Papworth Hospital NHS
NHS Foundation Trust

Excellence in heart and lung care

Quality Accounts 2010/11

Contents

1.0 Quality at the heart of the organisation

Statement from the Chief Executive

During 2010/11 the Trust has continued to make significant progress around the key quality measures that impact on patients, their families and visitors experiences through striving to ensure quality care is at the heart of what we do.

The principal objectives for the Trust centre around patient safety, patient experience and positive outcomes of care. Performance against national and local quality indicators in these areas are reported to the Board of Directors monthly. These Board-level reports form part of our Patient Safety Strategy, which we developed in 2009 and which has become an integral part of our culture of putting quality first.

In addition to this, we recognise that, in order to offer assurance to patients that we provide high quality care, we must demonstrate high levels of reported patient satisfaction and excellent clinical outcomes. These are both demonstrated within these accounts.

The principal objectives for the Trust centre around patient safety, patient experience and positive outcomes of care.

The commitment to high-quality care will continue through a number of priorities for 2011/12, which have been developed in consultation with clinical staff, other stakeholders, commissioners and the Trust's Governors. These priorities will be addressed later in the quality accounts.

Integral to our quality performance is an organisation where staff feel recognised and rewarded and their commitment to the quality agenda is evident in the continued improvement and excellent results I am proud to report in this quality account.

The information and data contained within this report has 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 performance of the Trust.

Stephen Bridge
Chief Executive

Part 2

Quality improvement priorities

Underpinning all of our work at Papworth Hospital is our vision statement to be the leading hospital providing excellence in specialist heart and lung patient care, based on research, education and innovation. We are committed to the highest levels of clinical quality, personalised and effective care, value and growth.

Trust quality assessment

Following cessation of the Standards for Better Health system, the Trust was required to submit the Care Quality Commission's self assessment for registration. A certificate of registration dated 1 April 2010 was issued on the 13 May 2010.

During 2010/11 Papworth Hospital was not visited for inspection by the Care Quality Commission. A system of mapping against the CQC standards for care has commenced and a series of internal inspections against these standards started in April 2011.

Overview of governance arrangements

Effective governance within the Trust is maintained via robust management processes, which are integrated within committee structures that feed directly to the Board of Directors, providing assurance that safe, effective and quality care is delivered within a risk management framework.

Our focus is growth, value and effectiveness, with a commitment to the highest levels of clinical quality and providing the best standards of personalised care possible to our patients.

Clinical governance & risk management

Comprehensive and robust clinical governance and risk management underpin our quality agenda and the Care Quality Commission Standards of Care. This provides the vehicle for a whole organisation approach to driving forward the quality agenda.

How we have prioritised our quality improvement initiatives

To determine our priorities for 2010/11, we reviewed our clinical performance indicators for the year, as well as on-going consultation with our service users on the range and quality of services provided. We used a wide range of methods to gather information, including national patient surveys, real time patient feedback from our Patient Experience Tracker (PET), concerns, compliments and complaints. We also used our patient safety focus groups and Board to Ward walk-arounds to gather issues raised by staff as well as patients. Having identified some priorities, we then spoke to our clinical teams, governors, Patient and Public Involvement Committee and Local Involvement Networks (LINks) before making our final choices.

Our Board of Directors has agreed that, whilst there has been excellent progress on last year's priorities, further improvements can be made in some areas. Three of these priorities are, therefore, carried forward to 2011/12.

The following table summarises the five quality improvement priorities identified last year along with the outcome. More detailed information in relation to these priorities can be found in parts two and three of this document.

Summary of performance on 2010/11 priorities

		Goals 2010/11	Outcomes
1	Reducing patient falls	To reduce patient falls by 20%	By quarter 4, falls were reduced from 51 to 40, achieving a 20% reduction
2	Increase response to acutely ill deteriorating patients	Implementation of a 24 hour, 7 day a week acute pain management service. Commence a continuous positive airway pressure trial Introduce non-medical prescribing within the ALERT Team Launch situation, background, assessment, responses (SBAR) communication tool.	Achieved Achieved Achieved Achieved
3	Reduction in medication related errors	To reduce significantly the number of administration related medication errors Increase reporting of medication incidents by 50%	Some reduction achieved, but remains the second largest category of incidents reported, therefore carried forward to 2011/12 Reporting of medication incidents increased by 72%
4	Reduction in wound infections	To reduce the rate of surgical site infections (SSIs) in coronary artery bypass graft (CABG) patients from 9.69% to 8% in 2010/11	Surgical site infection rate reduced to 5.85% by quarter 4
5	Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE)	To risk assess all patients admitted as inpatients for VTE, thereby reducing associated harm	Documented risk assessments increased from 66% to 97% by quarter 4

Our selected priorities for 2011/12 are as follows.

Priority 1: Reducing patient falls

Rationale
Reducing patient falls remains a top priority for the hospital. In June 2010 the National Patient Safety Agency (NPSA) published a reminder to NHS organisations to follow the guidance published by The Patient Safety First Campaign in 2009, which came after 283,438 slips, trips and falls were reported to them between October 2008 and September 2009. This was a significant increase on previous years.

At Papworth Hospital, falls account for 21% of the total patient safety incidents reported during 2010/2011, making this the highest reported event. Therefore, there continues to be significant work to reduce these incidents and prevent falls whenever possible. The focus has been on increasing assessment of the patients' risk of falling and will now also include education of patients at risk as well as our staff to help prevent falls occurring.

Baseline
Table 1 opposite demonstrates the number of falls reported per quarter. In 2010/11 our target was to reduce the number of falls by 20% from 53 per quarter to 43, which remains our goal and which we measure through our in-house incident management system. As this target remains a challenge, we are carrying forward this priority into 2011/12.

Analysis of the falls incidents identifies few common factors, except that most occur when a patient is trying to go the bathroom on their own.

Initiatives implemented in 2010/11
1. Review best practice from other Trusts and utilise the National High Impact Actions work
2. Raise fall-prevention awareness
3. Roll out training across the Trust
4. Produce an information leaflet for patients and their carers
5. Roll out across all clinical areas the top ideas from a test site
6. Re-audit compliance with the Falls Prevention procedure

These streams of work have resulted in updating of the Falls Prevention procedure and giving regular training sessions, including skills refresher week in October 2010. A system is now in place in all clinical areas whereby staff, on a daily basis, identify and display when and if a fall occurs. This is then monitored closely through monthly audit.

Through the 'Releasing Time to Care' project, 60% of the ward areas audit the completion of falls risk assessment and implementation of a care plan. In these areas, compliance with completing a risk assessment on admission ranged from 75% to 100% in quarter 4 2010/11, as demonstrated in Graph 1 opposite.

Goals for 2011/12

- To reduce preventable falls by 20%
- To increase the use of Falls Risk Assessments
- To educate patients and carers about preventing falls in hospital
- To undertake a thorough investigation of all falls to look for the root cause and falls resulting in serious harm will be reported to our commissioners as serious incidents
- Ensure all inpatient areas audit compliance with falls risk assessment on admission using the 'Releasing time to care' data collator on a monthly basis
- Plan and deliver falls-prevention awareness week, both for staff and members of the public
- Display information about preventing falls to reinforce messages given to patients and carers about mobilisation whilst in hospital

Monitoring

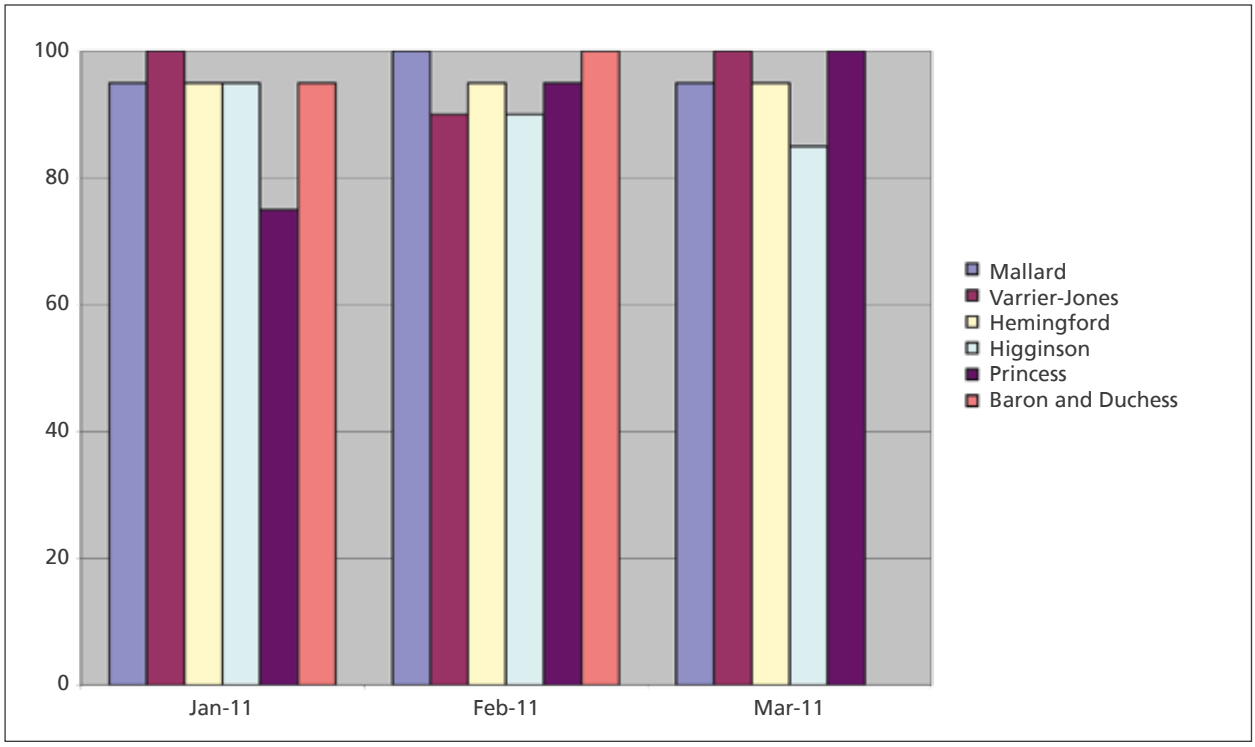
The Falls Prevention Group will monitor (via Datix, the Trust's risk management system) and report on performance to the Risk Management Group which, through the Director of Nursing, feeds directly to the Board of Directors.

The focus has been on increasing assessment of the patients' risk of falling and will now move to education of patients at risk to help prevent a fall occurring.

Table 1 Number of falls per quarter

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2009/10	53	42	38	25
2010/11	51	50	44	40

Graph 1 Risk assessment audit on admission



Responsible Officers

Executive Lead:	Ann-Marie Ingle, Director of Nursing
Implementation Lead:	Josie Rudman, Assistant Director of Nursing
Programme Lead:	Pam Fitzgerald, Modern Matron Cardiac Services

Priority 2: Reducing medication errors

Rationale
Medication incidents remain the second largest category of incidents reported during 2010/11. The trend continues upwards, although this is not reflected in a proportionate increase in the severity impact nor in incidents resulting in harm to the patient.

Baseline
20% of incidents reported related to medication errors in 2010/11.

Initiatives Implemented in 2010/11
In addition to the established Trust wide multidisciplinary Medicines Safety Group, we have initiated smaller specialty specific groups in the cardiac and thoracic directorates. These meet quarterly to look at specialty-specific issues relating to medication safety, and focus on the initiatives set out at the beginning of 2010/11. *See Table 2.*

The Trust has also re-launched the guidance for investigating medication incidents during 2010/11, introducing a standardised approach across the hospital using the root cause analysis methods of investigation. We have created a process where evidence of learning from medication incidents is explicit, and thus developed a more robust approach to managing and supporting staff involved in medication incidents.

We have also focused on patient involvement through the development of patient information that encourages a true partnership approach to improving medicines safety throughout the hospital. Patient engagement in this safety initiative is a considerable improvement.

Positive progress has been made in this area with an overall increase in reported medication incidents. This is the excellent result of our raising of the profile for this safety initiative. There has been a significant increase in openness and transparency regarding incident reporting with our positive safety culture. Although the indicators set for 2010/11 have not all been achieved, we have achieved many improvements, and we are now able to measure the impact of future initiatives to improve medicines safety.

