Papworth Hospital NHS
NHS Foundation Trust

2011/12

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Quality Accounts

Quality Accounts
2011/12

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Part 1

Statement on Quality from the Chief Executive

Stephen Bridge

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

During 2011/12 the Trust 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. We have also seen excellent results in both our inpatient and outpatient surveys this year with a 72% response rate to both surveys. We consider this a positive indication that our patients talk to us about the services we provide and through their detailed feedback we are able to continuously focus our improvement and drive the patient experience forward.

The commitment to high-quality care will continue through our five priorities for 2012/13, 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, evidenced through the excellent staff survey results we saw this year. Their commitment to the quality agenda is evident in the continued improvement and excellent results I am once again proud to report in this quality account.

I am pleased with the outcomes from the CQC inspections this year, which have also fed our quality agenda, details of which are evidenced within these accounts.

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

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

The following table summarises the five quality improvement priorities identified for 2011/12 along with the outcome.

Summary of Performance on 2011/12 Priorities

		Goals	Outcomes
1	Reducing patient falls	• Reduce preventable falls by 20% • Increase use of falls assessments • Patient and carer education on preventing falls in hospital • All falls are subject to root-cause analysis and those resulting in serious harm are reported to commissioners • Falls Prevention Awareness Week • Other goals identified for reducing patient falls in 2011/12 were achieved *See Part 3 - Review of quality performance 2011/12 (clinical safety domain) for further information*	Not achieved Achieved Achieved Achieved Achieved
2	Reducing medication errors	• Produce patient information on medicines safety • Monitoring and audit of omitted medicines at ward level • Redesign inpatient prescription chart • Continue Trust-wide education programme *See Part 2 Priority 4 for 2012/13 for further information*	Achieved Ongoing Achieved Ongoing
3	Reducing Central Venous Catheter Bloodstream Infections (CVC-BSI)	• To reduce catheter-related bloodstream infections by 25% *See Part 3 - Patient safety domain - for results*	Achieved
4	Prevent delays in discharge	• Improve the patient experience when being discharged from an inpatient stay and reduce the Trust's overall length of stay measurements *See Part 2 Priority 3 for 2012/13 for further information*	Partially achieved/ ongoing
5	VTE prevention	• To continue to deliver improvements in the standard of VTE prevention by maintaining over 90% compliance in VTE risk assessment of all inpatients • Repeat the risk assessment within 24 hours of admission and whenever there is a change in the patients condition • Over 90% of all inpatients receive appropriate prophylaxis • Root-cause analysis on all VTE events which occur either in hospital or within 90 days of discharge from Papworth Hospital • VTE awareness week • All other goals identified for VTE prevention in 2011/12 were achieved. *See Part 3 - Review of quality performance 2011/12 (clinical safety domain) for further information*	Achieved Partially achieved Achieved Achieved Achieved

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. Two of these priorities are, therefore, carried forward to 2012/13.

Our priorities for 2012/13 reflect the three domains of quality

Priorities for 2012/2013

Our priorities for 2012/13 reflect the three domains of quality, patient safety, clinical effectiveness and patient experience. Our priorities are: delivering harm-free care, end-of-life-care, reducing delays in discharge, reducing medication errors and implementation of the equality delivery system. Reducing delays in discharge and reducing medication errors are carried forward from 2011/12 priorities in recognition that further improvements can still be made in these areas.

To determine our priorities for 2012/13, 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 Trust-wide patient experience data collection tool, concerns, compliments and complaints. We also used our patient safety focus groups and Board-to-Ward walk-arounds to identify issues raised by staff as well as patients. Having identified some priorities, we then spoke to our clinical teams, Governors, Patient & Public Involvement and Membership Committee and Local Involvement Networks representatives (LINks) before making our final choices.

Priority 1: Delivery of Harm-free Care

Overall Leads

Executive Lead: Director of Nursing
Implementation Lead: Assistant Director of Nursing
Programme Leads: Senior Nurses Trust-wide

Goal

To deliver harm-free care as defined by the absence of pressure ulcers, falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections (CAUTI).

Rationale

The Department of Health Quality, Innovation, Productivity and Prevention (QIPP) work-stream has proposed a new mindset for patient safety, delivering one plan to reduce multiple harms. The aim is to deliver harm-free care as defined by the absence of pressure ulcers, falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections (CAUTI). Previously, the three former potential harms have been considered as separate priorities.

Using the NHS Safety Thermometer (a point-of-care survey instrument), teams will measure and report harm and the proportion of patients that are harm-free during the working day. It is a new approach following a pilot programme, Safety Express, tested by over 100 NHS provider organisations. The aim is to think about complications from the patient's perspective and aim for the absence of all four harms to each and every patient. Harm-free care is led by a group of senior nurses at Papworth Hospital who have specific responsibilities in these four areas for prevention of potential harm.

Baseline

Prevalence audits in February and March 2012 were performed to test the data collection tool and method of data reporting. A census audit commenced in April 2012 and was reported to the national website within the required time-frame.

Reporting and Monitoring

Monthly data submitted into the NHS Safety Thermometer will be used to measure, monitor and analyse patient harms and harm-free care at an organisational level. These will be census data from all inpatients on a set date. Data will be submitted quarterly to the National Information Centre to establish a national baseline of performance on the four harms. Participation in this data collection is nationally recognised through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Absence of Pressure Ulcers

The ambition is that all grade 2, 3 and 4 avoidable pressure ulcers will be eliminated by December 2012.

Reducing Falls and Reducing Harm from Falls

This has been a priority for the Trust for the last three years and continues to be the most frequently reported incident. There were 186 incidents of patient falls during 2011/12 (2010/11 185) resulting in harm for 42 patients (2010/11 34). See Part 3 - other information for further detail.

Prevention of Venous Thromboembolism (VTE)

VTE is the term used to describe a blood clot that can either be a deep vein thrombus (DVT), which usually occurs in the deep veins of the lower limbs, or a blood clot in the lung known as a pulmonary embolus. From April 2011 to March 2012 an average of 96% of all our inpatients were risk assessed to identify their risk of developing a VTE. As required by the Department of Health, all VTE events which occur in hospital or within 90 days of discharge are subject to a root-cause analysis to establish whether the event was hospital acquired and whether it could have been prevented.

Hospital-wide prevalence audits are conducted monthly to assess the appropriateness of VTE prophylaxis and reported to the Clinical Governance Management Group quarterly.

Catheter Associated Urinary Tract Infections (CAUTI)

The definition of catheter-associated urinary tract infections is challenging and depends on clinical as well as laboratory criteria. Most patients who require urinary catheters at Papworth Hospital do so for a short period of time only and data from an audit performed in June 2011 on inpatients on the surgical wards demonstrated no infections due to urinary catheters.

In the absence of a large-scale audit to provide baseline data from which to set a target for reduction, we propose to implement a Trust-wide education initiative around a revised catheter care procedure and aseptic non-touch technique to improve the care of our patients.

Priority 2: End-of-Life Care

Overall Leads

Executive Lead: Director of Nursing
Implementation Lead: Assistant Director of Nursing
Programme Lead: Supportive and Palliative Care Team

Goal

To ensure that patients identified as approaching the end of their lives have an appropriate pathway in place.

Rationale

Implementation of the Liverpool Care Pathway (or an adaptation of this framework) can improve the quality of end-of-life care. A priority for the Trust will be to ensure that patients identified as approaching the end of their lives have a pathway, such as this, in place. This will be through end-of-life care training, education and awareness, as well as improved identification of end-of-life patients.

Baseline

50 sets of case notes were reviewed to provide a baseline. Of these, 28 patients had their care noted as changed to terminal care, and all of these decisions were documented in the medical notes as discussed with the patient or their relatives. Four of these patients were noted to have a 'preferred priorities of care' document, and eight were placed on the Papworth Pathway (adapted Liverpool Care Pathway). Six records had noted that the preferred place of death was achieved. It was noted that most patients had a rapid deterioration and the 'Do Not Attempt to Resuscitate' order was placed close to the time of death.

Initiatives Implemented in 2011/12

- Global Trigger Tool (GTT) for mortality was utilised to measure our palliative and supportive care to provide the baseline
- Training for end-of-life care for 15 key non-medical practitioners
- National audit of end-of-life care participation

Goals for 2012/13

Re-establish an End-of-Life Care Steering Group. Improve the education of clinical staff on end-of-life care issues by:

- Identifying levels of training required for each staff group and specialty
- Identifying modes of delivery suitable for each staff group
- Implementing and evaluating training

This is linked to the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework attaches a financial incentive to the goal of training staff in palliative care and identifying all patients who would benefit from having a care pathway in place and ensuring that this information is communicated to the GP as per the Gold Standards Framework.

Monitoring

Reporting via the End-of-Life Care Steering Group to the Clinical Governance Management Group.

- Training update
- Quarterly audit of patient and GP discharge summary commencing in quarter 2
- GTT for mortality used to gather data on:
  - change to terminal/end-of-life care and communication with the patient and/or relatives
  - implementation of Papworth Care Pathway
  - preferred place of death achieved

Priority 3: Prevent Delays in Discharge Following an Inpatient Stay

(Carried forward from 2011/12)

Overall Leads

Executive Lead: Director of Nursing
Implementation Lead: Assistant Director of Nursing

Goal

To improve the patient experience when being discharged following an inpatient stay, and thereby reduce our overall length of stay measurements.

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 that focusing on patients with simple discharge needs is likely to have the greatest immediate impact because, critically:

- The numbers of patients affected is 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

There were 23 occasions reported by our staff in relation to delayed discharge or transfer during 2011/12. This equates to 1.8 % of our reported incidents. An improvement on the 2010/11 figures where 56 such incidents were reported by staff.

Our 2011 inpatient survey, although excellent throughout, highlighted that there are some issues relating to discharge. 26% of patients, an improvement of 1% from 2010/11, who responded to the survey reported that they had been delayed at discharge. Comments were made on waiting for medicines, waiting for a doctor review, being told they could go home in the morning but not ready until the afternoon and being asked to vacate the bed space prior to discharge resulting in long waits in the day room.

Initiatives in 2011/12	Achieved/update
Utilise the discharge module of the Productive Ward project across all inpatient areas	Achieved and ongoing
Introduce 'predicted date of discharge' for all patients and display this on the 'patient status at-a-glance' boards in each ward area	Partially achieved
Increase Professional Support Services (PSS) weekend activity in-line with patient needs - Occupational Therapists working on Saturdays from October 2011	Achieved
Explore the current discharge process and improve effectiveness in the areas of waiting for medicines, the wait to see the doctor and the wait for transport. Pharmacy now provides a Saturday service to dispense medicines for discharge from November 2011	Ongoing
Identify simple discharges and introduce nurse-led discharge where appropriate	Ongoing
Introduce IPM PAS update to track delayed discharges	Not achieved

More work is required for all these initiatives. This work is linked to many service improvement initiatives such as pathway reviews, changes to admission times and the introduction of an admission lounge.

Goals for 2012/13

The overall goals for this priority are to improve the patient experience when being discharged following an inpatient stay and to reduce the overall length of stay. This remains unchanged from 2011/12.

In addition to the 2011/12 initiatives listed above we plan to invest in the Professional Support Services team to allow for a more proactive approach to complex discharge. This investment will allow for the introduction of a new band 4 assistant practitioner role within the Social worker team, and for the Occupational Therapy Saturday service commenced in 2011/12 to continue on a substantive basis.

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.

Priority 4: Reducing Medication Errors

(Carried forward from 2011/12)

Overall Leads

Executive Lead: Director of Nursing
Programme Lead: Clinical Governance Manager
Implementation Lead: Chief Pharmacist

Goal

To improve medicines safety at Papworth Hospital.

Rationale

Medicines safety is of paramount importance to the Trust. There is good engagement and awareness of staff regarding medicines safety, facilitated through the Trust-wide and specialty medicines safety groups. In particular staff are aware of the importance of reporting any potential 'near miss' incidents, in addition to any actual medication errors. 'Near miss' reporting accounts for 20% of total medication incidents reported which has increased by over 50% since Q1 2011/12, reflecting a good reporting culture in the Trust. The severity of medication incidents is monitored with over 99% of incidents falling into the no harm category. Trends in reporting of medication errors are monitored through the Trust-wide medicines safety group so targeted education can be identified and in particular highlight the lessons learnt.

