2</td>
<td>Priorities for improvement and statements of assurance from the Board</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Priorities for 2019/20</td>
<td>15</td>
</tr>
<tr>
<td>Priority 1</td>
<td>Quality Improvement</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>• Staff training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Projects</td>
<td></td>
</tr>
<tr>
<td>Priority 2</td>
<td>A Safe Hospital Move</td>
<td>19</td>
</tr>
<tr>
<td>Priority 3</td>
<td>Optimise Lorenzo</td>
<td>21</td>
</tr>
<tr>
<td>Priority 4</td>
<td>Leadership and Culture</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>• Including recruitment and retention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statements of assurance from the Board</td>
<td>26</td>
</tr>
<tr>
<td>Part 3</td>
<td>Other Information</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Patient Safety Domain</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Patient Experience Domain</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Clinical Effectiveness of Care Domain</td>
<td>67</td>
</tr>
<tr>
<td>Annex 1</td>
<td>What others say about us</td>
<td></td>
</tr>
<tr>
<td>Annex 2</td>
<td>Statement of Directors’ responsibilities in respect of the Quality Report</td>
<td></td>
</tr>
<tr>
<td>Annex 3</td>
<td>Limited Assurance Report on the content of the Quality Report and Mandated Performance Indicators</td>
<td></td>
</tr>
<tr>
<td>Annex 4</td>
<td>Mandatory performance indicator definitions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glossary</td>
<td></td>
</tr>
</tbody>
</table>
Part 1 Statement on quality from the Chief Executive

Providing high-quality, safe and effective care is at the heart of everything we do here at Royal Papworth Hospital. We are extremely proud to have gained an excellent reputation for quality in heart and lung medicine, but we know we must continually work to improve the care we provide to our patients. This Quality Account provides an overview of the quality of services that we have provided to patients during 2018/19 as well as our key priorities for improving quality in the year ahead.

In the last year, our staff and partners have worked extremely hard to maintain our excellent quality standards whilst remaining on our Papworth Everard site for an extended period following the delay in the move to our new hospital. We moved over 200 staff to Royal Papworth House in June 2018 and had to manage carefully the consequences of the delay in our move to the new Royal Papworth Hospital bringing forward essential equipment to our existing site and supporting our staff who had been eager to move to their new site. Our move is now secure, and we will be accepting our first patients at the new hospital in May 2019. I remain extremely proud that, despite all the changes we are going through as an organisation, we have maintained our excellent scores in the NHS Friends and Family Test, with 97% of our inpatients and 98% of our outpatients saying that they would recommend us as a place to receive treatment (February 2019).

Notable achievements in the last year include the introduction of a new pathway for patients suffering from high-risk NSTEMI, a type of heart attack caused by a severely narrowed artery. This new pathway means that patients identified as being high-risk are now transferred directly to Royal Papworth Hospital for treatment within 24 hours, rather than first being admitted to an acute hospital. This change in practice offers huge benefits to patients, as research and guidelines state that high-risk patients achieve better outcomes if they receive treatment to unblock the heart’s blood supply within 24 hours. In the six months since the new ‘Rapid NSTEMI’ pathway was launched in September, 134 patients have been accepted onto the pathway (over twice as many as predicted) with 87.3% patients receiving treatment within 24 hours of referral (and 91.8% receiving treatment within 24 hours of arrival at the Trust). As well as helping our patients receive quicker, safer treatment, the pathway has also led to a wide range of efficiencies in the wider healthcare system. Transferring patients directly to Royal Papworth has saved ambulance transfers and bed days spent in referring hospitals. In six months it has delivered system savings of over £240,000 through reduced A&E attendances alone. This service improves the quality of care for patients and has helped to ease pressures on NHS services across the region.

Over the last 12 months we have improved digital maturity, becoming a Lorenzo Digital Exemplar site. We have introduced new functionality such as 'Lorenzo on the Wall' screens in clinical areas. We have achieved interoperability between our electronic patient record and the Epic system used at Cambridge University Hospitals through a two-way interface to record laboratory results. Achieving this bidirectional link to the Epic system at CUH, means that the time to receive results has reduced. We have also introduced an important system called OpenHealthConnect, which will enable our systems to communicate with those used in the community. We have improved patient safety and have seen a continued reduction in the number of medication errors through the introduction of ePrescribing. We have reduced our carbon footprint by removing paper charts and have digitised over a million records. Our digital solutions mean that clinicians in all departments have up-to-date information relating to patient care, without having to wait for paper-based records to be transferred across the hospital, which allows better informed, quicker decisions about patient care. Looking forward, our new hospital offers state of the art technology, and we will ensure that digital opportunities are leveraged to improve the quality of delivery of clinical and non-clinical services.

In the midst of all this change, the patients continue to receive excellent care, with complaints being fewer than 1 per 1000 patient episodes and the patient tracker demonstrating that we provide care with dignity and respect. The Trust has engaged with the National Frailty Agenda, and has joined a number of workstreams such as TAVI to ensure that the patient remains at the centre of all that we do. We have made changes in the In House Urgent patient pathway to improve the timeliness of transfer for surgery, including standardising the preparation of patients in the referral process. With the introduction of the Clinical Cardiac Network (hosted by Royal Papworth Hospital), we will continue to improve pathways and equity of access to our services for all patients in the region.

The year ahead will be an important one for Royal Papworth Hospital. Our first patients will be treated in our new state of the art hospital on the Cambridge Biomedical Campus. The move to our new, purpose-built hospital provides co-location with Cambridge University Hospitals, offering benefits to patients. The move will see:
• The creation of a single centre for pulmonary and upper gastrointestinal cancers
• Co-located cardiothoracic surgery adjacent to the regional trauma centre at CUH
• Speedier cross-referrals between specialties and earlier interventions

The move also offers the opportunity to build closer links with research organisations and industry on the Campus. Our plans to build a Heart Lung Research Institute (HLRI) on the Campus are progressing with our partners at the University of Cambridge. The Institute will enhance training and career development opportunities for our staff alongside other health and life sciences organisations on the Campus and deliver an array of opportunities to enhance the care that we provide to our patients now and in the future.

With the launch of our Quality Strategy 2019-22 Royal Papworth Hospital has made a commitment to embed and support Quality Improvement within the organisation. It is important for our staff to recognise and believe that quality is everybody's business, and we need to ensure that staff feel empowered to speak up when they feel that patient care is unsafe or the patient doesn’t receive the service they deserve. We want staff at all levels to feel that they are supported by the organisation to act and make a change. We want our staff not only to come to work to do their job, but also to come to work to do their job better.

We recognise the value of continuous clinical quality improvement in supporting clinical effectiveness and in improving patient safety and the patient experience. It is also recognised that, service improvement and cost improvement will benefit from supporting the Quality Improvement agenda. Together with our Board of Directors and Council of Governors, and in consultation with our clinical staff, we have developed a series of quality priorities for 2019/20 that will help us make the most of the opportunities presented by our new hospital. These priorities will be addressed later in the Quality Accounts.

As ever, we rely on the support of all of our stakeholders to continue improving our services and maintain our reputation for care and innovation. I would like to thank all our staff, governors, volunteers and patient support groups and our system partners for helping us to deliver some significant improvements in the last year, while also helping us prepare for a safe and successful move to our new hospital.

The information and data contained within this report have been subject to internal review and, where appropriate, external verification. Therefore, to the best of my knowledge, the information contained within this document reflects a true and accurate picture of the quality performance of the Trust.

Stephen Posey
Chief Executive
23 May 2019
Information about this Quality Report

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

Every NHS trust, including NHS foundation trusts, has to publish a Quality Account each year, as required by the NHS Act 2009, in the terms set out in the *NHS (Quality Accounts) Regulations 2010.*

NHS foundation trusts are also required by NHS Improvement (NHSI) to publish a Quality Report as part of the foundation trust’s Annual Report and Accounts. The Quality Report includes all the requirements of the Quality Account regulations but includes additional requirements as set out by Monitor in its *Annual Reporting Manual* and in the document entitled *Detailed Requirements for Quality Reports.* Foundation Trusts are given the option of either publishing their whole Quality Report as their Quality Accounts or removing the additional NHSI requirements. Royal Papworth publishes its Quality Report in its entirety as its Quality Accounts. References to Quality Report and Quality Account should therefore be treated as the same throughout this document.

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 2018/19.

To help readers understand the report, a glossary of abbreviations or specialised terms is included at the end of the document.
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 2019/20 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 2018/19 priorities

Our 2017/18 Quality Report set out our quality priorities for 2018/19 under the three quality domains of patient safety, clinical effectiveness and patient experience. See our 2017/18 Quality Account for further detail: https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports

The following table summarises the five quality improvement priorities identified for 2018/19 together with the outcomes. The table below demonstrates achievements against the 2018/19 Goals.

<table>
<thead>
<tr>
<th>PRIORITY 1</th>
<th>Goals 2018/19</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Embed an improved safety culture through implementation of SCORE culture tool across the organisation</td>
<td>Implement SCORE Culture Survey in Cath Labs prior to move to NHP and repeat following the move</td>
</tr>
<tr>
<td>2</td>
<td>Deterioration and complications</td>
<td>The quality improvement projects overall aim was to reduce the ward incidents in relation to the recognition of deteriorating patients (2017/18 = 2 reported SIs) After the delivery of each training session, a cycle of monitoring for the following measures will be undertaken: • Improvement in timely observations using the electronic VitalPAC system • Spot checks of fluid balance charts against the urine output recordings on VitalPAC for patients who have urinary</td>
</tr>
<tr>
<td>3</td>
<td>Medicines Safety / Falls Risk Reduction</td>
<td>To reduce falls by 10% by April 2019 on one ward in the In House Urgent patient population</td>
</tr>
</tbody>
</table>

The initial aim was to rationalise medication that may have the potential to increase the risk of falls. Data was collected but no changes were made to the medication due to the complex nature of this cohort of patients. This aspect of the work will be re-visited at a later stage of the project.

The goal was therefore refined part way through the year:

**To reduce falls by 10% per 1000 bed days by April 2019 for Cardiac Surgery patients on Mallard Ward.**

As a result of the small steps for change implemented and studied, the average number of falls over the reporting period on Mallard Ward has reduced and this is indicative of an improvement compared with the number of falls during the same period in 2017/18. Measures implemented:

- Providing staff training
- Reinvigorating the falls link Nurse role
- Supporting falls link nurses to deliver on the ward teaching and falls prevention work
- Implementation of a new approach to multidisciplinary intentional rounding
- Introduce a patient information leaflet on falls prevention
- Launch the updated Falls Policy

---

catheters in place

- Improving the use of SBAR when verbally escalating a patient to the ALERT Team
- Explore and introduce the practice of out of hours multidisciplinary Safety Huddles for Cardiology and Surgical wards
- Evidence of documentation supporting appropriate escalation of patients with high risk or critical early warning scores.

output underway

The use of SBAR as a communication tool is now included in managing the deteriorating patient at study days

Safety Huddles have been introduced and the first audit of Safety Huddles is underway

- Implementation of deteriorating patient study days, which have now been extended to band 5/6 nursing staff.
- Feedback and learning from previous serious incidents within training
- Production of DN749 (hospital at night) completed
- NEWS2 online training available on education intranet site
Flow and Transfers – Implementation of Red to Green

- To define appropriate escalation triggers and actions to support flow.
- To look at the role of the Operations Centre in coordinating activity across the site.
- Staff training
  - Model the effects of TTOs written at least one day in advance to discharge.
  - Embed Pharmacy prescribers at ward level and work with ANPs to support discharge.
- Promote early use of transport booking system.
- Create internal escalation policy for transport issues.
  - Liaise with commissioners to refine escalation processes.
- Review discharge planning arrangements
  - Develop a criteria lead discharge policy which could be adopted by the organisation.

ACHIEVED

Every day three times a day, the Operational Manager indicates which triggers have been activated, which calculates into a hospital status. Daily SitREP is distributed at least three times a day and includes the following summary of information:

- Who is on duty for escalation
- Expected Elective Admissions
- Transfers
- Cancellations
- Bed availability
- Number of patients on Red or Green Days
- In house urgent & ACS information
- Repatriations
- Staff Summary
- Next day planning
- Additional information

- Training on Red to Green has been delivered. A further online tool will be made available in the next few months, which staff will be prompted to complete within two months of starting at the trust.
- TTOs written at least one day in advance of discharges is a business as usual process.
- ANPs continue to support the ward and further recruitment has been successful so continued/further support can be accommodated.
- Most transport is requested on the transport bookings system and the Transport Booking Coordinator makes the bookings, releasing ward staffs’ time, but currently only covering from 10:00 to 18:00. By April 2019 a further Transport Coordinator will be in post and the hours of service will be from 07:30 to 18:00 Monday to Friday. Out of these hours the Clinical Ward Administrative support will cover.
- Internal escalation policy with already
written and is within the transport procedure, currently this is a limited resource but further resource is in the planning stages.

This project will form business as usual and will not be carried forward in the Quality Account for 2019/20

| 5 | Build QI capability | ACHIEVED

The Cambridge Quality Improvers Network has been established in 2018/19 with Terms of Reference agreed and regular attendance from CUH, EAHSN representation and CPFT. Remote interest has been expressed by CCS and NWAFT. The network has encouraged cross-organisational support and discussion regarding the local and national QI agenda.

The project leads and QI support team have attended EAHSN QI training sessions. All Leads have completed Bronze online QI training. QI leads have been supported in the initiation of their project by the external QI Coach, who has provided training in the basic principles of QI.

Attended EAHSN Deteriorating Patient Workshop

ACHIEVED

The QISG has met monthly throughout 2018/19. The QI priorities are monitored and reviewed at each meeting.

The Trust has been supported with the three identified QI projects by an external QI Coach. We have used their expertise to support the development of aims and principles of QI to core team members of the QI projects.

We have initiated the transition of the Clinical Audit team to a more QI approach, this will include ongoing clinical audit priorities. 2018/19 has been challenging for the QI team due to unplanned staffing difficulties, and we have not yet managed to achieve full transition. However, we have focused on building knowledge, skills and capability within the team.

The QI Support team have attended the following workshops:

- PDSA and driver diagrams
- LIFE QI workshop
- Measurement for Improvement
- Attended Yorkshire and Humber Silver QI training

| 5 | Build QI capability |

- **Working with our partners – develop a Cambridge QI network**
  - To develop the network group, set Terms of Reference and meet every 4-6 months

- **Access the QI training delivered by EAHSN**
  - All identified QI leads to have undergone QI training
  - Monitor take up of EAHSN QI training

- **Support and monitor of QI across the organisation**
  - Monthly meeting of the Quality Improvement Steering Group
  - Commission coaching support for the three identified QI projects aligned to the Quality account
  - Transition the Clinical Audit department into a Quality Improvement support function

| 5 | Build QI capability | ACHIEVED

- **The Cambridge Quality Improvers Network** has been established in 2018/19 with Terms of Reference agreed and regular attendance from CUH, EAHSN representation and CPFT. Remote interest has been expressed by CCS and NWAFT. The network has encouraged cross-organisational support and discussion regarding the local and national QI agenda.

- **The project leads and QI support team have attended EAHSN QI training sessions.**
  - All Leads have completed Bronze online QI training.
  - QI leads have been supported in the initiation of their project by the external QI Coach, who has provided training in the basic principles of QI.

- **Attended EAHSN Deteriorating Patient Workshop**

- **ACHIEVED**

- The QISG has met monthly throughout 2018/19. The QI priorities are monitored and reviewed at each meeting.

- The Trust has been supported with the three identified QI projects by an external QI Coach. We have used their expertise to support the development of aims and principles of QI to core team members of the QI projects.

- We have initiated the transition of the Clinical Audit team to a more QI approach, this will include ongoing clinical audit priorities. 2018/19 has been challenging for the QI team due to unplanned staffing difficulties, and we have not yet managed to achieve full transition. However, we have focused on building knowledge, skills and capability within the team.

- The QI Support team have attended the following workshops:
  - PDSA and driver diagrams
  - LIFE QI workshop
  - Measurement for Improvement
  - Attended Yorkshire and Humber Silver QI training
<table>
<thead>
<tr>
<th>PRIORITY 2</th>
<th>Goals 2018/19</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| 1         | Increasing Direct Care Time (DCT) through action research project, starting with one ward and then rolling out across the Trust | • Improve Direct Care Time: to aim for minimum of 40% DCT  
• Wards to monitor DCT through quarterly activity follows  
• Report DCT quarterly through PIPR  
• Measuring DCT on a quarterly basis by doing activity follows. These are reported into PIPR.  
• We completed Direct Care Time Activity follows for all wards in each quarter in 2018/19 (100%)  
• We achieved the 40% DCT target in Q3 2018 delivering 40.7% DCT (Q1 39.2%, Q2 36.7%, Q4 38.7%).  
• Over the year, seven out of the eight ward areas have seen DCT delivered above the 40% target in at least one of the quarters and the one area that did not meet the target achieved 39%.  
• Wards have provided feedback and identified where there are variations in DCT delivered. This has included the impact of time spent supporting other staff on the ward and some areas where there may be variations in data recording which is being addressed.  
• The optimisation of Lorenzo has the potential to improve DCT. |
| 2         | Reducing complaints and PALS Concerns relating to communication | Monitor complaints on a monthly basis relating to communication issues. To show an overall reduction in complaints relating to communication against baseline at 31/03/2018 | Complaints are monitored and reported from ward to Board in the following ways  
• Monthly Matron’s report discussed at ward, business unit and directorate level  
• Lessons learned shared at site-wide multi-professional meetings  
• Actively identifying communication elements within complaints, reported incidents and Friends & Family Test feedback  
• Overall complaint numbers remain low and are closely monitored. |
| 3         | Evidence of improved communication through patient stories | To start meetings with a relevant and appropriate patient story. | • Trust-wide meetings from Business Unit to Trust Board now routinely commence with a patient story.  
• Patient stories are gathered from a wide variety of sources to allow further exploration when issues have been highlighted through other channels such as incidents and complaints.  
• Stories are also gathered from relatives and staff and shared in the same forum.  
• Patient stories to include what ‘Always events’ patients and their families feel are important so that these are continually refreshed.  
• All patient story templates include discussion about ‘always events’  
• To include Patient stories in Quality reports across all areas and provide a summary of Patient stories are included in monthly Matron’s Directorate reports |
<table>
<thead>
<tr>
<th>PRIORITY 3</th>
<th>Goals 2018/19</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 To retain a compassionate, expert workforce that is proud to work at Royal Papworth Hospital NHS Foundation Trust and feels developed and supported to make decisions, innovate and improve the lives of our patients.</td>
<td>1. Improve our staff Friends and Family score (% strongly agree/agree) Baseline: Treatment: 100% Recommend to Work: 42% 2. To maintain an appraisal rate above 90% across all groups of staff. Baseline: 88.38% 3. To increase number of staff signed up to Trust benefit scheme. Baseline: 463</td>
<td>Friends and family scores are now recorded in the Trust's monthly 'pulse' surveys. However, response rates are often in the low hundreds of staff. The 2018 Staff survey had 54% of the Trust respond, yielding results of recommend for treatment (88.6%) and recommend to work (63.2%). These results represent a modest improvement from the 2017 Staff survey results for treatment (85.8%) and a slight decline (from 63.3%) for recommend to work. The Trust achieved an above 90% appraisal rate for six of the last twelve months but five of these have come consecutively since November 2018. Increased engagement with managers and improved reporting arrangements have driven this improvement. As at March 2019, 615 staff were active users of the benefit app, representing over 30% of the Trust’s staff. Access to discounts, vouchers and other rewards through the app has been a visible element of the Trust’s staff engagement strategy.</td>
</tr>
<tr>
<td>2 To attract a diverse and skilled candidate pool across all staff groups by developing a strong employment brand through the use of social media and expanding the geographical area of advertising campaigns. Promotion of Royal Papworth’s unique selling point ‘fantastic reputation’.</td>
<td>Continued extension of training and development pathways Improved advertising Support non-EU staff achieve NMC accreditation Collaborative working with CUH &amp; Campus partners</td>
<td>The Trust has been able to increase the number of nurse apprenticeships from 7 to 10 (with nine more due to start in 2019/20). There has also been the successful introduction of a Critical Care HCSW/Nurse Apprenticeship with six staff appointed as at March 2019. The Trust has used social media, particularly Facebook and LinkedIn as part of its recruitment campaigns with some success and has attended recruitment fairs jointly with CUH. The Trust has also successfully assisted over 50 overseas nurses to achieve their NMC during 2018/19. The majority of these staff have come from EU countries and have had assistance with language courses as well as support in ward areas.</td>
</tr>
<tr>
<td>3 To recruit staff that share the Trust values ensuring that vacancies are filled in a timely manner. To have efficient recruitment processes and a strong corporate induction that supports the Royal Papworth</td>
<td>To reduce time to hire to a target of 51 days Development of tailored approaches for areas that are difficult to recruit to</td>
<td>The Trust’s time to hire has averaged 59 days during 2018/19, a reduction from an average of 71 in 2017/18. The Trust has focused on nurse recruitment and successfully reduced nurse vacancy rates from 9.55% to 4.5% over the year.</td>
</tr>
<tr>
<td>PRIORITY 4</td>
<td>Goals 2018/19</td>
<td>Outcomes</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>1. Ensure a safe move to our new facilities at Waterbeach, Royal Papworth House, Huntingdon and Royal Papworth Hospital, Cambridge.</td>
<td>Increased communications with staff</td>
<td>Weekly briefings with senior leaders have supported the move process supported by monthly ‘pulse’ surveys to capture staff feedback around the move.</td>
</tr>
<tr>
<td></td>
<td>Maintain a robust governance programme in relation to the moves</td>
<td>Rigorous governance process in place with Committee and full Board oversight of the sequence of moves and comprehensively documented Go/No Go decisions in place with extensive risk assessments and supporting plans in place for each phase of the move sequence.</td>
</tr>
<tr>
<td></td>
<td>Deliver a safe move to RP House, Waterbeach RP Hospital</td>
<td>Successful move to RP House and Waterbeach in line with Trust plans and successful Go decision achieved at Board in March 2019 for completion of the move to the Biomedical Campus followed by positive CQC registration visit in April 2019 and move confirmed for May 2019.</td>
</tr>
</tbody>
</table>
| 2. Implement our Workforce Race Equality Scheme and prepare for the implementation of the Workforce Disability Equality Scheme. | Submit data against the nine indicators by the 31 July and publish this and our action plan on our website by the end of September 2018 | WRES data submitted and action plan published. The action plan delivered:  
- Refreshed Governance of WRES  
- Updated and ratified Equality and Diversity policy in consultation with key stakeholders.  
- Freedom to Speak Up Guardian appointed and supported by regular communications to the Trust on the role of the FTSU Guardian  
- FTSU Guardian to report into Equality and Inclusivity steering group and Board  
- Non-Executive director sponsor for the FTSU Guardian role.  
- Unconscious bias training rolling out across the organisation. Embedding e-learning unconscious bias training as mandatory for all recruiting managers in the first instance.  
- BME network set up with first meeting of BME network on 28/09/18 and an active role developing in the organisation.  
- Mandatory training compliance by all staff achieving competency in Level 1 CSTF at induction (delivered by EDS lead) three year online mandatory refresher.  
- Integrating Equality and Diversity insight into the current line manager training offer. Ensure training covers using the |
### 3. Refresh the Trust’s clinical vision and strategy.