Goals for 2011/12
- Roll out our patient information on medicines safety to engage the patients in improving medicines safety
- Roll out ward level monitoring and auditing of omitted medicines not correctly documented to identify trends and take actions for improvement
- Review and redesign our medicines prescription chart to further improve prescribing practice and reduce prescription errors
- Focus on reducing checking errors through education, training and support

Monitoring
Monitoring for achievement against goals will be through the Cardiac and Thoracic Medication Incident review groups, and by exception to the Clinical Governance Management Group.

Table 2 Reducing medication errors - achievements 2010/11

Pilot indicators for 2010/11	Achieved/update
What: Increase reporting of medication incidents by 50% **Measure:** Produce 'run chart' of number of incidents reported	Reported medication incidents increased by 72% (from 133 to 229)
What: Reduce errors relating to insulin by 75% **Measure:** Audit of practice utilising the Think Glucose toolkit	The diabetes specialist nurse has redesigned the diabetes observation chart and raised the profile of insulin management across the Trust. The numbers of reported incidents relating to failure to follow Trust Insulin protocol have been too small to draw significant comparisons with the target set
What: All omitted medicines reported with the clinical reason for omission **Measure:** Night staff to check all charts and count incidents	The number of medication incidents relating to omissions reported has increased. We have introduced a Trust wide audit procedure to monitor the rate of omitted medicines within each clinical area. We have tried this in two areas
What: Reduce by 90% number of incidents relating to 'failure to check' **Measure:** Plot reported incidents then apply contributory factors taxonomy to identify root causes	This has not been achieved, partly due to the increase in overall reporting of medication incidents

Responsible Officers

Executive Lead:	Ann-Marie Ingle, Director of Nursing
Programme Lead:	Carole Moderate, Clinical Governance Manager

Priority 3: Reducing central venous catheter bloodstream infections (CVC-BSIs)

Rationale
Bloodstream infections associated with central venous catheter insertion are a major cause of morbidity nationally. These infections are caused by contamination of a catheter with bacteria or yeast from another part of a patient's body or from a caregiver. A 2006 prevalence survey found that 42.3% of bloodstream infections in England are central line related. As well as the impact on recovery following treatment and the length of stay in hospital for our patients, in 2000, the National Audit Office (NAO) estimated the additional cost of a bloodstream infection to be £6,209 per patient.

Baseline
'Matching Michigan' is a quality improvement project based on a model developed in an intensive care unit in Michigan, USA which saved around 1,500 lives over 18 months. The project consists of technical interventions (evidence based changes in clinical practice) and non-technical interventions (linked to leadership, teamwork and culture change), which have been shown to significantly reduce the incidence of Central Venous Catheter bloodstream infections (CVC-BSIs) to a mean of 1.7 CVC-BSI/1,000 CVC patient days. We have base-lined our data and benchmarked with Michigan and other cardiothoracic units nationally. The mean over a 15 month period was 3.6 CVC- BSI/1,000 CVC patient days, the median being 3.4 (range 1.4-6.4).

Initiatives implemented in 2010/11
- Raised the profile of the initiative
- Established baseline data
- Established a working group to review data and set actions
- Introduced the recommended central line insertion checklist
- Introduced the use of 'Chloraprep' for cleaning of skin prior to line insertion

Goals for 2011/12
Our goal is to reduce catheter related bloodstream infections by 25% in 2011/12 and a further 25% in 2012/13 to bring us in line with Michigan. We will achieve this goal by the following actions:
- Introducing antimicrobial coated central venous catheters (CVC) for selected patient groups
- Introducing Clinell green 2% chlorhexidine in 70% alcohol wipes for intravenous access port cleansing
- Adopting aseptic and non-touch technique (ANTT) in critical care, then hospital wide
- Commencing needle-free connector trials to replace 3-way taps
- Implementing CVC integrated care pathways for wards
- Undertaking root cause analysis of CVC BSI
- Monthly data analysis
- Trust-wide project dissemination

Our goal is to reduce catheter related bloodstream infections by 25%.

Monitoring
We have established a Matching Michigan Project Group who meet regularly to monitor actions and report to the Infection Prevention and Control Committee on a monthly basis.

Responsible Officers

Executive Lead:	Ann-Marie Ingle, Director of Nursing
Implementation Lead:	Stephen Webb, Consultant Anaesthetist
Programme Lead:	Maura Screaton, Modern Matron Critical Care

Priority 4: Prevent delays in discharge following an inpatient stay

Rationale
What happens during the discharge process is a key part of a patient's experiences of hospital care (DH 2004). The cost of delayed discharge from acute hospitals can be estimated at approximately £155m per year (DH 2003, Impact Assessment).

From the point of view of improving overall bed availability the Department of Health (2004) suggests focusing on patients with simple discharge needs is likely to have the greatest immediate impact because, critically:

- The numbers of patients you can impact are very large (at least 80% of discharges are simple)
- The actions needed do not usually require any other agency's involvement to succeed

The High Impact Action (NHS Institute for Innovation and Improvement 2010) 'Ready to go, no delays', tells the story of how acute Trusts have improved discharge processes, including introducing nurse led discharge. Reducing length of stay at Papworth Hospital has been agreed as a key priority throughout all of our services.

Baseline
Table 3 below demonstrates the number of occasions reported by our staff in relation to delayed discharge or transfer during 2010/11. This equates to 6% of our reported incidents. This year our inpatient survey, although excellent throughout, highlighted that there are some issues relating to discharge. 27% of patients who responded to the survey reported that they had been delayed at discharge. The reasons for this are depicted in Graph 2 below.

Goals for 2011/12
The overall goal for this priority is to improve the patient experience when being discharged following an inpatient stay, and reducing our overall length of stay measurements.

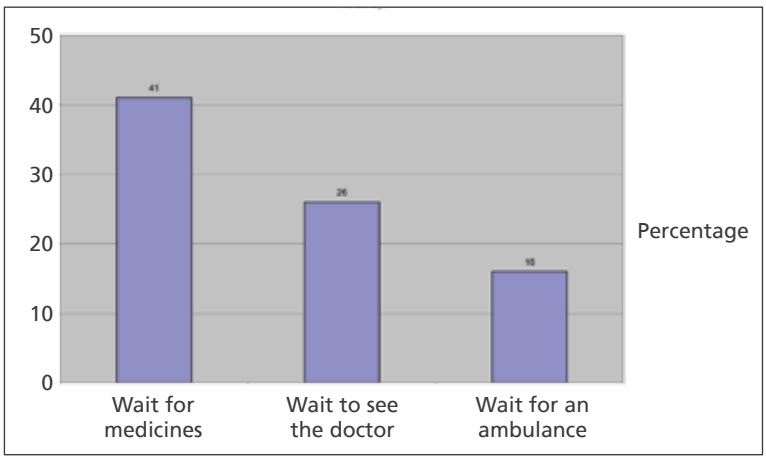
Within 2011/12 we plan to introduce the following initiatives:

- Utilise the discharge module of the Productive Ward project across all inpatient areas
- Introduce 'predicted date of discharge' for all patients and display this on the 'patient status at-a-glance' boards in each ward area
- Increase Professional Support Services weekend activity in-line with patient needs
- Explore the current discharge process and improve effectiveness in the areas of medicines wait, the wait to see the doctor and the wait for transportation
- Identify simple discharges and introduce nurse led discharge where appropriate
- Introduce IPM PAS update to track delayed discharges

Monitoring
The improvements in the discharge process will be monitored through the Productive Ward Steering Group and reported to the Nursing Advisory Committee, which feeds directly to the Board of Directors via the Director of Nursing.

Table 3 Delayed discharge or transfer during 2010/11

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2010/11	20	10	12	14



Graph 2

Of the patients that reported a delay, 66% stated that they were delayed up to two hours and 11% stated that they were delayed longer than four hours.

Responsible Officers

Executive Lead: Ann-Marie Ingle, Director of Nursing
Implementation Lead: Josie Rudman, Assistant Director of Nursing

Priority 5: To maintain high-quality venous thromboembolism (VTE) prevention thus reducing avoidable death, disability and chronic ill health from VTE

Rationale
VTE prevention is a national priority that has been recognised at the highest level and placed at the top of the health agenda for this year, featuring in the NHS Outcomes Framework for 2011/12. The risk of developing VTE in hospital is a thousand times greater than with long haul travel and a patient is one hundred times more likely to die from VTE in hospital than MRSA (Professor Sir Bruce Keogh, NHS Medical Director, March 2011).

VTE is the most common cause of hospital deaths in the UK that can be prevented and last year, NICE placed the prevention of VTE in its list of top ten cost-saving interventions. As the NHS moves towards a period of transition, VTE prevention has a significant role to play in delivering the Quality Innovation Productivity and Prevention (QIPP) agenda and in informing patient choice and it is for these reasons that we are keeping VTE prevention as one of our priorities for improvement for 2011/12.

Baseline
At the beginning of this initiative, between June and September 2010, our first point of prevalence audits demonstrated an average of 45% compliance.

Initiatives implemented in 2010/11
From June 2010 mandatory risk assessment data collection was linked to the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework attaches a financial incentive to the goal of risk assessing 90% of patients for VTE and bleeding on admission. Trusts report this data to the Department of Health through a system called UNIFY. As with the majority of Trusts around the country, Papworth Hospital fell considerably below the 90% target of documented risk assessments in the early stages of this initiative.

However, through local campaigns, network events, training and education, we have seen a steady rise in the number of patients who are risk-assessed for VTE on admission to hospital and we have reported over 90% compliance with this CQUIN since October 2010 as illustrated in Table 4.

The Department of Health has announced that this nationally mandated goal will remain the same in 2011/12.

The Trust VTE Risk Assessment and Prophylaxis document was approved and added to the Trust intranet (DN500) in August 2010 and written information for patients was provided for patients coming in to hospital for surgery. VTE prevention features on the staff induction days and on the annual statutory training day that all staff are required to attend.

A mechanism for identifying acute VTE events in hospital has been put in place through the radiology reports which includes VTE notification. This is searched for on a monthly basis by the PACS Manager and a report is sent to the office of the Director of Nursing. A root cause analysis is then initiated by the Trust medical lead for VTE prevention.

A mechanism for identifying acute VTE events in hospital has been put in place through the radiology reports which includes VTE notification.

Table 4 Percentage of inpatients with documented risk assessment for VTE

Month	Percentage of inpatients with documented risk assessment for VTE
September 2010	66.01%
October 2010	90.08%
November 2010	90.44%
December 2010	91.12%
January 2011	97.89%
February 2011	97.08%
March 2011	97.00%

Goals for 2011/12

To continue to deliver improvements in the standard of VTE prevention ensuring safe and effective care for patients. We plan to achieve this by the following actions:

- Continue to maintain over 90% compliance in documented VTE risk assessments of patients admitted to Papworth Hospital
- The risk assessment will be repeated and documented within 24 hours of admission and whenever there is a change in the patient's clinical condition
- VTE prophylaxis based on national clinical guidance will be audited monthly on a random selection of patients and any shortfalls will be fed back to the clinical areas and directorate managers
- The Procedure for Suspected VTE document reflecting current best evidence will be approved and added to the Trust intranet site promoting consistency in approach to treatment
- All patients will receive written and verbal advice on admission and discharge
- Root cause analysis to be performed on any acute VTE event identified in a patient whilst in hospital or if brought to our attention by another Trust, occurring within 90 days of discharge from Papworth Hospital
- Root cause analyses and associated actions will be fed back to Clinical Governance Management Group and reported in the quarterly Quality and Safety report. They will be disseminated to the Papworth Medical Advisory Committee via the Medical Director and the Nursing Advisory Committee via the Director of Nursing
- The Board of Directors will be notified through the monthly update in the Director of Nursing Patient Safety paper which will then inform the commissioners. Sharing of lessons learnt and subsequent action plans will be disseminated to relevant committees and directorates and monitored through the Clinical Governance Management Group for completion
- Information on VTE prevention is disseminated during the Clinical Skills Refresher week.
- Raise awareness about the availability and use of foot impulse devices currently in use in theatre

New initiatives to be implemented in 2011/12

- Amended VTE risk assessment tool introduced to facilitate documentation of the second risk assessment, with a prompt to repeat if there is any change in the patients' clinical condition
- Introduction of the new Papworth Hospital drug chart which incorporates the VTE risk assessment tool. This will link the assessment and treatment in one document
- Patient advice on VTE prevention described in the new 'Handbook for inpatients - coming into hospital' guide to be launched later this year. In the meantime, copies of the leaflet designed by the East of England NHS are being distributed to all inpatients
- VTE prevention features in the Patient Safety Focus days taking place in April 2011
- Investigate the purchase of intermittent pneumatic compression devices to be used for very high risk patients such as thoracic oncology patients undergoing surgery
- 15 minute elearning course designed for hospital induction training programmes by the Kings Thrombosis Centre to be completed by all medical and nursing staff within one month of starting work at Papworth Hospital
- Incorporate VTE advice in the Integrated Care Pathway documentation to include both admission and discharge advice
- Update the VTE risk assessment and prophylaxis document in accordance with the latest NICE guidance, to include specific recommendations for cardiac and thoracic surgical patients
- Add an appendix for cohort exemptions as approved by the Medical Director. Currently there is no national, authoritative, clinically defined list of cohorts agreed to be at low risk or no risk

Monitoring

Root cause analyses are monitored via the Clinical Governance Management Group. Patient Risk Assessment census reported monthly to Department of Health.