The range of tasks that may involve the reporting of either

actual error, or a near miss, can be the prescribing, monitoring effectiveness, dispensing, preparation of intravenous infusions, equipment issues (e.g. pumps), administration, non-administration and dispensing of medicines. We are confident that our transparent and fair culture as well as a detailed review of all reported incidents by our Medicines Safety Group are helping to highlight and improve medicines safety at Papworth Hospital.

Baseline

30% of incidents reported (actual and 'near miss') related to medication incidents in 2011/12.

Initiatives Implemented in 2011/12

In addition to the established Trust-wide multidisciplinary Medicines Safety Group, the specialty specific groups in the cardiac and thoracic directorates are now meeting regularly to review incidents at a local level and target specialty specific actions to reduce medication incidents.

The Medicines Safety Group and Pharmacy team have focused on the reports of omitted doses of medicines in 2011/12. The National Patient Safety Agency (NPSA) action plan for omitted doses was completed in December 2011. One of the key actions from this was to produce training resources to reinforce to the ward staff the importance of ensuring that medicines are not omitted unless specifically requested by the medical staff and recorded on the patient's prescription chart. Staff have been reminded how to obtain medicines if not readily available on their ward. The Medicines Safety Group is monitoring the monthly checks for omitted doses via the ward sisters and as part of the Productive Ward initiative.

The revised inpatient prescription chart incorporates the venous thromboembolism risk assessment, which links to a pre-printed prescription for pharmacological thromboprophylaxis.

The diabetes specialist nurse has introduced a specific diabetes prescription chart, which is in line with the recommendations within the NPSA alert on the prescribing and use of insulin products. This has improved the prescribing practice of insulin for both 'regular' and 'as required' dosing.

Goals for 2012/13

- To reduce the number of *orange medicines related incidents to a maximum of 2 per year - 3 in 2011/12 and 2 in 2010/11. (*moderate severity harm in which the patient requires significant intervention and/or may lead to a prolonged length of stay)
- Continue monitoring any incidents that result from omitted doses to be assured that the impact of both the new inpatient prescription chart and additional training have been effective. Monitor the availability of supporting documentation on the prescription chart when doses are to be intentionally omitted
- Focus on any incidents reported that involve insulin, anticoagulants, anti-epileptics and immunosuppression, in order to monitor the NPSA rapid-response action plans as part of an ongoing audit plan. This will also be linked to local Commissioning for Quality and Innovation (CQUIN) payment framework
- No 'never events' in relation to medicines use

Monitoring

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

Goals for 2011/12	Achieved/update
Engagement of patients in improving medicines safety by provision of related information	All patients who receive medicines reconciliation by members of the pharmacy team will receive an information booklet entitled: 'Medication Safety - a patient's guide' from early 2012 once recommendations have been reviewed and actioned from the Trust's reading panel.
Monthly ward-level monitoring and audit of omitted medicines, demonstrating trends analysis and monitoring action plans	Ongoing monitoring at ward level of medication omissions has demonstrated over a 50% reduction in occurrence in most areas.
Radical re-design of inpatient prescription chart with the aim of improving prescribing practice and decreasing prescribing errors	New inpatient prescription chart piloted in one ward in November/December 2011, and further refined post-pilot. Introduced Trust-wide in January 2012. Pharmacy-issued training resource packs for both nursing and medical staff to aid with the prescribing and administration of medicines. Clinical ward pharmacists will perform prescription audits three times a year. Action plans are monitored via the Drugs and Therapeutics Committee.
Ongoing education, training and support to reduce checking errors	Training sessions have been updated for new staff and annual Medicines Management training is available to all staff as per the Trust training needs analysis.

Priority 5: Implementation of the Equality Delivery System (EDS)

Overall Leads

Executive Lead: Director of Human Resources
Implementation Lead: Assistant Director of Human Resources
Programme Lead: Head of Operational Human Resources

Goal

To support the delivery of better outcomes for patients and better working environment for staff.

Rationale

The EDS is designed to deliver better outcomes for patients and better working environments for staff, which are personal, fair and diverse. Using the EDS, NHS organisations are required to analyse equality performance against 18 outcomes grouped under the following four goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and inclusive staff
- Inclusive leadership

These outcomes align with the NHS Constitution, the NHS Outcomes Framework, the Human Resources Transition Framework, the Human Rights Act, and the Care Quality Commission's Essential Standards of Quality and Safety.

The EDS covers nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnicity, religion or belief, sex and sexual orientation.

Baseline

A core part of the EDS is engagement with local interests (stakeholders, service users, staff, staff-side, community groups and local government). During 2011/12, the Trust arranged a series of meetings to introduce EDS to groups representing people with these protected characteristics and also engaged its own staff.

Unlike other initiatives, which have involved self-assessment of its own performance by the Trust, one of the key features of EDS is the use of an independent grading process to measure equality and diversity performance in the Trust.

In March 2012, a panel comprising eight external assessors from a variety of special interest groups and patient experience representatives convened to assess the Trust's equality performance. The panel reviewed each of the 18 outcomes embodied within the EDS using the following grading system:

Red = Undeveloped
Amber = Developing
Green = Achieving
Purple = Excelling

As part of the assessment process, a number of Papworth Hospital staff were interviewed by the assessment panel, including modern matrons, the chair of the staff-side, and human resource representatives.

In summary, the Trust's gradings comprised:
2 x amber (developing)
10 x green (achieving)
6 x purple (excelling)

Full details, including a synopsis of the panel's reasons for the grades that were given, are included on the Papworth Hospital public website. In due course, these grades will be published nationally by the Department of Health and also taken into account by the Care Quality Commission (CQC).

The Trust Board of Directors is committed to ensuring that EDS objectives become embedded in all aspects of the Trust's activities. We will continue to involve stakeholders, seek to improve services and facilities for protected groups, further develop the knowledge, skills and awareness of our staff in respect of Equality and Diversity, and enhance Equality and Diversity leadership.

Goals and Objectives 2012/13

In 2012/13, the Trust will deliver the following objectives to ensure that the four principal goals in the EDS are consolidated and/or progressed:

Goals for 2011/12	Objectives
Better health outcomes for all	To review the patient data collected and capture information that reflects the nine characteristics to ensure that all patients are treated with dignity and respect
Improved patient access and experience	Specific focus on dementia patients in line with the national CQUIN and the need to work across health and social care, engaging consultant geriatricians with this cohort of patients to ensure their healthcare services are not marginalised
Empowered, engaged and inclusive staff	Equality and diversity training programmes are developed over the next year and that equality and diversity training becomes mandatory from April 2012
Inclusive leadership	The Board of Directors demonstrates its commitment to equality and diversity by signing up to become positive, fair and diverse champions

Action plans will be identified for each objective and the Trust's Equality Taskforce will monitor progress.

The outcome of the assessment and objectives will be published on the Trust's Internet.

Progress will be monitored and reviewed by the Equality and Diversity Task Force, a group established by the Trust Board of Directors.

Monitoring

The Equality and Diversity Taskforce meets six times a year to monitor actions and reports to the Board on a regular basis.

Baseline Measurements

- Staff survey results to demonstrate an increase in number of staff reporting they have undergone training in equality and diversity. The 2011 staff survey demonstrated 48% of staff had received equality and diversity awareness training in last 12 months
- Statistics will be presented in a format demonstrating where discrimination against any of the nine protected characteristics may have occurred. These cases will be investigated and actions will be identified to inform initiatives to enable the reduction of inequality within the organisation

2.2 Statements of Assurance from the Board

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare quality accounts for each financial year. 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 (voting membership is three Non-executive Directors), Governors, the Patient, Public Involvement and Membership 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 2011/12 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 website: www.papworthhospital.nhs.uk

The data reviewed should aim to cover the three dimensions of quality - patient safety, clinical effectiveness and patient experience. 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 2011/12 represents 100% of the total income generated from the provision of NHS services by Papworth Hospital for 2011/12.

Information on Participation in Clinical Audits and National Confidential Enquiries

All NHS trusts are required to report on their participation in national clinical audits. The Department of Health's advisory body on clinical audit, the National Clinical Audit Advisory Group (NCAAG) has drawn up a list of national audits to support providers. The audits that are relevant to individual providers will depend on the range of services delivered by the provider. During 2011/12, 13 national clinical audits and two national confidential enquiries covered NHS services that Papworth Hospital provides.

During 2011/12, Papworth Hospital participated in 12 of the 13 (92%) national clinical audits and two (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audit and Patient Outcomes Programme 2011/12

The national clinical audits and national confidential enquiries that Papworth Hospital was eligible to participate in during 2011/12 are as follows:

Audit title	Audit source
Acute care	
Emergency use of oxygen	British Thoracic Society
Pleural procedures	British Thoracic Society
Cardiac arrest	National Cardiac Arrest Audit
Long-term conditions	
Chronic pain	National Pain Audit
Bronchiectasis	British Thoracic Society
Elective procedures	
Coronary angioplasty	National Institute for Cardiovascular Outcomes Research (NICOR) Adult cardiac interventions audit
CABG and valvular surgery	Adult Cardiac Surgery Audit
Acute Myocardial Infarction & other Acute Coronary Syndrome	Myocardial Ischaemia National Audit Project (MINAP)
Cardiac arrhythmia	Cardiac Rhythm Management Audit
Cancer	
Lung cancer	National Lung Cancer Audit
Blood transfusion	
Bedside transfusion	National Comparative Audit of Blood and Transfusion
Medical use of blood	National Comparative Audit of Blood and Transfusion (interim report only).
The Heart Failure Audit	Papworth Hospital did not contribute due to the complexity in completing the data set, as there are different work-streams at Papworth through which heart failure patients are managed. The Trust will aim to participate in 2012/13.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential enquiries that Papworth Hospital participated in, and for which data collection was completed during 2011/12, 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.

Audit title	Audit source	Compliance with audit terms
The National Clinical Audit and Patient Outcomes Programme 2011/12		
Acute care		
Emergency use of oxygen	British Thoracic Society	100%
Pleural procedures	British Thoracic Society	100%
Cardiac arrest	National Cardiac Arrest Audit	100%
Long-term conditions		
Chronic pain	National Pain Audit	Awaiting publication
Bronchiectasis	British Thoracic Society	100%
Elective procedures		
Coronary angioplasty	NICOR Adult cardiac Interventions Audit	100%
CABG and valvular surgery	Adult Cardiac Surgery Audit	100%
Acute Myocardial Infarction & other ACS	MINAP	100%
Cardiac arrhythmia	Cardiac Rhythm Management Audit	100%
Cancer		
Lung cancer	National Lung Cancer Audit	33% [1](see explanation below)
Blood transfusion		
Bedside transfusion	National Comparative Audit of Blood and Transfusion	100%
Medical use of blood	National Comparative Audit of Blood and Transfusion	100% (interim report only)

[1]National lung cancer audit - few implications for Papworth as this audit records the patients by the hospital in which they were first seen. Since almost no patients are referred direct from their GP to Papworth the data which is completed by Papworth counts towards the district general hospital's participation rate.

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 below:

Title	Cases inc.	Prospective forms returned	Questionnaires returned	Case notes returned	Sites participation	Organisational questionnaire returned
Cardiac arrest	2	3	2	2	1	1
Peri-operative care	5	11	-	5	1	1
Surgery in children	0	0	0	0	1	1

The reports of 13 national clinical audits were reviewed by the provider in 2011/12 and Papworth Hospital intends to take the following actions to improve the quality of healthcare provided. Below is a sample of audits discussed at relevant group meetings.

- Emergency use of oxygen - while Papworth compares favourably with the national data, improvements to the prescription charts were required and have now been implemented Trust-wide
- Pleural procedures - a local action plan has been completed and implementation is currently underway. Areas of improvement include documentation and use of procedure specific consent forms
- Bronchiectasis - assurance received that the Trust complies with the standards recommended in the guideline for non-CF Bronchiectasis. Therefore no further action is required.