1. To secure the mutual benefits through the work of the CTP for:
   - Improved patient pathways
   - Service efficiencies
   - Research opportunities

2. To refresh the Trust’s clinical vision and strategy.

1. In September last year, the Trust introduced a new pathway for patients suffering from high-risk NSTEMI (non ST elevated myocardial infarct) – a type of heart attack caused by a severely narrowed artery. The new pathway means that patients identified as being high-risk are now transferred directly to Royal Papworth Hospital for treatment within 24 hours, rather than first being admitted to an acute hospital. This change offers huge benefits to patients, as research and guidelines state that high-risk patients achieve better outcomes if they receive treatment to unblock the heart’s blood supply within 24 hours. In the six months since the new ‘Rapid NSTEMI’ pathway was launched in September, 134 patients have been accepted onto the pathway with 87.3% patients receiving treatment within 24 hours of referral (and 91.8% receiving treatment within 24 hours of arrival at the Trust). As well as helping patients receive quicker, safer treatment, the pathway has also led to a range of efficiencies in the wider healthcare system. Transferring patients directly to Royal Papworth has saved ambulance transfers and bed days spent in referring hospitals. In six months it has delivered system savings of over £240,000. This service improves the quality of care for patients and has helped to ease pressures on NHS services across the region.

   The Trust has worked with Campus partners to develop the opportunities for collaborative research with an MoU being agreed with Philips. Plans are progressing with the University of Cambridge on the development of the Heart and Lung Research Institute.

2. The Trust has started the review of its strategy, broadly following the Monitor / NHSI Strategy Development Toolkit. This work builds on the development during 2018 of strategies for Research, Digital, Nursing and Quality. The process began with two Clinical Vision workshops, in June 2018 and January 2019, where Directorates presented their own views on the clinical opportunities and risks, and potential strategies for the future.

   Work has progressed during January and February 2019 to develop an overview of the strategic environment, drawing on recent strategy work, national plans and policy developments, and the insights and expertise of Trust leaders and has resulted in a “Context Scoping” paper. A further workshop was held on the 7 March where the Trust
Board and leaders of the organisation discussed the Context Scoping paper and agreed the five “Big Questions” that emerged. These will form the framework for strategy discussions in the next phase of development.

<table>
<thead>
<tr>
<th>PRIORITY 5</th>
<th>Goals 2018/19</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75% of clinical staff will have undertaken Clinical Familiarisation prior to move</td>
<td>A total of 97% of staff at band 6 and above and 90% of staff at band 5 and below attended clinical familiarisation prior to the move.</td>
</tr>
<tr>
<td>2</td>
<td>90% of on call managers / staff will have undergone emergency planning and command and control centre training</td>
<td>In addition to the two sessions run in the summer of 2018. Two further Command and Control sessions have been run in April 2019 with over 90% attendance. The remaining staff have booked separate sessions to ensure 100% compliance prior to the move sequence.</td>
</tr>
<tr>
<td>3</td>
<td>To achieve and maintain staff vacancies of below 10%</td>
<td>The overall Trust vacancy rate achieved was at 10.6% in February 2019, an improvement since September 2018 when the rate reached its highest level in the year at 13.3% (which was expected and aligned to our original planned move date). The vacancy rate will increase as we enter the new financial year as we reflect planned increases in establishment. Within this headline figure there has been a significant improvement in our nurse vacancy figure which is at 3.2% (including PRP staff) which compares to 9.1% rate in March 2018.</td>
</tr>
<tr>
<td>4</td>
<td>Rotas are completed in advance of the move articulating operational centre staff (new site and old site) and command and control centre staff, as well as on-call out of hours support.</td>
<td>All rotas completed and checked to match ramp down, ramp up, command and control and patient transfers. Volunteer rotas completed. Command and Control rotas and Operations Centre rotas completed.</td>
</tr>
<tr>
<td>5</td>
<td>Stakeholders will be informed and updated as to progress.</td>
<td>Weekly briefings with staff have been in place throughout the year, with a broad suite of communications being undertaken with the wider stakeholder group.</td>
</tr>
<tr>
<td>6</td>
<td>Go No Go decision is taken in August 2018 ready for the September 2018 Board of Directors meeting.</td>
<td>Following the delay in the move a re-phased master commissioning plan was agreed by the Board which moved the Go No Go decision to the Board meeting on the 28 March. The Board approved a Go decision at this meeting.</td>
</tr>
<tr>
<td>7</td>
<td>The Command and Control centre is set up and run effectively and then day to day running handed to the operational team following “cutover”.</td>
<td>This will now happen in April / May 2019 due to the hospital move delay.</td>
</tr>
<tr>
<td>8</td>
<td>The two week hospital cutover programme is delivered and the patients and staff move safely across to the new site.</td>
<td>This will now happen in April / May 2019 due to the hospital move delay.</td>
</tr>
<tr>
<td>9</td>
<td>Decommissioning is commenced on the old site.</td>
<td>Plans are in place and the decommissioning sequence has commenced on the old site.</td>
</tr>
</tbody>
</table>
Priorities for 2019/20

Our priorities for 2019/20 reflect the three domains of quality, patient safety, clinical effectiveness and patient experience. Our priorities are:

- Quality Improvement
- A safe Hospital Move
- Optimise Lorenzo
- Leadership and Culture

To determine the priorities for 2019/20, the Trust has reflected on the Quality Strategy refresh and what the Trust needs to achieve this year. With the backdrop of the financial pressures on the whole NHS, the Trust needs to continue to explore more efficient ways of working whilst maintaining and improving safety. With this as a principle, the next section describes the areas in which the Trust feels it must improve or initiatives that need to be completed in order to continue to be a relevant contributor to cardiothoracic treatment and care. We have reviewed clinical indicators, listened to the patients (through PALs concerns, complaints, patient experience feedback, support groups and listening events) who use our services and consulted with staff to ensure that the goals are specific and measurable.

Progress and achievement of goals in relation to our priorities will be reported to and monitored by the Quality and Risk Committee (a Committee of the Board of Directors). Reports will also be presented to the Patient and Public Involvement Committee (PPI) and the Council of Governors.
Royal Papworth Hospital has made a commitment to embed and support Quality Improvement (QI) within the organisation. We recognise the value of continuous clinical quality improvement in supporting clinical effectiveness, improving patient safety and the patient experience. Although not the primary focus, supporting Quality Improvement also contributes to service improvement and cost improvement.

For 2019/20, we will continue to focus on the three QI projects identified in 2018/19 and further develop the goals for 2019/20. We will also continue to build capacity in the Quality Improvement team through 2019/20 to support the delivery of the Quality Account priorities. Our aim is to support operational leads with coaching support and support from the central QI team. Projects will be logged and monitored using the LIFEQI project management system. By starting small, we can test the systems that are in place to support QI and identify any additional resources that are needed to grow our capability and QI portfolio.

The following work streams will be continued in 2019/20

1. **Embed an improved safety culture through implementation of the SCORE culture tool across the organisation**

   Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support it. Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes and these measures can be used to monitor change over time. One of the benefits of measuring safety culture is that it provides a tangible indicator of the current status and progress over time of organisations and teams implementing improvements.

   The SCORE survey is an updated version of the Safety Attitudes Questionnaire (SAQ), which has been developed and refined since 1993 and has undergone rigorous validation and reliability research. The SCORE survey is an anonymous, online tool that teams can use to assess their culture. It provides an overview but also detail in specific focus areas such as communication and staff burn out. Once the survey has been completed, the results are provided to that team alone for them to use to start conversations internally about what and how they would like to improve. The results are not shared with anyone else and will never be used for benchmarking or performance management.

   In addition, the Trust is also set to launch the Culture and Leadership programme (King’s Fund and NHSI) in 2019/20, which includes a baseline culture survey across the organisation, led by the Director of Workforce and Organisational Development.

   **Aim for 2019/20**

   - Implement SCORE Culture Survey in selected clinical areas across the Trust

   EAHSN have confirmed that there is no regional support for the SCORE Culture Survey from April 2019. The survey is now considered part of the enabling themes of Culture and Human Factors which runs through all national key work streams being supported by the Patient Safety Collaborative. However, we have been advised that we can identify five areas to survey in 2019/20 and must have gone live with the surveys by July 2019.

2. **Deterioration and complications**

   It is essential that patients have timely detection and prompt, effective management of clinical deterioration. The main areas that need to be addressed to improve the outcomes for patients are the failure to undertake observations or to escalate the findings to an appropriate level of seniority. A team of Advanced Nurse Practitioners support the nursing and medical staff throughout the trust, in the management of the deteriorating patient to ensure timely and efficient care, (ALERT Team). In January 2018, the ALERT team introduced specific training for registered Nurses (including band 4 support workers) on the recognition of the deteriorating patient, and the significance of observation changes.

   **Aim for 2019/20**

   100% of patients on Varrier Jones Ward with a MEWS of 4 or more will receive the correct actions according to RPH guidelines by 2020
Goals for 2019/20

- Improvement in timely observations using the electronic VitalPAC system (Mindray system when implemented)
- Improvement in the appropriate escalation of the deteriorating patient
- Spot checks of fluid balance charts against the urine output recordings on VitalPAC for patients who have urinary catheters in place.
- Improving the use of SBAR when verbally escalating a patient to the ALERT Team
- Improving appropriate use of saturation finger probes
- Explore and introduce the practice of a structured out of hours multidisciplinary Safety Huddles for Cardiology and Surgical wards. DN749 (hospital at night) guidelines policy implemented.
- Extend and establish Deteriorating Patient Study Days (band 4, 5 and 6)
- Establish competency assessment for completing patient observations for band 2/3
- Preparation for implementation of NEWS2 (launch 18 March 2019)
- Preparation for implementation of Mindray (launch 1 May 2019)

3. Falls Risk Reduction

Fall prevention and reduction remains a priority for the Trust, and we aim to build on the work achieved to date which will include the roll out and spread of change ideas which have demonstrated a reduction in falls. It is recognised that the primarily single rooms patient environment in the new hospital may impact on falls prevention and numbers of falls reported. We will therefore continue to focus on one ward area for the first six months after the move to consolidate actions, and demonstrate through PDSA cycles and data analysis the change ideas which translate into demonstrable falls prevention and reduction. We also aim to scrutinise further reported falls data to identify and better understand our falls in order to help focus further change ideas and actions.

Aim for 2019/20

To reduce falls by 10% per 1000 bed days by April 2019 for Cardiac Surgery patients on Mallard Ward (New Papworth Hospital - 5 North)

Goal for 2019/20

- Roll out and spread the good practice on Mallard Ward / 5 North
- Implement multi-disciplinary intentional-rounding forms hospital-wide
- Complete a re-audit of the use of bed-rails
- Audit the use of falls prevention care plans
- Review the quality and completeness of falls risk assessment
- Use reported Datix incident forms and mini RCA data reported from falls on on 5 North to identify actions to prevent /minimise falls
- Monitor the impact of the new environment of single rooms on 5 North relating to falls prevention and number of falls

4. In House Urgent (IHU) Pathway – newly formed QI project during 2018/19

The IHU patient is a time-critical patient with unstable cardiac disease who is already in an acute hospital bed with significant red bed days. These patients require urgent intervention not only to restore homeostasis and improve cardiac function but also to reduce red bed days and improve patient flow and increase capacity within the system. The IHU pathway at Royal Papworth Hospital has been a challenge with inconsistent staff working within the pathway and inconsistent processes. Previous efforts to remedy the problem have not been successful.

Issues are multi-faceted and quite complex, with hospital processes, specialist services, patient cancellations, critical care / ward bed availability and staffing levels being daily obstacles in meeting the target of seven days from MDT to surgery. We must ensure that our referral system is robust and our capacity favourable when prioritising these patients for appropriate intervention. Once accepted by RPH, these patients need to be managed safely and according to national standards even in the face of potential risk of cancellation.

The In House Urgent quality improvement project was launched on 18 September 2018, the project lead recruited, and core team formed. Baseline data has been collected from June to October 2018. Monthly monitoring of IHU pathway, scheduling and cancellations is in place.
Aims for 2019/20:
- 100% of patients who are referred into the IHU pathway will be assessed appropriately at MDT
- 98% of patients on IHU pathway will have their surgery within ten days (start date = when fit for surgery)
- 98% of all cancelled surgery will be rescheduled within five days

Goals for 2019/20
- Develop pathway standards for referral, MDT, Cardiology and Surgery
- Agree ownership of IHU patients between Cardiology, Surgery and ANP
- ANP to attend twice-weekly bed meeting
- To engage with the Central Bookings team to ensure accurate and equitable allocation of IHU capacity
- Daily monitoring of IHU spreadsheet, referrals and waiting times for IHU surgical slots
- Operational Manager to assist with the scheduling and rescheduling of IHU patients
- Theatre Manager to assist in the allocation of IHU patients and procedure for rescheduling within five days
- Review IHU pathway staffing requirement
- Review the IHU / elective surgical waiting lists
- Update the PRIS Referral Form / System

5. Build QI capability

Royal Papworth Hospital has made a commitment to embed and support Quality Improvement within the organisation. We recognise the value of continuous clinical quality improvement in supporting clinical effectiveness, improving patient safety and the patient experience. Although not the primary focus, supporting Quality Improvement will benefit service improvement and cost improvement. 2018/19 has been challenging for the QI team due to unplanned staffing difficulties, and we have not yet managed to achieve full transition.

Aim for 2019/20:
- Build and develop QI capability within the QI team and across the organisation

Goal for 2019/20
- Develop a QI road map to articulate the direction of travel and in particular how national, mandatory and local clinical audits, other clinical effectiveness assurance and reporting on patient experience outcomes will be prioritised in addition to the Trust’s quality improvement priorities
- Rebuild the QI team to full establishment, reviewing the team requirements to achieve the ambitions that will be set out in the road map and recruiting into vacant posts.
- Access local and national training to support and develop the QI capability within the QI support team
- Develop a QI faculty supported by the leadership team
- Development of QI training tools including access to online QI training, face to face training and development of training materials on individual elements of QI methodology to support staff who are embarking on QI projects
- Expand the membership of the QI Steering Group to include the project leads for the three main QI projects, operational engagement and strengthen the links with service improvement
- Launch the QI road map and priorities going forward at a Trust event during 2019/20

Executive Lead:
- Chief Nurse

Implementation Lead:
- Associate Medical Director, Clinical Lead for Clinical Governance

Programme Leads:
- Assistant Director for Quality and Risk
- Clinical Governance Manager
- Advanced Nurse Practitioner – ALERT
- Falls Prevention Lead
- Nurse Consultant Advanced Clinical Practice
- Leadership team
Priority 2: A Safe Hospital Move

Goal

To safely move the Royal Papworth Hospital from its existing site in Papworth Everard to the new hospital site on the Cambridge Biomedical Campus, with particular emphasis on preparing the staff for a safe move during the two-week cutover period in April / May 2019.

Rationale

Moving a whole hospital is a once in a career event, and the majority of staff have never experienced a whole hospital move before. There are added complexities with moving a heart and lung tertiary centre which include a high number of Critical Care patients with complex needs, complex infection control precautions in the Cystic Fibrosis population, emergency access patients such as transplant activity, primary percutaneous Catheter interventions (for heart attacks) and the ECMO retrieval service.

Careful planning is required therefore; the Hospital Cutover Group was set up and charged with planning and executing a safe move.

Baseline

Staff have actively engaged in departmental readiness and the operational readiness part of the project is progressing well. All actions within the Hospital Cutover Group are being delivered on time and external engagement from stakeholders has been positive. Of note, is the East of England Ambulance and Amvale Ambulance Service’s engagement in planning the patient transfer programme. Clinical Familiarisation has been completed and Command and Control training will be completed prior to the move period. All actions in the Cutover Plan are up to date with only the move process now to complete. The Trust hosted a successful CQC Registration Site Visit.

The Hospital Cutover Plan has been shared with stakeholders which include the Emergency Planning and Resilience forum, Cambridge University Hospitals Operations team, referring hospitals and commissioners (local and specialist).

Milestones so far:

- 75% of clinical staff will have undertaken Clinical Familiarisation prior to move - Achieved.
- 90% of on call managers/staff will have undergone emergency planning and command and control centre training – Achieved.
- To achieve and maintain staff vacancies of below 10% - Partly Achieved
- Rotas are completed in advance of the move, setting out operational centre staffing (new site and old site) and command and control centre staffing, as well as on-call out of hours support – Achieved
- Go No Go decision to be taken in March 2019 ready for the Board of Directors meeting – Achieved.

Goals 2019/20

- Stakeholders will be informed and updated as to progress.
- The Command and Control centre is set up and run effectively and then day to day running handed to the operational team following cutover.
- The two week Hospital Cutover Programme is delivered and the patients and staff moved safely across to the new site.
- Decommissioning is completed on the old site.
- Evaluation written and lessons learnt shared inside and outside the organisation.
**Monitoring**
Action through the Hospital Cut over group reporting to:

Project Management Team and Strategic Projects Committee of the Board of Directors, overseeing the Master Commissioning Plan and the Delivery Programme.

**Executive Sponsor:**
Chief Nurse / Medical Director

**Operational lead:**
Deputy Chief Nurse
Deputy Project Director
Associate Director for Estates and Emergency planning lead

**Project lead:**
Deputy Chief Nurse
Deputy Project Director
Associate Director for Estates and Emergency planning lead
Priority 3: Optimise Lorenzo

Goals

1. **Delivery of the Lorenzo Digital Exemplar Programme**
   The core of the optimisation programme will be delivered through the Exemplar programme. Through the Lorenzo Exemplar programme pathway optimisation will deliver a reduction in clinical variance to aid in the reduction of avoidable patient harm. The programme will also aid in retiring old software, centralising patient information, reducing the clinicians’ need to access different systems and releasing time for patient care.

2. **Deliver a safer and improved patient experience**
   We continue to face challenges in delivering meaningful user centred reporting to the clinical teams. The Digital Department is continuing to work closely with the clinical teams to address these issues to ensure a safer and improved patient experience.

3. **Improve our ability to utilise data for quality assurance, research and audit.**
   To unlock the system potential, the Trust needs to be able to extract data which can be utilised for quality assurance (dash boards), research and audit. This means that there needs to be a commitment to writing queries to enable questions to be answered without a systematic manual search of the system. An example may be how many patients received appropriate VTE prophylaxis following a VTE risk assessment or how many patients received smoking cessation intervention.

Rationale

Lorenzo is an electronic patient record (EPR) system that went live within the Trust in June 2017. The new EPR is just one part of a multi-faceted programme to help revolutionise how patient care is delivered over the coming years at the Trust. The programme has five key areas: Communication and Engagement, System Functionality, Business Change, Training, and Benefits Realisation.

Since go live, the Operational Teams have been monitoring performance in terms of the data quality in a systematic way starting to standardise processes and performance across the Trust. The Lorenzo programme has transitioned from its implementation phase to business as usual (BAU) embedding and consolidation phase. The Trusts’ ambition for 2019/20 is to deliver enhanced clinical safety with both EPMA part 4 closed loop medication distribution and haemonetics vein to vein blood administration, and improved user experience through Personas (Lorenzo web view) with voice recognition in clinics.

Baseline Performance Data

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target /Position at March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL 1: Delivery of the Lorenzo Digital Exemplar Programme</strong></td>
<td></td>
</tr>
<tr>
<td>Maximise benefits from Lorenzo User Group</td>
<td>Identify Super Users Forum (target for competency based learning programme )</td>
</tr>
<tr>
<td></td>
<td>Identification prioritisation and resolution of issues</td>
</tr>
<tr>
<td></td>
<td>DXE digital road map – influence their system</td>
</tr>
<tr>
<td></td>
<td>User Champion to chair that group –</td>
</tr>
<tr>
<td></td>
<td>Supporting with communications</td>
</tr>
<tr>
<td>Delivery of competency based learning programmes</td>
<td>Number of Programmes</td>
</tr>
<tr>
<td></td>
<td>Number of staff completing programmes</td>
</tr>
<tr>
<td></td>
<td>Impact on incidents/data quality</td>
</tr>
<tr>
<td></td>
<td>Digital Strategy Board</td>
</tr>
</tbody>
</table>

**GOAL 2: Deliver a safer and improved patient experience**
<table>
<thead>
<tr>
<th>Implementation of real-time bed management.</th>
<th>Lorenzo on the wall and the enabling of staffs’ competence for real-time admission transfer and discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the average length of stay for elective patients</td>
<td>Outcome measures improvement in reporting and data quality impact on RTT/Finance/reduce adverse events</td>
</tr>
<tr>
<td>Closed loop medication distribution</td>
<td>Reduction in medication incidents</td>
</tr>
<tr>
<td>Vein to vein blood administration</td>
<td>Reducing the risk of transfusion incidents by having a digital chain form venepuncture to administration of blood products.</td>
</tr>
</tbody>
</table>

**Goal 3:** Improve our ability to utilise data for quality assurance, research and audit.

<table>
<thead>
<tr>
<th>Develop a ward and Trust wide dashboard</th>
<th>Ward and Trust dashboard developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>To convert free text into data that can be pulled</td>
<td>Increase in number of CDC forms to enable capture of structured clinical data</td>
</tr>
</tbody>
</table>

**Monitoring**
KPIs reported to Board and Committees of the Board in PIPR and spotlight reports

**Executive Lead:**
Andrew Raynes, Chief Information Officer

**Implementation Leads:**
Eamonn Gorman Chief Nursing Information Officer/Chris Johnson Chief Medical Information Officer

**Programme Leads:**
Eamonn Gorman Chief Nursing Information Officer
Chris Johnson Chief Medical Information Officer
Priority 4: Leadership and Culture, including Recruitment and Retention

Goals

To retain, attract and recruit a diverse workforce who share the values of Royal Papworth Hospital NHS Foundation Trust, providing them with a high-quality recruitment and onboarding process.

To engage our workforce in defining, developing and owning an organisational culture that embodies high-quality, compassionate care.

To build leadership capability at all levels of the organisation through a mixture of high-quality internal and external training interventions.

Rationale

In 2019/20 the Trust will undergo the greatest organisational change in its 100 year history, namely the move to our new hospital on the Cambridge Biomedical Campus (CBC) site. The new facilities present an opportunity in terms of attracting staff locally, nationally and internationally to a brand new, purpose-built hospital. It also presents a wonderful opportunity to develop and implement a culture, or way of doing things, that champions a commitment to high-quality care.

2019/20’s goals seek to maintain a focus on retaining and recruiting staff to enable the Trust to make best use of our new state of the art facilities to deliver excellent patient care. It sees the final year of the Trust’s three-year recruitment and retention strategy where the Trust seeks to capitalise on its recruitment successes and develop the leadership and culture agenda.

Progress against Objective One will be measured by monitoring the Trust's Friends and Family, turnover and vacancy rates. These provide a high-level picture of progress across retention, attraction and recruitment performance.

The Trust’s 2018 Staff Survey results highlighted the need to improve the experience of staff from BAME backgrounds in the organisation. The Trust began this journey in 2018/19 with the establishment of the BAME network and the Equality, Diversity and Inclusivity Steering Group. BAME participation in leadership and development training, the continued growth of the network, and celebrating the contribution of BAME staff form part of the goals of engaging our workforce and building leadership capacity.

Culture in organisations, often described as ‘the way we do things round here’, fundamentally affects the way staff treat patients and each other. The biggest influence on culture is the leadership in the organisation. Collective and compassionate leadership is the key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients; and can support sustainable operational and financial performance. To this end, the Trust’s goals for 2019/20 include goals to engage the workforce in creating the culture that the organisation wishes to embody.

Ensuring staff have an appraisal and that the appraisal is of good quality is important both to the engagement and leadership goals for 2019/20, Therefore, both the appraisal rate and staff’s reported experience of appraisals are included as metrics.

The prompt publishing of rosters is an important part of helping staff to maintain a good work/life balance by providing clarity around working times. This element is monitored against the Trust’s goal of engaging its workforce.

The culture of an organisation impacts behaviour at all levels within and across organisations. Staff performance and engagement are directly affected by organisation culture, which in turn impacts patient satisfaction, care quality, financial performance and patient experience.