We will continue to deliver improvements in the standard of VTE prevention ensuring safe and effective care for patients.

Responsible Officers

Medical Lead:	Karen Sheares, Consultant Physician (for Medical Director)
Responsible Officer:	Helen Munday, Lead Nurse Practice Development (for Director of Nursing)

2.0 How did we review our services (statements of assurance from the board)

The Directors are required under the Health Act 2009 and the National service (Quality Accounts) regulations 2010 to prepare quality accounts for each financial year. Monitor 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 (membership three non-executive directors), governors, the Patient and Public Involvement Committee of the Board of Governors and clinical colleagues. Indicators relating to the quality accounts are part of the key performance indicators reported monthly to the Board of Directors and Directorates as part of the monthly monitoring of performance.

Scrutiny of the information contained within these indicators and its implications as regards patient safety, clinical effectiveness and patient experience are reported to the Board of Directors, governors and sub-committees as required.

During 2010/11 Papworth Hospital provided and/or sub-contracted six NHS services in the following areas:

- Cardiology
- Cardiac surgery
- Thoracic surgery
- Respiratory Support and Sleep Centre (RSSC)
- Transplant and Ventricular Assist Devices (VADs)
- Thoracic medicine

Full details of our services are available on the Trust web site: www.papworthhospital.nhs.uk

Papworth Hospital has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by Papworth Hospital for 2010/11.

3.0 Continually learning

Information on participation in clinical audits and national confidential enquiries

During 2010/11, 12 national clinical audits and three national confidential enquiries covered NHS services that Papworth Hospital provides.

During 2010/11, Papworth Hospital participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The National Clinical Audit and Patient Outcomes Programme 2010/11

The national clinical audits and national confidential enquiries that Papworth Hospital was eligible to participate in (and indeed did participate in) during 2010/11 are as follows:

Acute care
- Emergency use of oxygen (British Thoracic Society)

Long term conditions
- Diabetes (National Adult Diabetes Audit)
- Chronic pain (National Pain Audit)
- Bronchiectasis (British Thoracic Society)

Elective procedures
- Cardiothoracic transplantation (NHS Blood Transfusion UK Transplant Registry)
- Coronary angioplasty (National Institute for Clinical Outcome Research Adult Cardiac Interventions Audit)
- Coronary artery bypass graft and valvular surgery (Adult Cardiac Surgery Audit)

Cardiovascular disease
- Acute myocardial infarction and other acute coronary syndrome (Myocardial Ischaemia National Audit Project)
- Pulmonary hypertension (Pulmonary Hypertension Audit)

Cancer
- Lung cancer (National Lung Cancer Audit)

Blood transfusion
- O neg blood use (National Comparative Audit of Blood Transfusion)
- Platelet use (National Comparative Audit of Blood Transfusion)

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

- Surgery in children
- Peri-operative care
- Cardiac arrest

The national clinical audits and national confidential enquiries that Papworth Hospital participated in, and for which data collection was completed during 2010/11, 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.

The National Clinical Audit and Patient Outcomes Programme 2010/11 - 100%

Acute care
- Emergency use of oxygen (British Thoracic Society) - 100%

Long-term conditions
- Diabetes (National Adult Diabetes Audit) - 100%
- Chronic pain (National Pain Audit) - 100%
- Bronchiectasis (British Thoracic Society) - 100%

Elective procedures
- Cardiothoracic transplantation (NHSBT UK Transplant Registry) - 100%
- Coronary angioplasty (NICOR Adult Cardiac Interventions Audit) - 100%
- CABG and valvular surgery (Adult Cardiac Surgery Audit) - 100%

Cardiovascular disease
- Acute myocardial infarction & other ACS (MINAP) - 100%
- Pulmonary hypertension (Pulmonary Hypertension Audit) - 100%

Cancer
- Lung cancer (National Lung Cancer Audit) - 100%

Blood transfusion
- O neg blood use (National Comparative Audit of Blood Transfusion) - 100%
- Platelet use (National Comparative Audit of Blood Transfusion) - 100%

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - 100%

A breakdown of the data collection requirement for the national confidential enquiries that Papworth Hospital participated in is presented in Table 5 below.

The reports of six national clinical audits were reviewed by the provider in 2010/11 and Papworth Hospital intends to take the following actions to improve the quality of healthcare provided. No actions were required by Papworth Hospital as a result of the review of the other four national clinical audits.

Elective and emergency surgery in the elderly

Provision of an online training package for staff undertaking Malnutrition Universal Screening Tool (MUST) to ensure all elderly surgical admissions should have a formal nutritional assessment as soon as practicable after their admission so that malnutrition can be identified and managed appropriately.

Parenteral nutrition (PN)*

Changes have been made to the updated version of PN policy advising against starting out-of-hours for non-critical care patients.

* Administration of nutrition directly into the bloodstream.

Local clinical audits

The reports of 57 local clinical audits were reviewed by the provider in 2010/11 and Papworth Hospital intends to take the following actions to improve the quality of healthcare provided:

Compliance with the local falls policy
- A training session on falls awareness was included in the skills week held during October 2010

Oxygen prescription and administration in thoracic medicine
- Integrate current oxygen prescription chart into existing drug chart
- Specify device and flow-rate independently on the drug chart

Discharge service evaluation
- Concentrate on repatriation and intermediate care delays

Audit of compliance with NICE guidance for lung cancer
- Education for all medical staff and specialist nurses to write which information is being given to patients about their disease in case notes
- Education for all medical staff and specialist nurses about resources available and appropriate referrals of patients with symptoms of breathlessness

Protection of vulnerable adults and young people audit staff survey (re-audit)
- Poster at skills refresher week in October 2010 to maintain awareness

Anaesthetic record keeping
- To assess feasibility of implementing a reminder prompt for Propofol administration

Table 5 National confidential enquiries that Papworth Hospital participated in

Title	Spreadsheet received	Cases applicable	Case notes received	Questionnaire received	Organisational questionnaire received
Surgery in children	Yes	0	N/A	N/A	Yes
Peri-operative care	Yes	5	100%	100%	Yes
Cardiac arrest	Yes	2	100%	100%	N/A

Information on clinical research

Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided or sub-contracted by Papworth Hospital NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 3,234. *See Table 6.*

The Trust's focus on NIHR* Portfolio research activity is demonstrated by the success of the Papworth Research & Development and Clinical Trials Unit in securing peer-reviewed NIHR research grant funding and a 45% increase in the number of actively recruiting portfolio studies. Papworth Hospital was involved in conducting 30 clinical research studies in heart disease and 51 clinical research studies in respiratory disease during 2010/11. The remaining nine studies were of generic health relevance. There were 35 clinical staff leading, as chief investigator, research projects approved by a research ethics committee at Papworth Hospital during 2010/11.

By maintaining a high level of participation in clinical research the Trust demonstrates Papworth Hospital's commitment to improving the quality of healthcare.

The Trust's research strengths are applied patient-focused pragmatic trials and health technology assessment of the clinical and cost-effectiveness of new interventions. Evidence from our research helps patients and healthcare professionals make decisions about treatment. It is also used to decide what care is offered in the NHS and worldwide. The Trust remains committed to improving inpatient outcomes by undertaking clinical research that will lead to better treatments for patients undergoing care in the NHS.

Information on the use of the CQUIN framework

A proportion of Papworth Hospital NHS Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Papworth Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Papworth Hospital had seven goals as part of the CQUIN payment framework agreed with local commissioners in 2010/11. They were:

- Venous thromboembolism (VTE) - assessment, prophylaxis and root cause analyses (national)
- Patient experience - improved overall results on the inpatient survey (national)
- Increase in the application of the Global Trigger Tool (a tool which helps us identify the rate of adverse events resulting in harm to our patients)
- Completion of the primary PCI patient data set
- Reducing the rate of surgical wound infections for coronary artery bypass grafts
- Increase in surgical resection rates for lung cancer
- Achievement of target times for primary PCI

The amount of income in 2010/11 conditional upon achieving quality improvement and innovation goals was £1,266k and the amount received was £1,190k (94%). Overall there has been excellent progress in our CQUIN goals. An area of non-achievement was in VTE, for which full implementation was slower than that set out in the CQUIN. However, by the end of the financial year Papworth Hospital achieved the highest rate of VTE assessment across the East of England.

Further details about the CQUIN scheme are available electronically at (www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)

Table 6 Number of patients recruited for research projects

Type of research project	No. of patients recruited (No. of actively recruiting studies) per financial year	
	2009/10	2010/11
NIHR portfolio studies	431 (22)	399 (32)
Non-NIHR portfolio studies	866 (73)	684 (58)
Tissue bank studies	1,815 (36)	2,151 (44)
Total	3,112 (131)	3,234 (134)

*NIHR = National Institute for Health Research

Information relating to registration with the Care Quality Commission (CQC) and periodic/special reviews

Papworth Hospital is required to register with the Care Quality Commission and its current registration status is unconditional registration which means we are meeting government regulations on a range of areas of practice.

The Care Quality Commission has not taken enforcement action against Papworth Hospital during 2010/11.

Papworth Hospital has not participated in any special reviews or investigations by the CQC during the reporting period.

Information on the quality of data

Quality indicators form an integral part of a comprehensive range of performance indicator's for Papworth Hospital. Indicators are reviewed annually to ensure alignment and comparison with local, regional and national priorities. The delivery of each indicator against its respective target is the responsibility of a range of executive and clinical leads. The indicators are routinely monitored and reviewed on a monthly basis and where performance is adverse, corrective action plans are developed. Performance is ultimately reviewed by the Board of Directors.

Papworth Hospital submitted records during 2010/11 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data. For Papworth Hospital the percentage of records in the published data:

- Which included the patient's valid NHS number was: 99.3% for admitted patient care and 99.7% for outpatient care
- Which included the patient's valid General Medical Practice Code (code of the GP with which the patient is registered) was: 97.9% for admitted patient care and 98% for outpatient care

Overall there has been excellent progress in our CQUIN goals.

The information quality and records management attainment levels assessed within the information governance toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. Papworth Hospital's information governance assessment report overall score for 2010/11 was 68%. The Trust achieved a satisfactory level (level two 'red') on all key requirements in the information governance toolkit.

Papworth Hospital will be taking the following actions to improve data quality during 2011/12:

- The further development of the roles of our staff that are responsible for and administer databases
- Setting out clear maps of how data flows into and out of the organisation
- Formal refresher training for the clinical coding team

Papworth Hospital was not subject to the payments by results clinical coding audit during the reporting period by the Audit Commission.

Part 3

4.0 Review of quality performance 2010/11

The following illustrates a review of our quality performance last year. We have selected examples from the three domains of quality (safety, patient experience and effectiveness of care). This also includes two of our priorities from last year which we have not carried forward (ALERT and pressure ulcers), as we are satisfied that we have embedded these areas into everyday practice. We will continue to monitor our performance as part of our Trust key performance indicators.

Safety domain

Healthcare associated infections

We have continued to demonstrate improvements in our MRSA bacteraemia and C. difficile infection rates across the hospital. *See Table 7.*

Methicillin-resistant *Staphylococcus aureus* (MRSA)

MRSA bloodstream infections are the most serious form of MRSA infection and are associated with significant morbidity and mortality. Hand-hygiene remains an important infection control measure to reduce the risk of spread of MRSA on the hands of healthcare workers.