The reports of 63 local clinical audits were reviewed by the provider in 2011/12 and Papworth Hospital intends to take the following actions to improve the quality of healthcare provided:

Title	Improvements
Audit of Cystic Fibrosis (CF) patients and outcomes following referrals from shared care paediatric care and main Cystic Fibrosis centres	The CF Multi Disciplinary Teams (MDT) recommended increased communication and educational links between the Papworth CF dieticians and the paediatric dieticians in the East Anglia CF network to improve the Body Mass Index (BMI) of CF patients prior to transition to adult care
Monthly rolling record-keeping audit	Education of doctors already in post and continuation of record-keeping at Trust induction
National Patient Safety Agency (NPSA) Chest Drain Audit	Continual education on use of chest drain insertion documentation (stickers) and consent specific consent forms
World Health Organisation (WHO) checklist	Review of documentation currently used; training of staff working in theatres
National Patient Safety Agency (NPSA) - Midazolam	All staff involved in conscious sedation aware of the Trust conscious sedation guidelines. All staff involved in conscious sedation to attend sedation course (2011 conscious sedation day - Saturday, November 5th). Re-audit in 12 months' time
Re-audit of Hickman line infections	Effective patient and carer education, continue with detailed and meticulous patient and carer education at initiation of treatment. Regular patient review and patient education
Discharge prescriptions audit	Updating of doctors handbooks; improvement will be seen once electronic discharge is implemented
Malnutrition Universal Screening Tool (MUST)	The audit shows 91% patients who had been an inpatient for more than two days were assessed using MUST within 48 hours of admission. The dieticians have put a lot of work into promoting MUST during Skills Weeks and providing ward training sessions
Speed of antibiotic administration for sepsis in critical care	Overall, the majority of antibiotics for sepsis are administered within one hour. However, there is still substantial room for improvement
Lung cancer diagnostic Quality, Innovation, Productivity and Prevention (QIPP) Project 'How can the diagnostic pathway be designed more efficiently to ensure patients gain access to timely, cost effective and appropriate diagnostics?'	The overarching observation from the results is the variability in pathways and costs across the region. Through sharing best practice locally and nationally, streamlining services and aligning pathways, there is a huge opportunity to limit variation
Matching Michigan - central venous catheter bloodstream infection minimisation initiative	A reduction in infections has been achieved in the Intensive Care Unit

Information on Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Papworth Hospital in 2011/12 who were recruited during that period to participate in research approved by a research ethics committee was 3,369. See table below.

Type of research project	No. of patients recruited per financial year	
	2010/11	2011/12
NIHR Portfolio Studies	399	1,037
Non-NIHR Portfolio Studies	684	366
Tissue Bank Studies	2,151	1,966
Total	**3,234**	**3,369**

NIHR= National Institute for Health Research

The Trust's focus on NIHR Portfolio research activity is demonstrated by the success of the Papworth Research & Development Directorate in securing peer-reviewed NIHR research grant funding and a 160% increase in number of patients recruited to NIHR portfolio studies. Papworth Hospital was involved in conducting 30 clinical research studies in heart disease and 65 clinical research studies in respiratory disease during 2011/12. The remaining four studies were of generic health relevance. By maintaining a high level of participation in clinical research the Trust demonstrates Papworth's commitment to improving the quality of health care.

The Trust's research strengths are in 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 patient outcomes by undertaking clinical research that will lead to better treatments for patients undergoing care in the NHS.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of Papworth Hospital's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between the Papworth Hospital 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. Further details about the CQUIN scheme are available electronically at (www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)

The amount of income in 2011/12 conditional upon achieving quality improvement and innovation goals was £1,191,278 (2010/11 £1,266,000) and the amount received was £1,060,237 [89%] (2010/11 £1,190,000 [94%]).

Information Relating to Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

The CQC is the regulatory body which grants licences to practice healthcare in England. The CQC only issues licences to organisations that can rigorously prove they can offer safe quality healthcare.

Papworth Hospital is required to register with the CQC and its current registration status is 'registered without conditions'. The CQC has not taken enforcement action against Papworth Hospital during 2011/12.

Papworth Hospital has not participated in any special reviews or investigations by the CQC during the reporting period. See section 3 for futher information on CQC inspections during 2011/12.

Information on the Quality of Data

Accurate and reliable data is essential for safely and effectively managing an organisation such as Papworth Hospital. For example how we 'code' a particular operation or illness is important. It not only allows us to receive income to cover the cost of care, but it also anonymously informs the wider health community about illness or disease trends.

Papworth Hospital submitted records during 2011/12 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 in excess of 99% for admitted patient care and in excess of 99% for outpatient care
- which included the patient's valid General Practitioner Registration Code (code of the GP with which the patient is registered) was 100% for admitted patient care and 100% for outpatient care

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 2011/12 was 70% and was graded green. The Trust achieved a minimum of level 2, with some level 3, on all requirements in the information governance toolkit. The Information Governance Toolkit is available on the Connecting for Health website www.igt.connectingforhealth.nhs.uk

Papworth Hospital will be taking the following actions to improve data quality during 2012/13:

- Further development of the roles of staff that are responsible for and administer databases
- Formal refresher training for the clinical coding team
- Undertake regular monthly audits to check for consistency and accuracy in case notes and clinical coding
- Business Support team regular data quality checks and monthly team briefings to address data quality issues
- Policies and procedures are updated

Papworth Hospital was subject to the payments by results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) was 2% compared to the National average of 9.1%. The results should not be extrapolated further than the actual sample audited, which covered cardiac surgery and a random selection. The report from the Audit Commission confirmed that the Trust is continuing to perform to a high standard with regard to both clinical coding and data quality. All recommendations from the Data Quality Assurance Audit have been implemented and the Audit Commission have confirmed there are no key areas that the Trust has to address.

Part 3

Other Information - Review on Quality Performance 2011/12

The following illustrates a review of our quality performance last year. We have selected examples from the three domains of quality (clinical safety, patient experience and clinical effectiveness of care).

Patient Safety Domain

Healthcare Associated Infections

We have continued to demonstrate improvements in our Clostridium difficile (C. difficile) infection rate and maintain the low MRSA bacteraemia rate within the Trust.

Improvements in our MRSA bacteraemia and C. difficile infection rates

Goals 2010/11	Outcome	Goals 2011/12	Outcome
No more than 2 MRSA bacteraemias	Total for year = 1	No more than 1 MRSA bacteraemia	Total for year = 1
No more than 13 C. difficile cases	Total for year = 9	No more than 10 C. difficile cases	Total for year = 8
Achieve 100% MRSA screening of all patients	Average 97%	Achieve 100% MRSA screening of all patients	Average 99%

Methicillin-resistant Staphylococcus Aureus (MRSA)

MRSA bloodstream infections are the most serious form of MRSA infection and are associated with significant morbidity and mortality. An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review). Reports of MRSA cases include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not. The indicator excludes specimens taken on the day of admission or on the day following the day of admission as these are considered "community" acquired infections rather than those acquired at the hospital. Specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was

admitted, are also attributed to the Trust. Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

Hand-hygiene remains an important infection control measure to reduce the risk of spread of MRSA on the hands of healthcare workers. In addition many other measures are taken to prevent the spread of MRSA infection including MRSA screening of all patients admitted to the hospital, treatment of MRSA carriers, isolation of patients and maintenance of a high level of cleaning standards across the Trust.

MRSA Screening

MRSA can live harmlessly on the skin and mucosal surfaces (mainly nose, throat and groin) 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 NHS Midlands and East Strategic Health Authority Cluster require provider trusts to achieve the routine screening of all elective and emergency admissions. Papworth Hospital continues to audit the screening of patients and achieve high rates of compliance with this practice.

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. Once MRSA colonisation is identified then treatment can be given to try to eradicate the MRSA carriage, with the aim of preventing further spread of infection in the hospital. Patients continue to be barrier nursed until clearance of the MRSA is completed. Patients who are found to be MRSA positive and have already been discharged or are discharged during the decolonisation process are sent letters and followed up by their GP in the community.

C. 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 severe 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.

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.

However, it is not only older patients who 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 pain and colitis suggestive of severe C. difficile disease. This makes the management and prevention of CDAD in this group of patients challenging and on average one or two cystic fibrosis patients develop CDAD at Papworth each year. To help prevent and treat infection in this group of patients, the Trust introduced an Infection Control Procedure for Patients with Cystic Fibrosis in September 2011.

The Trust continues to achieve the targets set by the Strategic Health Authority for the reduction of C. difficile infection. This is delivered by prompt isolation of patients and the maintenance of high standards of hand hygiene and environmental cleaning. A monthly audit programme monitors compliance to all of the above and actions plans are carried out if required, which are reported to the Infection Prevention & Control Committee on a six-weekly basis.

Central Venous Catheter Bloodstream Infections (CVC-BSI)

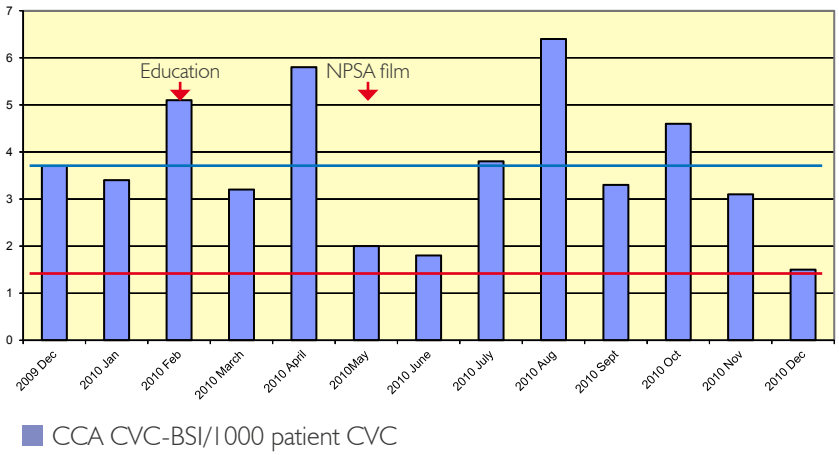
Bloodstream infections associated with central venous catheter insertion are a major cause of morbidity nationally. These infections are caused by contamination of a catheter with bacteria or yeast from another part of a patient's body or from a caregiver. This impacts on recovery following treatment, extended length of stay and significant cost to the organisation. During 2010/11, Papworth Hospital adopted the principles of 'Matching Michigan', 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 [1].

The Trust goal for 2011/12 was to reduce catheter related bloodstream infections by 25%

[1]The use of CVC-BSI per 1000 CVC patient days is the NPSA standard reporting mechanism for this type of infection to enable standard CVC-BSI rate reporting and comparison of CVC-BSI rates nationwide.

The graph below shows our baseline results from December 2009 to December 2010.



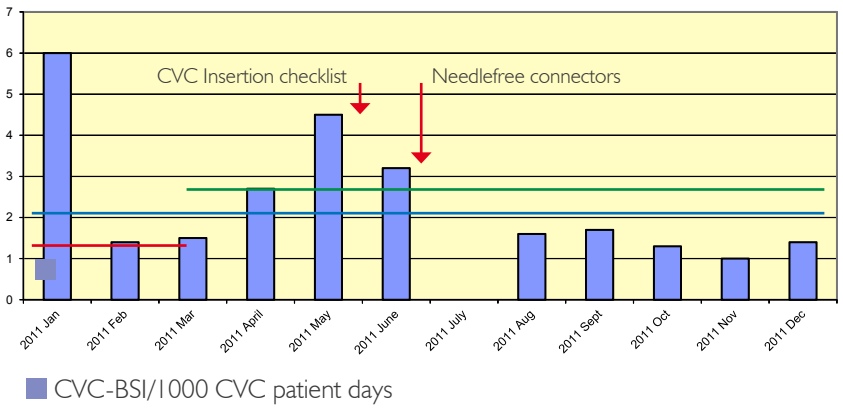
The blue horizontal line = 3.7 CVC-BSI/1,000 CVC patient days. This equates to the average CVC-BSI rate in Critical Care at Papworth Hospital from December 2009 - February 2011.

