Quality Report 2018/19
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1. The quality report

1.1 Part 1 - Introduction

1.1.1 Statement from the chief executive

This Quality Report describes how we are continuing to improve the quality of care that we provide to our patients at Cambridge University Hospitals NHS Foundation Trust.

During 2018/19 we have made further progress in delivering consistently safe and high quality care in line with the priorities set out in our new Quality Plan which was approved by the Board of Directors in September 2018.

Our progress in 2018/19 should be seen in the context of the challenging environment in which the NHS is operating, including continued rapid growth in demand for services.

Key quality achievements during 2018/19 have been:

- The Care Quality Commission’s latest inspection of our services published in February 2019 rated the Trust as ‘Good’ overall and as ‘Outstanding’ for being both Caring and Well-Led. End of Life Care became the first of our services to receive an overall rating of ‘Outstanding’.
- The Trust continues to achieve one of the best mortality rates within the NHS – currently the 4th best performing trust in the country and the best performing trust among teaching hospitals outside London.
- A new improvement and transformation directorate was established to lead and support a programme of continuous quality improvement across our hospitals.
- Further improvements in our 2018 NHS staff survey results, with staff engagement and staff recommending our hospitals for treatment both above the national average.

The report describes in detail performance during 2018/19 against the ten quality priorities identified at the start of the year. Five of the priorities were achieved. For the other five, while progress was made, we did not achieve our targets.

We will continue to focus on these areas in the year ahead, learning from where we fell short, alongside our 2019/20 priorities as set out in the report. This includes further improving our safety culture and systems and how we learn from harm, and striving to remove unexpected variations in practice and outcomes through an ongoing focus on getting the fundamentals of care right for all our patients and across all our services.
Our quality achievements are testament to the professionalism and commitment of our 10,000 members of staff who are dedicated to providing safe, kind and excellent care to our patients and their families across Addenbrooke’s, The Rosie and the wide range of other locations from which we provide services.

I would also like to take this opportunity to thank our patients and partner organisations for their continued support and encouragement in working with us to improve the quality of our services.

In particular, we will continue to work actively in the year ahead with our partners in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) to plan and run services across the local region in a more coordinated way, to agree system-wide priorities, and to work collectively improve the health and well-being of the local population.

Finally, I confirm that to the best of my knowledge the information in this document is accurate.

Roland Sinker
Chief Executive
1.1.2 **2018/19 activity**

During 2018/19 we have been treating more patients than ever before the following table sets out key activity numbers.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances*</td>
<td>117,074</td>
<td>121,871</td>
<td>4.10%</td>
</tr>
<tr>
<td>Visits to outpatients</td>
<td>757,112</td>
<td>818,893</td>
<td>8.16%</td>
</tr>
<tr>
<td>Births</td>
<td>5,389</td>
<td>5,330</td>
<td>-1.09%</td>
</tr>
<tr>
<td>Day cases</td>
<td>122,021</td>
<td>126,305</td>
<td>3.51%</td>
</tr>
<tr>
<td><strong>Total inpatients</strong></td>
<td><strong>69,069</strong></td>
<td><strong>70,665</strong></td>
<td><strong>2.31%</strong></td>
</tr>
<tr>
<td>– elective</td>
<td>15,288</td>
<td>15,693</td>
<td>2.65%</td>
</tr>
<tr>
<td>– emergency &gt; 85 years old</td>
<td>6,716</td>
<td>6,787</td>
<td>1.06%</td>
</tr>
<tr>
<td>– emergency &lt; 85 years old</td>
<td>40,169</td>
<td>41,522</td>
<td>3.37%</td>
</tr>
<tr>
<td>– maternity</td>
<td>6,896</td>
<td>6,663</td>
<td>-3.38%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,070,665</strong></td>
<td><strong>1,143,064</strong></td>
<td><strong>6.76%</strong></td>
</tr>
</tbody>
</table>

*ED (A&E) – Not including Minor Injuries Unit (MIU) attendances

The Trust has continued to see growth in demand throughout 2018/19 however the drivers of growth have been in different areas of patient care compared to last year.

We saw a slowing of the growth in Emergency care both for A&E attendances and emergency inpatients in the first 9 months of the year, such that activity was below planned levels. This enabled us to mitigate some of the expected shortfalls for bed capacity, and has allowed a higher volume of planned elective inpatient work to be undertaken. Day case activity has also increased this year and has exceeded planned levels, reflecting our focus on treating patients in the most appropriate setting.

Maternity care has delivered a sustained volume of births compared to the reduction seen last year. There has been a small reduction in the requirement for ante-natal maternity admissions.

The largest growth this year has been in outpatient attendances and this in part has been driven by a referral rate 6% higher than last year.

The level of growth for hospital care poses a continuing financial challenge for CUH and the wider health economy.

1.1.3 **Data and terms used in this report**

Unless stated otherwise, the data presented in this report is the latest available at 31 March 2019.

For an explanation of terms and abbreviations please see the glossary set out in Appendix E.
1.2 Part 2 - Priorities for improvement and statements of assurance from the board

Please note: Reviewing performance against 2018/19 priorities for improvement are given in detail in Part 3 of this document.