C. difficile
Clostridium difficile (C. difficile) is a common pathogen in older people with an asymptomatic carriage rate between 2-20%. The spectrum of C. difficile-associated disease (CDAD) ranges from asymptomatic carrier status through to clinical diarrhoea, to fulminant colitis and toxic megacolon. Antibiotics have commonly been associated with CDAD but are not the only risk factor. Other associations include exposure to antineoplastic agents, gut motility altering drugs, surgery and chronic illnesses.

However, it is not only older patients that are affected by C. difficile. In particular, the cystic fibrosis population is known to have a higher carriage rate of C. difficile than the general population, possibly due to the need for repeated courses of broad spectrum antibiotics for chronic lung infection. Due to the underlying cystic fibrosis illness, these patients may not present with classical diarrhoeal symptoms of C. difficile disease but are more likely to present with abdominal symptoms suggestive of severe C. difficile disease. This makes the management and prevention of CDAD in this group of patients challenging.

The ability of C. difficile to produce spores enables the organism to survive in the environment. Faecal-oral transmission allows colonisation of the gastro-intestinal tract. Disruption to the host's normal bowel flora allows C. difficile to multiply in the colon. Toxins are produced which, on binding to target cells in the colon, cause damage to these cells resulting in inflammation and mucosal injury.

Prevention relies on reducing exposure to risk factors so as to limit disruption of host bowel flora. Infection control measures are important in limiting spread. CDAD is of great clinical importance as a cause of hospital acquired diarrhoea and has undergone an apparent change in epidemiology and disease patterns. There is now more recognition regarding the ability of different strains to affect morbidity, mortality and ease of spread. For example, there has been increased interest in the 027 strain as one which is associated with a higher morbidity and mortality where strict infection control practices are paramount in limiting spread.

We have continued to demonstrate improvements in our MRSA bacteraemia and C. difficile infection rates across the hospital.

Table 7 Improvements in our MRSA bacteraemia and C. difficile infection rates

Goals for 2009/10	Outcome	Goals 2010/11	Outcome
No more than 3 MRSA bacteraemias	Total for year = 2	No more than 2 MRSA bacteraemias	Total for year = 1
No more than 20 C.difficile cases	Total for year = 12	No more than 13 C.difficile cases	Total for year = 9
Achieve 100% MRSA screening of elective patients	Average 96% (commenced December 2010)	Achieve 100% MRSA screening of elective patients	Average 97%

MRSA screening
MRSA can live harmlessly on the skin and mucosal surfaces (mainly nose, throat and perineum) in about 10% of healthy people (colonisation).
The purpose of screening is to identify patients carrying MRSA and offer decolonisation treatment to eradicate MRSA carriage. This not only reduces the risk of cross transmission between patients but also reduces the risk of MRSA infection developing. Infection occurs when the bacteria gain access to usually sterile sites.

The east of England Strategic Health Authority required provider Trust organisations to achieve the routine screening of all elective and emergency admissions within the East of England by 1 April 2009. This was in line with the Department of Health target of 31 March 2009 for elective admissions but ahead of the Department of Health target of April 2011 for screening all emergency admissions. The early compliance of 1 April 2009 for emergency admissions supported the delivery of the Strategic Health Authority's pledge, and demonstrates Papworth Hospital's commitment to this goal to provide the safest healthcare in England.

The definition of screening is microbiological testing of a sample taken from potential carriage sites on or before admission with the purpose of identifying patients colonised with MRSA and to actively de-colonise.

ALERT

(Acute life threatening events: recognition and treatment)

ALERT is a service we now provide 24 hours, 7 days a week delivered by advanced nurse practitioners, which recognises and responds to the deteriorating patient quickly, reducing re-admission to critical care and further deterioration in the patient's condition.

The ALERT service has now been running for 17 months. Data is collected on every patient using an electronic data collection tool. This data is collected on every readmission to critical care, first admission to critical care, acute pain management referral and Alert Team referral. Electronic data has been collected since September 2010 and, during this time, the team has seen 1,113 patients who fall into two categories - routine critical care follow-up (89) and ward referrals (1,024). Of these 1,024 referrals, 217 had been discharged from critical care less than 24 hours and 50 were transferred in from another hospital.

The team also provides support and advice to all nursing staff in all ward areas and also assists with technical tasks such as cannulation, venepuncture and naso-gastric tube insertion. The team also provides bedside training in areas such as observations, fluid management, pacing, ECG's etc. The team supports the medical team in providing timely intervention with the primary objective being a reduction in patient deterioration and the acquisition of appropriate levels of care being delivered in the right place.

Goals 2010/11	Outcome
Implementation of a 24 hour/7 day a week Acute Pain Management Service	Patients are routinely followed up post cardiac and thoracic surgery and patients with patient controlled analgesia (PCA), epidural or extrapleural analgesia are referred to the Acute Pain Management Service (APMS) for monitoring. This service is supported by the lead consultant anaesthetist for acute pain and the lead consultant anaesthetist for chronic pain. The team has admitted 64 patients to the APMS since January 2011
Continuous Positive Airways Pressure (CPAP) trial within the Cardiology HDU for patients in acute cardiogenic pulmonary oedema	Achieved: Data is also being collected regarding the CPAP trial
Introduction of non-medical prescribing within the ALERT team.	Two team members have successfully completed both the advanced skills in clinical assessment module and non-medical prescribing module
Launch of: • SBAR (situation, background, assessment, response) communication tool) • Intelligent fluid management bundle	Achieved

New Initiatives for 2011/12
- Introduction of a new study day for clinical staff on 'Recognition and management of the deteriorating patient'
- Launch of 'The Deteriorating Patient', eLearning package
- Ratification of the 'Management of the Deteriorating Patient procedure', ensuring we comply with NICE CG 50 guidance
- Revision of neurological observation charts and escalation criteria to improve recognition of neurological disorders and consequent management
- Revision of the current fluid balance charts,

fulfilling recommendations from the intelligent fluid management bundle
- Sepsis care bundles
- New documentation on the management of the patient with a tracheostomy, standardised using Intensive Care Society Recommendations and in line with current practice on critical care
- Advanced nurse practitioner guidelines for the management of the cardiothoracic surgical patient

Monitoring
The ALERT Service Steering Group will monitor and report on performance to the Patient Safety Steering Group, which feeds directly to the Board of Directors via the Director of Nursing.

Pressure ulcers

Pressure ulcers have been defined as ulcers of the skin due to the effect of prolonged pressure in combination with a number of other variables, including patient co-morbidities and external factors such as friction and skin moisture. There are four grades of pressure ulcer, ranging from 1 to 4, with 4 being the worst.

Throughout 2010/11, we have continued to make excellent progress in the management and monitoring of our pressure ulcers. The table below shows our pressure ulcer prevalence data for the last three years. *See Table 8.*
In 2010 we increased our pressure ulcer prevalence audits to twice yearly. This data is seen as gold standard for interpretation of pressure ulcer rates in a healthcare organisation. Initiatives for 2011/12 include:
- Pressure ulcer prevalence audit to be carried out quarterly from 2011
- Pressure ulcer reporting, investigating and management protocol introduced to facilitate effective and timely reporting of pressure ulcers developed within, and transferred into, the Trust
- Grade 3 and 4 pressure ulcers transferred into the Trust to have a root cause analysis investigation within 24 hours of the pressure ulcer being identified. Grade 3 and 4 pressure ulcers transferred into the Trust will be reported as serious incidents. This is in addition to the existing practice to undertake root cause analysis investigations of all grade 3 and 4 pressure ulcers that develop at Papworth Hospital, and which are reported as serious incidents
- Continued education on pressure ulcer prevention, identification, reporting and management in Trust wide mandatory training days

Goals 2010/11	Outcome
Monthly incident reporting to be migrated from a paper system to an electronic risk reporting system (Datix)	Achieved
Root Cause Analysis (RCA) to be introduced for all grade 2 and above pressure ulcers and resultant action plans to be implemented as appropriate	In year, we refined this to all grade 3 and above pressure ulcers, as per national standard, which has been achieved
Continued education on pressure ulcer prevention, identification, reporting and management in Trust wide mandatory training days	Pressure ulcer incident and prevalence figures are disseminated to all ward areas, Modern Matrons and the Director and Assistant Director of Nursing. Pressure ulcer incidence/prevalence monitoring forms part of the Trust wide Quality and Safety Measures, which are reported to the Quality and Risk Committee (Committee of the Board of Directors) via the quarterly Quality and Safety Report. It is through continued audit of pressure ulcer prevalence and incidence that staff awareness of prevention and management of pressure ulcers is raised and maintained

Table 8 Pressure ulcer prevalence data

Year (inpatient numbers audited)	Overall n/percentage of pressure ulcers/moisture lesions developed at Papworth Hospital (all grades)
2008 (n=224)	n=29/224 (13%)
2009 (n=222)	n=10/222 (4.5%)
June 2010 (n=289)	n=2/289 (0.7%)
Dec 2010 (n=266)	n=7/266 (2.6%)

Board to ward focus groups

In 2009 Papworth Hospital signed up to the National Patient Safety First campaign, which emerged from the Department of Health's recommendations for improving safety in hospitals. As part of this campaign we developed a patient safety strategy, the aim of which was to build a safety culture where patient safety comes first. As part of this strategy, we introduced patient safety focus groups led by the Chairman of the Board of Directors and a Non-executive Director, with an Executive Director present.

Goals 2010/11	Outcome
To embed quarterly focus groups and report key themes to our Quality and Risk Committee	Our focus groups have become an established medium for patient safety discussions. For 2011/12, we have expanded this to include our non-executive directors and chairman on unannounced clinical visits

Our staff asked us to	We did
Look at nurse staffing levels in ward areas due to increased activity levels and difficulties in recruiting	• A full nursing establishment review was carried out • Staffing levels were increased in some areas • On-going review throughout the hospital • Recruitment trip to Dublin with subsequent appointments made • Re-invigorated existing Recruitment & Retention Group • Increased involvement at student job fairs
Reduce delays in the recruitment process.	• Introduced a system to fast track post requests
Provide low-profile beds, particularly for patients at risk of falling	• Introduced 100% electric beds throughout the hospital, where required, which can be lowered appropriately

Surgical site infections

NICE (2008) states in its guidance on the prevention and treatment of surgical site infection that up to 20% of all healthcare acquired infections (HCAIs) are caused by surgical site infections. These affect more than 5% of patients who have had surgery.

Goals 2009/10	Outcome	Goals 2010/11	Outcome
Reduction in infection rates in our patients undergoing coronary artery bypass graft and valve surgery	Infection rates reduced from 9.69% to 8%	Reduction in infection rates in our patients undergoing coronary artery bypass graft and valve surgery	Infection rates reduced from 8% to 5.85%

Patient experience domain

Delivering same-sex accommodation

In early 2009, the Department of Health pledged that men and women should not normally have to share sleeping accommodation or bathroom facilities to respect their privacy and dignity. The gold standard for patients is single-sex wards.

However, it was recognised that some hospitals cannot provide this facility and agreed, therefore, that single-sex accommodation can be provided in:

- Single rooms with en suite or adjacent bathroom facilities, or
- Wards with male and female bays, but these must have designated male and female bathroom facilities and no mixing of the sexes in bays.

The complexity of Papworth Hospital's ageing estate and design has posed a significant challenge. However, on 10 March 2010, we were declared compliant. The on-going challenge of delivering this agenda is a daily part of the role of the nursing staff, as bays are required to flex in line with the gender of our patient mix.

Goal 2010/11	Outcome
100% of patients do not share sleeping or washroom facilities with members of the opposite sex (excluding critical care and high dependency areas)	Declaration of compliance published on website. Committed to a programme of audit throughout 2011/12 to ensure there is no misclassification of reports of compliance. Following the extensive work during 2009/10, and the resulting compliance when inspected in March 2010, there were no reported breaches during 2010/11

Patient Environment Action Team (PEAT) inspection

In view of the ageing estate of Papworth Hospital, it is essential we strive to deliver a positive environment for our patients. Every year all Trusts providing inpatient services in England are inspected by a Patient Environment Action Team (PEAT) and assessed against the following standards: organisation policy information, specific cleanliness, toilets and bathrooms, cleanliness and environment, infection control, environment, access and external areas, food and hydration and privacy and dignity. This serves to provide us with a basis for our improvement and maintenance programmes. *See Table 9.*

A detailed action plan is being developed to address particular areas of improvement within clinical areas in particular bathroom areas and visitor rooms requiring refurbishment. The plan will be monitored by the Nursing Advisory Committee. It was noted that whilst the Trust had improved its scores since last year, the age of some of the buildings and access across the site internally and externally did impact on the scores especially for people with disabilities.