The red horizontal line = 1.4 CVC-BSI/1,000 CVC patient days (the Michigan rate).

The education programme for Matching Michigan commenced in February 2010 and the staff at Papworth Hospital produced a DVD (supported by the National Patient Safety Association - NPSA) demonstrating best practice of CVC insertion in May 2010.

A CVC insertion checklist was introduced in May 2011 and needlefree connectors came in to use shortly after. There were no catheter related blood stream infections in July 2011.

The graph below illustrates the reduction in CVC-BSI infection rates from January 2011 to December 2011 in the critical care unit.



The green horizontal line = Trust CQUIN target of 2.7 CVC-BSI/1,000 CVC patient days which is where a 25% reduction would be from the average of 3.7 in 2010/11.

The blue horizontal line = 2.2 CVC-BSI/1,000 CVC patient days and this is an actual reduction of 40% in catheter related bloodstream infections from an average of 3.7 CVC-BSI/1,000 CVC patient days in December 2009 to Feb 2011 to 2.2 CVC-BSI/1,000 CVC in January 2011 to December 2011.

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 shear and skin moisture. There are four grades of pressure ulcer, ranging from 1 to 4, with 4 being the worst.

Throughout 2011/12, 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 on grade 2, 3 and 4 pressure ulcers for the last 2 years.

National reported figures - pressure ulcer prevalence June 2010 onwards-pressure ulcer grades 2 and above

Inpatients audited per month (n)	% of patients who developed pressure ulcers at Papworth (n)
Papworth (n)	Achieved and ongoing
June 2010 (289)	0.7% (2)[1]
December 2010 (266)	0.8% (2)[1]
March 2011 (290)	2.4% (7)
June 2011 (271)	0.7% (2)
September 2011 (279)	0.4% (1)
December 2011 (300)	1.3% (4)

[1] Figures are different to those reported in the 2010/11 Quality Account as a result of a data review.

In 2011 we increased our pressure ulcer prevalence audits to quarterly but as with any prevalence audit, statistically, there will always be minor fluctuations in the rates.

Initiatives for 2012/13 include:

- Quarterly pressure ulcer prevalence audits will become monthly as part of the National Safety Thermometer harm-free care initiative from April 2012 (see Part 2, priority 1 for 2012/12)
- Continue the Root Cause Analysis (RCA) process for all grade 3 and 4 pressure ulcers for both developed within, and transferred into, the Trust
- Continue action planning and dissemination of lessons learnt from the RCA of all grade 3 and 4 pressure ulcers that develop at Papworth Hospital
- Ensure that the rates of pressure ulcers developed at Papworth Hospital continue to be displayed in all clinical inpatient areas for patients, relatives and staff to see
- Have a standing agenda item in the Clinical Audit meeting to report the pressure ulcer rates
- Continue education on pressure ulcer prevention, identification, reporting and management in Trust-wide mandatory training days

Goals 2011/12	Outcome
Pressure ulcer prevalence audit to be carried out quarterly	Achieved
Pressure ulcer reporting, investigating and management protocol introduction	Achieved. This protocol has raised staff awareness on the importance of the correct reporting and investigating of grade 3 and 4 pressure ulcers
Introduce RCA for grade 3 and 4 pressure ulcers transferred into the Trust	Achieved. In addition, all RCA/action plans of grade 3 and 4 pressure ulcers are reported to the Trust-wide Band 7 and senior nurse meetings

To facilitate the elimination of all avoidable pressure ulcers by the end of 2012, the NHS Midlands and East Strategic Health Authority Cluster established a Programme Board Steering Group in September 2011, which incorporated an expert working group. Papworth Hospital has representation on both groups through the Nurse Consultant in Tissue Viability, who has been instrumental in the development of the Pressure Ulcer Toolkit; of which care bundles are essential components.

In line with the national campaign to reduce pressure ulcers, we will be revising the way we audit pressure ulcers.

Falls

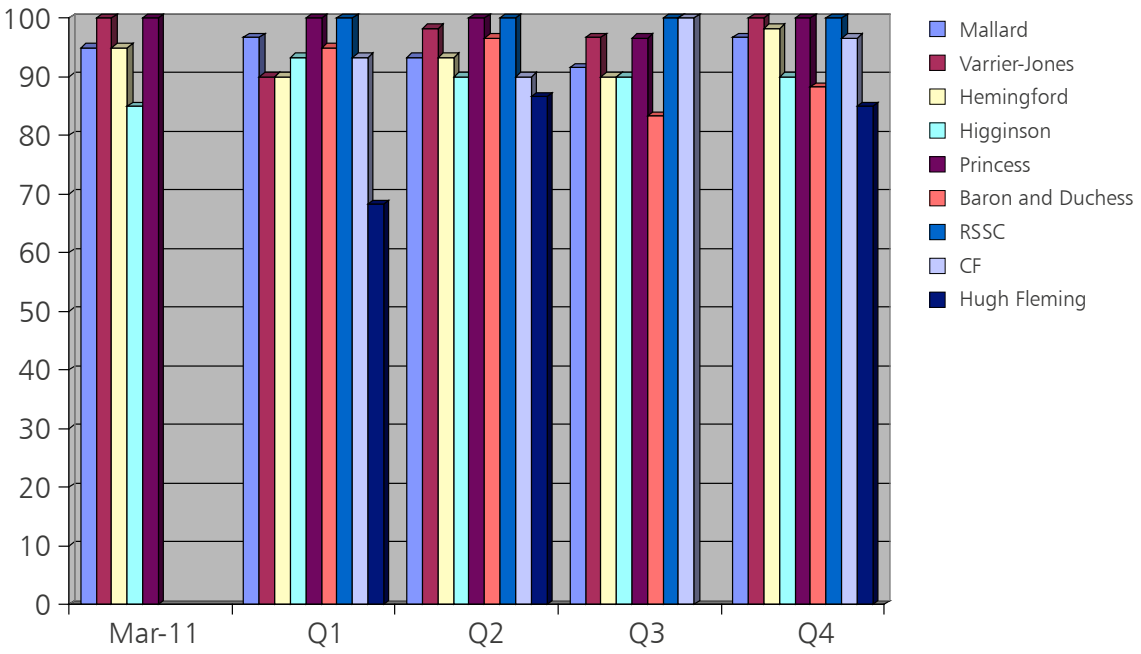
At Papworth Hospital falls account for 186 of the patient safety incidents reported during 2011/12 making this the highest reported event. Therefore there continues to be significant work to reduce this number and prevent falls whenever possible. The focus has been increasing assessment of patients' risk of falling and education of patients at risk to help prevent a fall occurring.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2010/2011	51	50	44	40
2011/2012	50	39	33	64

Analysis of the falls incidents reveal very little in the way of trends except that most occur when a patient is trying to mobilise to the bathroom on their own or when mobilising unaided around the bed space. A disappointing rise in falls was observed in quarter 4 despite successfully introducing all the initiatives identified for 2011/12, highlighting the need for falls prevention to remain as a priority for 2012/13. The sudden increase is as yet unexplained, but work continues around this to identify further work streams for the future.

Through the Productive Ward Programme 'Releasing time to care' project 60% of the ward areas audited the completion of a falls risk assessment on admission and implementation of a care plan. In 2010/11 the compliance of these areas ranged from 75% to 100% in quarter 4. By quarter 4 2011/12, 100% of ward areas were auditing risk assessment completion on admission which demonstrated 95% compliance with this standard.

Graph shows risk assessment audit on admission by ward area



Goals 2011/12	Outcome
To reduce preventable falls events by 20%	Achieved Q2 and Q3, not achieved Q4
To increase the use of Falls Risk Assessment	Achieved
To educate patients and carers about preventing falls in hospital	Achieved and now ongoing

New initiatives to enable these goals 2011/12

All inpatient areas will audit compliance with Falls Risk assessment on admission using the Productive Ward Programme 'Releasing time to care' data collator on a monthly basis	Achieved
Run a falls prevention awareness week, both for staff and members of the public	Achieved
Actively educate patients to seek help prior to mobilising independently	Achieved
Display information about preventing falls to reinforce messages given to patients and carers about mobilisation whilst in hospital	Achieved
All falls incidents reported via Datix will trigger a RCA checklist.	Achieved

See also priority 1 for 2012/13 - Delivery of harm-free care

Prevention of Venous Thromboembolism (VTE)

Month	% of inpatients risk-assessed for VTE
September 2010	66.01
October	90.08
November	90.44
December	91.12
January 2011	97.89
February	97.08
March	97.00
April	96.47
May	97.00
June	98.00
July	97.50
August	97.60
September	95.00
October	95.40
November	96.30
December	94.60
January 2012	96.70
February	96.80
March	95.10

VTE prevention is a top clinical priority for the NHS, recognised by the National Quality Board, the NHS Management Board, and the Academy of Medical Royal Colleges.

The National VTE Prevention Programme is fully implemented within the organisation and a range of measures has been introduced through the programme. These include the national mandatory data collection of VTE risk assessment for all inpatients, which is again linked to a national CQUIN goal for 2012/13, the implementation of NICE Clinical Guideline 92, and compliance with the NICE VTE quality standard.

The percentage of inpatients risk-assessed at Papworth Hospital has been reported monthly to the Department of Health since September 2010. Between April 2011 and March 2012 an average of 96% of all our inpatients have been risk assessed for VTE every month as illustrated in the table opposite.

Prevalence audit of the appropriateness of VTE prophylaxis is ongoing and reported quarterly to the Clinical Governance Management Group. 100% of our patients have received appropriate prophylaxis since October 2011, which is an outstanding achievement and is shown in the table below.

In March 2012 two patients included in the audit refused to wear anti-embolism stockings despite medical advice and explanation that their risk assessment identified that they were at risk of developing a VTE.

Month 2011/12	% Appropriate prophylaxis
April	86.6
May	100.0
June	95.6
July	100.0
August	96.9
September	94.6
October	100.0
November	100.0
December	100.0
January	100.0
February	100.0
March	97.0 *2 patients refused anti-embolism stockings against advice, so if not included in analysis total is 100%

The NHS Standard Contract for Acute Services introduced the requirement for a root cause analysis (RCA) on all VTE episodes identified in inpatients and patients discharged within 90 days. The Trust is compliant with this requirement and has conducted all necessary RCAs to date since September 2010. The RCAs and any identified actions are reported to and monitored by the Clinical Governance Management Group.

We held our first VTE Awareness Week in September 2011 in which 276 staff updated their knowledge and skills in VTE risk assessment and prevention. We also had the opportunity to trial, and train staff in the use of, Intermittent Pneumatic Compression Devices, which are now available in the Trust for very high-risk patients at the request of their consultant.

In recognition of the continued efforts to deliver improvements in the standard of VTE prevention to our patients, Papworth Hospital was named as an Exemplar Centre for VTE prevention and invited to join the national VTE exemplar network in March 2012.

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.

In April 2009 a surgical-site surveillance programme of patients undergoing coronary artery bypass graft (CABG) +/- valves was implemented to monitor infection rates. Following two years of full surveillance on CABG +/- valve patients, we adapted the programme to focus on other cardiac surgery, namely valve only, atrial septal defect repair (ASD) and ventricular septal defect repair (VSD), as well as thoracic surgery and pulmonary endarterectomy (PEA) surgery . This was to obtain baseline data of surgical site infection rates in patients following these other procedures. Surgical-site surveillance for patients undergoing CABG +/- valve was conducted in quarter 2 only as we wanted to maintain surveillance in this group whilst maximising our resources in the additional areas as stated above. From October 2011 we also introduced transplant recipients into the surveillance programme. Results from the year's additional surveillance will follow when data collection is complete.

Goals 2010/11	Outcome	Goals 2011/12	Outcome
Reduction in infection rates in our patients undergoing CABG and valve surgery	Infection rates reduced from 8% to 5.85%	Reduction in infection rates in patients undergoing CABG +/- valve. Plus additional surveillance of other cardiothoracic surgery	Infection rates for Q2 (July-Sept) CABG +/- valve reduced to 4% (from 5.2% in the equivalent quarter in 2010).[1] Combined additional surveillance infection rate 1.29%.