Improving the capability and diversity of the Trust’s leadership is also an important goal for 2019/20
Baseline Performance Data

<table>
<thead>
<tr>
<th>KPI</th>
<th>Position at March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL 1: To retain, attract and recruit</strong> a diverse workforce who share the values of Royal Papworth Hospital NHS Foundation Trust, providing them with a high-quality recruitment and onboarding process.</td>
<td></td>
</tr>
<tr>
<td>Staff Friends and Family score (% strongly agree/agree)</td>
<td>Treatment: 73% Recommend to Work: 46%</td>
</tr>
<tr>
<td>Turnover of staff (annualised) %</td>
<td>19.42%</td>
</tr>
<tr>
<td>Vacancy rate</td>
<td>March 2019 11.01%</td>
</tr>
<tr>
<td>Nurse Vacancy Rate</td>
<td>Qualified staff 4.34% Unqualified staff 28.38%</td>
</tr>
<tr>
<td>Number of Associate/Assistant Practitioners in the organisation</td>
<td>Number</td>
</tr>
<tr>
<td>Number of Apprentices in the organisation</td>
<td>Number</td>
</tr>
<tr>
<td><strong>GOAL 2: To engage our workforce</strong> in defining, developing and owning an organisational culture that embodies high-quality, compassionate care.</td>
<td></td>
</tr>
<tr>
<td>BAME staff experience: i. Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion ii. Percentage of staff experiencing discrimination at work from their manager/team leader or other colleague in last 12 months</td>
<td>Staff survey score 2019 vs 2018</td>
</tr>
<tr>
<td>Publishing rostering in a timely manner</td>
<td>Percentage compliance with our publication deadline March 2019: 16%</td>
</tr>
<tr>
<td>Papworth Discount App</td>
<td>Total Active users March 2019: 619</td>
</tr>
<tr>
<td>Appraisal Rate</td>
<td>90.29%</td>
</tr>
<tr>
<td>Appraisals are of a good quality</td>
<td>Staff survey score 2019 vs 2018 2018: 5.4 (higher better)</td>
</tr>
<tr>
<td>Achieving Equality Delivery System 3 2019</td>
<td>Completion of Assessment against EDS3 Standards</td>
</tr>
</tbody>
</table>

**Goal 3: To build leadership capability** at all levels of the organisation through a mixture of high-quality internal and external training interventions.
| Staff attending internal or external leadership development opportunities (YTD total) | 2018/19 total: 315 |
| Development and adoption of a formal talent management strategy | Strategy agreed and published by March 2020 |

**Monitoring**
Workforce KPIs reported to Board and Committees of the Board in PIPR and spotlight reports
Staff engagement survey results
National NHS Staff Survey results

**Executive Lead:**
Director of Workforce and Organisational Development

**Implementation Leads:**
Deputy Director of Workforce and Organisational Development, Head of Resourcing and Leadership and Development Manager, Head of Communication

**Programme Leads:**
Recruitment Services Manager
Head of Leadership and Organisational Development
Head of Employee Relations
Recruitment and Retention Nurses
2.2 Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by Royal Papworth Hospital NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare quality accounts for each financial year. NHSI has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports, which incorporate the legal requirements, in the NHS Foundation Trust Annual Reporting Manual.

Indicators relating to the Quality Accounts were agreed following a process which included the input of the Quality and Risk Committee (a Committee of the Board of Directors), Governors, the Patient and Public Involvement Committee of the Council of Governors and clinical staff. Indicators relating to the Quality Accounts are part of the key performance indicators reported to the Board of Directors and to Directorates as part of the monitoring of performance.

Information on these indicators and any implications/risks as regards patient safety, clinical effectiveness and patient experience are reported to the Board of Directors, Governors and Committees as required.

Part 2.2 includes statements and tables required by NHSI and the Department of Health and Social Care in every Quality Account/Report. The following sections contain those mandatory statements, using the required wording, with regard to Royal Papworth Hospital. These statements are italicised for the benefit of readers of this account.

During 2018/19 Royal Papworth Hospital NHS Foundation Trust provided and/or sub-contracted six relevant health services. Royal Papworth Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in six of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Royal Papworth Hospital NHS Foundation Trust for 2018/19.

Full details of our services are available on the Trust web site: https://royalpapworth.nhs.uk
National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

During 2018/19, 12 national clinical audits and 2 national confidential enquiries covered relevant health services that Royal Papworth Hospital NHS Foundation Trust provides. During 2018/19, Royal Papworth Hospital NHS Foundation Trust participated in 12 of the 12 (100%) national clinical audits and 2 of the 3 (50%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Royal Papworth Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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.

<table>
<thead>
<tr>
<th>National clinical audits relevant to Royal Papworth Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation rate 14/14 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Audit Source</th>
<th>Compliance with audit terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>100</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford</td>
<td>100</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Perioperative diabetes</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>See breakdown</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>University of York</td>
<td>100</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>NHS Benchmarking Network</td>
<td>100</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK</td>
<td>100</td>
</tr>
<tr>
<td>National Audit of Cardiac Rhythm Management (CRM)</td>
<td>Barts Health NHS Trust</td>
<td>100</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>Barts Health NHS Trust</td>
<td>100</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>Barts Health NHS Trust</td>
<td>100</td>
</tr>
<tr>
<td>National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)</td>
<td>Barts Health NHS Trust</td>
<td>100</td>
</tr>
<tr>
<td>National Congenital Heart Disease (CHD)</td>
<td>Barts Health NHS Trust</td>
<td>100</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)*</td>
<td>Royal College of Physicians</td>
<td></td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>King's College London</td>
<td>100</td>
</tr>
</tbody>
</table>
The National lung cancer audit records the patients by the hospital in which they were first seen. Since almost no patients are referred direct from their GP to Royal Papworth, the data which is completed by Hospital counts towards the district general hospitals participation rate.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - 50%

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Cases included</th>
<th>Cases excluded</th>
<th>Clinical Q returned</th>
<th>Case notes returned</th>
<th>Organisational questionnaire returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative diabetes</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0 Study still in progress</td>
</tr>
<tr>
<td>Long term ventilation</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0 Study still in progress</td>
</tr>
</tbody>
</table>

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

The reports of 11 national clinical audits were reviewed by the provider in 2017/18 and Royal Papworth Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Example includes:

Below is a sample of audits discussed at relevant group meetings.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Report Published</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Perioperative diabetes</td>
<td>Yes</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>Yes</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>Yes</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
</tr>
<tr>
<td>National Audit of Cardiac Rhythm Management (CRM)</td>
<td>No</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>Yes</td>
</tr>
<tr>
<td>National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)</td>
<td>Yes</td>
</tr>
<tr>
<td>National Congenital Heart Disease (CHD)</td>
<td>Yes</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)*</td>
<td>Yes</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The reports of 52 local clinical audits were reviewed by the provider in 2018/19 and Royal Papworth Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. A sample of actions is listed below:

Critical Care Pain Observation Tool (CPOT)

Royal Papworth Hospital aims to ensure that pain assessment will be accomplished in 100% of CRU and ICU patients, both verbal and non-verbal. This target is fulfilled through the introduction of the Critical Care Pain Observation Tool (CPOT) as part of the routine pain management of ICU/CRU patients.

The use of the CPOT is expected to improve pain management in CRU and ICU patients. Actions taken as a result include:
• Ensure that all bedside nurses involved know how to perform the assessment (through the electronic dissemination of relevant documents and video resources)
• Involve the teaching team, to ensure that standards are maintained
• Explore the feasibility of an electronic CIS version of the CPOT in order to minimize workload/ensure a smoother workflow during daily nursing
• Produce a pain management protocol based on CPOT

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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 3,038. See table below:

<table>
<thead>
<tr>
<th>Type of research project</th>
<th>No. of participants recruited per financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/16</td>
</tr>
<tr>
<td>NIHR portfolio studies</td>
<td>1,065</td>
</tr>
<tr>
<td>Non-NIHR portfolio studies</td>
<td>542</td>
</tr>
<tr>
<td>Tissue bank studies*</td>
<td>2,361 (2,659)</td>
</tr>
<tr>
<td>Total</td>
<td>3,968</td>
</tr>
</tbody>
</table>

NIHR = National Institute for Health Research
* Tissue bank studies include 2 studies registered on the NIHR portfolio. Total figure given in brackets to avoid double counting as participants are included in NIHR portfolio studies.

By maintaining a high level of participation in clinical research, the Trust demonstrates Royal Papworth’s commitment to improving the quality of health care.

During 2018/19 the Trust recruited to 63 studies, of which 58 were portfolio studies (2017/18: 67 studies and 58 portfolio studies).

The Trust recruits to studies in a wide variety of disease groups, including cystic fibrosis, lung cancer, motor neurone disease, heart failure, atrial fibrillation, cardiac surgery and idiopathic pulmonary fibrosis. The Trust continues to sponsor a number of single and multi-centre studies. In September 2018 the Clinical Trials Unit gained full accreditation from the UKCRC.

Quality is at the heart of all our research activities. Royal Papworth ranked as the top recruiting site in the UK for over 20% and in the top three highest recruiters for over 50% of the multicentre NIHR portfolio studies we supported. The Trust remains committed to improving patient outcomes by undertaking clinical research that will lead to better treatments for patients undergoing care in the NHS. We would like to say thank you to all those who participated in our research over the past year.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Royal Papworth Hospital NHS Foundation Trust’s income in 2018/19 was 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 payment framework

Further details of the 2017/18/19 national Specialised and non-specialised CQUINs are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/.

At the time of writing 100% achievement had been reached to Quarter 3, Quarter 4 submission date is Friday 3 May 2019.

The amount of income available in 2018/19 conditional on achieving quality improvement and innovation goals was £2,650k. (2017/18: £2,569k). The amount expected to be achieved is £2,640k (2017/18: £2,544k [99%]).
For further information on CQUIN performance for 2018/19 see Part 3 of the Quality Report. For further information on CQUIN priorities for 2019/20 see the Performance Report section of Annual Report.

Care Quality Commission (CQC) registration and reviews

Royal Papworth Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is ‘registered without conditions’. The Care Quality Commission has not taken enforcement action against Royal Papworth Hospital NHS Foundation Trust during 2018/19. Royal Papworth Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Royal Papworth Hospital welcomed the CQC to the new hospital in April 2019 to undertake their registration visits ahead of the move to the new hospital on the Cambridge Biomedical Campus. In April 2019 the CQC registration team confirmed that they would be recommending that the new site be registered without conditions.

Royal Papworth Hospital NHS Foundation Trust is subject to periodic review by the CQC and received an unannounced inspection in the first week of December 2014. See Part 3 – Other information. The report of this inspection is available on the CQC website at http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8932.pdf

The Trust has completed a Routine Provider Information Request at the CQC’s request, so can expect an inspection of core services and well led within review the next six months.

Data Quality

It is essential that we produce accurate and reliable data about patient care. For example, how we ‘code’ a particular operation or illness is important as that not only allows us to receive the correct income for the care and treatment that we provide, but it also anonymously informs the wider health community about illness or disease trends.

Royal Papworth Hospital NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient’s valid NHS number was 100% (national average 99.4%) for admitted patient care and 100% (national average 99.6%) 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 99.9%) 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 with regard to patients’ and staff is done so safely and legally. The information governance toolkit is the way that we demonstrate our compliance with information governance standards. All NHS organisations are required to make annual submissions to NHS Digital in order to assess compliance.

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

The Information Governance Toolkit is available on the NHS Digital website: https://www.igt.hscic.gov.uk/

Clinical Coding

Royal Papworth Hospital was not subject to the Payment by Results clinical coding audit during 2018/19.

Royal Papworth Hospital’s annual independent clinical coding audit was carried out by Jane Wannacott Ltd during February 2019.

Royal Papworth Hospital has achieved the following Information Governance levels:
1. Information Governance Requirement 14-505: An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months. Attainment level 1

2. Information Governance Requirement 14-510: Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards. Attainment level 3

Royal Papworth Hospital NHS Foundation Trust will be taking the following actions further to recommendations aimed at continuing to improve data quality:

- Continue to attempt to recruit experienced substantive qualified staff;
- The existing training program initiated for the current trainees will continue but will move to a self-directed learning style in the six months leading to the September 2019 Accredited Clinical Coding exam in order to promote independence and to relieve the pressure on the experienced team
- A quarterly Information Governance tracking audit will be performed to identify and address themes in coding errors earlier.
- Actively seek to place the coding team in one geographical location to ensure that junior coders always have access to an experienced coder for day-to-day coding support and to address some of the feedback from Coders in other Trusts regarding split-site working, which is thought to be affecting recruitment.

**LEARNING FROM DEATHS**

During April 2018 to March 2019, 163 of Royal Papworth Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 40 in the first quarter; 28 in the second quarter; 44 in the third quarter; 51 in the fourth quarter.

By 17/05/19, 61 case record reviews and 5 investigations have been carried out in relation to 163 of the deaths. In 1 case(s) a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

4 in the first quarter; 13 in the second quarter; 28 in the third quarter; 23 in the fourth quarter.

One representing 0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; one representing 2% for the third quarter; 0 representing 0% for the fourth quarter.

**Mortality Case Record Review process**

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

The 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 case record review, this is reported as a patient safety incident triggering an investigation process. The local procedure is set out in DN682 Mortality Case Record Review Procedure.

Analysis of number of deaths by Clinical Directorate shows that most deaths in Royal Papworth Hospital occur in Cardiology and Surgery, with smaller numbers in Transplant, Thoracic Medicine and Respiratory ECMO.

**Lessons learnt & Actions taken in 2018-19**

Actions which Royal Papworth Hospital has taken in the reporting period, and proposes to take following the reporting period, in consequence of what Royal Papworth Hospital has learnt during the reporting period:
Lesson learnt: Following the introduction of the case record review process in April 2017 the Trust sought to review all inpatient deaths by case record review.

Action taken: In 2018-19 a more selective approach for case record reviews has been taken based on criteria recommended by the Independent Advisory Group to Royal College of Physicians’ National Mortality Case Record Review Programme.

Lesson learnt: The need to record and discuss deaths on a regular basis was identified as well as linking deaths to case record reviews and incident investigations

Action taken: In 2018-19 the Serious Incident Executive Review Panel (SIERP) was set up to meet weekly to discuss deaths in the previous week and link to case record reviews and incident investigations. The Clinical Audit team and Patient Advice & Liaison Service team jointly administer the case record review database and ensure that all patient details are recorded on a weekly basis.

Lesson learnt: Following the introduction of the electronic health record in June 2017, some difficulties had been experienced in conducting case record reviews. A range of different sources currently need to be accessed to perform a case record review (Current Admission Folder, Lorenzo, Electronic Medical Record, Metavision) and it can be difficult to make clear judgements on the quality of care.

Action taken: In 2018-19 there have been improvements in access to the Current Admission Folder and there is ongoing work to ensure that Lorenzo clinical records are saved and uploaded contemporaneously.

Lesson learnt: The introduction of the case record review process has acted as an additional safety net to identify patient safety concerns in the Trust. It is important not to miss any patient safety concerns which have not been identified through the incident reporting system.

Action taken: In 2018-19 the case record review process did not reveal any patient safety concerns which had not already been reported as an incident indicating a strong patient safety reporting culture in the Trust.

Lesson learnt: Post-mortem reports may needed to make a full judgement of the quality of care in patients who have died. The post-mortem reports for deaths which are referred to the Coroner and proceed to Coroner’s investigation or inquest may be difficult to access.

Action taken: In 2018-19 agreement with HM Coroner for Cambridgeshire and Peterborough has been reached for post-mortem reports to be released earlier to the Trust when case record reviews or incident investigations are being conducted.

Lesson learnt: In addition to the case record review process deaths are also discussed at specialty Mortality & Morbidity meetings. The need to improve the standard of Mortality & morbidity meetings has been identified to ensure cases are discussed openly in a multidisciplinary forum, lessons are learnt and actions are taken.

Action taken: In 2018-19 specialty Mortality & Morbidity meetings the quality of case discussions has been improved through the additional collective judgement of the overall quality of care using the NCEPOD grading tool.

Lesson Learnt: In 2018-19 one patient’s death was considered more than 50% likely to have been potentially avoidable. This case was identified and investigated through the Serious Incident investigation. Lessons learnt included the need to clearly assess and communicate the introduction of new clinical equipment into a clinical area.

Actions taken: New processes have been set up for the risk assessment of new clinical equipment, appropriate training, correct storage and labelling and communication to clinical teams.

Impact & Developments in 2019-20

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

- Local training updates will be arranged for all case record reviewers in the Structured Judgement Review methodology
• A business case is being developed for funding to implement a system for case record reviews which links with the current Datix Incident Reporting & Risk Management System.

• The regional *East of England Learning from Deaths Forum* (chaired by the Associate Medical Director) which is supported by the supported by Eastern Academic Health Science Network and NHS Improvement will continue to meet providing a network to learn and share practice from other organisations in the region.

• Appointment of a Medical Examiner for Royal Papworth will support the *Learning from Deaths* agenda and the case record review process and incident investigation process by providing an initial rapid assessment of all deaths to identify patient safety concerns with staff and relatives.

3 case record reviews and 0 investigations were completed after 01/04/2018 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.

1 representing 0.5% of the patient deaths during the previous reporting period 2017/18 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 following core set of indicators applicable to Royal Papworth Hospital on data made available to Royal Papworth Hospital by the Health and Social Care Information centre are required to be included in the Quality Accounts.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017/18 (or latest reporting period available)</th>
<th>2018/19 (or latest reporting period available)</th>
<th>Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…</th>
<th>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…</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients aged 16 or over readmitted to the hospital within 28 days of discharge from the hospital<a href="#">^1</a></td>
<td>Trust rate was 9.01% for 2011/12 placing the Trust in Band B1. National average was 11.45%. Highest rate for an acute specialist trust was 14.09%. Lowest rate for an acute specialist trust was 0.00%.</td>
<td>Trust rate was 9.01% for 2011/12 placing the Trust in Band B1. National average was 11.45%. Highest rate for an acute specialist trust was 14.09%. Lowest rate for an acute specialist trust was 0.00%.</td>
<td>Readmission rates are low due to the quality of care provided.</td>
<td>We will continue to monitor. Percentages could be distorted by readmissions following an inpatient stay for investigations in which there was no treatment intended for the underlying condition.</td>
</tr>
<tr>
<td>The trust’s responsiveness to personal needs of its patients during the reporting period<a href="#">^2</a></td>
<td>Trust score was 76.1 in the 2016/17 survey. National average score was 68.1. National highest score was 85.2. National lowest score was 60.0.</td>
<td>Trust score was 78.4 in the 2017/18 survey. National average score was 68.6. National highest score was 85. National lowest score was 60.5.</td>
<td>Our staff pride themselves on providing patients with safe, high-quality, and well-coordinated care treating our patients with respect and dignity. This level of care is reflected in the Trust achieving results in the top 10% of trusts in the inpatient survey.</td>
<td>We will continue to use data from the inpatient survey to identify areas for improvement.</td>
</tr>
</tbody>
</table>

[^1]: This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

[^2]: Data from National Inpatient Survey.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017/18 (or latest reporting period available)</th>
<th>2018/19 (or latest reporting period available)</th>
<th>Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</td>
<td>85.8% of the staff employed by, or under contract to, the trust in the 2017 staff survey would recommend the trust as a provider of care to their family or friends.</td>
<td>88.6% of the staff employed by, or under contract to, the trust in the 2018 staff survey would recommend the trust as a provider of care to their family or friends.</td>
<td>Trust staff have experienced significant organisational change for an extended period with the changes to base for many support staff having an impact on how teams work across the Trust. In addition the impact of the delay in the move to our new hospital, with the need to remain on our old site for a prolonged period, with pressures on equipment and environment, had a negative impact on morale. We have also continued to progress optimisation of our new EPR system which presents further change for our staff. These factors have undoubtedly impacted negatively on staff satisfaction and engagement.</td>
</tr>
<tr>
<td>[Data from National Staff Survey]</td>
<td>Average for acute specialist trusts was 88%.</td>
<td>Average for acute specialist trusts was 89.1%.</td>
<td>The Trust will continue to focus on retaining, attracting and recruiting a diverse workforce. We have made good progress in reducing vacancy rates in 2018/19.</td>
</tr>
<tr>
<td></td>
<td>The Highest scoring specialist trust was 93%.</td>
<td>The Highest scoring specialist trust was 94.8%.</td>
<td>Quality priority 4 details the actions we will take to retain, attract and recruit staff. We have implemented an organisational change programme to ensure that there is effective communication and support for managers, teams and individual staff. We will continue to seek feedback on how we can improve staff engagement. We have established our BAME network and FTGU Guardian role and will work with these roles, our Staff Engagement Champions, Staff Governors and Staff Side representatives to disseminate key information.</td>
</tr>
<tr>
<td></td>
<td>The Lowest scoring specialist trust was 79%.</td>
<td>The Lowest scoring specialist trust was 77.5%.</td>
<td>See Annual Report – Staff Report section for other information on the 2018 Staff Survey.</td>
</tr>
<tr>
<td>Friends and Family Test – Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOT STATUTORY REQUIREMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In 2017/18 97.4% of our patients would recommend our service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In 2018/19 96.4% of our patients would recommend our service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust continues to promote the FFT test achieving a response rate of 47% in 2018/19. Responses are reviewed at the weekly Matrons meeting, and actions are monitored. Improvements made as a result of patient feedback are displayed on our ‘you said we did boards’.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust will continue to monitor Friends and Family scores. There are actions in place to improve the Friends and Family response rates for both inpatients and outpatients.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18 (or latest reporting period available)</td>
</tr>
<tr>
<td>2018/19 (or latest reporting period available)</td>
</tr>
<tr>
<td>Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons…</td>
</tr>
<tr>
<td>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…</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The percentage of patients who were admitted to hospital and were risk assessed for VTE during the reporting period [Since April 2015 data published quarterly not monthly]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust achieved 95.8% for 2017/18.</td>
</tr>
<tr>
<td>Acute Trust average was 95.2% for Q1 to Q3 2017/18.</td>
</tr>
<tr>
<td>Highest acute provider 100%. (Q1-4)</td>
</tr>
<tr>
<td>Lowest acute provider Q1 51.38% Q2 71.88% Q3 76.08% Q4 67.04%</td>
</tr>
<tr>
<td>Trust achieved 92.64% for 2018/19.</td>
</tr>
<tr>
<td>RPH: Q1 94.33% Q2 93.44% Q3 90.56% Q4 92.22%</td>
</tr>
<tr>
<td>Acute Trust average was: Q1 95.62% Q2 95.44% Q3 95.60% Q1 to Q3 95.55% 2018/19.</td>
</tr>
<tr>
<td>Highest acute provider 100%. (Q1-3)</td>
</tr>
<tr>
<td>Lowest acute provider Q1 75.84% Q2 68.67% Q3 54.86%</td>
</tr>
<tr>
<td>Concerns were identified following the falling level of compliance with the VTE standard. Trust wide education had continued to ensure VTE documentation on admission and reassessment during admission was complete. Auditing compliance since the introduction of Lorenzo has been time consuming.</td>
</tr>
<tr>
<td>A baseline review was undertaken in November 2018 and an action plan put in place to address the falling compliance against 95% target. Actions agreed are delivering improvements and support the optimisation of Lorenzo. NHS improvement are also working with us to monitor compliance and the improvement of risk assessment on admission. This metric is monitored through QRMG and the Q&amp;R Committee.</td>
</tr>
<tr>
<td>VTE events of which we are notified and have occurred within 90 days of discharge from hospital are subject to RCA. A scrutiny panel has been set up to capture wider...</td>
</tr>
</tbody>
</table>
### Indicator

<table>
<thead>
<tr>
<th>2017/18 (or latest reporting period available)</th>
<th>2018/19 (or latest reporting period available)</th>
<th>Royal Papworth Hospital NHS Foundation Trust considers that this score or rate is as described for the following reasons...</th>
<th>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...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number and, where applicable, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. (i) Number (ii) Rate per 100 admissions (iii) Number and percentage resulting in severe harm/death Note 3</td>
<td>(i) Trust number for 2017/18 was 2298. The Acute Specialist Trust highest total was 6396, the lowest was 649 and the average was 2902. (ii) Rate per 100 admissions was not available. The highest, lowest and average Acute Specialist Trust rate per 100 admissions was not available. (iii) 5 resulted in severe harm/death equal to 0.22% of the number of patient safety incidents.</td>
<td>Data is submitted to the National Reporting and Learning System in accordance with national reporting requirements.</td>
<td>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.</td>
</tr>
<tr>
<td>Trust rate was 8.1 in 2017/18 for Trust apportioned patients aged 2 years and over (5 cases). [3 cases on Royal Papworth trajectory].</td>
<td>Trust rate was 3.9 in 2018/19 for Trust apportioned patients aged 2 years and over (2 cases).</td>
<td>The Trust rate is based on two cases attributed to the Trust in 2018/19. Infection prevention and control is a key priority for the Trust.</td>
<td>See Part 3 of report – Other Information.</td>
</tr>
</tbody>
</table>
harm/death was 0.92%, the lowest was 0% and the average was 0.24%.

harm/death was 0.38%, the lowest was 0% and the average was 0.12%.