Goal 2010/11	Outcome
Maintain or improve on level of performance year on year	The validated outcome of the assessment by the National Patient Safety Agency is identified below. Feedback from the team was extremely positive and, in particular, the significant improvement in all areas including the overall cleanliness of clinical areas together with the tidiness/state of the estate inside and outside since the last inspection

Table 9 Assessment of environment

	2010	2011	Change
Environment and cleaning	Good	Good	→
Food and hydration services	Good	Excellent	↑
Privacy and dignity	Good	Good	→

National Inpatient Survey

We are delighted that Papworth Hospital has again scored so highly in a national survey of patients. However, we are not complacent and consistently involve our patients in decisions about their care, listen to their views and monitor their feedback, reviewing and revising our practices accordingly.

Our staff are really proud of these results and it is thanks to their care, dedication and commitment that the hospital achieves such excellent feedback from our patients.

We are delighted that Papworth Hospital has again scored so highly in a national survey of patients.

Goal 2010/11	Outcome
To remain with the top 20% of Trusts reporting maintained or improved patient experience	Our Trust has successfully achieved this goal

Effectiveness of care domain

Primary Percutaneous Coronary Intervention (PPCI) Service

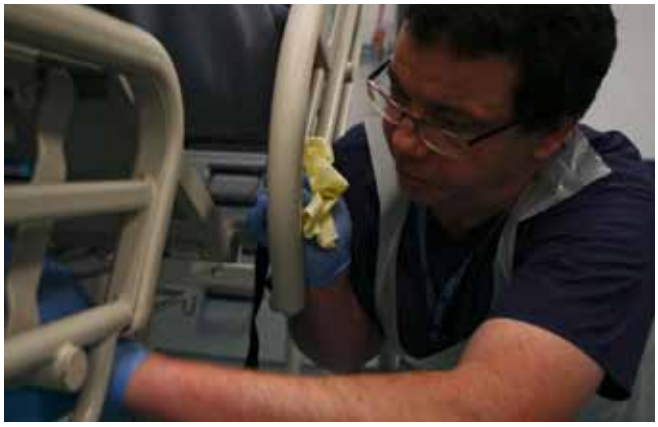
The National Service 3 Framework for coronary heart disease in 2000 set out standards for the treatment of heart attack, which commended a technique for unblocking arteries carrying blood to the heart muscle as the main or first treatment for patients suffering a heart attack. This is known as primary angioplasty or primary percutaneous coronary intervention (PPCI).

The Primary PCI service opened at Papworth Hospital on 22 September 2008 with a limited catchment area. This was increased in September 2009 and now covers the majority of the East of England which has an anticipated travel time of less than 90 minutes. A pilot study to establish the travel time from the East Suffolk area has been completed and Papworth Hospital are waiting to be informed of the final decision of whether this area will be formally included in the catchment area.

Within the calendar year of 2010 the range of number of activations per month was 46 to 68. Of these activations the range of the number of patients who went onto have a PPCI was 33 to 51 patients. There is little seasonal variation in the number of activations and subsequent treatment.

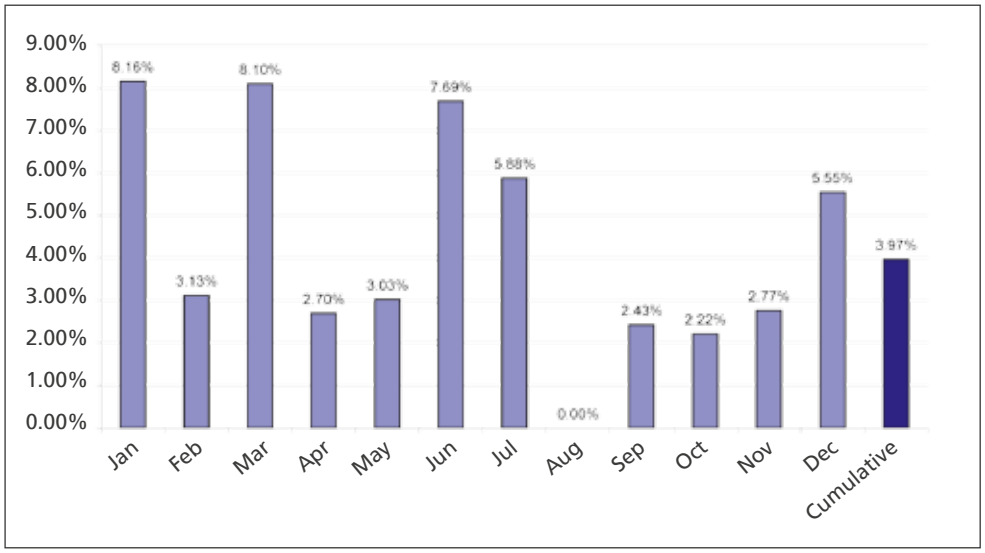
Information relating to mortality up to 30 days post procedure is collected retrospectively from the national spine. The percentage figures below represent an actual figure of between 0 and 4 deaths per month, with a total number of deaths within 30 days during 2010 being 18 patients. Papworth Hospital's 30 day mortality rate for PPCI patients was 3.97% in 2010 and therefore much in line with national audit targets at around 4%. *See Graph 3.*

Initiatives for 2011/12
There are a number of planned improvements for the coming year, including further analysis of patient delays with action plans, and improving our information system in reporting major and minor complications.



Goal 2010/11	Outcome
Achieve the standards for 'door-to-balloon' time (90 minutes) and 'call-to-balloon' time (165 minutes)	Four patients exceeded the door-to-balloon time standard. Two of these were due to simultaneous PPCI activations so the catheter lab was not available. The other two were due to patients needing emergency care prior to being able to have a PPCI. 12 patients exceeded the call-to-balloon time standard. All of the 12 patients attended an accident and emergency department at a District General Hospital prior to their transfer to Papworth Hospital.

Graph 3 30 day mortality for PPCI 2010



Direct care time (productive series)

Papworth Hospital engaged with the productive series through the productive ward in September 2008. The main aim of this change project is to release time back into direct care applying lean methodologies. The productive series was developed by the NHS Institute for Innovation and Improvement and offers a systematic way of delivering safe, high quality care to patients across the hospital by applying lean methodology to release time for staff to put back into patient care. Lean methodology, once applied, cuts out wasted time in a process.

The productive series is beginning to be truly embedded in the way staff deliver care to the patient. There has been excellent patient engagement in the project, resulting in a patient presenting how they felt the productive ward project impacted positively on their journey whilst an inpatient at Papworth Hospital, at a national level.

The priorities for 2011/12 are

- Work collaboratively through the admission and discharge module
- Implement patient status-at-a-glance as a whole Trust
- To ensure data is collected regularly to provide a clear picture of how well the teams are achieving quality targets

The project continues to be monitored through the Productive Ward Steering Group, which reports to the Nursing Advisory Committee through to the Board via the Director of Nursing.

The main aim of this change project is to release time back into direct care.

Goals 2010/11	Outcome
The main aim of this change project is to release time back into direct care by applying lean methodologies	All ward areas have engaged with the productive ward initiative, and are at different stages on this journey. Productive principles are being used across the Trust in areas such as physiotherapy and transplant services. Theatres have undergone a training programme to prepare the team for roll out of productive theatres and have commenced their first modules. All areas that have engaged in the project have managed to release varying amounts of time and have put this back into direct care time. A data collator has been developed to enable all areas to record their audit information and print graphs to display in the clinical areas
Patient status-at-a-glance	Order placed for new patient status-at-a-glance boards. Education programme planned for early 2011/12

Emergency planning

The many challenges facing NHS organisations, including major incidents, outbreaks of infectious diseases and terrorism threats, mean that robust major incident and business continuity plans are not only in place but are regularly tested and evaluated by the clinical teams.

Goals 2009/10	Outcome
Review and update existing business continuity plans throughout the Trust	Our internal auditors reviewed our business continuity processes in March 2010 and gave us a 'green' rating (* see below)

* Provides substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

Overall quality performance against Trust selected metrics, national priorities and CQC standards

Performance of Trust against selected metrics

Throughout 2010/11 we have continued to measure our quality performance against a number of metrics. Table 10 sets out our performance against those national targets included within Monitor's compliance framework. Table 11 below sets out our performance against other Department of Health national priorities and a range of local priorities.

Table 10 Trust performance against Monitor's compliance framework

Acute Targets - national requirements	Target	Performance
Clostridium difficile - year on year reduction	13	9
MRSA - meeting the MRSA objective	2	1
Cancer - 31 day wait for second and subsequent treatment	94%	100%
Cancer - 62 day wait for first treatment from GP referral*	79%	87.9%
Maximum 18 weeks from referral to treatment for admitted patients	>90%	94.9%
Maximum 18 weeks from referral to treatment for non-admitted patients	>95%	97.9%
Acute Targets - minimum standards	**Target**	**Performance**
MRSA screening all elective inpatients	100%	97%
Cancer - 31 day wait from diagnosis to first treatment	96%	100%
All Trusts	**Target**	**Performance**
Compliance with the requirements regarding access for people with learning disability	Compliance	Achieved from Q2

** reduced tolerance levels have been issued by CQC for certain specific single cancer sites. As Papworth Hospital only treats lung cancer the revised threshold applies.*

Table 11 Examples of Trust performance against other national and local priorities

Domain	Metric	Target	Performance
Patient experience	Operations cancelled for non-medical reasons	<1.5%	1.4%
	Percentage readmitted within the 28 day guarantee	5%	14.7%
	26 week inpatient waits	0%	0% (four breaches)
	13 week outpatient waits	0%	0% (two breaches)
Patient safety	Number of patient related adverse incidents	<800	909
	Number of patients risk assessed for VTE on admission	>90%	Achieved over 90% from September, over 97% from January 2011
	Rate of harm as assessed using the global trigger tool (GTT)	Reduce by 50% by 2013 (baseline 7%)	Average rate of harm for 2010/11 is 4.1% (reduction of 41.3%). Range 0 - 10.74%
Patient experience	% of patients reporting they were treated with privacy and dignity	>90%	>96%
	Number of complaints	<50	38
	Patient Environment Action Team (PEAT) score. Excellent (100%), good (90-95%), acceptable (< 90%)	Excellent	Excellent/good Two categories remained 'good' and one increased to 'excellent'
Effectiveness of care	Cardiac surgery in-hospital mortality within statistical limits using 50% of EuroSCORE (a method of identifying risks to our patients)	>95%	>97%

Monitor ratings

Monitor (The Independent Regulator of NHS Foundation Trusts) issues a financial risk rating (FRR) to Foundation Trusts based on quarterly financial returns. This rating is based on a formula determined by Monitor which measures financial performance using a composite indicator. The rating ranges from '5' to '1' with '5' the highest rating. Monitor also issues a red, amber-red, amber-green, green (RAG) rating for governance, where 'green' indicates low risk and 'red' indicates high risk (during 2009/10 the rating was red, amber and green). A summary of the planned and actual ratings for 2010/11 and 2009/10 are provided below.

During the year, Papworth Hospital achieved the second highest available financial rating of four in Q1 to Q3 and the highest rating of five in Q4. In line with Monitor's compliance framework, Papworth Hospital was downgraded to 'amber-green' in Q2 and Q3 for governance. *See Table 12 and 13.*

The Q2 governance rating was due to a breach of the year to date C. difficile trajectory (eight cases vs seven cases trajectory). The year end position was within trajectory with a total of nine cases against a trajectory of 13.

During the year, Papworth Hospital achieved the second highest available financial rating of four in Q1 to Q3 and the highest rating of five in Q4.

The Q3 governance rating was due to a failure to meet the 62 day cancer wait target for first treatment from urgent GP referral. Papworth Hospital as a specialist centre only treats lung cancer. The 62 day wait covers the whole of the patient pathway and can impact on the Trust because of the small numbers involved and its position as the last centre of referral on the pathway. In recognition of this the CQC have introduced reduced tolerance levels for certain single cancer sites, of which Papworth Hospital is one. Whilst Papworth Hospital temporarily breached in Q3, in Q4 and for the whole year the Trust was compliant.