1.2.1 CUH Vision, Strategy and Values

The Trust’s vision is to improve people’s quality of life through innovative and sustainable healthcare, underpinned by our values of Together – Safe, Kind and Excellent. We will seek to achieve this as a Trust, as a wider health and care system, as a biomedical campus and through our role regionally, nationally and internationally.

Our strategy is reviewed on an annual basis, using the seven-stage framework of strategy development developed by NHSI.

Our strategy sets out four priorities:

- **Improving patient journeys** – ensuring that patients see the right person as soon as possible, with no long waits for treatment, and able to leave hospital at the right time.

  The way innovation and improvement has been achieved successfully in healthcare, is to follow the patient journey. In doing this at CUH, we are identifying opportunities to re-design how care is delivered to improve patients’ experiences, improve health outcomes and minimise waiting. Through this we will strengthen services by improving productivity.

- **Working with our communities** – working and collaborating with partners to keep people well and at home for longer.

  The NHS Long Term Plan promotes a new model for integrated primary and community services which will enhance out-of-hospital care and enable people to receive care closer to home. In moving towards these new
models of care, as well as leading and working with partners across our Sustainability and Transformation Partnership (STP) for Cambridgeshire and Peterborough, our aim is to prevent more episodes of illness, reduce length of stay in hospital, and reduce duplication of interventions and tests. This key priority for CUH will not only improve the quality of care for patients and communities, but support better population outcomes and deliver better value.

- **Strengthening the organisation** – having the right staff in the right places to look after patients, with facilities that are fit for purpose.

  We will continue to focus on improving the leadership, governance and capability of CUH, incorporating cultural change and organisational development work. Making progress against our strategic priorities has been dependent on effective leadership and accountability for decisions. We will continue to build on this over 2019/20. We will continue to create a culture in which there is healthy and open communication around performance and best practice, supported by appropriate intelligence and robust data.

- **Contributing nationally and internationally** – continuing to develop research, education and innovation in healthcare that will lead to treatments of the future.

  CUH is a leading teaching hospital, with particular expertise in a number of specialties. It is co-located on the bio-medical campus alongside Cambridge University and other leading research institutes including the Medical Research Council and Cancer Research UK, as well as the wider biomedical cluster across Cambridgeshire. These partnerships present us with significant opportunities for the redevelopment of core NHS clinical facilities as well as maximising the potential for research and innovation to lead to new ways of preventing and treating disease, such as with the development of the East of England Children’s Hospital and Cancer Research Hospital. Success will mean outstanding services and world-class research, where clinicians feel supported to develop innovative ways to improve clinical practice, with CUH making the most of opportunities in highly specialised services, teaching and bioscience research.

During 2018, we updated the cross-cutting core strategic programmes that sit under the four priorities. Progress reports on each of these core strategic programmes are now presented to the public Board every four months, alongside a composite dashboard of key metrics. Taken together, these allow us to monitor progress against delivery of our strategy.

In line with stage seven of NHSI’s strategy development framework, we are currently in the process of reviewing our strategy as our vision and the wider health and care context evolves. This review takes account of the progress we have made to date and the current challenges and opportunities we face. An initial strategy seminar was held with the Board in February 2019, and a further session will be held in March to determine the strategic choices we will make in 2019/20 and beyond. The output of this will be discussed with our staff and inform our strategy and vision for 2019/20.

**What is our approach to quality and improvement?**

As part of our organisational values, we will put quality first. We will always be patient focussed and responsive, so that our values are lived by each and every staff member. Our values are embodied in our ‘Improving Together’ approach:
Underpinning this are expectations (ways of working) of everyone who works here, to ensure that our values are realised whilst working with one common goal - improving outcomes for our patients and ensuring that we all deliver safe, effective and responsive care.

Improving Together
The Trust has prioritised improvement, under the banner ‘Improving Together’, as key to supporting the delivery of its strategy and future sustainability. Central to this is working towards a culture of sustainable continuous improvement, where frontline staff deliver improvement as part of their day-to-day working and improvement becomes “what we do”.

Improving Together is our overarching approach to improvement within the Trust. We have recognised that we need to give our staff the permission to choose to improve. We aim to create a sustainable culture within the Trust that, with time, will reach out to all 10,000 staff, where they are engaged to improve services and embed change, thereby building the Trust’s capability for improvement.

An improvement and transformation directorate was newly established in 2018. An executive director and clinical director were appointed and the CUH Together, nursing lead, transformation and PMO teams brought together. The team’s roles and supporting structure are developing and will be refined further.

The improvement and transformation team will continue to support the wider Trust, embedding improvement champions within all areas of the organisation, supporting and encouraging other staff. Clinical and non-clinical staff who have already led improvements will support others to improve, thereby building and growing our improvement capability and capacity.
Improving Together will frame our journey of sustainable continuous improvement and hence there will never be an end point. Common improvement methodologies will be utilised, which are easily understood by staff and used to support change.

Education and training on improvement skills will be provided widely throughout the Trust to build internal capability; we will adopt a coaching approach that supports and encourages staff to improve.

We will regularly measure staff awareness of Improving Together to ensure that we are embedding a process of continuous improvement and that it is far reaching and understood by all. An analysis, monitoring and evaluation approach will be established to ensure sustainable benefits are realised.

We will actively celebrate improvements within and external to the Trust, holding regular celebration events. We will be open and honest when things have not gone well and use these to further improve the experience and outcomes of our patients.