Data Source: Health and Social Care Information Centre portal as at 10/04 2018 unless otherwise indicated

Note 1
Emergency re-admissions within 28 days of discharge from hospital. Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.

Note 2
The number of *Clostridium difficile* (C. difficile) infections, for patients aged two or over on the date the specimen was taken. A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health and Social Care guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken. Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. Accountability is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one). The Quality Accounts Regulations requires the C. difficile indicator to be expressed as a rate per 100,000 bed days. If C. difficile is selected as one of the mandated indicators to be subject to a limited assurance report, the NHS foundation trust must also disclose the number of cases in the quality report, as it is only this element of the indicator that Monitor intends auditors to subject to testing.

Note 3
The indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death. A patient safety incident is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare’. The ‘degree of harm’ for patient safety incidents is defined as follows: ‘severe’ – the patient has been permanently harmed as a result of the incident; and ‘death’ – the incident has resulted in the death of the patient. As well as patient safety incidents causing long term/permanent harm being classed as severe, the Trust also reports ‘Patient Events that affect a large number of patients’ as ‘severe’ incidents to the NRLS.
Part 3 Other Information

Review of quality performance 2018/19

2018/19 has been another busy year for Royal Papworth Hospital and its staff, with the Hospital treating 22,795 inpatient/day cases and 93,852 outpatient episodes from across the UK. For additional information see section 1.2 Performance Analysis of the Annual Report.

The following section provides a review of our quality performance in 2018/19. We have selected examples from the three domains of quality (clinical safety, patient experience and clinical effectiveness of care). These are not all the same as in the 2017/18 Quality Accounts but reflect issues raised by our patients and stakeholders, which also feature highly in the Department of Health and Social Care’s agenda. They include information on key priorities for 2018/19 where these have not been carried forward as key priorities for 2019/20. Pulmonary endarterectomy is included as Royal Papworth is the only centre in the UK to provide this surgery. There is also an update on the Extra Corporeal Membrane Oxygenator (ECMO) service for which Royal Papworth Hospital is one of five centres nationally that provide this service for adults.

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

The Quality Strategy has been reviewed and refreshed in 2018 and builds on the foundations and achievements from the previous Quality Strategy. We have made excellent progress over the past three years. This report is our opportunity to reflect on our achievements and journey so far and refresh our Quality Ambitions and Objectives for the next three years. Our Strategy is aligned to and takes into account the National Quality Improvement (QI) agenda, current QI research and National QI leadership programmes. The Strategy includes the Trust Board endorsement to implement the Culture and Leadership Programme co-designed by NHS Improvement and the King’s Fund, which will start in 2019 and support the delivery of our Quality Strategy.

We want quality 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.

In order to build on the foundations of the previous strategy, we have refreshed our three Quality Ambitions for the next three years. The work streams that have been identified to underpin the Quality Account and the Ambitions will be reviewed annually to allow the flexibility to encompass local, regional and national changes in the health economy.

Quality Strategy Ambitions:

1. Safe – Provide a safe system of care and thereby reduce avoidable harm
2. Effectiveness and Responsive Care – Achieve excellent patient outcomes and enable a culture of continuous improvement
3. Patient Experience and Engagement - We will further build on our reputation for putting patient care at the heart of everything we do

The quality improvement strategy continues to be enacted through the Quality Account priorities.
Open and Transparent / Duty of Candour

Openness when things go wrong is fundamental to the partnership between patients and those who provide their care. There is strong evidence to show that when something goes wrong with healthcare, the patients who are harmed, their relatives or carers want to be given information about what has happened and would like an apology. Being open about what has gone wrong and discussing the problem promptly and compassionately can help patients come to terms with what has happened and can help prevent such incidents becoming formal complaints or clinical negligence claims. The Trust aims to promote a culture of openness and transparency, which it sees as a prerequisite to improving patient safety and the quality of a patient’s experience. The three most important elements of being open are:

- Providing an apology and explanation of what has happened
- Undertaking a thorough investigation of the incident
- Providing support for the patients involved, their relatives/carers and support for the staff
- Offering feedback on the investigation to the patient and/or carer

We have a named family liaison member of staff who is responsible for sending the initial duty of candour letter and maintaining contact with the patient and/or family throughout the investigation period. Family liaison contact details are provided in the letter. A copy of the duty of candour letter is attached to the Datix system for audit purposes.

In 2018/19, the Trust reported 14 serious Incidents and duty of candour was completed in 100% of cases. For incidents reported as Moderate Harm, duty of candour is completed once the investigation and/or clinical review confirm that acts or omissions in the incident resulted in actual harm to the patient.

Training on the principles of being open and duty of candour are provided as part of the Investigation Skills workshop training provided by the Trust.

The Trust monitors compliance against our requirements for duty of candour at the Serious Incident Executive Review Panel (SIERP) and the Quality and Risk Management Group (QRMG) reporting by exception to the Quality and Risk Committee of the Board of Directors.
Patient safety domain

Healthcare Associated Infections

Royal Papworth Hospital places infection control and a high standard of hygiene at the heart of good management and clinical practice. The prevention and control of infection was a key priority at Royal Papworth Hospital throughout 2018/19 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 2018/19 as part of the annual infection prevention and control audit programme, and the compliance figures were monitored through the Infection Control Pre and Peri-operative Care Committee (ICPPC).

During 2018/19 the total number of Clostridium difficile cases on our trajectory was two, against a ceiling of four, and the total number of MRSA bacteraemias attributable to the Trust was one, against a ceiling of zero. The MRSA bacteraemia rate has reduced from the previous year as detailed in the table below. All MRSA bacteraemias and cases of C. difficile are reported to our Commissioners. We perform root cause analysis (RCA)/post infection reviews (PIR) on each case of C.difficile or MRSA bacteraemia to review the events and enable continuous improvement of practice. Any subsequent lessons learned are shared with the Commissioners and discussed at scrutiny panels. If the RCA/PIR does not show any avoidable factors, i.e., there were no lapses in the care of the patient, the case will not be counted against the ceiling target.

Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. Predominantly, they are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. Many countries and regions now have a high reported prevalence of healthcare-associated CPE. The Trust has a robust procedure in place to ensure that screening and isolation of patients in relation to CPE is carried out to minimise the risk of spread. This procedure was produced using the Public Health England (PHE) Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (2013). There has not been any ongoing spread of CPE within the Trust in 2018/19.

Escherichia coli (E.coli)

Data collection for E.coli, Klebsiella spp. and Pseudomonas aeruginosa BSI has been provided via the PHE Data Capture System. The rates of E.coli bacteraemia are available on the PHE Public Health Profile website.

Analysis of E.coli data from the year 2017/18 showed the following:

The total number of E.coli bacteraemias – 11 out of which 7 were hospital acquired and 4 – community acquired.

Out of 11 E.coli bacteraemias, the following sources of infection have been identified:

Hospital acquired:
- Sternal wound – 1
- Enteritis – 1
- Ischemic bowel – 1
- No source identified - 4

Community acquired:
- Cholecystitis – 2
According to PHE Public Health Profile website, Papworth *E. coli* bacteraemia counts and rates are as follows:

As can be seen from the above tables, the rates of *E. coli* bacteraemia at Papworth remain low compared to those in England as a whole. The trend of *E. coli* bacteraemia is shown in the following graphs (Papworth – in blue dots).

To achieve a 10% reduction of *E. coli* bacteraemia on the previous year, the Trust’s ceiling target would be 10 bacteraemias up to the end of March 2019.

**Heater-cooler units and M.chimaera infection**

We continue to isolate M.chimaera from BAL in transplant and cardiac surgery patients from time to time. A meeting held by PHE six months ago could not find an answer to this fact. None of the patients had M.chimaera infection.
M.chimaera in BAL is not related to heater coolers because their new design prevents transmission via aerosols and regular testing showed no Mycobacteria in water tanks.

Currently the situation has been monitored and a further meeting with PHE is planned in April.

Trust Hand hygiene compliance figures 2018-19 (April-Mar)

<table>
<thead>
<tr>
<th>Month</th>
<th>Hand Hygiene Compliance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>98%</td>
</tr>
<tr>
<td>May 2018</td>
<td>99%</td>
</tr>
<tr>
<td>June 2018</td>
<td>98%</td>
</tr>
<tr>
<td>July 2018</td>
<td>98%</td>
</tr>
<tr>
<td>August 2018</td>
<td>98%</td>
</tr>
<tr>
<td>September 2018</td>
<td>98%</td>
</tr>
<tr>
<td>October 2018</td>
<td>98%</td>
</tr>
<tr>
<td>November 2018</td>
<td>98%</td>
</tr>
<tr>
<td>December 2018</td>
<td>97%</td>
</tr>
<tr>
<td>January 2019</td>
<td>100%</td>
</tr>
<tr>
<td>February 2019</td>
<td>98%</td>
</tr>
</tbody>
</table>

MRSA bacteraemia and C. difficile trajectory infection rates*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No MRSA bacteraemia</td>
<td>No MRSA bacteraemia</td>
<td>3 MRSA bacteraemia</td>
<td>No MRSA bacteraemia</td>
<td>1 MRSA bacteraemia</td>
<td>No MRSA bacteraemia</td>
<td></td>
</tr>
<tr>
<td>No more than 5 C. difficile cases</td>
<td>Total for year = 0</td>
<td>No more than 5 C. difficile cases *</td>
<td>Total for the year= 3</td>
<td>No more than 4 C. difficile</td>
<td>Total for the year 2</td>
<td>No more than 11 C.difficile</td>
</tr>
<tr>
<td>Achieve 100% MRSA screening of patients according to agreed screening risk assessment</td>
<td>98%</td>
<td>Achieve 100% MRSA screening of patients according to agreed screening risk assessment</td>
<td>98.7%</td>
<td>Achieve 100% MRSA screening of patients according to agreed screening risk assessment</td>
<td>97% data collected between April 18 – February 19 Q4 data is not currently available</td>
<td>Achieve 100% MRSA screening of patients according to agreed screening risk</td>
</tr>
</tbody>
</table>

Data Source: Mandatory Enhanced Surveillance System (MESS) and PHE Health Care Associated Infection Data Capture System

*Please note: The figures reported in the table are the number of C.difficile cases and MRSA bacteraemias attributed to the Trust and added to our trajectory ceiling targets.

Surgical site surveillance

From April 2009, we have undertaken continuous surgical site surveillance of CABG patients to monitor infections post-surgery using the Public Health England (PHE) surveillance protocol. Following a bundle of interventions in pre-, intra- and post-operative care in line with NICE guidance CG74 and WHO recommendations, infection rates have fallen from 9.85% in 2009/10 to 3.5% for CABG in 2017/18 for inpatient and readmissions only. The current national benchmark for inpatient and readmissions for SSI in CABG is 3.5% (PHE 2018).
We are continuing with surveillance in both CABG and Valve patients. Our rates have remained consistent and within national benchmarks over the last 12 months. We continue to promote good pre-, intra- and post-operative care of our patients to reduce their risk of developing SSI, using a bundle of interventions. As we move to the new Royal Papworth site in the coming months, we will be monitoring our SSI rates as before to ensure that patient safety and quality of care is maintained.

### Influenza

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for “frontline” staff 2018/19 was 79% Trust wide.

In 2018/19, the Trust continued to receive flu-related ECMO patients into the Critical Care Unit.

In February there was a serious outbreak of flu which affected Hugh Fleming, Mallard and Varrier Jones Wards. The outbreak led to the closure of both Hugh Fleming and Mallard Wards, resulting in cancelled operations and admissions. Over this period 186 beds (in daily counts of beds closed) were empty and closed on Hugh Fleming from the 05/02/19-13/02/19. Once reopened on the 14/02/19 through to the 22/02/19, there were 87 beds which remained empty and closed as these were unable to be staffed safely. Mallard Ward had 219 beds closed between the 06/02/19 and the 22/02/19. Varrier Jones Ward was also affected with one bay closed and 10 beds closed and empty between the 15/02/19 and the 18/02/19. The outbreak was declared as a major incident on the 7 February. A full Serious Untoward Incident (SUI) Report was completed.

### Sepsis

Sepsis in patients is a potentially life threatening condition and without treatment can prove fatal. Care failings seem to occur mainly in the first few hours when rapid diagnosis and simple treatment can be critical to the chances of survival. Recent reports by the Surviving Sepsis Campaign (2013) and the Parliamentary Health Service Ombudsman (2013) and more recently the NCEDOD report in 2015 entitled ‘Just Say Sepsis’ have highlighted ongoing shortcomings in early recognition of potential sepsis leading to missed opportunities to save lives.

The Sepsis 6 care bundle was introduced in 2014 and had been adapted from the 2008 Surviving Sepsis Campaign (SSC) Guidelines for the Management of Severe Sepsis and Septic Shock (Daniels 2011). The purpose of using the bundle is to ensure a safe, standardised approach to the initial assessment of patients with potential sepsis and their subsequent management within the ward setting. It is also envisaged that by using the sepsis bundle, the medical and nursing teams will have the knowledge and understanding to recognise and promptly initiate treatment to patients and therefore reduce the complications associated with severe sepsis.

Sepsis management and treatment has also been on the National and Local agenda for CQUINs with current targets aimed at prevention of resistance whilst ensuring the early recognition and treatment of Sepsis continues.
An initial audit was undertaken at Royal Papworth Hospital in November 2015. The report focused on the use of the bundle on all patients who were identified and managed as having potential Systematic Inflammatory Response (SIRS) / SEPSIS. The following results were sourced from a retrospective audit undertaken in April 2018, covering the period April 2017 to March 2018. This follow up audit was delayed whilst waiting for the NICE national guidelines to be published in 2016. It should be noted that circumstances during 2017 could have had a significant effect on the results obtained in the audit. In June 2017 Royal Papworth Hospital implemented a transition from paper patient case notes to an electronic patient record system. The implementation was not as smooth as predicted and caused significant issues for staff regarding documentation and sourcing of information. As the following audit relies on determining compliance through the documentation of criteria, this should be taken into account when viewing the results.

As evidenced in the results and following confirmation from the staff on the wards, the introduction of the electronic system had a significant effect on the ability to locate the Sepsis 6 care bundle for this audit. Due to the low numbers of care bundles found, Standards 3 and 10 were not audited.

### Standards

<table>
<thead>
<tr>
<th>Aspect to be measured</th>
<th>Expected standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  SIRS criteria to be met for all patients referred for Sepsis</td>
<td>100%</td>
</tr>
<tr>
<td>2  Sepsis 6 care bundle to be present in patient notes</td>
<td>100%</td>
</tr>
<tr>
<td>3  Sepsis 6 care bundle documentation to be complete</td>
<td>100%</td>
</tr>
<tr>
<td>4  IV Abx to be commenced within one hour of referral</td>
<td>100%</td>
</tr>
<tr>
<td>5  ABG/Lactate measured within one hour of referral</td>
<td>100%</td>
</tr>
<tr>
<td>6  Blood cultures to be taken within one hour of referral</td>
<td>100%</td>
</tr>
<tr>
<td>7  Fluid challenge administered within one hour of referral</td>
<td>100%</td>
</tr>
<tr>
<td>8  High Flow Oxygen administered within one hour of referral</td>
<td>100%</td>
</tr>
<tr>
<td>9  FBC/Catheterisation commenced</td>
<td>100%</td>
</tr>
<tr>
<td>10 Care bundle used until resolved</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Results

<table>
<thead>
<tr>
<th>Aspect to be measured</th>
<th>Expected standard</th>
<th>Achieved standard 2015</th>
<th>Achieved Standard 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  SIRS criteria to be met for all patients referred for Sepsis</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>2  Sepsis 6 care bundle to be present in patient notes</td>
<td>100%</td>
<td>50%</td>
<td>41%</td>
</tr>
<tr>
<td>3  Sepsis 6 care bundle documentation to be complete</td>
<td>100%</td>
<td>79%</td>
<td>N/A</td>
</tr>
<tr>
<td>4  IV Abx to be commenced within one hour of referral</td>
<td>100%</td>
<td>89%</td>
<td>73%</td>
</tr>
<tr>
<td>5  ABG/Lactate measured within one hour of referral</td>
<td>100%</td>
<td>84%</td>
<td>57%</td>
</tr>
<tr>
<td>6  Blood cultures to be taken within one hour of referral</td>
<td>100%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>7  Fluid challenge administered within one hour of referral</td>
<td>100%</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td>8  High Flow Oxygen administered within one hour of referral</td>
<td>100%</td>
<td>62%</td>
<td>84%</td>
</tr>
<tr>
<td>9  FBC/Catheterisation commenced</td>
<td>100%</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>10 Care bundle used until resolved</td>
<td>100%</td>
<td>16%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The current guidance from SSC highlights the importance of implementation of all the components of the Sepsis bundle to ensure effective management of patients. The results of this audit have again highlighted failures in achieving 100% in the majority of the set standards. It should be noted that circumstances during 2017 could have had a significant effect on the results obtained in the audit. In June 2017 Royal Papworth Hospital implemented a transition from paper patient case notes to an
electronic patient record system. The implementation was not as smooth as predicted and caused significant issues for staff regarding documentation and sourcing of information and this should be taken into account when viewing the results.

The highlighted areas that need significant improvement are ensuring use of the Sepsis 6 Care Bundle and ensuring that within 1 hour Fluid Challenge is administered, ABG/Lactate is measured and IV antibiotics are given. Improvements were seen since the 2015 audit in regards to meeting the SIRS criteria and the undertaking of Blood Cultures, High Flow Oxygen and Urine Output measurement within 1 hour.

**Recommendations and Action Plan**

Continue to deliver training and education on the management of patients with potential or confirmed sepsis on the Professional study day and induction programmes for all trained new staff.

To highlight to all staff during the deteriorating patient study days the importance of using the electronic sepsis bundle

To include in the guidelines (DN 598) the location (sign posting) of the bundle in Lorenzo

Sepsis link nurses on the wards to continue updating their teams on any new developments and also ensure that standards are being met

To conduct another audit in six months to a year to ensure that the set recommendations have been implemented

**Acute Kidney Injury (AKI)**

Acute Kidney injury remains on the agenda at Royal Papworth Hospital. The numbers of patients who develop an Acute Kidney injury continues to fluctuate as one would expect as the incidence can be dependent of the acuity of the patient and also the type of procedure the patient is admitted for. We still see more patients developing stage 1 Acute Kidney injury. Guidelines remain in place for the management of Acute Kidney injury and Fluid management for patients in hospital and follow the up to date recommendations from NICE. The most recent inclusion to the guidelines is in relation to paediatric patients. Whilst Royal Papworth does not have many young children, we occasionally admit them for specific procedures.

We provide quarterly reports of our incidence of AKI to the National Renal Registry

*The table below shows our current figures for the incidence of AKI at Royal Papworth Hospital.*

<table>
<thead>
<tr>
<th>Month</th>
<th>% of Trustwide Inpatients with AKI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>1%</td>
</tr>
<tr>
<td>May-17</td>
<td>2%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>3%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>4%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>5%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>6%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>7%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>8%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>9%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>3%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>4%</td>
</tr>
<tr>
<td>May-18</td>
<td>5%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>6%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>7%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>8%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>9%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>1%</td>
</tr>
<tr>
<td>Nov-18</td>
<td>2%</td>
</tr>
<tr>
<td>Dec-18</td>
<td>3%</td>
</tr>
<tr>
<td>Jan-19</td>
<td>4%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>5%</td>
</tr>
<tr>
<td>Mar-19</td>
<td>6%</td>
</tr>
</tbody>
</table>

We continue to receive regular reports on the number of patients who require haemofiltration in Critical Care. The data below shows which speciality the patients are admitted under.
As the data shows, our highest number of patients who require renal support has been with our Transplant/heat failure and ECMO patients.

For our ward patients, we have our Alert teams and Ward Based ANP’s who provide support to ensure our AKI pathway is completed for all patients who develop an AKI. Our ward pharmacists offer day to day guidance on safe prescribing to our medical teams for patients who have developed an AKI. Previous initiatives to ensure we provide our primary care teams with up to date information of Acute kidney injury when the patient is discharged home continues through the electronic discharge document which is sent directly to the patient’s GP on discharge.

Acute Kidney injury remains on the mandatory training schedule for all qualified staff. We continue to report the incidence of Acute Kidney injury through our laboratory reporting system currently in place. The patient is identified as either Acute Kidney injury stage 1, 2 or 3. With the introduction of our Electronic
Patient record system; Lorenzo, in June in 2017, we now have the specific care pathway accessed electronically. There is ongoing training for all staff in accessing and completing these forms.

**Pressure Ulcers**

Pressure ulcers (PU) have been defined as ulcers of the skin due to the effect of prolonged pressure in combination with a number of other variables including: patient co-morbidities; external factors such as shear and skin moisture. There are five categories of PUs, ranging from 1 to 4, with 3 and 4 being deep tissue injuries, plus deep tissue injury (DTI). In June 2018 NHS Improvement (NHSI) dictated the re-introduction in NHS organisations of a further PU category of unstageable to be measured. This metric was to be included in data collection from October 2018. In addition, NHSI asked organisations no longer to use the terms avoidable or unavoidable, as all PUs are harm. This organisation is replacing avoidable with "acts/omissions in care" and unavoidable with "all care in place". All PUs have a root cause analysis (RCA) investigation carried out, which is then scrutinised by the Trust PU Scrutiny Panel.

There is a continued national initiative to eliminate all PUs stemming from acts or omissions in care; there is a requirement that all NHS organisations carry out a Safety Thermometer Harm Free Care audit every month to collect point prevalence data on any new category 2, 3, 4 PUs in the Trust on census day. This audit has replaced the quarterly PU prevalence audit carried out within the Trust. However, the Safety Thermometer does not measure category 1 PUs, nor does it identify whether the PU has been acquired at the Trust. If the patient is long stay it will count PU in each month of the stay and so the PU is therefore counted twice (or more) as it is included in subsequent monthly audits. With this in mind we have reintroduced and will continue Trust-wide PU prevalence audits to run quarterly within the financial year.