Table 12 Monitor risk ratings 2010/11

	Annual plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	4	4	4	4	5
Governance risk rating	Amber-green	Green	Amber-green	Amber-green	Green

Table 13 Monitor risk ratings 2009/10

	Annual plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Amber	Amber
Mandatory services	Green	Green	Green	Green	Green

5.0 A listening organisation

What our patients say about us

2010 National Audit Inpatient Survey

Patients have once again placed Papworth Hospital in the highest scoring 20% of Trusts in England. They rated the hospital in the highest scoring 20% of Trusts in 50 out of 61 questions according to the Care Quality Commission's (CQC) comparison with 161 other Trusts.

This eighth national survey of adult inpatients showed that for questions about doctors Papworth Hospital scored 9 out of 10 and for questions about nurses scored 8.8 out of 10. *See Table 14.*

The National Inpatient Survey included responses from 66,000 patients from 161 acute and specialist Trusts. It posed 64 questions of which 61 were applicable to Papworth Hospital. At Papworth Hospital, 577 patients responded and the response rate was 69%, compared to a national average response rate of 50%. Patients were eligible for the survey if they were aged over 16 and had at least one overnight stay during June, July or August 2010.

Papworth Hospital used Quality Health to undertake the survey. A useful snapshot of the results for the 2010 inpatient survey is the key score comparisons which rates Papworth Hospital scores against the other 49 Trusts which used Quality Health. In Graph 4 below, the Papworth Hospital score is indicated by the diamond and the average score is indicted by the arrow in Graph 4 on the next page.

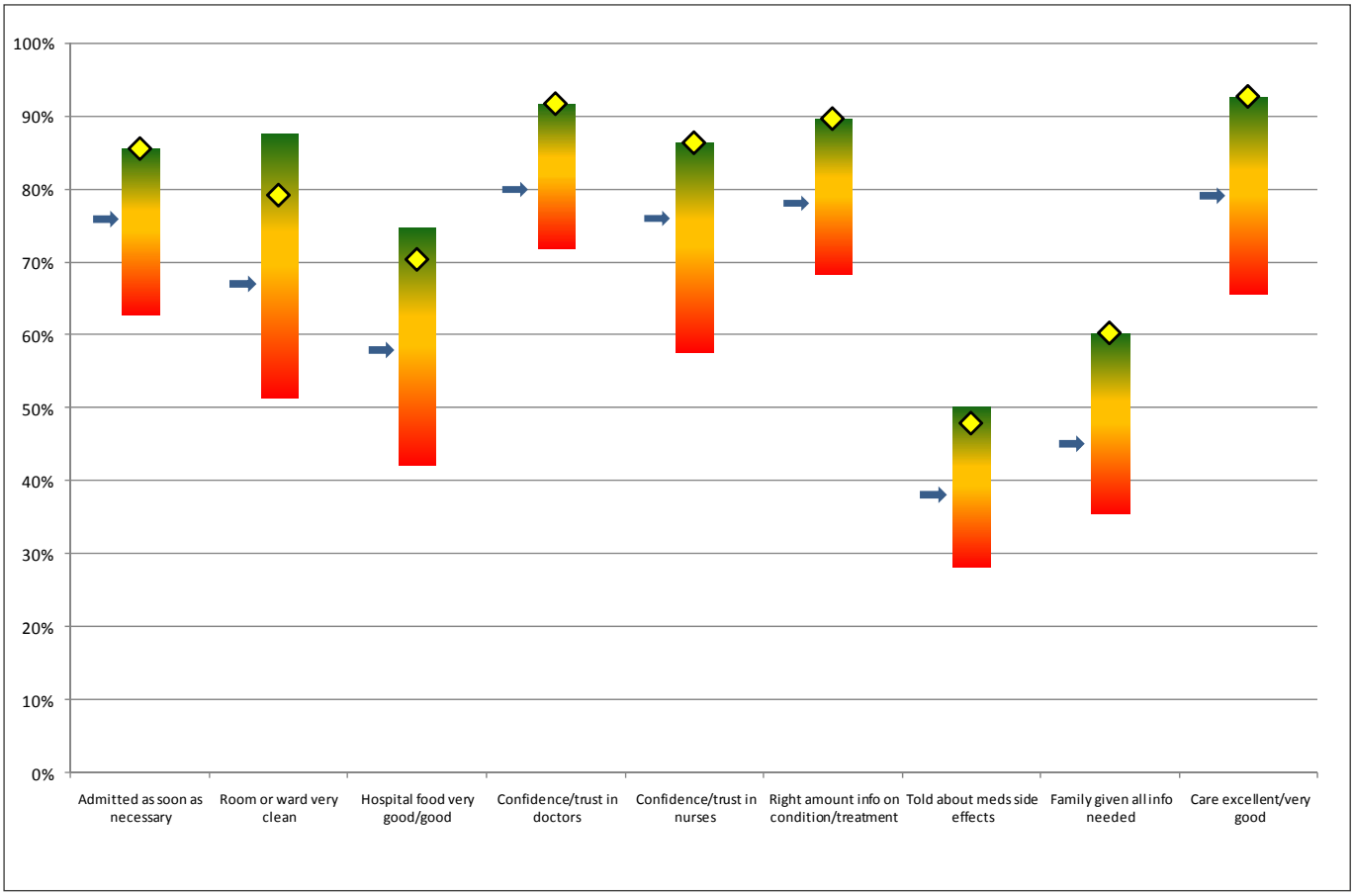
"I am a wheelchair user (full-time). Staff understand my needs and allowed me independence and didn't patronise me. Good understanding of how to treat disabled people."

From April 2011 improvement in patient experience scores formed part of the Commissioning for Quality and Innovation (CQUIN) payments to the Trust. At the time of writing this report preliminary results have been provided by Quality Health which confirm that Papworth Hospital has achieved the CQUIN for patient experience with an overall score of 76.9, against our 2009 overall score of 76.5.

Table 14 National survey of adult inpatients

	Based on patients' responses to the survey, Papworth Hospital scored	How this score compares with other Trusts
For questions about waiting lists and planned admissions, answered by those referred to hospital	7.1/10	Better
For questions about waiting to get to a bed on a ward	9.5/10	Better
For questions about the hospital and ward	8.6/10	Better
For questions about doctors	9/10	Better
For questions about nurses	8.8/10	Better
For questions about care and treatment	8.3/10	Better
For questions about operations and procedures, answered by patients who had an operation or procedure	8.5/10	About the same
For questions about leaving hospital	7.9/10	Better
For questions about overall views and experiences	7.1/10	Better

Graph 4 Key scores comparison



Responses to the specific parts of patient experience that Papworth Hospital had to show improvement on are as follows:

	Papworth Hospital percentage 2009	Papworth Hospital percentage 2010	National comparable data 2010
Were you involved as much as you wanted to be in decisions about your care and treatment?	66%	67% ↑	53%
Did you find someone on the hospital staff to talk to about your worries and fears?	53%	57% ↑	42%
Were you given enough privacy when discussing your condition and treatment?	79%	79% ↔	72%
Did a member of staff tell you about medication side effects to watch for when you went home?	47%	48% ↑	38%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	86%	84% ↓	71%

National Cancer Patient Experience Programme 2010 - National Survey Papworth Hospital NHS Foundation Trust

The national cancer patient experience survey was carried out by Quality Health on behalf of the Department of Health and compares results from 158 acute hospitals, and charts feedback from adult inpatients who were discharged between 1 January 2010 and 31 March 2010 on all aspects of their NHS cancer care. 100 postal surveys' were sent to Papworth Hospital patients, 71 were returned, giving a response rate of 74% (when patient deaths, and undelivered questionnaires are removed).

The survey results were split into two reports, the first gives percentage scores to each question and the second includes the free-text patient comments. In the first report there are 59 questions under 13 headings. Papworth Hospital patients scored us in the top 20% of hospitals for 36 of these questions and in the bottom 20% for five questions. It should be noted that questions relate to the whole patient journey including primary care, not just the Papworth Hospital part of it.

Of the five questions that Papworth Hospital patients scored in the bottom 20% three related to services provided by General Practitioners. The questions which related to Hospital care and treatment which were scored in the bottom 20% were:

- Patients never thought they were given conflicting information
- Doctor had right notes and other documentation with them

Our clinical teams are working on actions to improve these areas which we will report back next year.

Patients scored Papworth Hospital in the top 20% of hospitals.

In 36 of the questions, patients scored Papworth Hospital in the top 20% of hospitals. All these questions related to Papworth Hospital services. A second report included patient comments under three headings:

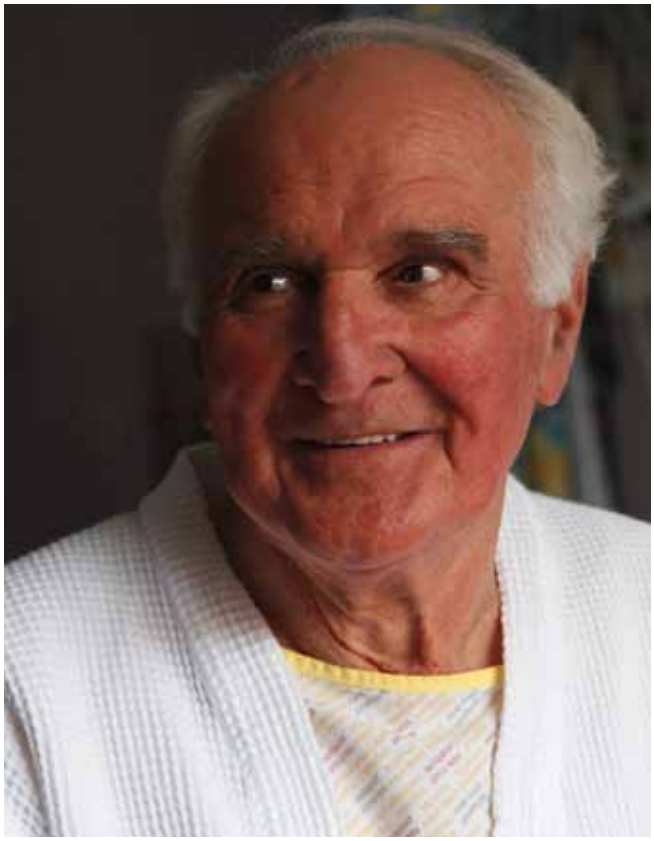
- Was there anything particularly good about your NHS Cancer care?
- Was there anything that could have been improved?
- Any other comments?

This report includes a wide range of positive and small number of negative comments about Papworth Hospital and other NHS centres.

Patient Reported Outcome Measures (PROMs)

The NHS Next Stage Review, 'Our NHS Our Future' (Darzi 2008), indicated that patient reported information would become an important component of efforts to measure and improve clinical quality. The Patient Reported Outcome Measures (PROMs) programme is a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The collection of this data will add to the set of information available on the care delivered to NHS-funded patients and will complement, and be used in conjunction with, existing information on the quality of services.

PROMs are being led by the Department of Health and are measures of a patient's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time.



At present there are four types of PROMs questionnaires for different surgery, hip replacement, knee replacement, hernia and varicose veins, but will incorporate all common operations in the near future. Papworth Hospital does not take part in the National PROMs due to the surgical procedures that are not undertaken at this specialist Trust. The PROMs group at Papworth Hospital have therefore designed a series of questionnaires applicable to the type of surgery carried out at Papworth Hospital.

We have now completed our first PROM for coronary artery bypass graft (CABG). During the period 20 July to 31 October 2010 142 patients attending pre-admission clinic for CABG were identified and asked to complete a questionnaire. A second questionnaire was then sent 12 weeks post procedure. A return rate of 87% compared favourably against the national standard of 66%.

The overall report was extremely positive, with high levels of quality and improvement to patient's physical and psychological well-being. Highlights included:

- 84% of patients reported that their outcome following surgery was either excellent or good
- A significant trend can be seen in the patient's health and wellbeing, identifying an increase in better health, including reduction in patients experiencing chest pain and reduction in breathlessness

Patient support groups

Our Trust has several patient support groups in areas such as:

- Pulmonary hypertension
- Immunology and lung defence
- Mesothelioma
- Pulmonary fibrosis

Examples of what our patients have said

What have you found helpful?
(Mesothelioma Support Group)

"Just listening and hearing about different issues and being able to talk about mine."