CQC Inspection

The CQC carried out unannounced visits to Papworth Hospital on 24 November 2011 and 10 April 2012 as part of their routine schedule of planned reviews. During the November visit, the Trust was assessed against five of the essential standards of quality and safety as described below:

- Outcome 01 - Respecting and involving people who use the service
- Outcome 04 - Care and welfare of people who use the service
- Outcome 07 - Safeguarding and protecting people who use the service from abuse
- Outcome 13 - Sufficient staffing to keep people safe and meet their health and welfare needs
- Outcome 16 - Assessing and monitoring the quality of service provision to manage risks and assure the health, welfare and safety of people who receive care

Three areas were judged as compliant (meaning that people who use the service are experiencing the outcomes relating to the essential standard):

- Outcome 01- the CQC considered that people's dignity and privacy was maintained and upheld at all times and that individuals were actively involved in making decisions about their treatment options
- Outcome 07 - the CQC reported that the majority of staff with whom they spoke were knowledgeable and trained in respect of safeguarding awareness and procedures and as a result, people were protected from the risk of harm
- Outcome 13 - the CQC were assured that people receive care and treatment in a timely manner due to having enough staff on duty for the majority of the time

Two areas were judged as non-compliant (meaning that people who use the service are not experiencing the outcomes relating to the essential standard):

- Outcome 16 - Assessing and Monitoring the Quality of Service Provision was given a minor concern, which means that people who use the service are safe, but not always experiencing the outcomes related to this essential standard
- Outcome 04 - Care and Welfare of People who use the Service was given a moderate concern. This was in relation to documentation of patient records and less than adequate observation of some patients in the Intensive Care Unit

A response was submitted to the CQC and an internal action plan was produced to address the shortcomings identified.

On 10 April 2012 the CQC re-inspected and the Trust was judged compliant in these two outcomes (Outcome 16 and Outcome 04).

Three further outcomes were assessed and these were:

- Outcome 2 - Consent to Care and Treatment
- Outcome 5 - Meeting Nutritional Needs
- Outcome 13 - Staffing

The Trust was judged compliant in all three outcomes and feedback was positive in all areas.

This initiative has enabled us to focus on safe discharge and helps reduce delays

Patient Experience Domain

Cardiac Admissions Lounge

The purpose of the Cardiac Admissions Lounge, which opened in February 2012, is to provide a more efficient service and appropriate environment for patients who are admitted to Papworth Hospital on the day of their cardiac procedure. This discrete area is situated between the Cardiac Day Ward and the Radiology Department. Patients are prepared for their procedure within the admissions lounge and following their procedure they are either admitted to the Cardiac Day Ward or to an inpatient ward for recovery and continuing care. This initiative has enabled inpatient ward staff to focus on safe discharge in the mornings and helps reduce delays in the catheter labs and theatres.

Patient Environment Action Team (PEAT) inspection

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 year's PEAT inspection was undertaken on 16 February 2012 and included an external validator appointed by the NHS Information Centre responsible for the management of PEAT. The outcome of the assessment is as follows:

	2011	2012	Change
Environment and Cleaning	Good	Good	→
Food and Hydration Services	Excellent	Excellent	→
Privacy and Dignity	Good	Excellent	↑

Feedback from the team was extremely positive, in particular the significant improvement in all areas including the overall cleanliness of clinical areas, the improved patient menu, the tidiness/state of the estate inside and outside and improved signage since the last inspection. The External Validator commented "It was a pleasure to be part of the PEAT team, from my view Papworth is well run, clean, maintained to a high standard and the patient food was also very good".

National Outpatient Survey

Papworth Hospital has achieved excellent results this year following the CQC's national outpatient survey. In this national survey of nearly 72,000 patients, Papworth Hospital scores were consistently high with the sections relating to 'Seeing a doctor' and 'Seeing another professional' scoring 9.42 and 9.3 out of 10 respectively. The highest individual question score was 9.81 out of 10 for 'Being treated with dignity and respect'. The hospital was also particularly praised by patients on questions relating to the cleanliness of the outpatient departments, scoring 9.4 out of 10.

The survey asked patients what they thought about different aspects of the care and treatment they received whilst at Papworth Hospital. In seven out of the nine sections of questions Papworth Hospital scored 'better' compared with other trusts and 'about the same' as other trusts in the other two sections. The response rate from Papworth patients was 72% compared to the national average of 53%.

Papworth People Annual Staff Achievements Awards

Dedicated members of staff from Papworth Hospital were presented with special awards by the Rt. Hon. Andrew Lansley, CBE, MP, Secretary of State for Health, at the first Papworth People Annual Staff Achievements Awards, on Thursday 22 September 2011.

The hospital's Public, Patient Involvement and Membership Committee was invited to select the final winners from 170 nominations submitted from patients, carers and colleagues.

The service provided by Papworth is part of the national network of services across England

Clinical Effectiveness of Care Domain

Respiratory Extra Corporeal Membrane Oxygenation (ECMO)

Papworth Hospital has been named as one of five centres in the country to provide the highly specialised Respiratory Extra Corporeal Membrane Oxygenation (ECMO) service, including specialised retrieval of patients from referring hospitals.

ECMO supports adults with severe potentially reversible respiratory failure by oxygenating the blood through an artificial lung machine. The extracorporeal life support is used to replace the function of failing lungs, usually due to severe inflammation or infection.

ECMO is a technique that oxygenates blood outside the body. It can be used in potentially reversible severe respiratory failure when conventional ventilation is unable to oxygenate the blood adequately. The aim of ECMO in respiratory failure is to allow the injured lung to recover whilst avoiding certain recognised complications associated with conventional ventilation. It is high

risk and is therefore only used as a matter of last resort in difficult cases. The procedure involves removing blood from the patient, taking steps to avoid clots forming in the blood, adding oxygen to the blood and pumping it artificially to support the lungs.

ECMO is a complex intervention, which is only performed by highly trained specialist teams including intensive care specialists and cardiothoracic surgeons as well as ECMO-trained nurses.

ECMO is a form of support rather than a treatment and its aim is to maintain physiological homeostasis for as long as it takes to allow the lung injury or infection to heal. This usually means a support time between 5 and 14 days but sometimes ECMO support is required for longer.

As a tertiary cardiothoracic centre, Papworth Hospital has been providing specialist ECMO services (both respiratory and cardiac) for a number of years to patients such as those undergoing heart or lung transplantation. ECMO can also be used to support other patient groups with potentially reversible respiratory failure such as Acute Respiratory Distress Syndrome (ARDS) sometimes seen in patients with community-acquired pneumonia or seasonal flu. The hospital is registered with the international Extracorporeal Life Support Organisation (ELSO) and is renowned for its experience using ECMO. This long experience in providing a high-quality ECMO service was recognised during the competitive process to become a national centre.

From 1 December 2011 the service provided by Papworth became part of the national network of services across England, which will provide a year-round ECMO service, including the retrieval of these patients from the referring hospital. This specialist retrieval team is available 24 hours a day to rapidly go to the referring hospital to stabilise and retrieve patients.

Papworth provides the service to patients in Cambridgeshire, Norfolk, Suffolk, Hertfordshire, Bedfordshire, Essex and North East London. Based on modelling by the National Specialist Commissioning Team which commissioned the service, Papworth is likely to receive around thirty patients each year but retains the flexibility to increase capacity in response to higher demand. Papworth will support the national service by accepting patients from the other centres if they reach full capacity.

Summary of ECMO activity at Papworth Hospital December 2011 - March 2012

Twenty-three patients suffering from acute respiratory distress syndrome have been referred for consideration of ECMO since the service began on 1 December 2011. Papworth Hospital mobile team went to assess most patients in the referring hospital. Eight patients were considered unsuitable for ECMO; one was diverted to another ECMO centre, in keeping with the national service set up, and 14 were admitted to Papworth Hospital. Of the 14 patients admitted to Papworth, four recovered without ECMO, ten were supported with ECMO. Six of those ten patients made a full recovery. The ten surviving patients' swift repatriation was facilitated by the close working relationships between the referring hospitals

Productive ward Programme 'Releasing time to care'

Papworth Hospital has been engaged with the Productive Series through the Productive Ward since 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. Lean methodology, once applied, cuts out wasted time in a process.

The Productive Ward project has enabled staff to improve ward processes and environments to allow nurses to spend more time on patient care thereby improving safety and efficiency. One of our patients wrote to the Chief Executive of the Trust about his stay on one of the surgical wards. He explained that he had noticed extensive information about the ward vision, The Productive Ward programme and the planned improvements. He highlighted each area of the ward vision in his letter and explained how he had seen the ward staff delivering their vision whilst caring for him during his stay on the ward. This case study is featured on the NHS Institute for Innovation and Improvement website at www.institute.nhs.uk/productiveward on the case studies page.

Survival Rates for Coronary Artery Bypass Surgery (CABG)

In August 2011 the Trust reported that survival rates for coronary artery bypass surgery at Papworth Hospital were better than 99% for the first time in the hospital's history. Mortality for patients having coronary artery bypass surgery at Papworth was less than 1%. In the year ending 1 April 2011, 824 patients had coronary artery bypass operations, including urgent, emergency, salvage and repeat operations. Mortality for that year was 0.85%, the lowest that the hospital has ever achieved.

As a specialist hospital, Papworth treats older and sicker patients than the national average, and often takes on patients who are turned down elsewhere. Despite this fact, Papworth Hospital's survival rates for coronary surgery are among the best in the world.

Overall Quality Performance against Trust Selected Metrics, National Priorities and CQC Standards

Performance of Trust against Selected Metrics

Throughout 2011/12 we have continued to measure our quality performance against a number of metrics. Table A sets out our performance against those national targets included within Monitor's compliance framework. Table B below sets out our performance against other Department of Health national priorities and a range of local priorities.

Table A - Trust performance against Monitor's Compliance Framework

Monitor Metrics and National Priorities	Performance 2010/11	Target 2011/12	Performance 2011/12
Clostridium difficile - meeting the C.Diff objective	9	10	8
MRSA - meeting the MRSA objective	1	1	1
Cancer - 31 day wait for second and subsequent treatment	100%	94%	100%
Cancer - 62 day wait for first treatment from urgent GP referral[1] (Reduced tolerance levels have been issued by CQC for certain specific single cancer sites. As Papworth only treats lung cancer the revised threshold of 79% applies)	87.9%	79%	85.9%
Referral to treatment time, 95th percentile wait for admitted patients	New 2011/12	<23 weeks	Achieved in each month of the year
Referral to treatment time, 95th percentile wait for non-admitted patients	New 2011/12	<18.3 weeks	Achieved in each month of the year
Cancer - 31 day wait from diagnosis to first treatment	100%	96%	95.5% (100% achieved Q3 and4)
Compliance with the requirements regarding access for people with learning disability	Achieved from Q2	Compliant	Achieved

[1]The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. An urgent GP referral is one which has a two-week wait from date that the referral is received to first being seen by a consultant. See http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103431.pdf

The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 - Two week wait). The clock start date is defined as the date entered onto the national database, Open Exeter, for recording cancer waiting times by the third party referring the patient to the Trust. The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice (A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf)

In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Table B - Examples of Trust Performance against Other National and Local Priorities

Domain	Metric	Performance 2010/11	Target 2011/12	Performance 2011/12
Patient Experience	Operations cancelled for non-medical reasons	1.4%	<1.5%	1.4%
	Percentage readmitted within the 28 day guarantee	14.7%	5%	14.7%
	26 week inpatient waits	0%	0%	0%
	13 week outpatient waits	0%	0%	0%
	Number of patient related adverse incidents reported via Datix (Incident Management System)[1]	909	<800	1262 (5.32% per 100 patient spells an increase of 1.19% from 2010/11)
	Number of patients risk assessed for VTE on admission	Achieved over 90%	>90%	Achieved over 90%
	MRSA Screening	New for 2011/12	>95%	Achieved at least 97% in each month
Patient Safety	Rate of harm as assessed using the Global Trigger Tool (GTT) [local priority]	Average rate of harm for 2011/12 was 4.1%.	Reduce by 50% by 2013 (baseline 7%)	Average rate of harm for calendar year 2011 is 2.37% (range 0.72 - 4.48%) This represents a 65% reduction since 2009
	% of patients reporting they were treated with privacy and dignity	96% (combined question)	>90%	96% Privacy 98% Dignity
	Total number of complaints received[2]	38	<40	61
	Patient Environment Action Team (PEAT) score. Excellent (100%) Good (90-95%) Acceptable (< 90%)	1 Excellent and 2 Good categories	Excellent	2 Excellent and 1 Good categories
Effectiveness of Care	Cardiac surgery in-hospital mortality within statistical limits using 50% of Euroscore (a method of identifying risks to our patients)	>97%	>95%	>97%

Note

[1]The Trust has reported an increase in patient falls in the last quarter of 2011/12 and this is addressed in the Trust priorities for the coming year. Reducing medication errors is another Trust priority carried over from last year. Additionally in 2011/12 in line with national requirements on VTE prevention all VTE episodes, which occurred either in hospital or within 90 days of discharge, were reported via the Datix system for the first time.