**Actual numbers of Pressure Ulcers:**

<table>
<thead>
<tr>
<th>Category</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>DTIs</th>
<th>Unstageable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of reported 2018/19 figures up to end of February 2019</td>
<td>19 (13 all care in place, 6 acts/omissions in care)</td>
<td>2 (1 all care in place, 1 acts/omission in care)</td>
<td>1 (1 acts/omission in care)</td>
<td>10 (8 all care in place, 2 acts/omission in care)</td>
<td>0</td>
</tr>
<tr>
<td>Number of reported 2017/18 figures up to end of February 2018</td>
<td>16 (5 unavoidable, 11 avoidable)</td>
<td>1 (unavoidable)</td>
<td>0</td>
<td>23 (19 unavoidable, 4 avoidable)</td>
<td>Not counted till Oct 2018</td>
</tr>
</tbody>
</table>

All care in place (previously classed as unavoidable) PUs will not stay at a standard rate, and it is not appropriate to compare rates year on year. It is important to note that because all care in place PUs mainly occur in patients within this Trust who have had complex cardiothoracic surgery with long theatre times, and these critically unwell patients have restrictions on repositioning when they are physiologically unstable, alongside high doses of vasopressors (drugs to increase circulation to major organs, but restrict circulation to the peripheral areas such as heels). We continue to scrutinise the RCA investigation findings in this group of patients. These investigations did not identify any actions that could have prevented PUs in this critically unwell group of patients.

**Continued Initiatives for 2019/20 include:**

- The Scrutiny Panel continue to scrutinise all category 2, 3, 4, DTI, or unstageable PUs developed within the Trust in order to identify lessons learnt and share good practice;
- Continue quarterly PU prevalence audits, to run alongside Safety Thermometer Harm Free Care monthly audits;
- Continue DATIX incident reporting for all category 2, 3, 4, DTI, and unstageable PUs developed within the Trust and all category 2, 3, 4, DTI, and unstageable PUs admitted/transferred into the Trust. In addition, the RCA has been incorporated into the DATIX reporting system which has streamlined the PU investigating process.
- Ensure that the rates of PUs developed at Royal Papworth Hospital continue to be displayed in all clinical inpatient areas for patients, relatives and staff to see;
- Have a standing agenda item in the Quality and Risk Management meeting to report the PU rates;
- Continue education on PU prevention, identification, reporting and management in Trust-wide mandatory training days. These include tissue viability link and associate link nurses teaching on the sessions to facilitate their development in the specialty. We are exploring different ways of providing in house PU prevention training; we are planning to look at online quizzes that staff can complete as part of their PU prevention training.

<table>
<thead>
<tr>
<th>Goal 2018/19</th>
<th>Outcome</th>
<th>Goal 2019/20</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presently exploring putting in house PU training online; to include mattress training</td>
<td>On-going</td>
<td>To increase tissue viability link nurse involvement in PU prevention education within their ward areas; to supplement the mandatory PU training.</td>
<td>On-going</td>
</tr>
<tr>
<td>New National Guidance is coming re PU definitions and these will need to be disseminated and policies adapted as appropriate. This problem will run alongside the move to the new Royal Papworth Hospital.</td>
<td>Achieved</td>
<td>Continue to embed the new PU categorisations introduced by NHSI June 2018</td>
<td>On-going</td>
</tr>
<tr>
<td>To continue the PU prevalence audit and increase to quarterly, to run alongside Safety Thermometer monthly audits. This schedule was only partially achieved in 2017/18, i.e. prevalence audit carried times 3 per year unable to do 4th quarter due to lack of staff to assist with the prevalence audit. Safety thermometer continues monthly.</td>
<td>Achieved</td>
<td>Continue quarterly Trust-wide PU prevalence audits.</td>
<td>Achieved and on-going</td>
</tr>
<tr>
<td>Work with IT to get in house PU training online; to include mattress training</td>
<td></td>
<td></td>
<td>On-going</td>
</tr>
</tbody>
</table>

**Patient Safety Incidents – Severity**

<table>
<thead>
<tr>
<th>Severity</th>
<th>18/19 Q1</th>
<th>18/19 Q2</th>
<th>18/19 Q3*</th>
<th>18/19 Q4*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Miss</td>
<td>82</td>
<td>101</td>
<td>95</td>
<td>72</td>
<td>350</td>
</tr>
<tr>
<td>No harm</td>
<td>393</td>
<td>379</td>
<td>463</td>
<td>402</td>
<td>1645</td>
</tr>
<tr>
<td>Low harm</td>
<td>104</td>
<td>119</td>
<td>118</td>
<td>108</td>
<td>451</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Severe harm</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Death caused by the incident</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Death UNRELATED to the incident</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Under investigation, not yet graded</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>104</td>
<td>137</td>
</tr>
<tr>
<td>Total</td>
<td>598</td>
<td>611</td>
<td>722</td>
<td>697</td>
<td>2628</td>
</tr>
</tbody>
</table>

Table 3c – Incidents by Severity (Data source: DATIX 09/04/19). *Incidents still under investigation have not yet been graded

Fluctuating numbers of patient safety incidents have been reported during the financial year. Those graded as near miss (13%), no/low harm over the last 12 months (80%) demonstrates a continuous readiness to report and learn from all types of incidents. There has been a request for staff to report incidents in order to demonstrate an open and fair culture of learning and no blame. This process also captures the clinical consideration given to all types of incidents, with moderate harm incidents and above being reviewed at the Trust’s new Serious Incident Executive Review Panel (SIERP).

The level of investigation carried out after a patient safety incident is determined by its severity. All
moderate harm incidents and above have investigations and associated action plans, which are managed by the relevant business unit and monitored by the Quality and Risk Management Group (QRMG). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and monitored by the QRMG. The (*) signifies a discrepancy in the total number of incidents awarded a severity grading and the total number of patient incidents in the quarter; as at 09/04/2019 not all incidents have been finally approved and grading confirmed. Lessons learnt are shared across the organisation via the quarterly Lessons Learnt report on the intranet, Grand Round presentations and local dissemination via Business Units and specialist meetings.

**Never Events**

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

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

During the financial year, the Trust has reported one Never Event. In March 2019, the Trust reported an incident relating to a misplaced naso-gastric (NG) tube. There was a failure in the processes relating to checking and confirming correct position of the NG tube prior to commencement of a small amount of liquid feed. There was low harm caused to the patient. Under our commitment to Duty of Candour a full disclosure was given to the patient and next of kin. A detailed investigation is underway at the time of this report and the outcome therefore is not available at this time. The incident will be subject to a full Root Cause Analysis investigation and consideration of human factors. Lessons learnt and recommendations will be translated into an action plan, which will be monitored for completion by the Quality and Risk Management Group.

**Reducing falls and reducing harm from falls**

Falls prevention remains a top priority for the Trust and is monitored through incident reporting and the Safety Thermometer. Under Health and Safety law, the Trust has a responsibility to protect all patients from harm and “so far as is reasonably practicable” carry out “suitable and sufficient” risk assessments to that ensure they remain safe. In addition, the Trust has nominated the reduction in falls in Mallard Ward (5 North) as one of its Quality Improvement projects. Since February 2019, all falls are reviewed to ascertain if the patient fell due to a medical condition or because of failure to meet best practice in the management of health & safety, and to ensure that appropriate action is undertaken. All falls are reviewed by the Fall Prevention Lead.

During the calendar year there has been a regular occurrence of assisted falls to the ground, recorded as “near miss”; actual falls have been graded from no harm to moderate and severe harm. Falls resulting in moderate injury have Root Cause Analysis (RCA) performed and falls that result in severe harm have a full Serious Incident (SI) investigation. All RCA falls investigations are reviewed at QRMG and at the Band 7 Nurses meetings.

There were two RCA undertaken on moderate harm incidents and one SI investigation.

The first (27075) involved a patient who had an unwitnessed fall. The patient had a history of falls. Unfortunately the patient fell while mobilising. The patient had a pre-existing cardiac condition and had been confused but on this occasion mobilised independently and fell, resulting in a subdural haematoma. The patient was later discharged with a neurological community rehabilitation referral.

The second (27916) involved a patient who also had an unwitnessed fall, had a complex cardiac history, and had been transferred to Papworth for assessment. At times she was able to mobilise independently which was encouraged. It was confirmed that the fall had occurred due to the patient’s complex medical condition.

The third investigation (27608) was on a patient who sadly died. The patient was able to mobilise independently, got up but was known to furniture walk at home. She subsequently fell sustaining a hip fracture. The patient was transferred to another hospital for treatment, but was at risk of bleeding...
due to the level of anticoagulation therapy required for her medical condition. Sadly, the patient died from her medical condition later that day. A number of contributory factors were identified through the review. The resulting action was to share the outcome of the report which highlighted the importance of recording all medical documentation in a timely manner to aid ongoing assessment of the patient and investigation.

Concerning the fall that required a serious incident investigation in 2018/19, a number of actions have been put in place as a result:

- Improve documentation relating to the Falls Policy and the assessments contained within it
- The Falls Prevention Nurse is to provide on-going training on falls prevention across all wards
- Increase use of falls alarms
- Increase the use of Intentional Rounding, Enhanced Care and the supporting documentation on Hemingford Ward.

The table below demonstrates the number of actual falls per quarter across the year. Falls are reviewed quarterly at the Falls Meeting, which now forms part of the Sisters Meeting. The learning from falls incidents is shared at QRMG and among various clinical and nursing forums.

<table>
<thead>
<tr>
<th>Financial year by quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>54</td>
<td>37</td>
<td>54</td>
<td>28</td>
<td>173</td>
</tr>
<tr>
<td>2017/2018</td>
<td>46</td>
<td>28</td>
<td>56</td>
<td>36</td>
<td>166</td>
</tr>
<tr>
<td>2018/2019</td>
<td>43</td>
<td>27</td>
<td>37</td>
<td>49</td>
<td>156</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>37</td>
<td>54</td>
<td>28</td>
<td>495</td>
</tr>
</tbody>
</table>

Data source: DATIX™ 11/4/2019

Falls incident data by location 1/4/2018 – 31/3/2019

<table>
<thead>
<tr>
<th>Incidents by Directorate and Incident date (Quarter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate</td>
</tr>
<tr>
<td>Ambulatory Care</td>
</tr>
<tr>
<td>Cardiology</td>
</tr>
<tr>
<td>Cath Labs</td>
</tr>
<tr>
<td>Facilities</td>
</tr>
<tr>
<td>Professional Support Services</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Surgery</td>
</tr>
<tr>
<td>Theatres, Critical Care and Anaesthesia</td>
</tr>
<tr>
<td>Thoracic</td>
</tr>
<tr>
<td>Transplant</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Data source: DATIX™ 11/04/2019

Prevention of venous thromboembolism (VTE)

With an estimated incidence rate of 1-2 per 1,000 of the population, VTE is a significant cause of mortality and disability in England with thousands of deaths directly attributed to it each year. One in twenty people will have VTE during their lifetime and more than half of those events are associated with prior hospitalisation. At least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis, however currently VTE is one of the most common forms of hospital mortality. (All-Party Parliamentary Thrombosis Group Annual Survey Results, November 2018 www.apptg.org.uk).
Best practice in VTE prevention is summarised in NICE Quality Standard 3 (Venous Thromboembolism Prevention Quality Standard (https://www.nice.org.uk/guidance/qs3) published in June 2010 and updated in March 2018 (https://www.nice.org.uk/guidance/ng89). VTE prevention remains a clinical priority at Royal Papworth Hospital and the updated recommendations in the revised NICE quality standard have been incorporated into the Trust procedure on VTE prevention. VTE prevention is well established in the daily clinical care of patients within the Trust. We are also auditing and monitoring omissions with prescribed prophylaxis doses of Tinzaparin and Enoxaparin.

Royal Papworth Hospital has previously been recognised with a National award from Lifeblood: The Thrombosis Charity, for best VTE Prevention Programme. Royal Papworth Hospital successfully revalidated as a VTE Exemplar Centre in 2017 and contributes to National Nurses and Midwives Network (NNMN) for VTE (http://www.vteengland.org.uk/).

The NHS Standard Contract for Acute Services introduced the requirement for a root cause analysis (RCA) on all VTE episodes identified in inpatients and patients discharged within 90 days. The Trust is compliant with this requirement and conducts RCAs on all VTE events known to the Trust. In 2018/19, 17 VTE events were subject to RCA (compared with 32 in 2017/18), of which all 17 were deemed to be unavoidable with no acts or omissions in care. Where the findings of the RCA conclude that more could have been done to reduce the risk of VTE, this is communicated to the patient by their Consultant in line with the statutory Duty of Candour in the NHS.

VTE Action Plan

Following a recent review of VTE and falling compliance against 95% target of VTE risk assessment on admission a local action plan is in place. This involves key staff within the organisation to affect change and optimisation of Lorenzo to capture data for audit. NHS Improvement is also working with us to monitor compliance and the improvement of risk assessment on admission. This will be monitored through QRMG and shared with the Quality and Risk Committee.

The table below illustrates the percentage of patients who were risk assessed for VTE on admission to Royal Papworth Hospital:

### Percentage of patients risk assessed for VTE Q1-Q4 2018/19

<table>
<thead>
<tr>
<th>Month</th>
<th>Quarter</th>
<th>% of In-Patients Risk Assessed for VTE (Unify)</th>
<th>Quarterly %</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>Q1</td>
<td>94</td>
<td>94.33%</td>
</tr>
<tr>
<td>May 2018</td>
<td></td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>June 2018</td>
<td></td>
<td>94.33</td>
<td></td>
</tr>
<tr>
<td>July 2018</td>
<td>Q2</td>
<td>94.33</td>
<td>93.44%</td>
</tr>
<tr>
<td>August 2018</td>
<td></td>
<td>94.5</td>
<td></td>
</tr>
<tr>
<td>September 2018</td>
<td></td>
<td>94.24</td>
<td></td>
</tr>
<tr>
<td>October 2018</td>
<td>Q3</td>
<td>92.04</td>
<td>90.56%</td>
</tr>
<tr>
<td>November 2018</td>
<td></td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>December 2018</td>
<td></td>
<td>86.64</td>
<td></td>
</tr>
<tr>
<td>January 2019</td>
<td>Q4</td>
<td>86.66</td>
<td>92.22%</td>
</tr>
<tr>
<td>February 2019</td>
<td></td>
<td>96.66</td>
<td></td>
</tr>
<tr>
<td>March 2019</td>
<td></td>
<td>93.33</td>
<td></td>
</tr>
</tbody>
</table>

Data source: UNIFY database as reported in Quality and Risk Management Group Report

Sharing lessons learnt and good practice

All hospital associated VTE events are reported on DATIX. Findings from the RCAs are reported back via email to the Consultant and teams involved in the care of the patient, Clinical Director and QRMG, together with a copy of the RCA report. We recently shared information of our VTE pharmacological prophylaxis omissions audit and an anonymised RCA at the National Nurses Midwives Network (NNMN) for VTE in April 2019.
### Number of patients receiving appropriate prophylaxis from quarterly prevalence audit

<table>
<thead>
<tr>
<th></th>
<th>No of patient records</th>
<th>% of patients receiving appropriate VTE prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018 Q1</td>
<td>n = 17</td>
<td>100%</td>
</tr>
<tr>
<td>May 2018</td>
<td>n = 19</td>
<td>100%</td>
</tr>
<tr>
<td>June 2018</td>
<td>n = 31</td>
<td>100%</td>
</tr>
<tr>
<td>July 2018 Q2</td>
<td>n = 20</td>
<td>100%</td>
</tr>
<tr>
<td>August 2018</td>
<td>n = 35</td>
<td>84%</td>
</tr>
<tr>
<td>September 2018</td>
<td>n = 30</td>
<td>92%</td>
</tr>
<tr>
<td>October 2018</td>
<td>Prevalence audit on hold at present*</td>
<td></td>
</tr>
<tr>
<td>November 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 2019 Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reported in Quality and Risk Management Group Report

*The monthly prevalence audit has been relaunched with the ward link nurses for VTE and the formic audit form has been updated. To ensure we have 10 patients per clinical area returned this has been shared with matrons, sisters and the clinical directorates. The Lorenzo team are working with clinical audit to ensure the data quality in this area is robust to ensure lessons are learnt and shared.

### Delivery of Harm-Free Care

Harm-free care is defined by the absence of pressure ulcers, falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections (CAUTI). The Trust continues to use the NHS Safety Thermometer (a point of care survey instrument) whereby teams measure and report harm and the proportion of patients who are “harm-free” during one day each month.

The Table below demonstrates Royal Papworth Hospital’s rolling two-year comparison data

#### Patient Safety Thermometer - Harm Free Care - 2017/18 - 2018/19

![Graph showing percentage of harm free care from 2017/18 to 2018/19]
**Safety Thermometer**

The graph below provides a breakdown of the types of harm.

![Safety Thermometer Graph](image)

**Nurse Revalidation**

Nurse Revalidation has been an on-going process since April 2016. Nurses and midwives are required to renew their registration every year and revalidate every three years. Nurses individually receive reminders of their impending revalidation or re-registration date through email and can access the document via NMC online web page.

Nurses at Royal Papworth Hospital NHS Foundation Trust will have had a meeting (prior to their revalidation date) with their line manager / senior nurse in their Department to show their portfolio of evidence and demonstrate they have met the requirements and compliance sits at 100%.

**Patient Safety Rounds (PSR)**

Strong leadership is essential to build a safety-focused organisational culture. Patient Safety Rounds are a method of ensuring that leaders are informed first hand of the patient safety concerns of frontline staff as well as demonstrating visible commitment to safety by listening to staff and patients raising concerns. Patient Safety Rounds can act as a useful tool to:

- demonstrate organisational commitment to patient safety
- support open communication within the organisation
- identify opportunities for change and promote a culture of safety improvement
- encourage reporting of safety incidents, patient harm and near misses
- reassure patients and listen to their concerns

We have been running a programme of PSRs at Royal Papworth Hospital since 2015. Every year an annual programme of PSR is agreed at the Quality and Risk Management Group. It is the expectation that each visit is supported by a Head of Nursing or Matron, Consultant and Senior Manager, Executive Director, and when possible, a patient representative. There is always an invitation for a Non-Executive Director to join the PSR. Patient Safety Round participants introduce themselves to the local leadership team, who facilitate a brief tour of the area if appropriate. The PSR participants then approach staff and patients using a template of 10 questions to prompt and guide the discussion. The discussion focuses on the following 10 key areas:

- Past harm (patient safety incidents)
- Friends and family test
- Current barriers to safe care
During 2018/19 we included an invitation to the wider multi-disciplinary team (Pharmacists and other Allied Health Professionals) and undertook three PSRs up to December 2018. We paused our PSR programme from January 2018 to accommodate the work required to prepare for a safe move to the new hospital.

<table>
<thead>
<tr>
<th>Date</th>
<th>Clinical Area</th>
<th>Speciality</th>
<th>Report to QRMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2018</td>
<td>Thoracic outpatients</td>
<td>Thoracic Medicine</td>
<td>Yes</td>
</tr>
<tr>
<td>July 2018</td>
<td>Rescheduled to November 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept 2018</td>
<td>Catheter Labs</td>
<td>Cardiology</td>
<td>Yes</td>
</tr>
<tr>
<td>November 2018</td>
<td>Higginson Discharge Lounge</td>
<td>Various</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The philosophy is that the PSR prompts an immediate response and that on the spot actions are addressed at the time of the round, and taken forward by the relevant teams. However, if required, outstanding items can be taken to the relevant Business Unit (BU) and reported through the BU Quality and Risk Report.

**Patient Safety Rounds 2019/20**

A rolling programme of Patient Safety Rounds is currently being agreed to accommodate the clinical areas at the new Royal Papworth Hospital, and we aim to restart the programme from Quarter 2. We would like to encourage more patient and public involvement in the Patient Safety Round programme during 2019/20 and aim to do so through the Patient and Public Involvement Committee and the Patient and Carer Experience Group.
Patient experience domain

Patients and Carer Experience Strategy

Collecting Patient Stories is an important component in understanding how patients’ perceive the care that they have received. Patient Stories involve interviewing patients directly to gather their insights on the service and the care provided. Throughout this year the Trust has continued to embed the regular capturing of patient stories. These are collated on a monthly basis with a summary of themes, identifying both the positive and the areas for improvement identified. Patient stories are read back at professional and business unit meetings on a regular basis and influence changes in practice and service improvement.

Always Events are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. The Institute for Healthcare Improvement (IHI) laid the foundation for the development of the IHI’s Always Events framework. This framework provides a strategy to help health care providers identify, develop, and achieve reliability in person- and family-centred care delivery processes.

In 2017/18, ‘Always Events were agreed, finalised and launched at Nurses Day.

- Privacy will always be maintained
- Patients will always be listened to
- Patient buzzers will always be answered within 2 minutes
- Always include patient, family and friends in planning of care if patient wishes
- Always be open and honest
- Always know that I can speak to a specialist about my plan of care
- Always communicate delays, postponements, cancellations in a timely way.

Further presentations have taken place at:

- patient and carer listening events
- departmental meetings
- Patient and Public Involvement Committee

Further work is required throughout 2019/20 to audit improve and embed ‘Always events.

Patient Stories at Board

Patient stories have continued to form an integral element of capturing the patient experience throughout 2018/19. Senior nurses and Matrons have presented at the Board of Directors and at professional meetings such as C-PAC, Sister’s Forum, Management Executive and the Patient Experience and Safeguarding groups. Patient stories are also included in monthly Matron reports to directorates, this provides a valuable opportunity for discussion directly with the senior MDT and reports are circulated to teams for further learning. This practice will continue during 2019/20 and will be extended to more non-clinical meetings to assist in focussing all activity on ensuring the best possible patient experience.

Patient Stories-Matrons

The Matrons liaise with the ward team to identify a patient who would be willing to spend some time reflecting on their experience with the Matron. Feedback is promptly provided to the care team and immediate action is taken if concerns are raised. Individual patient stories are recounted at the start of Trust meetings of all types, including at Trust Board, to help focus the attendees on our patients. The stories are reviewed by Heads of Nursing and the responses themed. A quarterly report is submitted to the Clinical Advisory Committee so the information can be shared with the wider Nursing and Allied Health professional teams.

What is the best thing about your stay?

- Kind, considerate staff
- Expert care
- Professionalism of staff
• Respect and courtesy afforded by staff
• Welcoming environment

What is the worst thing about your stay?

• Cancellation and delays of procedures
• Poor communication between medical teams
• Doctors not introducing themselves
• Having to be moved to different bed spaces

Having reflected on your experience of being a patient at Papworth, are you able to suggest areas we can improve on?

• Need to improve communication related to cancellations and delays

Actions taken from the patients stories:

• A standard operating procedure to manage communication related to late cancellations of procedures has been implemented and

What would you want us ALWAYS to do?

• Always keep me informed about what is happening
• Always treat me with respect
• Always ensure there is time for my questions
• Always ensure that the environment is clean
• Always be honest and open about things

Dementia and Learning Disabilities

Research tells us that patients who have Learning Disabilities or who suffer with Dementia have significantly poorer health outcomes than the rest of the population. The inequalities evident in access to health care could potentially place many NHS trusts in contravention of their legal responsibilities as outlined in the Equalities Act 2010 and the Mental Capacity Act 2005, they are also likely to be in contravention of international obligations under the UN Convention on the Rights of Persons with Disabilities.

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.”

Patients who have Learning Disabilities or who suffer with Dementia are covered by the protected characteristics of the Equalities act and as an NHS trust we must ensure that care is personalised and is delivered in a way that recognises who the patient is and is driven by their needs. Our patients who have Learning Disabilities or Dementia will receive the essentials of care that are right first time every time

Dementia

Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. The condition has a significant impact on a person’s health, personal circumstances and family life.

It is well documented that inpatients with dementia are more likely to have adverse incidents, such as falls or poor nutrition, and have longer hospital stays than people with equivalent health needs who do not have dementia.

There is also increasing recognition that hospital staff and services need to understand the complexity of caring for and treating people living with dementia. The Alzheimer’s Society reported in 2016 only 2% of people living with dementia felt, in their experience, that all hospital staff understood their specific needs.

The aim for all people living with Dementia is set out in the Prime Minister’s challenge on dementia 2020 which states that:
'We want the person with dementia – with their carer and family – to be at the heart of everything we do. We want their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services, recognising that each person with dementia and their carer is an individual with specific and often differing needs including co-morbidities'.