Engaging with patients to help them be involved in the design and production of improvements must become the norm across all areas of the Trust, rather than a traditional top-down approach to change and quality.

We will actively capture lessons learnt and ensure that widespread dissemination of learning is in place.

We will maximise the use of digital enablers, utilising real-time data in our wards and clinical areas, in order to drive improvement and respond effectively to potential patient safety issues.

We will factor improvements into our appraisal process with all staff, providing opportunities for staff to deliver on improvement projects as part of their personal development plans (PDPs). We will encourage all clinical and non-clinical staff to be involved in and lead improvements, so that we have a co-ordinated approach to improvement that supports the delivery of our strategy.

**Our Approach to Improvement**

In order to successfully support the sustainability of CUH, the following aspects will be developed further to support the longer-term aspiration of the Trust in working towards a culture of sustainable continuous improvement.

We will procure and work with an experienced improvement partner who has a proven track record of implementing a sustainable improvement culture in peer organisations. In the meantime, the Trust will continue other approaches to increase improvement capacity and capability for all staff, for example in-house training; a leadership development programme delivered by the King’s Fund and the Judge Business School at Cambridge; and, in order to do things differently and at pace, the Trust will continue to use the accelerated design event (ADE) methodology which was adopted after working with Professor Helen Bevan and the NHS Horizons team.

We will continue to communicate the ethos of Improving Together to engage and empower staff at all levels to deliver sustainable clinically-led, continuous improvement.

We will move to a “distributed leadership” approach, where we connect and engage with a wider cohort of frontline staff who understand the Trust’s priorities and support delivery, at pace, of improvements in the areas which impact our agreed strategic priorities. Wider involvement will have a significantly greater impact on our pace and delivery.
We will work with our patients and partners to co-produce improvement, so that this approach becomes our norm.

We will build on our governance currently in place to ensure that we have oversight and accountability for our improvement programme.

1.2.2 Improving patient care and supporting our staff

Seven day hospital services

The Trust is required to be compliant against four priority clinical standards for seven day services. These standards require that for patients admitted as an emergency to the Trust:

- A review by a consultant takes place within 14 hours of admission (Standard 2)
- Diagnostic tests are available 24/7 (Standard 5)
- Consultants are available 24/7 to direct patient care (Standard 6)
- Patients receive daily reviews by a consultant following their admission (Standard 8)

In its last audit in April 2018 the Trust assessed itself as being compliant (>90%) against standards 5 and 6, but non-compliant against standards 2 and 8. The lower compliance rate for standards 2 (67%) and 8 (74%) was due primarily to issues with documentation – where consultants may have seen patients but not named themselves on clinical notes – and where doctors below the level of consultant had reviewed patients.

Results of this audit were triangulated against the Trust’s mortality rates which did not identify any patient safety concerns.

Work to improve compliance against the standards is being led by the Trust’s Medical Director with the support of the Clinical Audit team. A new assurance framework is in place from February which requires the Trust’s Board to monitor progress and approve twice-annual updates to NHSE/I, and this will support implementation. Any clinical safety issues identified through this work will be raised to the Mortality Surveillance Committee for further investigation.

Speaking up

The Government in its response to the Gosport Independent Panel Report, committed legislation requiring all NHS trusts and NHS Foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of this legislation, the Trust appointed a Freedom to Speak Up Guardian (FTSUG) in December 2016. The Director of Corporate Affairs is the Executive lead for raising concerns/whistle-blowing and there is Non-Executive Director linked to this area. The Board of Directors receives a six monthly report on progress and any key issues.

The key objective of the speaking up service for employees, workers and students is to provide support and independent guidance where normal channels are not working. The focus of the past two years has been to create the building blocks for the Trust’s speaking up service by engaging with a wide range of staff across the organisation, for example through divisional/departmental/team meetings, staff governors, staff-side, study days and open forums to raise awareness of the service and to hear views on the culture of speaking up at CUH.
A programme of work is in place to continue to raise awareness and visibility in engaging with staff across the organisation. In February 2018 the first cohort of local listeners were recruited to supplement the service offered by the FTSUG. In March 2019 another 50 expressions of interest have been received for future cohorts of local listeners. This initiative offers staff a range of options to support the improved culture of speaking up.

In the two-year period from January 2017 to December 2018, 102 members of staff have contacted the FTSUG to raise concerns. 44 staff members raised concerns in 2017 and 58 raised concerns in 2018. The latter figure, at 0.6% of the total workforce, is in line with the national average quoted by the National Guardian’s Office.

1. Data from staff surveys guides targeted approaches by the FTSUG in conjunction with management, human resources and patient safety/quality colleagues. In its annual Quarter 1 (April – June 2018) local staff survey, 90% of overall respondents confirmed that they can speak up to their line managers. Furthermore, 74% of respondents to the national staff survey (2019) confirmed that they feel secure to raise concerns about unsafe clinical practice.

2. Staff can contact the Freedom to Speak Up Guardian or local listener – details are provided on the Trust’s intranet pages, at corporate induction, posters and leaflets in work areas, concourse stands, new manager orientation, local area visits, meetings, away days, etc.

3. Staff can also raise concerns with other staff support services e.g. Human Resources, trade unions, professional bodies, chaplaincy, occupational health.