[2]*See Part 3 - Transparent and open section for analysis of complaints*

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 or Green (RAG) rating for Governance, where 'Green' indicates low risk and 'Red' indicates high risk. A summary of the planned and actual ratings for 2011/12 and 2010/11 are provided below:

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	5	4	4	4	4
Governance Risk Rating	Amber-Green	Green	Green	Amber-Red *See below	Green

	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

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

*Monitor's rules on how CQC minor and moderate concerns impact on the Governance Risk Ratings are included in the Compliance Framework (CF). In line with the Compliance Framework for 2011/12 Papworth Hospital could only achieve a maximum Red-Amber governance risk rating in the quarter following the Care Quality Commission inspection on the 24 November 2011. The 2012/13 Compliance Framework published on the Monitor website on 30 March 2012 included a revision to how Monitor incorporated CQC judgements in its governance risk ratings. Monitor stopped down grading trusts for minor and moderate CQC compliance judgements. Accordingly, the governance risk rating for Papworth was amended from **Amber-Red to Green** with immediate effect. In addition the subsequent CQC visit on the 10 April 2012 found that Papworth was meeting all the essential standards of quality and safety inspected.

Papworth Hospital has achieved excellent results from the CQC's national inpatient survey

A Listening Organisation

What our Patients say About Us

2011 National Adult Inpatient Survey

Papworth Hospital has achieved excellent results from the CQC's national inpatient survey of 161 acute and specialist NHS trusts. The survey asked patients what they thought about different aspects of the care and treatment they received whilst at Papworth Hospital. In eight out of the nine sections of questions Papworth Hospital scored 'better' compared with other trusts and 'about the same' as other trusts in the remaining one.

598 of our patients (71.36%) responded to the survey. The survey no longer groups results in the top or bottom 20% of scores. Instead, the expected range identifies scores better or worse than the majority of Trusts. Overall, Papworth remains in the best performing Trusts. In 36 of the 61 questions in the raw data Papworth was identified as being in the 'better' category, and 25 in the 'about the same' category.

Papworth Hospital scores were consistently high, with questions 'Did you have confidence and trust in the doctor treating you?' and 'Did you have confidence and trust in the nurse treating you?' scoring 9.5 and 9.2 out of 10, respectively. Patients scored the question 'Overall did you feel that you were treated with respect and dignity whilst in hospital' 9.5 out of 10. The hospital was also particularly praised by patients on questions relating to the cleanliness of their hospital room or ward, scoring 9.4 out of 10. The scores for all trusts are compared and scored as 'better', 'about the same' or 'worse' than other trusts.

The following table shows our performance compared to last year and the comparison against with Trusts surveyed this year:

	Based on patients' responses to the survey, Papworth Hospital scored		How this score compares with other Trusts
	2010/11	2011/12	2011/12 Result
For questions about waiting lists and planned admissions, answered by those referred to hospital	7.1/10	7.1/10	Better
For questions about waiting to get a bed on a ward	9.5/10	9.5/10	Better
For questions about the hospital and ward	8.6/10	8.7/10	Better
For questions about doctors	9/10	9/10	Better
For questions about nurses	8.8/10	9/10	Better
For questions about care and treatment	8.3/10	8.2/10	Better
For questions about operations and procedures, answered by patients who had an operation or procedure	8.5/10	8.5/10	About the same
For questions about leaving hospital	7.9/10	7.8/10	Better
For questions about overall views and experiences	7.1/10	6.8/10	Better

Examples of comments taken from the National Inpatient Survey are:

"You are a fantastic team and should all be very proud of your achievements."

"I have nothing but praise at the way I was dealt with at Papworth Hospital."

"I was treated with the utmost dignity and respect."

"The warmth of the young nurses and their attitude was very caring."

National Cancer Patient Experience Programme 2011/12 - National Survey Papworth Hospital NHS Foundation Trust

The National Cancer Patient Experience Survey is 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. The most recent available results from the National Cancer Patient Experience Survey are from the 2010 survey and were extremely positive about the Papworth Service. These were reported in the 2010/11 Quality Accounts.

An action plan considering the five areas where Papworth Hospital scored in the bottom 20% nationally was compiled after the publication of the 2010 results. The results of the survey were circulated widely within the team to highlight areas of good practice and areas of improvement. Three of the five areas related to care delivered in Primary Care rather than in hospital; these results were fed back to the relevant commissioners for them to address with Primary Care.

One area for Papworth to address was the issue of patients' perception that they sometimes received conflicting information (Papworth score 67%, National average 79%). As a tertiary centre, patients attending the Papworth service have also been seen at another hospital and there is the potential for different information to be given by different clinical teams. In addition, as a patient progresses through the diagnostic pathway, treatment options may change, as the understanding of the stage and progression of that patient's disease is known. The Papworth team plan to ask this question in more detail in a local survey which is planned for 2012 to get a greater understanding of this issue.

The second area for Papworth to address was ensuring clinicians had the correct documentation with them at clinic (Papworth score 91%, National average 95%). It is difficult to establish from the survey whether this was in reference to the

patient's experience at Papworth or at the referring hospitals. Also it is not clear from the survey whether there is an expectation from patients that records are shared across providers. At Papworth this has been addressed with the administration team who work hard to ensure test results and documents are available for the appointment. The hospital is rolling out an electronic patient record and electronic results ordering which will ensure all necessary information is available.

Responses are currently being collected from the 2011/12 survey, involving patients who were inpatients between September and November 2011; this report is expected to be published in the summer 2012.

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 this will incorporate all common operations in the near future. Papworth Hospital has not participated in these mandatory National PROMs, as they are not relevant to the surgical procedures that are undertaken at this specialist Trust. However, the PROMs group at Papworth Hospital has 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) and the figures showed that 78% of patients responded as having much better health following surgery. This response was given at 12 weeks post-surgery.

In November 2011, Papworth Hospital commenced participation in the national revascularisation PROM pilot that consists of two questionnaires - coronary artery bypass graft and angioplasty - and we are currently in the data collection phase of this pilot. The PROMs group is developing questionnaires for pulmonary endarterectomy patients as well as users of the physiotherapy and rehabilitation services.

Patient Support Groups

Our Trust has several patient support groups, which include:

- The Pulmonary Hypertension Support Group, which has recently formed a new committee and appointed a new co-ordinator. The group meets regularly, produces newsletters and is actively involved in fund-raising
- Immunology/Lung Defence Patient Focus Group which provides a regional, supra-regional and national integrated service for patients with recurrent respiratory infections. The support group is run by patients for patients to discuss treatments, socialise with fellow patients and discuss topics with invited speakers
- Mesothelioma Patient Support Group which meets every month and is aimed at patients and their carers. Talks have included relaxation, breathlessness and complementary therapies. There is also a separate monthly meeting specifically for carers so they can share their concerns and experiences with others in a similar situation
- Pulmonary Fibrosis Support Group, which was established to provide information, support and the opportunity for individuals with pulmonary fibrosis to meet others with the same or similar chest diseases

Examples of What our Patients Have Said

The Pulmonary Fibrosis Group

"We are members of Papworth Idiopathic Pulmonary Fibrosis Support Group formed by the initiative of these remarkable ladies. They have given us the opportunity to meet other sufferers and carers. Without their support we would be left in isolation."

Mesothelioma Patient Support Group

"The only people who can really understand about meso are patients and carers, so the group is really important to me."

"Knowing others are going through the same things and learning from them is so important, and the group helps us to do this."

"My advice would be come to a meeting, just come, then you'll see why it is so useful."

What our Staff Say About Us

Staff Survey

The findings of the 2011 national staff survey results show that staff responding to the survey rated Papworth as one of the top four best performing trusts in the country which scored highly on standard of care, staff motivation and feeling valued by colleagues. The overall staff engagement score for staff at Papworth Hospital is 3.87. This has significantly improved from 3.78 in 2010 and is above the national 2011 average for acute specialist trusts of 3.77.

Papworth's response rate was 63%, an increase from 56% in 2010 and above the national average of 54%.

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

- Percentage of staff receiving job-relevant training, learning or development in last 12 months
- Percentage of staff receiving health and safety training in last 12 months
- Staff motivation at work
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

The four key findings where staff experiences compare least favourably with other acute specialist trusts in England are as follows:

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Percentage of staff having equality and diversity training in the last 12 months
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months
- Percentage of staff suffering work related injury in last 12 months

In relation to patient care, staff were asked if they were satisfied with the quality of care they gave to patients and 91% (of those who felt it was applicable to them) agreed that they were satisfied. 91% of staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by the Trust and 81% of staff thought the Trust made patient or service user care its top priority. The results showed that staff felt positive about work with 71% saying they were enthusiastic about their role; 78% of staff said they were able to deliver the patient care they aspired to and 89% agreed their role made a difference to patients.

The percentage of staff who would recommend the trust as a place to work or receive treatment increased by better than 10% from the 2010 survey, putting the Trust as "Above (better than) average."

The results have been passed to the Heads of Department to discuss with their teams and identify key actions to improve staff satisfaction and engagement over the coming months.

Learning from incidents, complaints and claims is shared across the organisation

Transparent and Open

Throughout 2011/12 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 in number of incidents recorded in 2011/12 has increased on 2010/11.

The Trust has a robust mechanism in place for reporting, investigating and managing Serious Incidents (SIs). Learning from such incidents and actions taken contributes to improving safety for our patients.

We have had two never events during the year which are described under the category of retained instrument. Immediate actions undertaken by the Trust following these events were:

- The patients were informed and the events reported as Serious Incidents
- A Root Cause Analysis was conducted for both events to identify actions required and learning points
- Clinical procedures pertaining to the events were reviewed and updated
- Educational requirements of staff reviewed and additional training provided
- A working group developed a checklist (adapted from the World Health Organisation Theatre checklist), to facilitate robust and accurate evidence of removal of retained instruments

Patient Experience

Listening to the patient experience and taking action following investigation of complaints is an important part of our quality improvement framework. In 2011/12 Papworth Hospital received 61 complaints requiring investigation. 60 were relating to NHS provided services with 1 complaint relating to private patient services at Papworth Hospital. The overall numbers of complaints received has increased by 36% from the previous year when 39 complaints were received.

All complaints received have been subject to a full investigation, and throughout the year service improvements have been made as a result of analysing and responding to complaints. Not all complaints are upheld following investigation and the table below shows the number of complaints received and upheld by 1000 patient episodes. *There is still one complaint investigation ongoing from February and six from March so the outcome of these complaint investigations is not yet known which may influence the overall figures.

	Number of patient episodes	Number of complaints received	Complaints received per 1000 patient episodes	Complaints upheld per 1000 patient episodes
Q1 11/12	24,062	10 (1 private patient)	0.4	(9) 0.4
Q2 11/12	25,777	19	0.7	(6) 0.2
Q3 11/12	25,601	6	0.2	(4) 0.2
Q4 11/12	27,300	26	1.0	(8) 0.3
Total	**102,740**	**61**	**0.6**	**0.3**

Number of complaints reported and upheld per 1000 patient episodes

Out of the 61 complaints received in 2011/12, 45% were upheld or part upheld following investigation. Although the number of complaints remains low, and it is therefore difficult to extract meaningful trends from the data, the main increase is seen in communication and information, clinical care and delay in diagnosis/treatment or procedure. Actions identified from upheld and part upheld complaints are detailed each quarter. The table below shows a summary of some of the actions taken and improvements implemented as a result of complaints investigated during the year.