Going into hospital for a person with Dementia can be a difficult and distressing time. Someone with dementia may have to go into hospital for a planned procedure such as an operation, during a serious illness or if they have an accident or fall. This can be disorientating and frightening and may make them more confused than usual. Hospitals can be loud and unfamiliar, and the person may not understand where they are or why they are there.

Royal Papworth Hospital Dementia strategy was created in 2015 and was due to run until 2018 when we would have moved into our new hospital which has been constructed on the Cambridge Biomedical Campus. The move was delayed until April 2019. Minded of the move delay, the Strategy document has been extended to take us through the 2019/20 year. The new Royal Papworth Hospital has enabled some great spaces and design that will really benefit our patients. Extending this Strategy through 2019 will enable us to better understand our new environment and how we can really use the amazing space for our Dementia patients and others. That knowledge will then help inform the new Strategy to be published in 2020.

Patients with dementia will have safe individualised care, be treated with respect, and be well informed whilst in our care. Care is set around what the person needs and who they are. Our patients with dementia will receive the essentials of care that are right first time every time. Patients who are vulnerable and those who require reasonable adjustments are identified daily in the site safety briefing and adjustments are made by senior nurses as necessary and this has become embedded during previous years.

**Aims for Patients with Dementia**

1. To use Lorenzo (EPR) to ensure that Staff are able to access person centred care plans to address needs, that they are able recognise patients who may have Dementia, respond accordingly and record reasonable adjustments, activity and outcomes for these patients.
   - Creation of alerts covering Dementia including suspected and confirmed diagnosis. These have been established – however they are not routinely used.
   - Smart lists to highlight presence of patient with an alert in hospital have been enabled.
   - Use of alerts is not yet embedded in service and an audit of their use needs to take place in next 3 months.

2. The safeguarding leads publish safeguarding newsletters and have put a range of resources on the hospital Intranet. This is to give staff resources to better understand this condition.

3. Lead nurse for Dementia routinely sees patients who are identified as having Dementia or those patients whose behaviour gives concern. She carries out a detailed assessment of their needs

4. The design of New Royal Papworth Hospital has given consideration measures to reduce disorientation and to promote a dementia friendly environment for our patients.

5. Having a knowledgeable and caring workforce is essential and there is a study day planned 30/10/2019 for Frailty, Falls and Dementia.

6. Work is progressing regarding the care and treatment of frail patients and increased understanding of frailty and the impact of hospitalisation has on this group. By nature many patients with Dementia are frail and will benefit this work should lead to better outcomes for patients.

7. A sample of the information from 2000 All about me booklets – given to all Elective Cardiology patients linking their frailty score with outcomes such as length of stay, professional input and discharge destination is being examined by Research.
Learning Disabilities

Mencap defines a learning disability in the following way:

A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

People with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable, and therefore unjust and unfair. The health inequalities faced by people with learning disabilities in the UK start early in life, and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. People with a learning disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006).

The Equality Act 2010 imposes a duty to make “reasonable adjustments” for disabled persons. Reasonable adjustments are defined as “changes to practice and processes which are implemented to prevent any disabled persons from being at a disadvantage, whether by virtue of a physical feature of the premises or a process that places people with a disability at a disadvantage.”

The Department of Health and Social Care have continuously emphasised the importance of Primary, Acute and Specialist NHS Trusts in meeting the health care needs of people with learning disabilities (DoH, 2015). The Governments mandate to the NHS 2017-18 published by DOH makes it clear that it supports the principles of reducing health inequalities.

In 2018 Royal Papworth Hospital published it’s Learning Disability Strategy. The strategy recognised that “It is so important that even though the numbers are small (learning disability admissions equate to 0.3% of activity), that every person with learning disabilities receives the care they need and want and that this reasonable adjustment is recorded ”

July 2018 saw the publication of the learning disability improvement standards for NHS trusts. In October and November 2018 Royal Papworth Hospital undertook a self-assessment as part of the the NHSI improvements Standards for Learning Disability to better understand the experience of our patients

As a trust we have committed to:

1. Produce a Learning Disability Policy by end of August 2019 covering the care and pathways for this patient group.
2. Identify a staff member to undertake LeDeR training.
3. Build on the leaflets produced 2017 for patients with learning disabilities and increasing the range of easy read information.
4. Increase knowledge through training, safeguarding Newsletters and resources on Hospital Intranet.
5. Hear voice of our patients with Learning disability through patient stories and to embed that learning within the trust.

Frailty

The Trust has progressed work on identification of frailty throughout 2018/19. We are a part of the Specialised Clinical Frailty Network (SCFN) in wave one for TAVI and wave two for the Critical Care/Surgical Pathway. As a Trust we are ensuring frailty scores are done on every patient admitted to the hospital within all acute cardiology/surgical pathways. This has already been embedded within preadmission clinic for all pathways.

Wave one TAVI network

NHS Elect were commissioned to support the development of six specialist frailty networks and we are one of five Trusts in the country invited to take part in the wave one TAVI frailty network. Its objective is to strengthen clinical assessment of clinically frail patients with Aortic Stenosis, reduce the number of inappropriate physician referrals for specialised commissioning interventions including transcatheter aortic valve implantation (TAVI), and enhance the shared decision making process with patients/family to ensure the most appropriate care package for those patients.
The Trust was the first site to be visited by the Specialised Clinical Frailty Network in September 2018 and we received very positive feedback from the network team on processes and tools already in place such as the “All about me” booklet. The team were supported to undertake a mapping process during the visit which has been used to identify points which could be strengthened to enhance our care of frail patients. A QI project team has been convened to lead the improvement work locally supported by NHS Elect.

**Developments in 2018/19**

**Wave 1 TAVI:** All patients within the TAVI pathway are having frailty score checked prior to discussion at MDT. Questionnaires are also given to patients at follow-up clinics to assess quality of life post procedure.

**Wave 2 Critical Care/Acute Surgical Pathway:** We are implementing this within the IHU pathway. Every patient will have Rockwood Frailty Score undertaken. Any patient scoring five or more will be referred to the Anaesthetic lead and the team will undertake a Papworth Perioperative Assessment (form of Complex Geriatric Assessment). This will identify need for pre-optimisation and/or ensure appropriate decision making.

We have developed our ‘All about me’ booklets to include quality of life pre and post-surgery.

We have progressed Grant application to support research in the domain of frailty and cardiac surgery.

We continue to share good practice and initiatives at national and international conferences including members of the project team attending the Specialised Clinical Frailty Network Wave One first national event on the 26 September 2018.

**Rapid Non-ST-elevation myocardial infarction (Rapid NSTEMI):**

We reported the improvements in our Acute Coronary Syndrome (ACS) pathway in our 2017/18 Quality Accounts and noted that these improvements would help us to prepare for the launch a new pathway for a high risk sub-group of ACS patients transferred directly to the Trust for treatment without needing to be first assessed at a local hospital.

In September 2018 the Trust introduced its new pathway for patients suffering from high-risk NSTEMI (non ST elevated myocardial infarct) - a type of heart attack caused by a severely narrowed artery. The new pathway means that patients identified as being high-risk are now transferred directly to Royal Papworth Hospital for treatment within 24 hours, rather than being admitted to an acute hospital first. This change in pathway offers huge benefits to patients; research and guidelines state that high-risk patients achieve better outcomes if they receive treatment to unblock the heart’s blood supply within 24 hours. In the six months since the new ‘Rapid NSTEMI’ pathway was launched in September, 134 patients have been accepted onto the pathway receiving treatment within 24 hours of referral (and 91.8% receiving treatment within 24 hours of arrival at the Trust). As well as helping patients receive quicker, safer treatment, the pathway has also led to a wide range of efficiencies in the wider healthcare system. Transferring patients directly to Royal Papworth saves ambulance transfers, days spent in hospital, and has delivered system savings estimated at £240k in its first six months in A&E attendances alone – helping to ease pressure on the NHS across the region.

**Theatre Cancellations**

Cancellation of scheduled activity has been an area of concern in 2018/19 with a total number of 636. The four main reasons for cancellations were: Insufficient CCA staff; All CCA beds full with CCA patients; No ward bed available to facilitate transfer of patient out of CCA; Emergency and transplant operations took theatre time.

Key actions undertaken include an active recruitment programme both locally and internationally has improved the vacancy picture on CCA with vacancies moving from a 5.5% of registered nurses at the start of the year to a position where we are fully recruited and have a waiting of staff wishing to join the unit. This picture looks likely to continue as we move toward the new hospital.

CCA occupancy averaged at 91.36% over the year (with a target figure of 85%). Impact on occupancy was multifactorial – but included periods of high acuity as well as delayed flow out of the...
hospital due to pressures generally with the NHS. During the ECMO surge there were 50 theatre cancellations attributable to no critical care capacity.

Work with the wider hospital team to optimise patient flow and pathways outside of CCA continues to be a priority with the IHU Quality Improvement project underway as well as optimisation of clinical pathways at the new site.

**Patient Led Assessments of the Care Environment (PLACE) Programme 2018**

All healthcare providers are required to undertake 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,
- Privacy, Dignity & Wellbeing,
- Building Condition, appearance & maintenance,
- Dementia 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 table below demonstrates the Trust performance against the national average, and over the preceding 6 years. The Trust has scored above the national average in the cleanliness and condition, appearance and maintenance categories, demonstrating that despite the age of the site and impending move, the site is still of an exceptional standard.
<table>
<thead>
<tr>
<th>Area</th>
<th>2017 Site Scores</th>
<th>2018 Site Scores</th>
<th>2018 National Average</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>98.72%</td>
<td>99.66%</td>
<td>98.47%</td>
<td>The Trust’s cleaning service ISS are continuing with their recruitment initiatives as the turnover of staff increases due to the forthcoming move. They have maintained staff numbers throughout the year. The audit results show cleaning has again this year scored above the national average.</td>
</tr>
<tr>
<td>Food</td>
<td>94.56%</td>
<td>89.78%</td>
<td>90.17%</td>
<td>Food scores have seen a minor decrease this year. In efforts to improve the training/education/management of the Housekeepers, the Trust has employed a new Patient Catering Manager. The introduction of the Manager will help develop housekeeping staff skills such as presentation, allergen understanding and service times to maintain an effective housekeeping relationship, which in turn will allow us to deliver a more efficient food service to our patients.</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Wellbeing</td>
<td>72.21%</td>
<td>77.44%</td>
<td>84.16%</td>
<td>We have seen an increase in the scores this year. We expect to see a further increase in the scores within this category when we move to New Royal Papworth Hospital, with the introduction of single en-suite rooms, enhanced patient entertainment systems and a more patient focused care environment.</td>
</tr>
<tr>
<td>Condition, Appearance &amp; Maintenance</td>
<td>94.93%</td>
<td>95.23%</td>
<td>94.33%</td>
<td>The Trust has provided a focused investment in this area to maintain the condition and maintenance of the site particularly focusing on clinical areas. Significant progress has been made in addressing the impending backlog maintenance, this includes refreshing the site’s road markings, new flooring, gardening, decorating and major critical plant works. It is essential and remains a priority for the estate and facilities directorate, that we continue to deliver a safe and well maintained environment for our patients and visitors.</td>
</tr>
<tr>
<td>Dementia</td>
<td>75.32%</td>
<td>79.89%</td>
<td>78.89%</td>
<td>The Trust has maintained similar scores within these categories this year, considering the age of the estate the Trust is not fully Dementia or Disability friendly. In some areas it is difficult to achieve fully, but where possible we aim to reach these standards. The shortfalls will be rectified with the move to New Royal Papworth Hospital.</td>
</tr>
<tr>
<td>Disability</td>
<td>78.40%</td>
<td>77.94%</td>
<td>84.19%</td>
<td></td>
</tr>
</tbody>
</table>

**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

This is the sixth year the PLACE assessment programme that has run nationally following on from the successful PEAT audit process, allowing us to benchmark against the national average. We have continued to carry out the assessments with a greater number of smaller teams finding this less intrusive for the patients.

We’re 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 remains at a high standard across the whole Trust. This is reflected in the Trust score being above the national average in these categories.

Patient Assessors Feedback

The Governors and staff assessors who spoke to patients reiterated the excellence in which the Hospital is being maintained, even with its imminent move.

In closing please find below two of the Patient Assessors comments:

• **It is showing signs of its age but there are no aspects which were worthy of criticism – all clean in all areas examined. Extremely ok!**

• **An overall view is that the hospital offers a welcoming environment. The ward areas were very clean but are showing their age. The New Papworth will correct these shortcomings. The patients spoke very highly of the treatment they were receiving and thought the staff were fantastic. Nothing was too much trouble.**

Listening to Patient Experience and Complaints

Listening to the patient experience and taking action following investigation of complaints is an important part of our Quality Improvement framework. In 2018/19 Royal Papworth Hospital received 54 formal complaints from patients. Of the 54 complaints reported (24 inpatient and 30 outpatient complaints) 53 were relating to NHS provided services with 1 complaint relating to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has decreased on the numbers received during the previous year when 70 complaints were received (23% decrease).

Where a patient/ family member wish to escalate their concerns in a more formal way but do not wish to register their concern as a formal complaint, we log these concerns as “Enquiries”. Investigation of the issues raised follows the same robust process as a formal complaint and a written response, including any actions identified as a result of raising their concern, is provided. The Trust received 12 enquiries in 2018/19.

All formal complaints received have been subject to a full investigation, and throughout the year service improvements have been made as a result of analysing and responding to complaints. Not all complaints are upheld following investigation and the table below shows the number of complaints received per 1,000 patients and of those, the numbers upheld or part upheld. Figure below shows the trend of formal complaints and enquiries received by quarter.
<table>
<thead>
<tr>
<th>Period</th>
<th>Number of Patient episodes (Includes In Patients, Outpatients and excluding private patients)</th>
<th>Number of complaints received (excluding private patients)</th>
<th>Complaints received per 1000 patient episodes</th>
<th>Complaints upheld/Part upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 17/18</td>
<td>27,390</td>
<td>13</td>
<td>0.5</td>
<td>6</td>
</tr>
<tr>
<td>Q2 17/18</td>
<td>29,016</td>
<td>21</td>
<td>0.7</td>
<td>12</td>
</tr>
<tr>
<td>Q3 17/18</td>
<td>31,009</td>
<td>10</td>
<td>0.3</td>
<td>8</td>
</tr>
<tr>
<td>Q4 17/18</td>
<td>31,368</td>
<td>26</td>
<td>0.8</td>
<td>20</td>
</tr>
<tr>
<td>Total 17/18</td>
<td>118,783</td>
<td>70</td>
<td>0.6</td>
<td>46</td>
</tr>
</tbody>
</table>

**Private Patients Only (In-patients and Outpatients)**

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of complaints received (excluding private patients)</th>
<th>Complaints received per 1000 patient episodes</th>
<th>Complaints upheld/Part upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 17/18</td>
<td>4,844</td>
<td>4</td>
<td>0.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of complaints received (excluding private patients)</th>
<th>Complaints received per 1000 patient episodes</th>
<th>Complaints upheld/Part upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 18/19</td>
<td>31,259</td>
<td>11</td>
<td>0.4</td>
</tr>
<tr>
<td>Q2 18/19</td>
<td>30,361</td>
<td>13</td>
<td>0.4</td>
</tr>
<tr>
<td>Q3 18/19</td>
<td>30,505</td>
<td>15</td>
<td>0.5</td>
</tr>
<tr>
<td>Q4 18/19</td>
<td>31,733</td>
<td>14</td>
<td>0.4</td>
</tr>
<tr>
<td>Total 18/19</td>
<td>123,858</td>
<td>54</td>
<td>0.4</td>
</tr>
</tbody>
</table>

**Private Patients Only (In-patients and Outpatients)**

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of complaints received (excluding private patients)</th>
<th>Complaints received per 1000 patient episodes</th>
<th>Complaints upheld/Part upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 18/19</td>
<td>4,651</td>
<td>1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Number of complaints reported and upheld per 1,000 patient episodes

* Some of the complaints received in Q4 18/19 were not resolved at the time of reporting - Data source DATIX™ as at 11/04/2019.

Out of the 70 complaints received in 2018/19 **70%** were upheld or partly upheld following investigation* (2017/18: 61%). Communication / Information and Delay in Diagnosis/ Treatment or Referral categories are the highest reason for complaints. There has been a significant reduction in the number of complaints relating to communication. A comparison of complaints raised by primary subject by year is shown below.

<table>
<thead>
<tr>
<th>Complaints received by primary subject</th>
<th>2018/19</th>
<th>2017/18</th>
<th>2016/17</th>
<th>2015/15</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission arrangements</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>12</td>
<td>8</td>
<td>17</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Catering</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Patient charges</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Communication/Information</td>
<td>28*</td>
<td>41</td>
<td>18</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Delay in diagnosis/treatment or referral</td>
<td>10</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Equipment Issues</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Environment - Internal</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medication issues</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Transport Issues</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>53</td>
<td>70</td>
<td>57</td>
<td>61</td>
<td>43</td>
</tr>
</tbody>
</table>

Complaints by primary subject (Data source DATIX™ as at 15/04/2019)

*1 complaint under communication related to PP
Complaints by quarter by specialty (source Datix 15/04/2019)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>18/19 Q1</th>
<th>18/19 Q2</th>
<th>18/19 Q3</th>
<th>18/19 Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care (from 1.4.2017)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Radiology</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Research &amp; Development (inc Library)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Surgery</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Thoracic</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Transplant</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>13</strong></td>
<td><strong>15</strong></td>
<td><strong>14</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

Selection of actions taken as a result of upheld and part upheld complaints – 2018/19

The Thoracic Surgery Patient Information booklet has been reviewed; in particular, the section on the risk of persistent pain following thoracotomy.

We have reviewed the training for the Booking team to ensure the process for scanning referrals onto the system is understood and that they seek advice if the request is not explicit or clear prior to entering onto the system.

We have improved the handover of patients between surgeons undergoing thoracic surgery to identify any issues over work up prior to patient being admitted and ensure continuity of safe care.

We have added a section in patient letters explaining the possibility of cancellation of surgery in advance or on the day of surgery to better meet our patient expectation and experience.

We have ensured that patient information explaining the cancellation procedure at Royal Papworth Hospital is present on each ward and distributed to patients when there procedures are cancelled, to facilitate open and transparent communication.

We have introduced a process whereby the Consultant surgeon provides follow up via telephone with their patients when they are unable to attend the ward to discuss cancellation of procedure on the day of surgery. This will enable reassurance to be given and any questions or concerns to be addressed.

We have improved our menu section available to patients and introduced a New process for delivery of restaurant meals for ward patients.

Two new housekeepers have been trained to work on CFU to achieve the standard required regarding support with patient meals.

We have shared the learning from complaints to improve the standard of documentation and communication.

We have introduced the requirement for member of the medical team or Advanced Nurse Practitioner (ANP) to write the discharge summary for complex surgical patients. This will ensure that accurate and sufficient information is available for the GP or other healthcare provider.

Where transplants patients are admitted to local hospitals, we have introduced a weekly telephone contact for updates. This will ensure we continue to support and communicate with patients and relatives appropriately. This has been added to the weekly Nursing Allocation.

Where a long term patient does not attend an outpatient appointment, the clinic co-ordinator will contact them to ascertain why they haven’t attended.

All Complaints are detailed in the Quarterly Quality and Risk report available on our public website and reviewed at the relevant Business Units and specialty groups for shared learning.

Further information is available in our quarterly Quality and Safety Reports which are on our web site at: [https://royalpapworth.nhs.uk/our-hospital/information-we-publish/clinical-governance](https://royalpapworth.nhs.uk/our-hospital/information-we-publish/clinical-governance)

Care Quality Commission (CQC) Inspections

Royal Papworth Hospital has an excellent working relationship with the CQC Relationship Manager. The last CQC announced inspection was on the 3 and 4 December 2014 and following standard practice, an unannounced inspection followed on 14 December 2014.

The CQC looked at all the inpatient services, including the Progressive Care Unit and the Outpatients Department. The CQC talked with patients and staff from all the ward areas and outpatient services. The CQC observed how people were being cared for, talked with carers and/or family members, and reviewed patients’ records.

Overall the CQC found that the hospital provided highly-effective care with outcomes comparable with or above expected standards. The service was delivered by highly-skilled, committed, caring
staff, and patients were overwhelmingly positive about the care they received at the Hospital. The Trust received an overall rating of good with areas of outstanding practice. However, there were areas in which Royal Papworth could improve and action plans were put in place to address these. The full report is available on the CQC website at http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8933.pdf

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Caring</th>
<th>Effective</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Medicine</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>RI</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Trustwide</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
</tbody>
</table>

The ratings for Royal Papworth against the five key questions used by the CQC in their inspections of services are shown in the table below.
Clinical effectiveness of care domain

Donation after Circulatory Death (DCD) procedure

In response to the worldwide shortage of donor hearts for transplantation, the Transplant team at Royal Papworth Hospital has been at the forefront of a new technique that has significantly increased the number of hearts available for transplantation. The research shows that heart transplants from a new group of potential donors - known as DCD transplantation or 'Non-Beating Heart Transplantation' - will save hundreds of lives internationally as the heart transplant waiting list continues to grow and the availability of traditionally procured organs shrinks. This innovative technique has enabled surgeons at Royal Papworth to utilise donor hearts which were previously considered unsuitable to transplant. Historically, only hearts from donors who were brain-stem dead were transplanted following thorough assessment. Using the DCD method, hearts from patients where continued medical treatment has been deemed futile can also be used, potentially to save lives. This procedure is proving to be so successful at Royal Papworth, that the Hospital has been able to increase the number of people receiving a heart transplant by almost 40% - since the inception of the programme in 2015 there have been 64 DCD Heart Transplants. As a consequence of this increase Royal Papworth is performing 50 or more Heart Transplants per year which means we are the highest volume centre in the UK. Each DCD Heart Transplant undertaken also means that another patient will benefit from a traditionally-procured organ when it becomes available.

Royal Papworth Hospital Adult Cardiac Surgical Outcomes – April 2014 – March 2017 (published 4 December 2018)

Royal Papworth Hospital is one of the largest specialist cardiothoracic (heart and lung) hospitals in Europe and includes the country’s main heart and lung transplant centre. Over the last three years, it has performed the highest number of heart surgery procedures in the UK whilst achieving some of the best outcomes with one of the lowest cardiac surgery mortality rates. Over a three-year period, the hospital had a risk adjusted survival rate of 98.81%. The national survival rate for this group of patients is 98.16%. During that time, Royal Papworth also performed the most procedures, recording 5,722 cases, making it both the biggest and one of the best-performing cardiac surgery units in the UK. The data comes from the National Institute for Cardiovascular Outcomes Research (NICOR) report, which looked at hospital performance between 2014 and 2017.

This is an excellent result for and confirms the continuing high standards of care that are consistently delivered to our patients by our staff.

Data For Period April 2014 – March 2017
Risk adjusted In-Hospital Survival Rate

5722 operations with a risk-adjusted survival rate of 98.81%
Cancer - 62-day wait for first treatment from urgent GP referral

Background

This is the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. For the definition of this indicator see Annex 4.

Royal Papworth Hospital is the tertiary/specialist hospital for lung cancer in the west half of the Anglia region. Patients seen by their GP with suspected lung cancer are referred first to their local district general hospital (DGH), and then onto Royal Papworth for further investigation if lung cancer seems likely, and if the recommended treatment is likely to be potentially curative. The main treatment modality delivered at Royal Papworth is thoracic surgery. Patients who require chemotherapy, radiotherapy or other treatments are treated at Cambridge University Hospitals or at their referring trust.