4. Feedback to staff who use the Speaking Up service is given by keeping in regular contact and reviewing the situation, aiming for a satisfactory conclusion, with the emphasis on using existing management and support services as far as possible. Formal feedback is collected quarterly on the organisational learning from concerns raised and to seek information on the experience of those who have accessed the service and whether they would raise concerns in the future. To date, 82% have responded in the affirmative.

5. The Trust has a clear procedure available via the trust intranet page in ensuring staff are supported to raise concerns without feeling worried about any potential repercussions; the Freedom to Speak Up Guardian regularly reviews this aspect with staff who have raised concerns; this procedure is in line with NHSI’s national policy on raising concerns.

6. In the two-year period, two concerns have been raised formally as part of the Trust’s Raising Concerns (Whistleblowing) Procedure. These have been overseen by the Director of Corporate Affairs and have been subject to formal external investigations. Both have been concluded, with action plans in place to address the findings.

7. In the January 2019 report to the Board, a breakdown of concerns raised by theme and occupational group, was provided:

7.1. Across the past two years, around 35% of concerns raised relate to behaviour/attitude and 15% are patient-related. While it is difficult to make direct comparisons due to issues of data definition, both percentages are lower than the national average based on figures from the National Guardian’s Office. Examples of patient-related concerns raised at CUH relate to the patient transport service, communications
used by a range of staff with patients in clinical settings, clinical practice, information governance and the impact of staffing shortages. One of the priorities of the FTSUG in the period ahead is to meet with a range of staff across clinical settings to raise awareness that FTSU includes patient-related concerns and to better understand where patient-related concerns are being raised through other channels.

7.2. Trust procedure/practice concerns have accounted for 24% and 31% respectively of all concerns raised over the past two years. Concerns raised in this category include feedback on staff experience of human resources investigations, managing performance, sickness absence, disciplinary and grievance procedures, allocation of annual leave and time off for training.

7.3. Of the concerns raised with the speaking up service, 24% of cases are taken forward by the individual themselves; 26% involve line management and 40% relate to human resources policies and procedures. Empowering individuals to find the language and courage to address issues directly with line managers, to be supported and have the opportunity to resolve matters locally is a key part of the cultural change we are striving for.

The CUH Speaking Up service works alongside internal stakeholders to ensure that we, as a Trust, are transparent in how we manage speaking up cases, the lessons learned and changes practice, as appropriate. We aim to actively demonstrate our commitment to supporting those who speak up and ensure they do not suffer a detriment. Our efforts to influence the wider culture are for the ultimate benefit of patient care.

**Improving rota gaps for NHS Doctors and Dentists in training**

In line with the requirements of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Guardian of Safe Working provides both quarterly and annual reports to the Board of Directors. These reports which are based on the national template, provide details of Exception Reports, Work Schedule Reviews, Vacancies and Locum Usage.

The majority of vacancies at junior doctor level are in Clinical Fellow (non-training grade) posts rather than doctors in training (i.e. those employed on the 2016 contract). These postholders work alongside doctors in training on junior doctor rotas and such vacancies have the potential to negatively impact on the workload and access to training opportunities of doctors in training.

There isn’t a consistent pattern in relation to grade and speciality of these non-training grade vacancies. As such vacancies arise, the Medical Staffing team work with individual clinical teams to agree a timely recruitment process, changes to work schedules, and innovative ways to make such posts more attractive such as support for a PG Cert and other postgraduate qualifications.

**1.2.3 Priorities for quality improvement in 2019/20**

The priorities set for improvement for 2019/20 have been determined following a review by internal and external stakeholders, including staff, patients and the public. Priorities set for 2019/20 have been agreed by the Trust’s Board of Directors and Council of Governors, and reflect areas for improvement that align to the delivery of high quality, effective, safe and patient centred care. The
priorities are aligned to the five key questions posed by our regulator, the Care Quality Commission - namely Safe, Effective, Caring, Responsive and Well-Led.

Some priorities listed below are aligned to priorities set in 2018/19, with modifications made to ensure that the focus of improvement is within the Trust’s remit to deliver. It is recognised that the Trust works within a wider healthcare system, but specific areas of care delivery can be positively influenced by the Trust within the context of patient pathways which continue outside of the hospital environment.

1.2.4 Objectives and measures for 2019/20

**Safe**

*Our aim is to reduce avoidable harm to our patients by improving our safety culture, safety systems and how we learn from past harm.*

**Patient Safety Improvement Plan (2018-2020)**

The Trust Patient Safety Improvement Plan sets out the current patient safety improvement priorities for the Trust, as part of its commitment to a continuous patient safety improvement programme. The three current workstreams of improvement for 2018-2020 are:

- Continually learning and improving
- Just Culture
- Deteriorating patient

These three patient safety improvement workstreams are aligned to all four areas of the Trust strategy and were devised in response to both internal patient safety intelligence and mandated guidance from external bodies.

The three key safety improvement metrics (detailed in the table below) have been identified for 2019/20 and are aligned to each of the above three domains of work.