Summary of Actions Taken as a Result of Upheld and Part Upheld Complaints - 2011/12
Scoping exercise to increase capacity of Lung Defence clinics. Lung Defence clinic templates updated
Developed information for staff and patients detailing the processes followed at the hospital after a death
Review public access to hospital out of hours
Review signage
Review patient information to include information on accessing the site out of hours
Review of the patient pathway for assessing COPD and Asthma
Review and amend the Patient information guide for myocardial perfusion (MIBI) scan
Ensure patient information is made available to private patients when booking
Electrophysiology waiting times improved
Regular feedback of patient and relatives' experience across all directorates
Developed and confirmed the pathway for Pulmonary Hypertension patients so blood results are obtained one week prior to appointment
Booking process for urgent patients reviewed
Unannounced cleaning inspections over weekend periods initiated
Re-routed call bell for toilet from Hugh Fleming to Higginson Ward

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 Patient and Public Involvement and Patient Experience Strategy document and were also involved in setting the priorities for the Quality Accounts for the year.

The Patient Experience Panel (PEP) and Patient Support Groups have continued to meet during the year and members of the PEP were also involved in the Patient Environment Action Team Inspection (PEAT), which was carried out in February 2012.

During 2011/12 the PALS service received 2,063 enquiries from patients, families and carers, a large increase on the figures for last year (1,518). This year has been exceptionally busy, particularly over the last six months with the number of contacts to the service increasing dramatically and during March 2012; the PALS service recorded 236 contacts, which is the highest number since the PALS Service opened in 2003. 52 compliments were also received about the PALS service.

The PALS data is collated under seven headings; access, waiting, building relationships, information, communication, environment and quality of care. There is no specific trend for the increase this year but it is evident that we have received more requests for assistance with directions around the site, parking and transport queries, in particular with regard to the new system for booking patient transport for patients in Norfolk and Suffolk. The PALS service is also involved in helping relatives find local accommodation, as we are a national centre for some services. There has also been an increase in the number of requests for information and advice generally, as well as specific requests about the referral process and information about the treatments offered by the hospital compared to previous years.

The PALS service is well promoted within the hospital with the PALS office situated in the centre of the site, which is highly visible, and within easy access for patients, relatives and carers. There is also a section on the staff induction programme as to how the PALS service can provide help and guidance. The national PALS awareness week in June has helped to raise awareness and there is now an expectation from patients that there will be a PALS service to help with all their queries. Additionally, patients are offered the opportunity to receive copies of any correspondence regarding their treatment and the PALS manager contact details are given in the letter as a point of contact should the patient have any queries regarding the content and detail of the correspondence.

Volunteers

We have been very fortunate to be able to continue to recruit volunteers across the Trust with 29 being recruited during the year for areas including the gift shop, the greeter desk and additional chaplaincy and ward visitors. Three new areas for volunteering were identified during the year and volunteers now provide assistance on the Varrier-Jones Ward, in the clinical audit department and in the recently relocated Heritage Centre. Our total number of volunteers is currently 132.

Risk Management

Risk management forms an integral part of our business rather than a separate programme and responsibility for risk management implementation is accepted at all levels of the organisation. Incident reporting, monitoring of the corporate risk register, and Health & Safety form part of the overall quality-improvement programme for the Trust. Risk is present in all activities both clinical and non-clinical and during 2011/12 the reported non-clinical incidents average out at 51 over the year, which is slight increase on 2010/11.

The risk register is reviewed at all management group meetings throughout the year and progress on actions required to reduce the risk are monitored through the quality and safety report. Risk management continues to ensure that effective arrangements are in place for determining and implementing action required in response to safety alerts issued via the Central Alerting System (CAS).

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 2012/13.

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'.

As well as guidance NICE produces quality standards which are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

In 2011/12 NICE published 96 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.

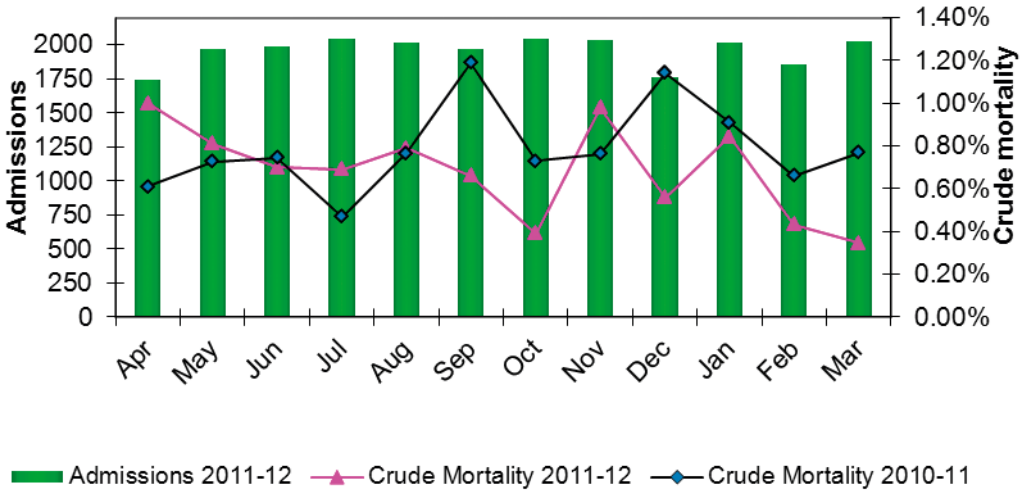
Monitoring Mortality

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.

The graph below illustrates monthly crude mortality rate per month for the rolling year 2011/12 and the admission rate against the crude mortality rate for the previous years (2010/11). The average mortality for 2011/12 was 0.69%* compared to 0.76% in 2010/11.

Mortality Rate Comparison



*The figure for 2011/12 may change slightly and will be reviewed once all patients (115) have been discharged for the year

The data were collected using the 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

Annexe 1

What others say about us

The following stakeholders have kindly provided us with their comments on the Quality Accounts and we appreciate their detailed scrutiny of this document. Some of these comments have been acted upon: additional information on the increase in the use of the PALs service and trends in complaints was included in response to the request from the Adults Wellbeing and Health Scrutiny Committee. The remaining comments will be taken into consideration when preparing the Quality Accounts for 2012/13, in particular reducing the use of technical terminology and jargon. 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) was responsible for commissioning £51.4m of specialised activity from the Trust during 2011/12 on behalf of the Primary Care Trusts in the East of England. We share the Trusts' commitment in ensuring that the services which we commission are of the highest quality, are clinically effective and ensure patient safety at all times.

The annual contract with the Trust reflects these priorities and contractually obligates the Trust to record, report and act on a wide range of quality measures. Monthly meetings are held with the Trust to ensure compliance, measure progress and initiate actions to maintain service quality. The Trust always approaches these issues with the SCG in an open, transparent and collaborative fashion.

It has been another successful year for the Trust: stretching targets for VTE screening, MRSA screening and the reduction of C.difficile infection and surgical site infection have all been achieved. Mortality rates following coronary artery bypass surgery and 30 day mortality following primary angioplasty are low against any comparator.

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's services we will continue to work with the Trust on ensuring compliance against what is a legal right for patients enshrined in the NHS Constitution. Cancer waiting times continue to be met.

The SCG and the Trust have identified a system-wide issue affecting delayed transfers of care to and from Papworth. We will be working with the Trust and other hospitals in the East of England to ensure delayed transfers are reduced during 2012/13.

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 2011/12. The 2012/13 contract with the Trust incorporates many of the new quality initiatives for both specialised and non-specialised services. The monthly contract review meetings will continue to 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 and NHS Peterborough (PCT Cluster) Commissioning Group

NHS Cambridgeshire and NHS Peterborough (the PCT Cluster) has reviewed the Quality Account produced by Papworth Hospitals Foundation Trust for 2011/12.

The host commissioner for Papworth is the East of England Specialist Commissioning Group (SCG). The PCT Cluster commissions the District General Hospital elements of Papworth's services. The SCG and PCT Cluster have joint performance meetings with the Trust where the quality and performance is reviewed throughout the year.

There are a range of Never Events published by the Department of Health. These are serious incidents that should not occur if healthcare is delivered to appropriate standards. Papworth had two Never Events in 2011/12. These related to retained instruments. The Quality Account gives details of these Never Events together with a summary of the action plan put in place to address the issues raised. Some information about Serious Incidents and incident reporting is also given. The PCT would like to see further details of lessons learnt from these incidents included in the Quality Account.

The Quality Account gives details of good practice and improvements achieved, but has limited discussion of areas where improvement is needed. Further detail of lessons learnt and action taken would illustrate both improvement and progress made.

The priorities for 2012/13 include two of those set out in 2011/12; preventing delays in discharges and reducing medication errors. The PCT will also look for continuing work on venous thromboembolism (VTE) prevention and reduction of patient falls, two of the 2010/11 priorities not taken forward to 2012/13. This will be supported by the use of the mandated National Patient Safety Thermometer which requires a holistic monitoring of four harms: pressure ulcers, falls, catheter associated urinary tract infections and prevention of VTE. Use of this tool is one of the three new priorities for 2012/13. The National Patient Safety Thermometer is also included in the Commissioning for Quality

and Innovation (CQUIN) scheme which gives trusts resources based on achievement against stretching goals for innovative services.

Details of initiatives to improve the patient's experience are given and the results of the 2011 National Inpatient and Outpatient surveys show how much patients value the service provided by Papworth. Results from the previous year are given for the Inpatient survey, allowing the direction of travel to be seen. The Quality Account shows the actions being put in place to address issues raised by the National Cancer Survey. For 2012/13, all providers will be using a Net Promoter question - 'Would you recommend the trust to family and friends?' This will allow comparison across the health economy and the PCT Cluster will be using this to further monitor patient experience in the services it commissions.

Detail of workforce planning, and capability and capacity required to achieve the priorities are not set out in the Quality Account. The results from the staff survey are given but details of actions in place to address less favourable results are not included.

The Quality Account has some areas where further explanation would be helpful for the public to understand. There is use of jargon and abbreviations which should be avoided. The Quality Account includes all the nationally mandated sections including a list of services and specialties provided by the Trust. The PCT Cluster has reviewed the data presented in the Quality Account and this appears to be in line with other data published.

Statement from Cambridgeshire Local Involvement Network (LINk)

Thanks were sent on behalf of the Cambridgeshire LINk Papworth Liaison Group for the invitation to comment on the Draft Quality Accounts for Papworth Hospital NHS Foundation Trust for 2011/12.

The group have met and discussed the Quality Accounts and feel that this year there are no formal comments that they wish to make. The group overall are very pleased with the levels of care and management in place at the hospital, and thought that the hospital had achieved excellent results with the survival rates for chronic thromboembolic pulmonary hypertension (CTEPH) and coronary bypass operations.

Statement from Adults Wellbeing and Health Scrutiny Committee

Cambridgeshire County Council Adults Wellbeing and Health Overview and Scrutiny Committee welcomes the Trust's achievements in reducing infection rates, VTE prevention, and falls. It congratulates the Trust for its achievements in relation to coronary bypass mortality, and for being a national exemplar in relation to VTE prevention.

We support the Trust's priorities for 2012/13. In relation to end-of-life care, we recommend that the Trust obtain the views of a sample of deceased patient's relatives to inform the development of the end-of-life care pathway. We suggest that views of the families of patients who die are also included in the PROMS measures.

We wish to highlight the importance of ensuring that the improvements in documentation and observation in the Intensive Care Unit are embedded in practice, and that the outcomes of the ECMO service are monitored and published.

Analysis is needed of the reasons for the large increase in the use of the PALs services, including identification of any issues or trends, and actions to address these. This also applies to any trends identified in the complaints data.