Like all other hospital trusts, Royal Papworth is expected to treat 85% of patients referred on this pathway within 62 days of referral. For the purposes of cancer waiting times (CWT) where patients are seen at multiple hospitals, a patient is split between the ‘first seeing’ hospital and the treating hospital. The network pathway means that Royal Papworth is not the first Trust to see any patients and therefore Royal Papworth is usually only accountable for 50% of any pathway where the patient is treated here. This means the numbers of treatments Royal Papworth records is very small for the 62 day pathway, which is only a small percentage of the patients it has on its Patient tracking list at any one time. Where patients are referred to Royal Papworth late (after 16 days as agreed in accordance with the regional best practice Lung pathway) in has been agreed that these breaches can be negotiated to be reallocated to the referring hospital, although these are not reflected in the nationally reported figures.

However with the introduction of the 38 day Inter Provider Transfer Rule, which is the rule that defines the breach allocation for the individual patients when the information is loaded onto the NHS digital Cancer Waiting Times System. Inter-provider transfers (IPTs) should be recorded when the responsibility for care is formally transferred.

The date that a referral request is received by the provider will mark the point at which the IPT is made. Providers should review their pathways and agree when a patient transfers whether the responsibility of care remains with the referring provider or transfers to the receiving provider. Where a request is made just for a diagnostic or MDT discussion only and the responsibility for care is not formally transferred this would not be recorded as an IPT in the Cancer waiting Times system. (*5.7.1 National Cancer Waiting Times Monitoring Dataset Guidance– Version 10.0*)
Data on patients treated are recorded on a national system, NHS Digital Cancer Waiting Times system records the hospital first seeing the patient (2 week wait) and the hospital treating the patient. The majority of patients that come through the service do not appear against Royal Papworth’s figures because they are first seen for their 2 week wait appointment at their DGH, and after we are involved in their diagnostics are referred back to their original DGH or onward to a tertiary centre that provide non-surgical treatments that are not provided at Royal Papworth as mentioned above.

Example scenarios where IPTs should be recorded are included below:

Scenario 1:-

Two IPTs would be recorded

• One from Trust A to Trust B as patient is discussed at MDT and followed up at Trust B (so transfer of care has taken place)
• One from Trust B to Trust C as patient has transferred to Trust C for treatment

Scenario 2:-

One IPT would be recorded

• One from Trust A to Trust C as patient has transferred to Trust C for treatment
• An IPT should not be recorded from Trust A to Trust B, as the patient just had a diagnostics at Trust B, and the patient was followed up with results at Trust A.

Scenario 3:-

No IPT would be recorded

• Transfer between Trust A and Trust B were just for diagnostics for which follow-up was at Trust A so no ITT recorded as no transfer of patients care.
• Transfer between Trust A and Trust C was just for a Specialist Multidisciplinary Team (SMDT) discussion, the outcome of which was for treatment to commence at Trust A so no ITT recorded as no transfer of patients care.

The rules which assign 62 day performance where at least one transfer of care as occurred prior to first treatment are set out below. (*5.7.5 National Cancer Waiting Times Monitoring Dataset Guidance*) – Details of provider breach reallocation

<table>
<thead>
<tr>
<th>Scenario</th>
<th>62-day wait (overall pathway)</th>
<th>38-day wait (investigative phase)</th>
<th>24-day wait (treatment commencement phase)</th>
<th>Investigating Provider (IP)</th>
<th>Trusting provider (TP)</th>
<th>Investigating</th>
<th>Trusting</th>
<th>62-day standard</th>
<th>38-day report</th>
<th>24-day report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IF: SUCCESS</td>
<td>SUCCESS</td>
<td>SUCCESS</td>
<td>0.5</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>IF: SUCCESS</td>
<td>SUCCESS</td>
<td>BREACH</td>
<td>0.5</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>IF: SUCCESS</td>
<td>BREACH</td>
<td>SUCCESS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>IF: BREACH</td>
<td>SUCCESS</td>
<td>BREACH</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>IF: BREACH</td>
<td>BREACH</td>
<td>SUCCESS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>IF: BREACH</td>
<td>BREACH</td>
<td>BREACH</td>
<td>0</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Performance against the 62-day target
For 2018/19 Royal Papworth is looking likely to achieve its full year cancer waiting time target (CWT) for 62-day patients after reallocations using the 38 day IPT rules. With a performance of 88.3% full year effect vs the target of 85% subject to March data being confirmed (see figures for 2018/19 and comparative figures for 2017/18 below).

We have seen increased number of referrals coming into the system and the team have worked very hard to maintain the same level of service.

We have seen increase in the number of 31 day patients that have been treated and an increase in the size of our Patient tracking list PTL that shows the number of cancer and potential cancer patients the team are monitoring at any one time. Although we may only treat approximately 5 to 14 patients a month on a 62 day pathway (this is a score of 2.5 to 7.0 as patients are shared) but the graph below shows how many patients in total are being looked after diagnosed or seen on our MDTs at any one time.

Thoracic surgeons have been very responsive and flexible to achieve target dates, which has facilitated us in meeting the 31 day standard also for 2018/19, with the average time taken from decision to treat (DTT) at Royal Papworth for the full year is 12 days.

This has been delivered with the support of Thoracic Surgery with the implementation of the following:

- Updated multidisciplinary team (MDT) notes to include target dates;
- An enormous amount of work by the teams involved to progress pathways and achieve targets;
- Twice weekly surgical PTL run through and analysis leading to better booking management of patients.

Royal Papworth Leads in Transplant Survival Rates
Royal Papworth Hospital has continued to measure extremely well against the other transplant centres in the U.K. These achievements have been highlighted by NHS Blood and Transplant’s (NHSBT) Annual Report 2017/18. As in previous reports Royal Papworth Hospital has the lowest offer decline rate in the country, meaning that we are looking at every possible donor to assess if each donor can be converted to a successful Transplant. We are the only centre in the country that will send one of our DCPs to scout potential donors in an attempt to increase the donor pool by active donor management prior to the retrieval teams’ arrival at the donor hospital. We are also by far the busiest Retrieval Team in the country.

Royal Papworth has the best risk adjusted 30 day, 1 year and 5 year survival post Heart Transplant and the best risk adjusted 90 day survival post Lung transplantation.

These results come against the backdrop of increasing clinical pressures and staff shortages. These achievements therefore, are even more remarkable and indicative of the dedication of the team.

**Respiratory Extra Corporeal Membrane Oxygenator (ECMO)**

Royal Papworth Hospital is one of five centres in England that provide the highly-specialised Respiratory Extra-Corporeal Membrane Oxygenation (ECMO) Service, including specialised retrieval of patients from referring hospitals.

ECMO supports patients with severe potentially reversible respiratory failure by oxygenating the blood through an artificial lung machine. The extracorporeal life support is used to replace the function of failing lungs, usually due to severe inflammation or infection. ECMO is used to support patient groups with potentially reversible respiratory failure such as Acute Respiratory Distress Syndrome (ARDS) sometimes seen in patients with community-acquired pneumonia or seasonal flu. The aim of ECMO in respiratory failure is to allow the injured lung to recover whilst avoiding certain recognised complications associated with conventional ventilation. It is high risk and is only used as a matter of last resort. The procedure involves removing blood from the patient, taking steps to avoid clots forming in the blood, adding oxygen to the blood and removing carbon dioxide, then pumping the blood back into the patient.

ECMO is a complex intervention and is only performed by highly-trained specialist teams including intensive care consultants, ECMO specialists, perfusionists together with ECMO-trained nurses. ECMO is a form of support rather than a treatment, and its aim is to maintain physiological homeostasis for as long as it takes to allow the lung injury or infection to heal. Support time is usually between five and 14 days but sometimes ECMO support is required for longer. ECMO support can also be used to support patients presenting with life-threatening conditions referred to a tertiary cardiothoracic centre, such as severe acute heart failure. This sort of ECMO support is not part of the nationally commissioned Respiratory ECMO Service but Royal Papworth Hospital has been offering it for a number of years to many patients. The Hospital is registered with the international Extracorporeal Life Support Organisation (ELSO) and is renowned for its experience using ECMO. This long experience in providing a high-quality ECMO service is recognised in the success of the residential Royal Papworth ECMO course, which attracts national and international delegates, with more than 500 delegates from five continents having attended so far. The multidisciplinary team has contributed to multiple scientific communications and articles published in the medical literature.

From December 2011, the service provided by Royal Papworth became part of the national network of services that provide a year-round ECMO service to all hospitals in the country. This includes the retrieval on ECMO of patients from the referring hospital by a dedicated highly-specialised team. Royal Papworth works very closely with the other four national 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 Royal Papworth by a Consultant in respiratory medicine or intensive care, and an ECMO specialist 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.

To ensure best practice across many hospitals, Royal Papworth invites team members of all referring intensive care units to attend an annual meeting to review indications and outcomes, as
well as share areas of best practice. The last annual meeting was held in Bury St Edmunds in October 2018. The five centres providing ECMO in England meet at least twice a year to review practices and outcomes and have weekly phone conferences to ensure that access to the service is maintained.

Summary of ECMO activity at Hospital since December 2011 - March 2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Referrals</th>
<th>Accepted</th>
<th>Supported with ECMO</th>
<th>Survival to discharge* (ECMO)</th>
<th>Survival to discharge* (all accepted)</th>
<th>30 day survival (ECMO)</th>
<th>30 day survival (all accepted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 2011/12</td>
<td>25</td>
<td>15</td>
<td>10</td>
<td>50%</td>
<td>66%</td>
<td>50%</td>
<td>66%</td>
</tr>
<tr>
<td>2012/13</td>
<td>111</td>
<td>28</td>
<td>22</td>
<td>68%</td>
<td>75%</td>
<td>64%</td>
<td>71%</td>
</tr>
<tr>
<td>2013/14</td>
<td>116</td>
<td>35</td>
<td>32</td>
<td>75%</td>
<td>77%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>2014/15</td>
<td>152</td>
<td>40</td>
<td>37</td>
<td>76%</td>
<td>75%</td>
<td>76%</td>
<td>75%</td>
</tr>
<tr>
<td>2015/16</td>
<td>202</td>
<td>54</td>
<td>50</td>
<td>70%</td>
<td>70%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>2016/17</td>
<td>149</td>
<td>36</td>
<td>35</td>
<td>86%</td>
<td>83%</td>
<td>83%</td>
<td>80%</td>
</tr>
<tr>
<td>2017/18</td>
<td>177</td>
<td>50</td>
<td>46</td>
<td>78%</td>
<td>78%</td>
<td>68%</td>
<td>62%</td>
</tr>
<tr>
<td>2018/19</td>
<td>201</td>
<td>54</td>
<td>54</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
</tr>
</tbody>
</table>

*discharge from Royal Papworth

Whilst difficult to compare due to the multiple conditions treated and the absence of risk stratification, survival rates are in keeping with international figures. The Extra Corporeal Life Support Organisation (ELSO) registry shows in January 2019 a survival of 59% for patients supported with respiratory ECMO.

**Pulmonary Endarterectomy**

Pulmonary Hypertension is a rare lung disorder in which the arteries called pulmonary arteries that carry blood from the right side of the heart to the lungs become narrowed, making it difficult for blood to flow through the blood vessels. As a result, the blood pressure in these arteries rises far above normal levels. It is a serious disease that leads to right heart failure and premature death. Patients usually present with symptoms of exertional breathlessness and as there are no specific features, the diagnosis is usually made late in the disease process. There is medical treatment available for some forms of Pulmonary Hypertension.

Chronic Thromboembolic Pulmonary Hypertension (CTEPH) is one type of PH and is important to recognise as it is the type of PH that is most treatable. The disease begins with blood clots, usually from the deep veins of the legs or pelvis moving in the circulation and lodging in the pulmonary arteries (this is known as a pulmonary embolism). In most people these blood clots dissolve and cause no further problems. In a small proportion of people the blood clots partially dissolve or do not dissolve at all and leave a permanent blockage/scarring in the pulmonary arteries leading to CTEPH. There are now three treatments for CTEPH and all are available at Royal Papworth: licensed drug therapy for inoperable patients, balloon pulmonary angioplasty for inoperable patients and the guideline recommended treatment, pulmonary endarterectomy surgery. The pulmonary endarterectomy (PEA) operation removes the inner lining of the pulmonary arteries to clear the obstructions and reduce the pulmonary artery pressure back to normal levels. This procedure allows recovery of the right side of the heart with a dramatic improvement in symptoms and prognosis for the patient.

Since 2000 Royal Papworth Hospital was commissioned to provide this surgery for the UK, and since 2001 has also been designated as one of the seven adult specialist PH medical centres. With better understanding of the disease, CTEPH is increasingly recognised in the UK but still probably remains under diagnosed. Over the last few years there has been a large increase in pulmonary endarterectomy surgery at Royal Papworth and the Hospital has been at the forefront of international developments in this field.
**Lorenzo**

Lorenzo is an electronic patient record (EPR) system that went live within the Trust in June 2017. The new EPR is just one part of a multi-faceted programme to help revolutionise how patient care is delivered over the coming years at the Trust. Through the introduction of the new system we have demonstrated how good use of IT can help improve safety and care for patients; for example, as a Trust, we have improved our digital maturity creating over one million clinical documents and with Electronic Prescriptions and Medicines Administration (EPMA) for all patient episodes, with early evidence of improving medicines safety. Our technology transformation programme is now fully underway.

**Seven Day Services**

The Seven Day Hospital Services Programme (7DS) introduced a new measurement system based on board assurance of the four priority clinical standards to replace the 7DSAT online survey tool from the Autumn of 2018. The intention is to ensure trust board oversight of 7DS and to reduce the administrative burden on trusts. This work is built on 10 clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013. Four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high-quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review at any time on any day of the week.

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

The Trust undertook its self-assessment against standards in Autumn/Winter 2019 which was reported to the Board in February 2019. Implementation and Board reporting against the assurance framework will be implemented in Summer 2019.

**Freedom to Speak Up/Whistleblowing**

The Trust has established the role of the Freedom to Speak Up Guardian (FTSUG) working alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

The role includes:

- Signposting staff to options for raising their concerns in line with the Trust Raising Concerns Policy  
- Recording and monitoring concerns raised so as to identify themes  
- Promoting the importance of staff raising concerns  
- Independently reporting to the Board on themes of concerns being raised and the “temperature” of the organisation  
- Networking with other FTSUGs to share good practice  
- Reporting quarterly to the FTSU National Office

Our Quality Strategy ambition to provide a safe system of care and reduce avoidable harm means that we encourage a culture of transparency where patient safety incidents are reported and reviewed to identify learning and improvements needed to promote the safest care.

The Trust has also committed to undertake a Culture and Leadership Programme that provides a series of practical resources to diagnose cultural issues, develop collective leadership strategies to address them and implement any necessary changes. This programme was co-designed by NHS Improvement, the King’s Fund and a number of NHS organisations to help trusts develop a culture that enables and sustains safe, high-quality, compassionate care.

The Director of Workforce and Organisational Development is the responsible executive director for raising concerns, and we have an identified Non-Executive Director lead.
Quality Performance against NHS Improvement selected metrics

Throughout 2017/18 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.

Operational performance Metrics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks Referral to Treatment (RTT)*</td>
<td>&gt;92%</td>
<td>83.38%</td>
<td>83.62%</td>
<td>83.82%</td>
<td>84.52%</td>
<td>85.65%</td>
<td>87.31%</td>
<td>88.45%</td>
<td>89.49%</td>
<td>90.49%</td>
<td>90.91%</td>
<td>90.35%</td>
<td>90.30%</td>
<td>87.41%</td>
</tr>
<tr>
<td>62 day cancer wait *</td>
<td>&gt;85%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>92.90%</td>
<td>78.6%</td>
<td>71.4%</td>
<td>100.00%</td>
<td>71.4%</td>
<td>71.4%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>80.00%</td>
<td>88.3%</td>
</tr>
<tr>
<td>31 day cancer wait</td>
<td>&gt;96%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>93.3%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>99.3%</td>
</tr>
<tr>
<td>6 week wait for diagnostic</td>
<td>&gt;99%</td>
<td>99.59%</td>
<td>99.14%</td>
<td>99.55%</td>
<td>99.60%</td>
<td>99.50%</td>
<td>99.23%</td>
<td>99.08%</td>
<td>99.18%</td>
<td>99.36%</td>
<td>99.42%</td>
<td>99.28%</td>
<td>99.31%</td>
<td>99.35%</td>
</tr>
<tr>
<td>C. difficile (sanctioned)</td>
<td>Less than 5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Number of patients assessed for VTE on admission</td>
<td>&gt;95%</td>
<td>94.00%</td>
<td>94.00%</td>
<td>94.33%</td>
<td>94.33%</td>
<td>94.50%</td>
<td>94.24%</td>
<td>92.04%</td>
<td>92.00%</td>
<td>86.64%</td>
<td>86.66%</td>
<td>96.66%</td>
<td>93.33%</td>
<td>92.64%</td>
</tr>
</tbody>
</table>

*This indicator has been subject to independent assurance. KPMG’s assurance report can be found in Annex3 to the Quality Report. The definition of this indicator can be found in Annex 4 to the Quality Report.
A listening organisation

What our patients say about us

2018 National Adult Inpatient Survey

The inpatient survey was carried out by Picker on behalf of the Care Quality Commission.

The Trust improved its overall response rate achieving a 63% response rate (59% 2017). This compares to an average 43% response rate for similar organisations (Picker 2018*).

A total of 62 questions from the survey could be positively scored and of these 61 could be compared historically between the 2017 and 2018 surveys. The results include every question where the Trust had the minimum required 30 respondents.

95%  Q68+. Overall: rated experience as 7/10 or more
99%  Q67. Overall: treated with respect or dignity
99%  Q24. Doctors: had confidence and trust

Historical comparison*

<table>
<thead>
<tr>
<th>Question</th>
<th>2017</th>
<th>2018</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food was very good or good</td>
<td>77%</td>
<td>71%</td>
<td>60%</td>
</tr>
<tr>
<td>Got enough to Drink</td>
<td>98%</td>
<td>96%</td>
<td>91%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall</th>
<th>2017</th>
<th>2018</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received information on how to complain</td>
<td>34%</td>
<td>28%</td>
<td>20%</td>
</tr>
</tbody>
</table>

One question was below average and worse than last year

<table>
<thead>
<tr>
<th>Planned admission</th>
<th>2017</th>
<th>2018</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date not changed by hospital</td>
<td>86%</td>
<td>78%</td>
<td>79%</td>
</tr>
</tbody>
</table>

*Picker was commissioned by 77 Inpatient organisations to run their survey this report presents our results in comparison to those organisations.

Overall in the 2018 survey the Trust performed significantly better than the Picker average for 51 indicators and there was no statistical change against historic performance for 57 indications.

There were four indicators where the Trust performed significantly worse than in 2017:

Three questions were better than the average but were worse than last year

One question was below average and worse than last year
Each of these questions will be explored and an action plan formulated where necessary. The one area where our score was below average had been identified by our operational teams and is being addressed through work to improve and unify the operation of the booking function and teams at Royal Papworth House. This work looked at cultural change and a movement towards a responsive and professional business support function.

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

From 1 April 2012, a new question was added to the patient experience survey that is conducted amongst a sample of patients admitted to Royal Papworth Hospital. The question is "how likely are you to recommend our service to friends and family if they needed similar care or treatment?" using an "extremely likely" to "not at all likely" scale. The question is used in other organisations and industries and is believed by the Department of Health and Social Care to give a real-time reflection of standards within a hospital. It allows hospitals to compare themselves and learn from the best performing trusts. Hospitals are required to ask the question to a minimum of 10% of their inpatients and the responses are fed back to the Board. Scores are publicly available, alongside other measures of clinical quality.

In this Trust, the responses are reviewed at the weekly Matrons’ Meeting, led by the Chief Nurse, and actions monitored. These are reported to every meeting of the Board.

**Friends and Family inpatient results 2018/19**

![Graph showing patient recommendations](image)

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


**Patient Support Groups**

Royal Papworth has several patient support groups, which include:

- **The Mesothelioma Social Group – PMSG** ([www.papworthmesosocial.com](http://www.papworthmesosocial.com)) meets monthly. Mesothelioma is a rare type of lung cancer caused by exposure to asbestos. Each year, around 2,500 people in the UK are diagnosed with the condition. Unfortunately at present, there is no cure. The group is for patients and their carers to get together with others experiencing similar concerns and issues. There is opportunity to share ideas and talk freely with supportive people. Some meetings will involve a presentation from an expert about an issue of interest such as breathlessness, exercise, clinical trials and treatments, recent developments with Mesothelioma UK. At other times, the group will go out for a social event such as cream tea at Anglesey Abbey or a cruise along the River Cam. There is also ample opportunity at the meeting for participants to chat...
over refreshments. Later in the afternoon there is a chance for carers only to meet to discuss their experiences and share their worries with support from a clinical nurse specialist.

Royal Papworth Hospital is one of the few hospitals fortunate to have secured further funding from Mesothelioma UK to support the input of a clinical nurse specialist. Kate Slaven undertakes this role and is currently chair of the social group. The group has a Facebook page and Twitter accounts as well as a website. Social media is helping members to access support remotely when they may not be able to attend the meetings in person.

The DVD developed and funded by the group, “Mesothelioma – the journey”, was adopted by Mesothelioma UK and is now offered to all new mesothelioma patients nationwide at the time of their diagnosis. It includes interviews with specialist doctors and nurses talking about the disease, treatment options and help available. The DVD also includes inspirational patients and carers talking about their personal experience of living with this condition.

Friday, 6 July 2018 was the annual Mesothelioma Day, and Royal Papworth Hospital marked the occasion with an event at Papworth Village Hall, organised by specialist nurse Kate Slaven and the Papworth Mesothelioma Social Group, which was set up 10 years ago to provide support to patients, relatives and carers.

At the event, guests were welcomed by Royal Papworth Chief Executive, Stephen Posey, and listened to a presentation from Dr Robert Rintoul about the progress that had been made in Mesothelioma treatment and research over the last 10 years.

Later, guests received a blessing from Hospital chaplain Rev’d. Eddie Turner, who released a group of doves in memory of people who have lost their lives as a result of the disease.

Members of PMSG state that on first coming to the group they were “welcomed with warmth; the general atmosphere of the group being so welcoming and fun”. The group is vibrant and fun and members have been surprised at how much they “look forward to attending” each month. Another member commented that “what helped was knowing we were not alone and that so many others had been and were going through what we were going through”.

Royal Papworth Pulmonary Hypertension Patient Support Group

The Royal Papworth Pulmonary Hypertension Patient Support Group is a friendly, welcoming group run by patients for patients with Pulmonary Hypertension.

The group is well supported by the Pulmonary Hypertension staff at Royal Papworth Hospital. They welcome members of all ages and not just from Royal Papworth Hospital but other pulmonary centres as well.

The group meets three times a year and has guest speakers for the meetings who talk about various aspects of Pulmonary Hypertension, including research into new therapies. Presentations are given by the PH specialist nurses, PEA nurses, pharmacists, physiotherapists and others.

In November, the group hold a very popular Christmas party, where members bring their wider families, if they wish, including children and grandchildren.

The group meetings are well attended with 35-40 members at most meetings and twice as many at the Christmas party in November. Young adults transitioning their care from Great Ormond Street Hospital are encouraged to attend the support group as a way of finding out about the Pulmonary Vascular Diseases Unit prior to attending the hospital for the first time.

The group is advertised in several ways; members produce a four page quarterly newsletter and information on the support group can be found on the Pulmonary Hypertension Association UK forum website and social media Facebook page. A small number of patients from other specialist centres such as Sheffield and London also attend the support group.