**The measures we will use in 2019/20 will be:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definitions</th>
<th>Baseline</th>
<th>Target</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Action Review (AAR) first wave of trainers complete training.</td>
<td>All first wave trainers successfully completed AAR training by 31 March 2020.</td>
<td>0</td>
<td>&gt;95%</td>
<td>This is a key element of the Just Culture work stream which forms part of the Trust current Patient Safety Improvement Plan (2018-2020). The Just Culture work stream will be launched in January 2019.</td>
</tr>
<tr>
<td>Internal Root Cause Analysis (RCA)</td>
<td>&gt;90% internal RCA investigations meet the quality</td>
<td>9%</td>
<td>&gt;90%</td>
<td>Key element of the Strengthening of the RCA investigations work</td>
</tr>
</tbody>
</table>
# Effective/Responsive

## Our aim is to consistently deliver high quality care that is effective, timely, patient centred and efficient.

We recognise that Delayed Transfers of Care (DTOCs) remain a challenge for everyone working in the healthcare system. In order for us to have a clear focus on ensuring that we will minimise delays to patients’ journeys, we have identified the following priorities to help us best understand where we have effective and responsive systems in place, and also to identify where we need to continue to improve.

**The measures we will use in 2019/20 will be:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definitions</th>
<th>Baseline</th>
<th>Target</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients that remain in an acute Trust bed for 21 days or more</td>
<td>Number of patients that remain in an acute Trust bed for 21 days or more. The national definition applies; with the main criteria being; acute patients only, 18+ only. Excludes regular day &amp; night attenders, day cases and zero length of stay (LoS) admissions.</td>
<td>186</td>
<td>116</td>
<td>The stranded patient metric from 2018/19 has been updated to ‘super-stranded’ (21 +LoS) in line with national priorities. The Trust has been set a target to reduce the number of beds lost to long stay patients by 25% from a baseline of 186 in 2017/18. This reduction indicates more effective and efficient patient pathways, improves patient experience (as they are more likely to...</td>
</tr>
<tr>
<td>Measure</td>
<td>Definitions</td>
<td>Baseline</td>
<td>Target</td>
<td>Rationale</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Occupancy rate at midnight</td>
<td>The number of G&amp;A patients occupying trust beds at midnight divided by the number of G&amp;A beds available. Definitions in the KH03 national return apply; the main exclusions are patients under obstetrics and critical care.</td>
<td>93.3%</td>
<td>92%</td>
<td>Lower occupancy levels support the appropriate placement of patients and enhance the operational efficiency of the hospital by ensuring that it can meet both elective and emergency demand. The baseline is the average occupancy rate from January-December 2018. 92% is the commissioned level agreed with NHSE/I based on anticipated growth levels for 19/20. There are no plans to increase our bed base in 19/20, therefore maintaining a flat line occupancy level will be a significant challenge especially if demand grows.</td>
</tr>
<tr>
<td>Accuracy of Clinically Fit Dates (CFDs) This excludes DTOC patients.</td>
<td>% of CFDs which accurately predict the date of patients’ discharges (excludes DTOC patients).</td>
<td>31.2%</td>
<td>40%</td>
<td>The Trust uses CFDs to predict patients’ likely date of discharge. The accuracy of CFDs is important as it enables the Trust to better manage patient flow and on-time discharges. This aligns with both the Quality Strategy and Plan. We propose to keep this measure increasing the target to 40%. Achievement of this metric will require ongoing support from the office of the Medical Director, since the accuracy of CFDs depends upon robust...</td>
</tr>
</tbody>
</table>
### % of early discharges

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definitions</th>
<th>Baseline</th>
<th>Target</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of early discharges</td>
<td>The percentage of patients who are discharged from the Trust before midday, as a proportion of all discharges. This excludes zero length of stay patients and time spent in the discharge lounge.</td>
<td>12.3%</td>
<td>20%</td>
<td>Earlier discharges create capacity in the morning when the organisation needs it. They create flow out of ED and support the correct placement of patients in the right specialty.</td>
</tr>
</tbody>
</table>

### Patient Experience/Caring

**Our aim is to further improve our delivery of patient care against our values in relation to compassion and communication.**

The measures we will use in 2019/20 will be:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definitions</th>
<th>Baseline</th>
<th>Target</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of complaints responded to within initial fixed timeframe (30, 45, or 60 working days) or within agreed extension with complainant.</td>
<td>The number of complaints which are answered within 30 working days or within an agreed timescale set by the complainant.</td>
<td>80% (estimate of current position)</td>
<td>80%</td>
<td>Ensuring that complaints are responded to within a timely manner is a key requirement of provider Trusts. This aligns to the Quality Strategy in improving the patients' journey and to quality priority 2 within the Quality Plan; this supports restoring patients' confidence and trust in the organisation after a negative experience and demonstrates a willingness of the Trust to take complaints seriously and work towards a resolution in a timely and proportionate manner.</td>
</tr>
<tr>
<td>Measure</td>
<td>Definitions</td>
<td>Baseline</td>
<td>Target</td>
<td>Rationale</td>
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<tr>
<td>Establish a formal process of recording actions developed and agreed from complaints investigations using the 'action module' on QSIS (Datix) for all complaints graded 3 and above.</td>
<td>The percentage of actions out of the total completed by the agreed date.</td>
<td>0</td>
<td>&gt;80% (Q4)</td>
<td>Ensuring that lessons are learned and action taken as a result of complaints is an essential component of the complaints process. This aligns to the Quality Strategy in improving the patients' journey and to quality priority 2 - Quality Plan; this supports restoring patients’ confidence and trust in the organisation and demonstrates that the Trust learns from negative experiences and works towards improving care and patient experience for future patients.</td>
</tr>
<tr>
<td>Good practice in undertaking ‘ReSPECT’ as defined by documenting: an understanding of what the patient or those close to them values or fears; a clinical plan which has been communicated to the patient or those close to them; a conversation which has been appreciated by the patient or their family; embedded across the service areas including outpatients.</td>
<td>All doctors (ST3) to have received training in undertaking the ReSPECT process. Training defined as; mandatory aligned to the current resuscitation training; Part 2 - session with CNS &amp; % of doctors to receive the training</td>
<td>0</td>
<td>90% of doctors ST3 or above to have had training (this KPI aligns to mandatory target). Part 2 session with the CNS to be agreed in q1 and report from q2 – q4.</td>
<td>All doctors to be competent and feel comfortable undertaking the ReSPECT process including having a good understanding of when to undertake the ReSPECT process.</td>
</tr>
</tbody>
</table>
**Staff Experience/Well-led**