"The feeling that I am not alone."

"Talking to people in the same circumstances."

"I think that over a short period of time friendships will be made as we are all in this together."

"The mesothelioma support group for patients and carers was one of the best things that has happened, as we got the chance to meet each other and discuss our feelings and hear news on various treatments, and the palliative support that is available to us. Congratulations and thank you Papworth!"

What our staff have learnt

- It is possible to make it work even in a disease with very limited life expectancy
- Hugely satisfying and rewarding
- Much more insight into patients' lives, viewpoints and expectations
- User group offers great opportunities for feedback on our services
- Carers really do feel isolated and welcome the opportunity of mutual support

General comments received

"I feel I have been treated with respect and dignity throughout by a professional and enthusiastic team…"

"… congratulate your staff team with the utmost exceptional person-centred skills I have ever come across."

What our staff say about us

Staff survey
All staff were given the opportunity to complete the National Staff Survey 2010 questionnaire and 56% of staff responded.

The four key findings for which our Trust compares most favourably with other acute specialist Trusts in England are:

- Percentage of staff receiving health and safety training in last 12 months
- Percentage of staff reporting good communication between senior management and staff
- Percentage of staff saying handwashing materials are always available
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months was a lower score

The key findings where our Trust compares least favourably with other acute specialist Trusts in England are:

- Staff intention to leave jobs
- Trust commitment to work-life balance
- Staff job satisfaction
- Support from immediate managers

In relation to patient care, staff were asked if they were satisfied with the quality of care they gave to patients and 90% (of those who felt it was applicable to them) agreed that they were satisfied.

89% said that if a friend or relative needed treatment they would be happy with the standard of care provided by the Trust and 78% of staff thought the Trust made patient or service user care its top priority.

The results showed that staff felt positive about work with 68% saying they were enthusiastic about their job and 89% agreed their role made a difference to patients.

6.0 Transparent and open

Throughout 2010/11 we have continued to be open and transparent in all aspects of the quality of our care. As part of the Trust's monitoring and assurance framework a Quality and Safety Report is produced each quarter detailing the quality and safety activity across the organisation. This information is presented to the Quality and Risk Committee to provide notification of trends, actions and assurance of our continual drive for quality and safety. Learning from incidents, complaints and claims is shared across the organisation and is available on our website. Quality and safety information is presented in the quarterly reports under the following headings:

Patient safety

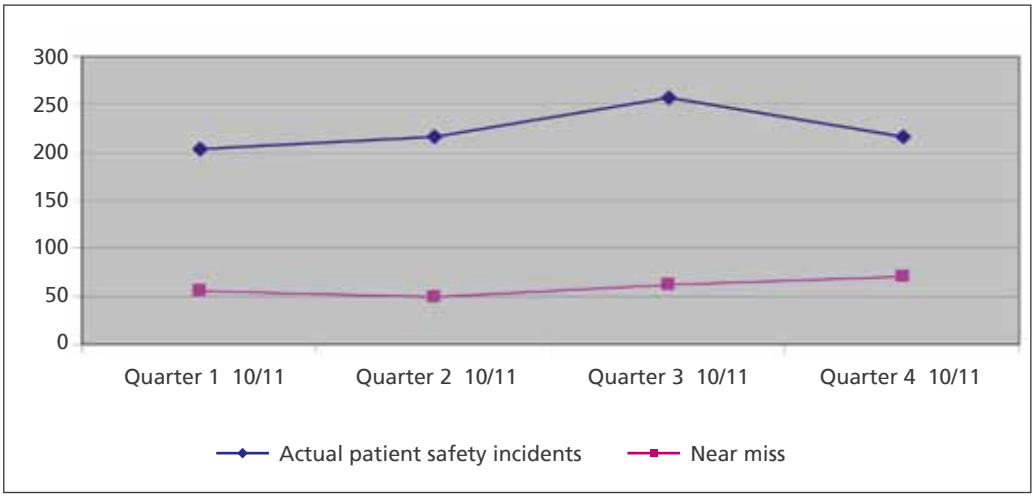
The number of reported patient safety incidents has remained constant over the year and there is an upward trend in near miss reports indicating a positive safety culture across the organisation. *See Graph 5.*

The Trust also has a robust mechanism in place for reporting, investigating and managing Serious Incidents (SIs). Learning from such incidents and actions taken contribute to improving safety for our patients. In the last year 2010/11 the Trust has reported six serious incidents.

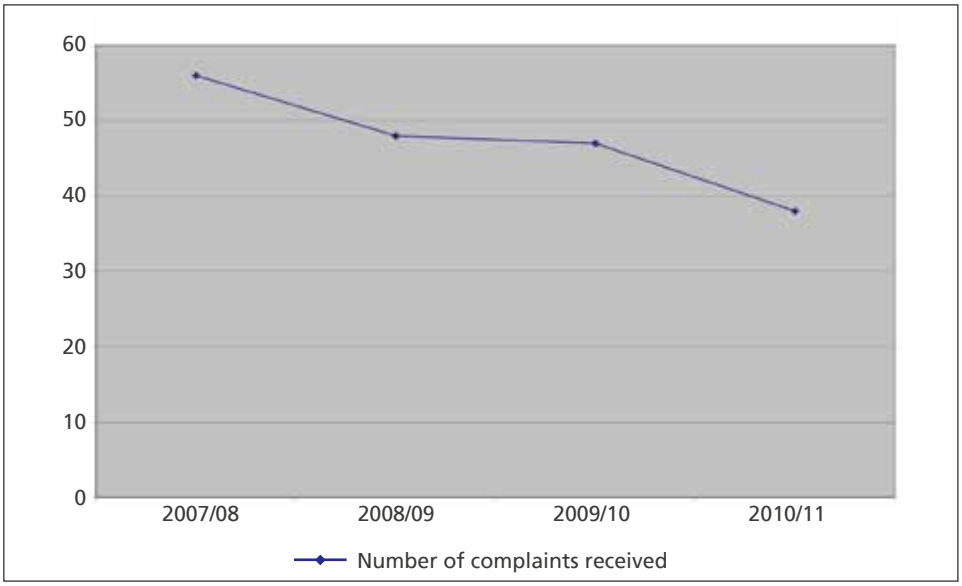
Patient experience

Listening to the patient experience and taking action following investigation of complaints is an important part of our quality improvement framework. The trend in the number of complaints received by the Trust has fallen year on year and in the last year 2010/11 the Trust received 39 complaints (4 from patients who accessed the private patient services). *See Graph 6.*

Graph 5 Patient Safety Incidents (actual and near miss) reported in 2010/11



Graph 6 Number of complaints received by year



Examples of actions taken following complaints investigated in 2010/11

Reflection on practice by nursing staff	Protocol for managing complications following angiogram developed
Change in administration process when patients transferred into the Grown Up Congenital Heart (GUCH) service	Review of documentation on transfer and discharge reviewed by cardiac services
Increase in cleaning standards monitoring in area highlighted by complaint	Administration systems have been reviewed
Environmental refurbishment in cardiac directorate	Review of Primary Percutaneous Coronary Intervention (PPCI) Protocol

Patient Advice and Liaison Service (PALS) report

The Patient and Public Involvement & Membership Committee (PPIM) met on three occasions during the year and were responsible for monitoring progress on the objectives set under the PPI and Patient Experience Strategy document and were also involved in setting the priorities for the Quality Accounts for the year. The new proposals agreed by the PPIM Committee for the development of a new process for producing patient information reflect current best practice and to further ensure adequate patient engagements, the reading panel has been extended to include governors and members of the Trust.

The Patient Experience Panel have continued to meet during the year and have been involved in agreeing the questions for the patient experience tracker and were also involved in the Patient Environment Action Team Inspection (PEAT) which was carried out in February 2011.

During 2010/11 the PALS service received 1,518 enquiries from patients, families and carers, a slight increase on the figures for last year (1,433). The fourth quarter of 2010/11 was exceptionally busy with March being the busiest month ever recorded and this can be attributed to an increase in the number of inpatient episodes compared with the same period last year.

"I could not do justice to staff at Papworth just by ticking boxes. My short stay was a wonderful experience of healing , not only of my body of my mind."

During the year 24 volunteers were recruited for various wards and departments throughout the Trust, including the gift shop, the greeter desk and ward visitors. The total number of volunteers is currently 137. 13 compliments were received about the PALS service.

As a direct result of comments from patients:

Our patients said...	We did...
They encountered problems when telephoning the radiology department	We changed the working arrangements in our radiology department to allow more flexible working within the department and they have extended the period when the telephones will be manned
Our signs were confusing in places	A complete review of on site signage and maps was carried out
Our relatives accommodation needed updating	Additional relative accommodation has been sourced by the Trust and the relatives hostel on site was completely refurbished
Those in financial difficulty struggled when accompanying relatives who were transferred in an emergency situation	A hardship fund was also set up to assist relatives and families who arrived at Papworth Hospital in emergency situations and provides assistance to take care of their initial financial needs

Risk management

Health and safety, non-clinical incident reporting and monitoring of the Trust risk register form part of the overall quality improvement programme. During 2010/11 reported non-clinical incidents average out at 47 over the year, which is the same as in 2009/10. The risk management functions have been subject to independent internal audit and the recommendations and actions will form part of the work streams for the risk management team during 2011/12.

The risk register is reviewed at all management groups throughout the year and progress on actions required to reduce the risk are monitored through the quality and safety report.

Effectiveness of care

Clinical effectiveness includes the provision of care in accordance with high-quality evidence-based clinical guidelines. The evaluation of practice through the use of clinical audit or outcome measures can lead to further improvement in the quality of care. The National Institute for Health and Clinical Excellence (NICE) provides patients, health professionals and the public with authoritative, robust and reliable guidance on current 'best practice'.

"Kindness, efficiency, involvement at all times at all levels. An outstanding example of how it should be done."

In 2010/11 NICE published 123 guidance documents on public health, health technologies and clinical practice. All guidance was reviewed by Papworth Hospital and where applicable to the Trust, a clinical lead was appointed to ensure the guidance was actioned through the appropriate clinical management group. Assurance of compliance and follow up of any actions outstanding is reported through the quality and safety report on a quarterly basis.

Monitoring mortality

The Hospital Standardised Mortality Ratio (HSMR) is a scoring system which works by taking a hospital's crude mortality rate and adjusting it for a wide variety of factors - population size, age profile, level of poverty, range of treatments and operations provided, etc. This establishes the mortality rate that would be expected for NHS hospitals and the observed rate for an individual hospital. This, along with a similar system more recently introduced, the Summary Hospital-level Mortality Indicator (SHMI), are both not applicable to Papworth Hospital as a specialist Trust due to case mix.

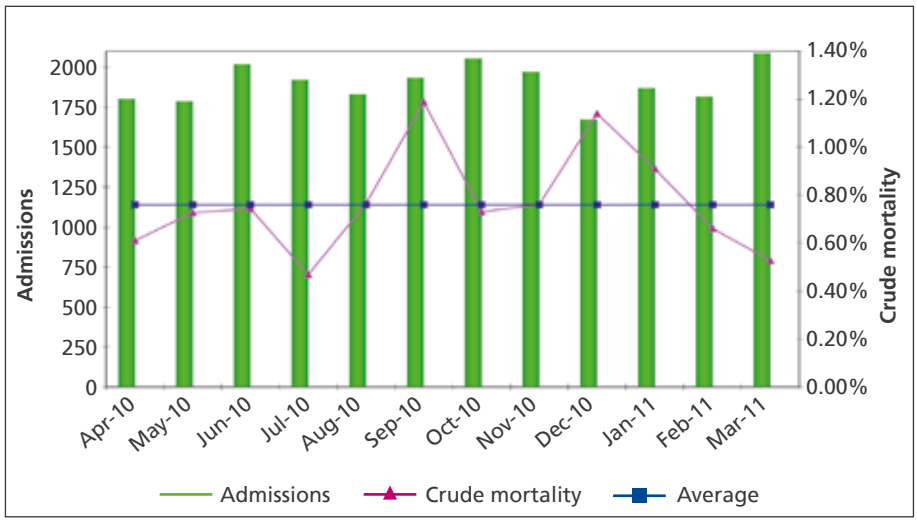
The reporting of crude mortality is just one of a number of quality measures which can be used to inform the organisation on how well it is performing in relation to patient safety and clinical quality.