The final report should contain information on what if any NICE guidance has yet to be implemented.

The risk management section should include information, and/or a link to more detailed information, on the risks, in terms of patient safety, clinical effectiveness and patient experience, associated with the location of the hospital, and the fact that it will be some time before it moves to the Addenbrooke's site, and how these risks are being addressed. It should also include information and/or a link on outstanding issues arising from the internal risk management audit.

We recommend that the final version of the Quality Account is written in a way which is accessible to the public, including clear explanations of any technical terminology.

Statement from Patient & Public Involvement/ Membership Committee (PPIM) Chair

(A Committee of the Board of Governors)

Excellent progress and results obtained in 2011/12 due to the hard work and dedication of staff at all levels.

The chosen priorities for 2012/13 will ensure that the clinical excellence, patient experience and ongoing staff development will be highly instrumental in maintaining patient safety and the aspirations of the Trust.

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 as amended 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 2011/12
- 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 2011 to May 2012
  - Papers relating to quality reported to the Board over the period April 2011 to May 2012
  - Feedback from Midlands and East Specialised Commissioning Group dated 15/05/2012
  - Feedback from NHS Cambridgeshire and NHS Peterborough dated April 2012
  - Feedback from governors dated 07/05/12
  - Feedback from LINks dated 25/04/2012
  - The Trust's complaints report under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15/05/2012
  - The 2011 National Inpatient Survey
  - The 2011 National Staff Survey
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2012
  - CQC quality and risk profiles dated 02/04/2012
- 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, and 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.monitor-nhsft.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 24 May 2012 Chairman

Date 24 May 2012 Chief Executive

Annexe 3

Limited Assurance Report on the Content of the Quality Report and Mandated Performance Indicators

Independent Auditor's Limited Assurance 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 Papworth Hospital NHS Foundation Trust's Quality Report (the 'Quality Report') and specified performance indicators contained therein.

Scope and Subject Matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Number of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia in the year ended 31 March 2012, as set out on page 20 of the Quality Report; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers during the year ending 31 March 2012, as set out on page 31 of the Quality Report.

We refer to these national priority indicators collectively as the "specified indicators".

Respective Responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with annexe 2 to chapter 7 of the FT ARM and the measurement of the specified indicators in line with the assessment criteria referred to on pages 19 and 31 of the Quality Report (the 'Criteria'). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ('Monitor'). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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

The Quality Report does not incorporate the matters required to be reported on as specified in Annexe 2 to Chapter 7 of the FT ARM;

- The Quality Report is materially inconsistent with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.
- We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board and Audit and Assurance Committee minutes for the period April 2011 to May 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
- Feedback from NHS Cambridgeshire and NHS Peterborough dated April 2012;
- Feedback from LINKS dated 25 April 2012;
- Feedback from the Cambridgeshire County Council Adults Wellbeing and Health Overview and Scrutiny Committee on the Quality Account 2011/12;
- Annual Quality and Safety Report 2011/12;
- Care Quality Commission Patient survey report 2011;
- The latest national Department of Health staff survey dated 2011;
- Care Quality Commission quality and risk profiles dated 2 April 2012;
- Head of Internal Audit's opinion on the effectiveness of the system of internal control at Papworth Hospital NHS Foundation Trust for the year ended 31 March 2012;
- Care Quality Commission Review of Compliance reports April 2012 and December 2011; and
- Information Governance Toolkit assessment summary report 2011/12 - prepared 2 April 2012.

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

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

This report, including the conclusion, has been prepared solely for the 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 2012, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.

Making enquiries of management.

Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.

Comparing the content requirements of the FT ARM to the categories reported in the Quality Report.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the Criteria on pages 19 and 31 of the of the Quality Report.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Papworth Hospital NHS Foundation Trust.

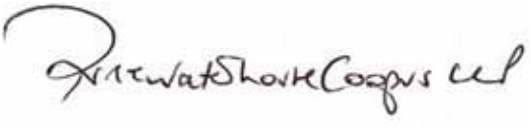
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that:

The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;

The Quality Report is materially inconsistent with the documents; and

The specified indicators have not been prepared in all material respects in accordance with the Criteria.



PricewaterhouseCoopers LLP
Chartered Accountants
Cambridge
Date: 29 May 2012

The maintenance and integrity of the Papworth Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Annexe 4

Services Provided by Papworth Hospital

Aims and Objectives

The aims and objectives of the Trust are 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 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 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. Diagnostic and screening procedures.
2. Treatment of disease, disorder or injury
3. Surgical 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 and Nominated Individual: The Trust's Chief Executive, Mr Stephen Bridge, Tel: 01480 364286

Glossary

A

Acute Respiratory Distress Syndrome (ARDS)

Acute respiratory distress syndrome (ARDS) is a life-threatening lung condition that prevents enough oxygen from getting to the lungs and into the blood.

Adults Wellbeing and Health Scrutiny Committee (OSC)

Purpose is to exercise the powers conferred by Section 21 of the Local Government Act 2000 and Section 7 of the Health and Social Care Act 2001 by co-ordinating the effective scrutiny of adult social care, health services and other related services and making reports to relevant local NHS bodies and local authorities.

C

Cardiac surgery

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

Care bundles

A collection of interventions (usually three to five) that may be applied to the management of a particular condition.

Care Quality Commission (CQC)

The independent regulator of health and social care in England. www.cqc.org.uk

Catheter associated urinary tract infections (CAUTI)

A catheter-associated urinary tract infection (CAUTI) occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause infection.

Central Venous Catheter Bloodstream Infections (CVC-BSI)

A central venous catheter related-bloodstream infection (CVC-BSI) is a bloodstream infection most likely caused by the presence of a central venous catheter (CVC). CVCs disrupt the integrity of the skin, making infection with bacteria or fungi possible. Infection may spread to the bloodstream.

Clinical audit

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

CDAD

C. difficile-associated disease.

Clostridium difficile (C. difficile or C. diff)

Clostridium difficile (C. difficile) are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. There are ceiling targets to measure the number of C. difficile infections which occur in hospital.

Commissioning for Quality Innovation (CQUIN)

A payment framework that enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of national and local quality improvement goals. Compliance Framework The Compliance Framework sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.

Compliance Framework

The Compliance Framework sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.

Coronary artery bypass graft (CABG)

A type of heart surgery where the blocked or narrowed arteries supplying the heart are replaced with veins or arteries taken from another part of the patient's body.

D

Delayed transfers of care

A national indicator. Assesses the number of patients who are delayed when being transferred from one health organisation to another e.g. from one hospital to another, or from hospital to community care.

Department of Heath (DH)

The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk/

E

East of England Specialised Commissioning Group (East of England SCG)

The role of the East of England SGC is to commission (buy) specialised health services for the population of the east of England on behalf of all Primary Care Trusts (PCT's) in the region. The East of England SCG provides a structure to represent the interests of patients who otherwise might not be prioritised or adequately

planned for because of the relatively few numbers and higher-than-average unit costs. Whilst the remit of PCTs is to seek the greatest health gain for the greatest number, the East of England SCG has a different but complementary role commissioning services for small numbers of specialised patients.

End-of-Life Care

The General Medical Council considers that patients are approaching the end of life when they are likely to die within the next 12 months. This includes patients who are expected to die within the next few hours or days, and those with advanced incurable conditions. End-of-life care may last a few days, or for months or years. End-of-life care begins when you need it, and will continue for as long as you need it.

Equality Delivery System (EDS)

The NHS Equality Delivery System (EDS) is designed to help NHS organisations improve equality performance and embed equality into mainstream NHS business and is one of the key products to come out of the Equality and Diversity Council (EDC).

Extracorporeal membrane oxygenation (ECMO)

ECMO is a technique that oxygenates blood outside the body (extracorporeal). It can be used in potentially reversible severe respiratory failure when conventional artificial ventilation is unable to oxygenate the blood adequately. The aim of ECMO in respiratory failure is to allow the injured lung to recover whilst avoiding certain recognised complications associated with conventional artificial ventilation. The procedure involves removing blood from the patient, taking steps to avoid clots forming in the blood, adding oxygen to the blood and pumping it artificially to support the lungs.

F

Foundation Trust (FT)

NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Papworth Hospital became a Foundation Trust on 1 July 2004.

G

Global trigger tool (GTT)

A tool to measure adverse events via a system of specific triggers. The triggers identify possible adverse events and actual events are rated by harm level to the patients. Over time the results are used to identify areas for improvement.

Governors

Foundation trusts have a board of governors, who are elected by the members.

H

Healthcare acquired infection (HCAI)

HCAI are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Hospital episode statistics (HES)

The national statistical data warehouse for the NHS in England. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.

Hospital standardised mortality ratio (HSMR)

A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average. 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.

I

Indicator

A measure that determines whether the goal or an element of the goal has been achieved.

Inpatient

A patient who is staying in hospital.

Inpatient survey

An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate.

Intensive Care Unit (ICU)

A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.

L

Local clinical audit

A type of quality improvement project that involves individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team

Local involvement networks (LINkS)
Local involvement networks (LINks) are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services.

Liverpool care pathway
The LCP is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life. It is a means to transfer the best quality for care of the dying from the hospice movement into other clinical areas, so that wherever the person is dying there can be an equitable model of care.

M

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

Midlands and East Strategic Health Authority
NHS Midlands and East is the Strategic Health Authority (SHA) cluster. comprises NHS East Midlands, NHS East of England and NHS West Midlands. It is responsible for ensuring that expenditure on health and health care across the region delivers better services for patients and value for money.

Monitor
The independent regulator of NHS Foundation Trusts
http://www.monitor-nhsft.gov.uk

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

N

National clinical audit
A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS trusts are expected to participate in the national audit programme.

National Institute for Health and Clinical Excellence (NICE)
NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. http://www.nice.org.uk

National Patient Safety Agency (NPSA)
An arm's length body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. http://www.npsa.nhs.uk

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

NHS Innovation and Improvement
Assists the NHS in transforming healthcare for patients by developing and spreading new work practices, technology and improved leadership.

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

NHS number
A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.

O

Operating Framework
An NHS-wide document which outlines the business and planning arrangements for the NHS.

Outpatient
A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but does not stay overnight.

Outpatient survey
A national survey of the experiences of patients who have been an outpatient. All NHS Trusts are required to participate.

P

Patient Environment Action Team (PEAT)

PEAT carry out an annual assessment of inpatient healthcare sites in England that have more than 10 beds. The assessment is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity. The results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Pressure ulcer

A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Primary coronary intervention (PCI)

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

Priorities for improvement

There is a national requirement for trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and clinical effectiveness.

Productive Ward

'The Productive Ward' - releasing time to care, focuses on lean methodology to improve ward processes and environments thus enabling staff to spend more time on direct patient care.

Q

Quality, Innovation, Productivity and Prevention (QIPP)

Department of Health QIPP targets are the basis on which the NHS is expected to contain rising costs and stay solvent.

R

Root Cause Analysis (RCA)

Root Cause Analysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviors, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.

S

Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

Secondary Uses Service (SUS)

A national NHS database of activity in trusts, which is used for performance monitoring, reconciliation and payments.

Serious incidents (SIs)

Previously known as Serious Untoward Incidents/SUIs. An incident requiring investigation that results in one of the following:

- Unexpected or avoidable death
- Serious harm
- Prevents an organisation's ability to continue to deliver healthcare services
- Allegations of abuse
- Adverse media coverage or public concern
- Never events, as updated on an annual basis.

Surgical Site Infection

A surgical site is the incision or cut in the skin made by a surgeon to carry out a surgical procedure and the tissue handled or manipulated during the procedure. A surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues.

U

Unitary tract infection (UTI)

An infection affecting the urinary system.

V

Venous thromboembolism (VTE)

VTE is the term used to describe a blood clot that can either be a deep vein thrombus (DVT), which usually occurs in the deep veins of the lower limbs, or a blood clot in the lung known as a pulmonary embolus. There is a national indicator to monitor the number of patients who have been risk assessed for VTE on admission to hospital.

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

A member of Cambridge University Health Partners

Papworth Hospital is a smoke free site