The group is friendly and sociable and offers support to individuals and their families; members have reported that meeting other patients with the same condition has helped them enormously, for example patients considering PTE surgery have had the opportunity to meet members and their families who have already gone through this procedure. One of the members still comes to the meetings following their transplant surgery and has shared their experience of this aspect as well.
What various patients have said about the support group:-

“I have been attending the Royal Papworth Pulmonary Hypertension Support Group as a patient for over 10 years. The PVDU team lead by Dr Joanna Peke-Zaba continues to support the patient Pulmonary Hypertension support group. The staff are dedicated to educating members of the support group in this rare life threatening lung condition. They show through their presentations to the group their expertise in treating both new and old patients. They educate patients on the types of treatment available for Pulmonary Hypertension, including medications, and PTE surgery “.

“The PVDU teams knowledge of this condition is unsurpassed and it is that knowledge that enables them to look after all their patients as individuals and tailor their treatments to the individual patients needs”.

“The team give people hope when all seems so bleak at times. They ensure that all patients get the best treatment that is available”.

“The Royal Papworth Pulmonary Hypertension support group, run by patients for patients with the support of the PVDU team, allows news members to meet other patients and their families with Pulmonary Hypertension, it encourages them to learn about their condition through education and patient experience at the group meetings. It allows them to understand they are not alone in this rare illness. This support can be invaluable as a newly diagnosed patient in my experience. They are given an insight into research and development and future trials and treatments available”.

“The support group membership has continued to grow every year by at least 10 members a year. In November each year we have a Christmas party for the patients and their families over 90 members attend these parties, Also members of the PVDU team attend these parties with their families. We have a children’s activity table run by patients for the children at the party, the children really enjoy making Christmas crafts to take home with them. It is a lovely social event enjoyed by all”.

The Royal Papworth Pulmonary Fibrosis Support Group

The PFS group was established in 2010 to provide information for individuals with Pulmonary Fibrosis, to give them support and to establish regular opportunities for the patients and their carers to meet.

Meetings are held every other month at The Hub in Cambourne and are regularly attended by an average of 60-70 participants. The meetings are planned and managed by a small committee who organise speakers and refreshments and give participants plenty of time to socialise.

An annual picnic is now part of the programme and has been successful in bringing together the families of the members as a way to thank them for their support. Recently communication with Idiopathic Pulmonary Fibrosis (IPF) sufferers has been widened with the development of a website accessed through the Trust’s public homepage and a regular newsletter.

Many of the members are regular attenders and find the meetings invaluable. What various patients have said about the Pulmonary Fibrosis Support Group:

“Speaking to others with IPF has been extremely helpful”

“Attending the support group meetings has helped my understanding of IPF”

“Going to the meetings has helped me to feel less isolated and alone”

“May I thank you and the team for a wonderful first meeting for us both, we came into the meeting not knowing what to expect, we were both so weighed down with the diagnosis, but after the very enjoyable afternoon, we both felt a great load had been lifted off our shoulders, we came out feeling much more positive.”

The Transplant Patient Support Group

The Transplant Patient Support Group is a patient-led body open to all pre- and post- heart and/or lung transplant patients.
As well as providing a focal point for links into the Transplant team on any current issues, it holds four Social and Support group meetings for patients each year, funded by donations. These well-attended meetings have regular guest speakers and allow patients and their families to meet in a friendly, non-clinic environment and share any experiences or concerns that they may have. The group produces its own Newsletter and has a very active Facebook page. They hold an annual patient get together to showcase some of the innovations and changes in Transplantation and to allow patients an opportunity to chat with staff in a more informal setting and to network with others.

Compliments from patients and families

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

There were 1,922 Compliments received across the Trust during Q4 2018/19. We now include the positive comments taken from the Friends and Family Surveys, which are completed by our patients.

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

The top three themes for compliments for Q4 in 2018/19 were:
- General Thank You
- Care/Support
- Kindness/Compassion/Courtesy

<table>
<thead>
<tr>
<th>Compliment Themes</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q1</td>
</tr>
<tr>
<td>Care/Support</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>High Quality of Professional Care/Team Work</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Kindness/Compassion/Courtesy</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>General Thank You</td>
<td>132</td>
<td>132</td>
</tr>
<tr>
<td>Improved quality of life/Recovery/Making a Difference</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Friendliness</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Dedication/Hard Work</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Excellence of Treatment</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Dignity and Respect</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Friends and Family Survey Compliments</td>
<td>0</td>
<td>1796</td>
</tr>
<tr>
<td>Total</td>
<td>384</td>
<td>384</td>
</tr>
</tbody>
</table>

What our staff say about us

Staff Survey 2018

NHSI’s requirements for disclosing the results of the NHS staff survey have been updated to reflect changes in the survey output from 2018 and these are included in the Staff Report section of the Annual Report.

Royal Papworth Staff Awards

On Thursday 14 March 2019, we held our annual staff awards ceremony in our new hospital, just a few weeks before it opened to patients. We received more than 350 nominations, a significant increase, on 2018 and so the judging panel faced the difficult decision of choosing winners across the 15 awards categories from the most caring and compassionate staff member to the team and leaders of the year. We were able to put on a fantastic evening of celebration for around 160 staff members.
Valuing Volunteers

We continue to be indebted to our volunteers. They give their time, energy and experience to aid patients and staff and contribute greatly to the ‘patient experience’. Volunteers enrich the lives of patients and their families, contributing significantly to the overall success of patient care. All the staff and patients at Royal Papworth are extremely grateful for the hard work and commitment which our volunteers provide. In 2018/19 we have launched our Volunteers Strategy. Our strategy aims to:

- Create and support a volunteer service at Royal Papworth Hospital that brings added value to our patients.
- Promotes and gives opportunities for people to volunteer.
- Develops partnership and networking with national, charitable and third sector organisations including volunteer support groups.

Our strategy will deliver the following benefits:

For patients and their families/carers
- Enhanced experience of services.
- Peer support and social interaction.
- Increased self-esteem and confidence.

For staff
- Additional help and support.
- Improved patient experience.
- More diverse and inclusive working environment.
- Learning from people with different expertise, giving opportunities to enhance skills/experience.
- Frees up capacity to concentrate on specialist care and clinical roles, which can improve productivity and reduce stress.
- Opportunities to develop people management skills.

And for the Trust
- Provision of better services.
- Improved patient experience.
- Greater involvement of local community whilst promoting the Trust’s values and achievements within the community.
- Provides support to achieve strategic and organisational objectives.
- Better two-way communication with patients.

For more information, see the Foundation Trust section of our Annual Report.
The CQUIN (Commissioning for Quality and Innovation) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed.

The two main commissioning contracts at Royal Papworth have different CQUIN targets in place. Nationally determined CQUINs cover both contracts, with the remainder down to local negotiation between the Trust and commissioner. The individual CQUIN targets are weighted resulting in the final financial value paid for achievement of each area. Non-achievement of a particular CQUIN results in a reduction of income equivalent to the CQUIN weighting multiplied by the overall CQUIN value. The 2019/20 CQUINS have been agreed and are listed in this year’s Annual Report.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Total Available 18/19</th>
<th>YTD Available</th>
<th>Achievement</th>
<th>Comments</th>
<th>RAG Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'k</td>
<td>%</td>
<td>£'k</td>
<td>£'k</td>
<td>£'k</td>
</tr>
<tr>
<td>NHSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GE3: Medicines Optimisation</td>
<td>88.50</td>
<td>4.7%</td>
<td>29.21</td>
<td>0.00</td>
<td>29.21</td>
</tr>
<tr>
<td>IM2: CF Patient Adherence</td>
<td>221.25</td>
<td>11.7%</td>
<td>165.94</td>
<td>55.31</td>
<td>55.31</td>
</tr>
<tr>
<td>NSTEMI Pathway</td>
<td>177.00</td>
<td>9.4%</td>
<td>123.90</td>
<td>17.70</td>
<td>53.10</td>
</tr>
<tr>
<td>NSTEMAC pilot</td>
<td>177.00</td>
<td>9.4%</td>
<td>53.10</td>
<td>17.70</td>
<td>17.70</td>
</tr>
<tr>
<td>Cardiac Clinical Network</td>
<td>221.25</td>
<td>11.7%</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>New Papworth Hospital</td>
<td>1000.00</td>
<td>53.1%</td>
<td>750.00</td>
<td>250.00</td>
<td>250.00</td>
</tr>
<tr>
<td>NHSE</td>
<td>1885.00</td>
<td>100%</td>
<td>1122.14</td>
<td>465.32</td>
<td>176.11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C&amp;P CCG (&amp; Associates)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Improvement of health and wellbeing of NHS staff</td>
<td>54.39</td>
<td>7.1%</td>
<td>10.88</td>
<td>10.88</td>
<td>0.00</td>
</tr>
<tr>
<td>1b Healthy food for NHS staff, visitors and patients</td>
<td>54.39</td>
<td>7.1%</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>1c Improving uptake of flu vaccinations</td>
<td>54.39</td>
<td>7.1%</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>2a Timely identification of sepsis in acute inpatient settings</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>2b Timely treatment of sepsis in acute inpatient settings</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>2c Antibiotic Review</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>2d Reduction in antibiotic consumption</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>6 Offering advice and guidance</td>
<td>163.34</td>
<td>21.3%</td>
<td>73.50</td>
<td>24.50</td>
<td>24.50</td>
</tr>
<tr>
<td>9a Tobacco screening</td>
<td>8.17</td>
<td>1.1%</td>
<td>6.13</td>
<td>2.04</td>
<td>2.04</td>
</tr>
<tr>
<td>9b Tobacco brief advice</td>
<td>32.67</td>
<td>4.3%</td>
<td>24.50</td>
<td>8.17</td>
<td>8.17</td>
</tr>
<tr>
<td>9d Alcohol screening</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>9e Alcohol brief advice or referral</td>
<td>40.83</td>
<td>5.3%</td>
<td>30.63</td>
<td>10.21</td>
<td>10.21</td>
</tr>
<tr>
<td>Engagement in STP process</td>
<td>153.09</td>
<td>20.0%</td>
<td>114.82</td>
<td>38.27</td>
<td>38.27</td>
</tr>
<tr>
<td>C&amp;P CCG (&amp; Associates)</td>
<td>765.43</td>
<td>100%</td>
<td>413.58</td>
<td>145.11</td>
<td>134.24</td>
</tr>
<tr>
<td>Trust Total</td>
<td>2650.43</td>
<td>100%</td>
<td>1535.72</td>
<td>485.83</td>
<td>539.55</td>
</tr>
</tbody>
</table>

Q4 indicators for 2018/19 are forecast to be achieved apart from CCG scheme 2d Reduction in Antibiotic Consumption.
Healthwatch Cambridgeshire and Peterborough

Royal Papworth Hospital Quality Account Statement 2018/19

Summary and comment on relationship
Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the Trust’s draft Quality Account.

Healthwatch is pleased to have a positive relationship with the Trust. The Trust is always responsive to feedback. We welcome the Trust’s commitment to learning and improving which is highly evident within this Account.

It has understandably been a challenging year for the Trust with the move to the new site at the Cambridge Biomedical Campus, it is very pleasing to see that this has not impacted on the high standards of care and we continue to receive very positive feedback from patients regarding the care provided by the Royal Papworth Hospital.

Highlighting improvements
The Trust is to be commended for meeting so many of its improvement objectives in 2018/19.
Healthwatch is particularly pleased to see:
• The commitment to learning from complaints
• That hearing, and acting upon, patient stories is being embedded at all levels of the organisation
• Identification of ‘Always Events’
• The commitment to openness and the Duty of Candour
• The establishment of the Freedom to Speak Up Guardian.

Challenges noted
We observe the challenges inherent in moving to the new site and the increased retirement and staff vacancy rate. The cost of living within Cambridge and difficulties travelling into the city will make recruitment harder. It is good to see that the Trust are very well sighted on this and have feasible plans to improve recruitment.

Healthwatch receives overwhelmingly positive feedback from patients and their families regarding the Royal Papworth Hospital. The negative points relate to the cost and ease of parking at the new Cambridge site.

Looking to the future
Healthwatch welcomes the number of patient experience quality improvements identified for 2019/20. We wish the Trust well in settling into the new hospital and achieving all of their identified priorities.
The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Royal Papworth NHS Trust Quality Account. The Committee has received a very clear and well formulated quality account on the whole, making it easy to read and digest. In particular, it is frank and open in relation to priority areas where progress has been slower than hoped for or where there has been a slippage in performance. For example, page 6 flags concerns about ward incidents relating to deteriorating patients, where targets have not been achieved for 2018-19. This is discussed in more detail in Part 3 and it is highlighted as a continued priority for 2019-20 (page 15).

In areas where progress has been made, for example in falls reduction, it is acknowledged that further progress is possible although it is not entirely clear what the challenges are in the new hospital setting. The challenge of moving a whole hospital to an entirely new site is dealt with through various priority targets having been set and monitored throughout the planning and moving period. Achieving a ‘safe hospital move’ remains a priority for 2019-20 with strong evidence of robust ‘go-no go’ points set down and achieved.

Two major areas are discussed in some depth: the shift in 2017 and operationalising of Lorenzo and the importance of leadership and culture. Lorenzo, with its electronic patient record system, is clearly taking quite a while to become embedded beyond the user champions and exemplar groups. The positive outcomes in terms of recording a range of data which can then be used to optimise bed management, throughput and reduced stay for example, is still a work in progress. There are also ambitions to provide better data for quality assurance, research and audit. It appears that the team understands the importance of staff training and support but still have a lot of work to do to change the approach. The comment on page 42 about sepsis is an interesting one, as it is seen as an area where there remain significant issues about documentation related to the EPRS.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). It has been helpful to see that Royal Papworth has a strong record of recruiting and retaining staff and the staff survey indicates that a high percentage of staff agree that the organization provides equal opportunities for staff to develop and get promotion, while a declining percentage report that they experience bullying and harassment; both indicators moving in the right direction.

The Quality Account features training and support for the workforce but more evidence on how the 2018-19 Priority 3 on workforce was being carried forward into 2019-20 would have been useful in the priority set for leadership and culture.

It is useful to see the preparation and progress that Papworth has made in preparing for a CQC inspection and the results of the mock inspection (page 62). There is only one ‘requires improvement’ (for diagnostics well-led category). The 2019-20 quality focus on ‘leadership and culture’ makes good sense in relation to the mock CQC outcomes, with page 22 and 23 earlier in the report flagging the work to be done on equality and diversity and on building leadership capability. It is noted that there are still targets to be added to this section.

The Health Committee looks forward to inviting representatives from the Royal Papworth NHS Trust later this year to attend committee to discuss issues relating to the relocation and to review the outcomes from the CQC inspection.
Patient and Public Involvement Committee (PPI) Committee and the Council of Governors

During 2018/19 the Council of Governors continued to work with the Board of Directors to ensure that the Trust continues to deliver services which meet the needs of patients, carers, staff and local communities. During the year five new Non-Executive directors were appointed following approval by the Council. The move to the new hospital was a challenging time for everyone and Governors were able to offer their support throughout and congratulate all those involved on a very successful outcome. As well as chairing committees Governors have sat as members or observers on others and have been encouraged to attend the monthly Board meetings. Other areas where Governors have been involved are 15 steps, PLACE, Patient Safety Rounds and mock CQC inspections. A number of Governors also undertake voluntary positions which gives them the opportunity to spend time talking to patients, carers and staff thereby providing valuable feedback.

Quality Priorities are selected each year by the Governors and the 2019/20 priorities are :-

1. Quality improvement - Staff training and projects
2. A safe hospital move.
3. Optimise Lorenzo.
4. Leadership and culture including recruitment and retention.

The move to the new hospital will enable the Governors to continue to contribute to the excellent track record of Royal Papworth and its staff. At the quarterly Council of Governor meetings in addition to the executive reports two innovations to reflect that we are in a clinical environment have been included. In the last year three clinicians have given presentations on cardiology topics, pulmonary endarterectomy and how IT is involved in patient care. Secondly a ‘Patient Story’ has been related by one of the Matrons or Senior Sisters which has provided an extra insight into the patient experience. Further speakers have been identified for both items for 2019/20.

Dr Richard Hodder, Lead Governor.
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 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.

- 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 2018 to 24 May 2019
  - Papers relating to quality reported to the Board over the period April 2018 to 24 May 2019
  - Feedback from Cambridge and Peterborough Clinical Commissioning Group has not been received to date.
  - Feedback from NHS Specialised Commissioning East of England has not been received to date.
  - Feedback from the Patient and Public Involvement Committee (PPI) Committee and Council of Governors dated 17 May 2019
  - Feedback from Healthwatch Cambridgeshire dated 17 May 2019
  - Feedback from Cambridgeshire Health Committee dated 15 May 2019
  - The Trust’s “Quality and Risk Report: Quarter 4 and annual Summary 2019”;
  - The Trust’s complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2018 National Inpatient Survey
  - The 2018 National Staff Survey
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC Inspection Reports published 27 March 2015

- The Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Report.

By order of the Board
Date: 23 May 2019  Chairman

Date: 23 May 2019  Chief Executive
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Royal Papworth Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Papworth Hospital NHS Foundation Trust’s Quality Report for the year ended 31 March 2019 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2018/19 (‘the Guidance’); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from governors, dated 17 May 2019;
- feedback from local Healthwatch organisations, dated 17 May 2019;
- feedback from Overview and Scrutiny Committee, dated 17 May 2019;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated February 2019;
- the 2017 national staff survey, dated June 2018;
- Care Quality Commission Inspection, dated 14 December 2014;
• the 2018/19 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 26 February 2019; and

• any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Royal Papworth Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Papworth Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;

• making enquiries of management;

• testing key management controls;

• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and

• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Royal Papworth Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:
• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;

• the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and

• the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

23 May 2019
Annex 4: Mandatory performance indicator definitions

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator

The total number of patients on an incomplete pathway at the end of the reporting period

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format

Reported as a percentage
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor

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


1 Cancer referral to treatment period start date is the date the acute provider receives an urgent (two week wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment commences if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131880
ANNEX 5 Glossary

C

CABG  Coronary artery bypass graft

Cardiac surgery  Cardiovascular surgery is surgery on the heart or great vessels performed by cardiac surgeons. Frequently, it is done to treat complications of ischemic heart disease (for example, coronary artery bypass grafting), correct congenital heart disease, or treat valvular heart disease from various causes including endocarditis, rheumatic heart disease and atherosclerosis.

Care Quality Commission (CQC)  The independent regulator of health and social care in England. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. The CQC publish what it finds, including performance ratings to help people choose care. www.cqc.org.uk

CCA  Critical Care Area.

Clinical audit  A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.

Clostridium difficile (C. difficile or C. diff)  Clostridium difficile (C. 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  Transplant using a non-beating heart from a circulatory determined dead donor.

Dementia  Dementia is a general term for a decline in mental ability severe enough to interfere with daily life.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Social Care (DHSC formerly DH or DoH)</td>
<td>The Government department that provides strategic leadership to the NHS and social care organisations in England. <a href="http://www.dh.gov.uk/">www.dh.gov.uk/</a></td>
</tr>
<tr>
<td>E</td>
<td></td>
</tr>
<tr>
<td>EDS</td>
<td>Equality Delivery System</td>
</tr>
<tr>
<td>EPR</td>
<td>Electronic Patient Record</td>
</tr>
<tr>
<td>Extracorporeal membrane oxygenation (ECMO)</td>
<td>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.</td>
</tr>
<tr>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Foundation Trust (FT)</td>
<td>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.</td>
</tr>
<tr>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Governors</td>
<td>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.</td>
</tr>
<tr>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Health and Social Care Information Centre</td>
<td>The Health and Social Care Information Centre is a data, information and technology resource for the health and care system.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>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.</td>
</tr>
<tr>
<td>Hospital standardised mortality ratio (HSMR)</td>
<td>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.</td>
</tr>
<tr>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>A measure that determines whether the goal or an element of the goal has been achieved.</td>
</tr>
<tr>
<td>Information Governance Toolkit</td>
<td>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.</td>
</tr>
</tbody>
</table>
Inpatient survey
An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate.

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.

Methicillin-resistant Staphylococcus aureus (MRSA)
*Staphylococcus aureus* (*S. aureus*) is a member of the *Staphylococcus* family of bacteria. It is estimated that one in three healthy people harmlessly carry *S. aureus* on their skin, in their nose or in their mouth, described as colonised or a carrier. Most people who are colonised with *S. aureus* do not go on to develop an infection. However, if the immune system becomes weakened or there is a wound, these bacteria can cause an infection. Infections caused by *S. aureus* bacteria can usually be treated with meticillin-type antibiotics. However, infections caused by MRSA bacteria are resistant to these antibiotics. MRSA is no more infectious than other types of *S. aureus*, but because of its resistance to many types of antibiotics, it is more difficult to treat.

MOU
A memorandum of understanding (MOU) is a formal document describing the broad outlines of an agreement that two or more parties have reached through negotiations.

Multi-disciplinary team meeting (MDT)
A meeting involving health-care professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.

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/](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 Clinical Research Network (NIHR CRN) Portfolio research
The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio is a database of high-quality clinical research studies that are eligible for support from the NIHR Clinical Research Network in England.

Never events
Never events are serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been implemented. Trusts are required to report if a never event does occur.

NHS Improvement
NHS Improvement is responsible for overseeing foundation trusts and
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.

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. From July 2012 data collected using the NHS Safety Thermometer is part of the Commissioning for Quality and Innovation (CQUIN) payment programme.

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.

Nursing and Midwifery Council

Non-ST-elevation myocardial infarction

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.

A Committee of the Council of Governors that provides oversight and assurance on patient and public involvement.

Pulmonary Thromboendarterectomy or Pulmonary Endarterectomy.

Public Health England

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.

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.

The term percutaneous coronary intervention (sometimes called angioplasty or stenting) describes a range of procedures that treat narrowing or blockages in coronary arteries supplying blood to the heart.

As above, but the procedure is urgent and the patient is admitted to hospital by ambulance as an emergency.
<table>
<thead>
<tr>
<th><strong>Priorities for improvement</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Account</strong></td>
<td>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 <em>Health Act 2009</em>. Amendments were made in 2012, such as the inclusion of quality indicators according to the <em>Health and Social Care Act 2012</em>. NHS England or Clinical Commissioning Groups (CCGS) cannot make changes to the reporting requirements.</td>
</tr>
<tr>
<td><strong>Quality Report</strong></td>
<td>Foundation trusts are required to include a Quality Report as part of their Annual Report. This Quality Report has to be prepared in accordance with NHSI annual reporting guidance, which also incorporates the Quality Accounts regulations. All trusts have to publish Quality Accounts each year, as set out in the regulations which came into force on 1 April 2010. The Quality Account for each foundation trust (and all other types of trust) is published each year on NHS Choices.</td>
</tr>
<tr>
<td><strong>Root Cause Analysis (RCA)</strong></td>
<td>Root Cause Analysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behavior, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.</td>
</tr>
<tr>
<td><strong>Royal Papworth Hospital or Royal Papworth</strong></td>
<td>Royal Papworth Hospital NHS Foundation Trust.</td>
</tr>
<tr>
<td><strong>Safeguarding</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>SDTIs</strong></td>
<td>Suspected deep tissue injuries</td>
</tr>
<tr>
<td><strong>Serious incidents (SIs)</strong></td>
<td>There is no definitive list of events/incidents that constitute a serious incident but they are incidents requiring investigation. <a href="https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf">https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf</a></td>
</tr>
<tr>
<td><strong>Sign up to Safety</strong></td>
<td>A national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of Sign up to Safety is the philosophy of locally-led, self-directed safety improvement.</td>
</tr>
<tr>
<td><strong>Systematic Inflammatory Response Syndrome (SIRS)</strong></td>
<td>An inflammatory state affecting the whole body, frequently a response of the immune system to ischemia, inflammation, trauma, infection, or several insults combined.</td>
</tr>
<tr>
<td><strong>UNIFY</strong></td>
<td>NHS England data collection, analysis &amp; reporting system.</td>
</tr>
</tbody>
</table>
Ventricular Assist Device.

Venous thromboembolism (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.

Workforce Race Equality Standard (WRES)