Graph 7 below illustrates the monthly in-hospital crude mortality rate at Papworth Hospital between for 2010/11. The average for 2010/11 is 0.76%.

The data were collected using the in-hospital patient administration system (PAS) and all patient admissions (episodes) were included. Deceased patients were counted as per admission date and not date of death.

For more information or detail regarding the Quality and Safety Reports please go to our website at the following link: www.papworthhospital.nhs.uk/content.php?/clinical_quality/healthcare_professionals/clinical_governance

Graph 7 Crude mortality rate



Annexe 1: What others say about us

The following stakeholders have kindly provided us with their comments on this year's Quality Accounts and we appreciate their detailed scrutiny of this document. Some of the comments made have been acted upon. We have particularly tried to ensure we use language accessible by the public, as pointed out by NHS Cambridgeshire, and have clarified our targets for next year. The remaining comments will be taken into consideration when preparing next year's Accounts. Papworth Hospital would like to thank all of the stakeholders below for their input.

East of England Specialised Commissioning Group
The East of England Specialised Commissioning Group (EoESCG) commissions specialised services from Papworth Hospital on behalf of all Primary Care Trusts in the East of England. The EoESCG has continued to work closely with the Trust who has again delivered demonstrable improvements in quality.

The Trust continued its impressive trajectory to reduce both MRSA bacteraemia and C. difficile with just one MRSA and nine C. difficile cases during the year. Root cause analysis is undertaken by the Trust on all cases and reported to the commissioner, alongside agreement of key actions for further improvements, as part of on-going contract monitoring.

While the Trust has delivered on the national standards for 18 week waits (95% admitted and 90% non admitted) there continue to be a small cohort of patients waiting in excess of 18 weeks for reasons unrelated to patient choice or clinical complexity. As commissioners of Papworth Hospital's services we continue to work with the Trust on ensuring compliance against what is now a legal right for patients enshrined in the NHS Constitution. Cancer waiting times continue to be met.

CQUIN initiatives during 2010/11 were met ensuring continued improvements in the quality of patient care, which are reflected within these quality accounts. Notably the Trust ensured that from October 2010 90% of patients were risk-assessed for venous thromboembolism. In the last quarter in excess of 97% of patients were being risk-assessed. The National Adult Inpatient Survey demonstrated the high level of patient satisfaction reported by Papworth Hospital patients, showed a year on year increase and remains one of the highest in the region.

During the year EoESCG and clinicians from NHS Cambridgeshire met with the Trust Director of Nursing to review general governance issues and the reporting of serious incidents. The Trust was able to evidence a strong commitment to governance and patient safety and demonstrated that a comprehensive system is in place to assess, review and reflect upon incidents and to subsequently ensure changes to practice where appropriate.

These quality accounts are a fair reflection of the continual importance the Trust attaches to providing a high quality service and the measurable success they have enjoyed during 2010/11. The 2011/12 contract with the Trust incorporates many of the new quality initiatives for both specialised and non-specialised services. The monthly contract review meetings will provide the forum in which both existing and new quality measures will be monitored and continually developed. In addition quarterly meetings will be held to review the Trust quality and safety report.

NHS Cambridgeshire Commissioning Group
NHS Cambridgeshire has reviewed the quality account produced by Papworth Hospital NHS Foundation Trust for 2010/11. The quality account is presented in an understandable and consistent format. In most areas a clear explanation of any clinical issues is given and jargon is avoided, although some information is not explained in language accessible to the public. The quality account includes all the nationally mandated sections. A list of services and specialties provided by the Trust is given. The Trust have shown a selection of actions taken as a result of local audit, some linked to priority areas for improvement.

There is a balance in the quality account between showing initiatives that have led to improvement and identifying the development areas where further work is needed. The Trust have identified five priority areas for improvement and has set out a range of initiatives for 2011/12. Three of these show significant patient collaboration in the new initiatives. There has also been involvement of service users in the development of the priorities.

The results from the National Patient Experience surveys for Papworth Hospital are extremely positive. The Trust has highlighted two areas from the National Cancer Programme where performance was not good. NHSC would like to see the actions plans in place to improve in these areas, particularly for patients feeling that they were receiving conflicting information. Papworth Hospital are focusing on improving patient experience of the discharge process. It would be of interest to understand how the Trust are monitoring patient experience in other areas of the services they provide. The Trust could consider using local surveys in particular areas where any concerns have been raised through incident reporting, PALS queries or complaints.

None of the current Patient Reported Outcome Measures (PROMs) relate to procedures carried out by Papworth Hospital. However, the Trust have been proactive in taking forward this patient experience initiative and have developed their own PROMs which have shown positive improvements in patient outcomes.

In the review of patient safety initiatives, the Trust summarises its mechanism for risk management, showing examples of actions taking following

complaints and PALS queries. It would also be useful to show trends and learning from incident reporting. The Trust show mortality rates and it would be useful for further commentary on how these are monitored and analysed.

There is a structure of regular meetings in place between NHSC, Papworth Hospital and other appropriate stakeholders to ensure the quality of Papworth Hospital services is reviewed continuously with commissioners throughout the year.

Statement from Cambridgeshire Local Involvement Network (LINk)
Since April 2010, we have visited the hospital on numerous occasions to canvas the opinion of patients, visitors and staff and have always found the feedback to be favourable. A few of our group members are also members of various hospital focus groups including the Papworth Patient Experience Panel and the Papworth Patient and Public Involvement/ Membership Group (PPIM).

We have maintained close links with Papworth Hospital throughout this period and feel that we are, therefore, qualified and pleased to confirm that we are in agreement with the structure of the quality accounts and with the key priorities that have been chosen for the coming year.

Statement from Suffolk Local Involvement Network (LINk)
It is pleasing to note that comments made in 2009/2010 have been taken into consideration. Especially with regard to the patient being the focus of clinical outcomes. It is appreciated that with the highly specialised services provided at Papworth Hospital, it is not always easy to use the best language for the patients and their carers. However, in the main this is a clear understandable document.

The hospital has not been complacent regarding patient falls and has set clear pathways to improve the patient experience having identified specific areas of concern. However, it is not clear if it is a few patients making several falls or many patients making a few falls. How many patients were involved in the 21% of patient safety reported incidents and how has this been addressed?

It is pleasing to see a change in culture with the increased reporting of medicine provision incidents coupled with its reported openness and transparency and the attempts to involve the patients in resolving the issues. Suffolk LINk looks forward to seeing the improvements in the 2012 report.

Addressing the patient comments around their discharge experience will help reduce stress for both the patients and their carers. Again it is pleasing to see that patients are being asked for their views and actually having a programme to address them over the coming year which will be monitored.

The achieving of the seven set goals by CQUIN together with the continued good progress and maintenance of standards was noted. How were these shared with the patients, their families and carers, and staff?

The quality data is full of names and numbers. This could be well over the heads of the patients and their families. This has been helped with the full name then initials and some clear graphs etc. Could not the very good outcomes be celebrated more and clearly presented for patients' consideration? They are lost in the commentary (eg the gold standard ulcer care).

The response to what the staff asked for is well presented and the outcomes clear. However, it would have been useful to see how patients have responded to the new approaches.

The patient domain section of the report is clearly presented and does not ignore areas where things need improvement across the estate and its impact on people with disabilities. It would be helpful if details of how patients are helping to shape improvements were identified. Travel time is always a worry for patients. Meeting the travel 90 minute target is often dependent on outside factors. Perhaps how these failed times and the treatment of the patients on arrival could have been mentioned. They have been highlighted and the goal is to achieve them.

Suffolk LINk is pleased to note that all the patient experience, acute, and effectiveness of care targets have been met. It was interesting to see what the staff and patients have said and the responses to them. The reaction to the PALS patient comments, especially the hardship fund is very good and much needed.

Statement from Adults Wellbeing & Health Scrutiny Committee
Cambridgeshire County Council Adults Wellbeing and Health Scrutiny Committee welcomes the achievements of Papworth Hospital NHS Foundation Trust, and supports the proposed priorities for 2011/12. We suggest that the Trust:

- Set specific targets for improvement in relation to patient falls, reducing medication errors, and preventing delayed discharge
- Set specific goals in relation to those areas of patient experience, including cancer patient experience, and patient safety where the quality account has identified shortcomings

Statement from Patient & Public Involvement/ Membership Committee (PPIM) Chair
As a governor and chair of the PPIM, as well as being a current patient, I am in total agreement with the initiatives identified within the quality accounts for the coming year, and praise the progress that was made on initiatives undertaken during the last financial year. I know from first hand experience that the Trust continues to put patients at the centre of all its services and comments made by patients are used to make improvements to our services.

Annexe 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 2010 to prepare quality accounts for each financial year.

Monitor 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 2010-11
- 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 2010 to May 2011
  - Papers relating to quality reported to the board over the period April 2010 to May 2011
  - Feedback from the commissioners dated 16/05/2011
  - Feedback from governors dated 16/05/2011
  - Feedback from LINks dated 17/05/2011
  - The Trust's complaints report under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, draft dated 20/05/2011
  - The 2010 National Inpatient Survey
  - The 2010 National Staff Survey
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 26/05/2011
  - CQC quality and risk profiles dated 6/04/2011
- The Quality Report presents a balanced picture of the NHS Foundation Trusts 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)

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

By order of the board

..... Date ..... Chairman

..... Date ..... Chief Executive

Annexe 3: Auditors' report

Independent auditors' report to the Board of Governors of Papworth Hospital NHS Foundation Trust on the Annual Quality Report.

We have been engaged by the Board of Governors of Papworth Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Papworth Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor'). 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 content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents. We read the other information contained in the Quality Report and considered whether it is inconsistent with those documents below:

- Board minutes for the period April 2010 to May 2011
- Papers relating to quality reported to the Board over the period April 2010 to May 2011
- Feedback from the commissioners dated 16/05/2011
- Feedback from governors dated 16/05/2011
- Feedback from LINks dated 17/05/2011
- The Trust's complaints report under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, draft dated 20/05/2011
- The 2010 National Inpatient Survey
- The 2010 National Staff Survey
- The Head of Internal Audit's annual opinion over the Trusts control environment dated 26/05/2011
- CQC quality and risk profiles dated 6/04/2011

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information. This report, including the conclusion, has been prepared solely for the Board of Governors of Papworth Hospital NHS Foundation Trust as a body, to assist the Board of Governors in reporting Papworth Hospital 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 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Papworth Hospital NHS Foundation Trust for our work or this report save 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:

- Making enquiries of management;
- 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 less 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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

.....

PricewaterhouseCoopers LLP
Chartered Accountants
Cambridge

Date .....

Annexe 4: Services provided by Papworth Hospital

Aims and objectives

The aims and objectives of the Trust is the provision of goods and services for the purpose of the health service in England. This does not preclude the provision of cross-border services to other parts of the United Kingdom.

Services

Papworth Hospital is the UK's largest specialist cardiothoracic hospital. Our services include cardiology, respiratory medicine, and cardiothoracic surgery and we are the country's main heart and lung transplant centre. We serve over three million people in the East of England. However, the specialist nature of much of our work means that patients from all over the UK come to Papworth Hospital for their treatment.

Other authorised services
The Trust is also authorised by Monitor to undertake the following authorised services:

- Research and development - including clinical trials
- Rent of space on-site to other NHS and Non-NHS organisations
- Autopsies
- Clinical training courses

The three regulated activities we provide are:

1. Treatment of disease, disorder or injury
2. Surgical procedures
3. Diagnostic screening procedures

Legal status of the Trust

Papworth Hospital NHS Foundation Trust was authorised on 1 July 2004 by Monitor, the independent regulator of NHS Foundation Trusts.

Trust's business address and location
Papworth Hospital NHS Foundation Trust
Papworth Everard
Cambridge
CB23 3RE
Tel: 01480 830541
Website: www.papworthhospital.nhs.uk

Registered person
The Trust Chief Executive, Mr Stephen Bridge (telephone number: 01480 364286).

Papworth Hospital NHS Foundation Trust
Papworth Everard
Cambridge
CB23 3RE
Tel: 01480 830541
Fax: 01480 831315

For more information about Papworth Hospital please visit our website **www.papworthhospital.nhs.uk**

A member of Cambridge University Health Partners