Our aim is to further improve the health and wellbeing of our staff to ensure we have a fit for purpose frontline workforce, leadership team and organisational culture.

The measures focus on monitoring how the organisation treats staff who are involved in an error or near miss and if they feel secure in raising concerns. These build on the current measures and align with the leadership and culture work streams. To further support front line staff, having a focus on the retention of band 5 nurses reflects the level of staffing impacting directly on the services in providing safe and high quality care. In addition, a measure that reflects the quality and value of staff appraisals supports how we monitor how they feel about working for the organisation.

The measures we will use in 2019/20 will be:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definitions</th>
<th>Baseline</th>
<th>Target</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel secure raising concerns about unsafe clinical practice within the organisation.</td>
<td>National staff survey 2019 Theme: Safety culture</td>
<td>74% in 2018</td>
<td>76%</td>
<td>Reflects staff perception of the organisation including Just Culture and specifically that staff feel psychological safe enough to raise patient safety concerns.</td>
</tr>
<tr>
<td>People saying ‘my appraisal helped me to improve how I do my job’.</td>
<td>National staff survey 2019 Theme: Appraisals &amp; support for development</td>
<td>26% in 2018</td>
<td>28%</td>
<td>Indicates how staff feel about working for the organisation and the value of appraisal.</td>
</tr>
<tr>
<td>Nursing and Midwifery vacancy rate.</td>
<td>Band 5 nursing vacancy rate</td>
<td>6.5%</td>
<td>4%</td>
<td>Reflects the level of staffing impacting directly on service safety and quality.</td>
</tr>
</tbody>
</table>
1.2.5  **Statements of assurance from the board**

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

**The board of directors**

The priorities and targets in our quality account were identified following a process which included the Board of Directors, clinical directors and senior managers of the Trust, and have been incorporated into the key performance indicators reported regularly to the Board of Directors as part of the performance monitoring of the Trust’s corporate objectives, and which are produced within the Trust’s data quality policy, framework and standards.

Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the Quality Committee.

The Board of Directors reviews the Trust’s integrated quality, performance, finance and workforce reports each month. Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

**Review of our services**

During 2018/19 Cambridge University Hospitals NHS Foundation Trust provided and/or sub-contracted 114 relevant health services.

The Cambridge University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 114 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 99% of the total income generated from the provision of relevant health services by the Cambridge University Hospitals NHS Foundation Trust for 2018/19.

**Participation in clinical research**

The number of patients receiving relevant health services provided or sub-contracted by Cambridge University Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 18910.

**Participation in national clinical audits and national confidential enquiries**

During 2018/19, 58 national clinical audits and 3 national confidential enquiries covered relevant health services that Cambridge University Hospitals NHS Foundation Trust provides.

During that period Cambridge University Hospitals NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2018-19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust was eligible to participate in during 2018-19 are as follows:

**List of eligible and participated in national clinical audit programmes**

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>What is the audit about?</th>
<th>Case Participation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP).</td>
<td>This audit examines the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales.</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia.</td>
<td>The BTS National Adult Community Acquired Pneumonia (CAP) Audit will run for a sixth time this winter. Previous BTS CAP audits have identified deficiencies and variation in care, and we intend to further investigate outcomes and variation of care in this round by linking data from the audit to HES and ONS data held by NHS Digital.</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP).</td>
<td>Colorectal (large bowel) cancer is the second most common cause of death from cancer in England and Wales.</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM).</td>
<td>The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.</td>
<td>100%</td>
</tr>
<tr>
<td>Case Mix Programme – Adult Critical Care - (ICNARC).</td>
<td>The aim of this audit is to improve resuscitation care and patient outcomes for the UK and Ireland.</td>
<td>100%</td>
</tr>
<tr>
<td>Cystectomy Audit British Association of Urological Surgeons (BAUS).</td>
<td>This audit look at the radical cystectomy removal of the bladder for cancer with urinary diversion or bladder reconstruction. The operative technique used may be open, laparoscopic or laparoscopic with robotic assistance. This audit delivers good quality data and it is used as a valuable tool in improving care – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme).</td>
<td>The audit looks at the change in patients’ self-reported health status for hip and knee replacement surgery – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about?</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFAP): Falls Audit &amp; Hip Fracture Databases.</td>
<td>The FFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Head and Neck Cancer Audit.</td>
<td>The Head and Neck Cancer Audit (HANA) focuses on patients who have cancer of the head and / or neck, of which there are approximately 10,000 cases per year. The aim of the audit is to improve the services and outcomes achieved for these patients.</td>
<td>100%</td>
</tr>
<tr>
<td>National Gastrointestinal Cancer Programme - Oesophago-gastric cancer (NOGCA).</td>
<td>This audit provides us with the most up-to-date information on the care and outcomes of patients diagnosed with Oesophago-Gastric (OG) cancer or oesophageal high grade dysplasia.</td>
<td>100%</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme includes Biologics and Audit.</td>
<td>The purpose of this audit is to measure the efficacy, safety and appropriate use of biological therapies in patients with inflammatory disease; and secondly seeks to improve the care for IBD patients in hospitals throughout the UK.</td>
<td>100%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR Programme).</td>
<td>The aim of this programme is to review deaths of people with learning disability and to use lessons learnt to make improvements to service provision.</td>
<td>100%</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN).</td>
<td>TARN is working towards improving emergency health care systems by collating and analysing trauma care – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review programme – MBRRACE-UK: -Perinatal Mortality Surveillance. -Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths). -Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity). -Maternal mortality surveillance.</td>
<td>The aim of the MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about?</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL).</td>
<td>The National Audit of Care at the End of Life (NACEL) focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales.</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older People (NABCOP).</td>
<td>The audit was set up to look at whether or not older women with breast cancer have different outcomes than younger women, and if there are differences between breast cancer teams in the patterns of care delivered to older women.</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia – Royal College of Psychiatrists.</td>
<td>The audit examines assessments, discharge planning and aspects of care received by people with dementia.</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA).</td>
<td>The purpose of this audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in UK and Ireland.</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Pulmonary Rehabilitation.</td>
<td>This audit aims to collect information on all patients referred to and who receive pulmonary rehabilitation for COPD – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma Secondary Care.</td>
<td>This audit aims to collect information on all people admitted to hospital adult services with asthma attacks – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Chronic Obstructive Pulmonary Disease (COPD) Secondary Care.</td>
<td>This audit aims to collect information on all people admitted to hospital with COPD exacerbations – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about?</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA).</td>
<td>The National Diabetes Audit is considered to be the largest annual clinical audit in the world, providing an infrastructure for the collation, analysis, benchmarking and feedback of local data across the NHS – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Foot care Audit (NDFA).</td>
<td>The National Diabetes Foot care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit (NaDIA).</td>
<td>The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit of diabetes inpatient care in England and Wales – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Transition Audit (NDTA).</td>
<td>The audit seeks to answer: 1. Is the transition from paediatric to adult care associated with changes in care process completion rates? 2. Is the transition from paediatric to adult care associated with a change in treatment target achievements (specifically HbA1c)? 3. Is the transition from paediatric to adult care associated with changes in the frequency of diabetic ketoacidosis (DKA)? – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes In Pregnancy - Adult (NDIP).</td>
<td>The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address the three key questions: - Were women with diabetes adequately prepared for pregnancy? - Were adverse maternal outcomes during pregnancy minimised? - Were adverse foetal/infant outcomes minimised? - continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA).</td>
<td>NELA aims to look at structure process and outcomes measures for the quality of care received by patients undergoing emergency laparotomy – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about?</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Endocrine and Thyroid Audit.</td>
<td>This clinical audit aims to help endocrine and thyroid surgeons to monitor their practice. It collects information on the results of surgery for every UK patient undergoing thyroid, parathyroid, adrenal or pancreatic endocrine surgery operations.</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit.</td>
<td>The aim of this audit is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.</td>
<td>100%</td>
</tr>
<tr>
<td>National Joint Registry (NJR).</td>
<td>The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>National Lung cancer (NLCA).</td>
<td>This audit was set up in response to the NHS Cancer Plan to monitor the introduction and effectiveness of cancer services.</td>
<td>100%</td>
</tr>
<tr>
<td>National Neurosurgery Audit Programme (NNAP).</td>
<td>The aim of this programme is to engage units in a comprehensive audit programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.</td>
<td>100%</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA).</td>
<td>The National Maternity and Perinatal Audit (NMPA) is a large scale audit of the NHS maternity services across England, Scotland and Wales. Using timely, high quality data, the audit aims to evaluate a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.</td>
<td>100%</td>
</tr>
<tr>
<td>National Ophthalmology Audit.</td>
<td>The project aims to collect and analyse a standardized set of nationally agreed cataract surgery data set, from all centres providing this service.</td>
<td>100%</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA).</td>
<td>The sole aim is to provide information that leads to an improved quality of care for those children and young people affected by diabetes – rolling audit.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about?</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Prostate Cancer Audit.</td>
<td>The audit covers organisational elements of the service and whether key diagnostic, staging and therapeutic facilities are available on site for each provider of prostate cancer services.</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry.</td>
<td>The audit addresses the outcome of surgery for patients who underwent two types of vascular procedures. The first is an elective repair of an infra-renal abdominal aortic aneurysm (AAA). The second is a carotid endarterectomy (CEA) – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP).</td>
<td>To assess whether babies requiring specialist neonatal care receive consistent All patients in the period meeting the criteria.</td>
<td>100%</td>
</tr>
<tr>
<td>Nephrectomy Audit British Association of Urological Surgeons (BAUS).</td>
<td>This audit looks at the removal of the kidney for benign or malignant disease – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC).</td>
<td>The Oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all oesophago-gastric cancer patients, both curative and palliative.</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICANet).</td>
<td>PICANet aims to support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.</td>
<td>100%</td>
</tr>
<tr>
<td>Percutaneous Nephrolithotomy (PCNL) British Association of Urological Surgeons (BAUS).</td>
<td>This audit examines percutaneous nephrolithotomy (PCNL) surgeries for the removal of stones from the kidney or ureter using a small puncture in the skin of the affected side – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Radical Prostatectomy Audit British Association of Urological Surgeons (BAUS).</td>
<td>This audit assesses the removal of the whole prostate gland and seminal vesicles for cancer of the prostate – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Replacement Therapy.</td>
<td>The Registry contains analyses of data submitted relating to direct clinical care and laboratory permit analysis with the purpose to improve the quality of care for renal patients.</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Title</td>
<td>What is the audit about</td>
<td>Case Participation %</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis.</td>
<td>The overall aim of the audit is to improve the care quality of care provided by specialist rheumatology services in the management of early inflammatory arthritis - continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP).</td>
<td>The audit collects information about care provided to stroke patients in the first three days of hospital - continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Seven Day Hospital Services Self-Assessment Survey.</td>
<td>This audit aim to measure and improve the provision of seven day services ensuring that patients receive consistent high quality safe care every day of the week.</td>
<td>100%</td>
</tr>
<tr>
<td>RCEM Vital Signs in Adults (care in emergency departments).</td>
<td>This audit looks at the reception of patients and the initial encounter with clinical staff. The clinical priority is determined by the presenting symptoms and the recording of vital signs and this is a foundation of clinical quality.</td>
<td>100%</td>
</tr>
<tr>
<td>RCEM Feverish Children (care in emergency departments).</td>
<td>This audit measures the use of standardised assessment and scoring methods to help clinicians spot the sick children.</td>
<td>100%</td>
</tr>
<tr>
<td>RCEM VTE risk in lower limb immobilisation (care in emergency departments).</td>
<td>The present audit is an opportunity for improvement about utilisation of risk assessment tools as well as the documented provision of written patient information.</td>
<td>100%</td>
</tr>
<tr>
<td>Specialist rehabilitation for patients with complex needs following major surgery.</td>
<td>This audit provides a comparative assessment of services provided by area in relation to specialist injuries caused by events such as road accidents and falls – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Stress Urinary Incontinence Audit Association of Urological Surgeons (BAUS).</td>
<td>This audit examines all surgical treatments for both primary and recurrent stress urinary incontinence – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry.</td>
<td>The audit aims to examine both life expectancy and quality of life for children and adults with Cystic Fibrosis – continuous data collection.</td>
<td>100%</td>
</tr>
<tr>
<td>Urethroplasty Audit British Association of Urological Surgeons (BAUS).</td>
<td>The aim of this audit is to develop a better understanding of the presentation of urethral stricture disease and to enable surgeons to share information regarding investigation, surgical management and surgeon-perceived outcome from their interventions – continuous data collection.</td>
<td>100%</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust participated in during 2018-19 are as follows:

**Participation in national confidential Enquiries**

<table>
<thead>
<tr>
<th>National confidential enquiry title</th>
<th>Participation (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary Embolism</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Bowel Obstruction</td>
<td>100%</td>
</tr>
<tr>
<td>Long Term Ventilation</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Learning from audit**

**National audits**

The reports of 27 national clinical audits were reviewed by the provider in 2018-19 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix C. for list of national clinical audit report outcomes and action plans).

**Local audits**

The reports of 243 local clinical audits were reviewed by the provider in 2018-19 (cut off 12/02/19) and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix D. for list of local clinical audit report outcomes and action plans).

**Use of the CQUIN payment framework**

The Commissioning for Quality and Innovation (CQUIN) programme is a national framework for locally agreed quality improvement schemes, and a proportion of a provider's income is conditional upon the CQUIN programme being achieved.

In 2017/18, Cambridge University Hospitals NHS Foundation Trust received a CQUIN payment of £13,692,276.

A proportion of Cambridge University Hospitals NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Cambridge University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The potential CQUINs income available if the Trust had met all of the CQUIN targets was £14,613,000.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically within the Trust’s internal systems. To request this information, please see the 'Feedback on the quality report and quality account' section (below) or email: trust.secretariat@addenbrookes.nhs.uk
Care Quality Commission registration and compliance

Cambridge University Hospitals NHS Foundation Trust (CUH) is required to register with the Care Quality Commission and is currently registered with no conditions attached.

The Care Quality Commission has not taken enforcement action against CUH during 2018/19.

CUH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust’s CQC rating remains consistent with an overall rating of Good. The full table of ratings from the October 2018 CQC inspection is available below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Requires</td>
<td>Outstanding</td>
<td>Good</td>
</tr>
<tr>
<td>Medical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Critical care</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Requires</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Outpatients and diagnostic imaging</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Requires</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Overall</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Requires</td>
<td>Outstanding</td>
<td>Good</td>
</tr>
</tbody>
</table>

Data quality

Data quality refers to assurance of the information about patients recorded by the Trust on computerised systems.

The Trust follows national guidelines about how these data are collected and stored, and we undertake regular audits to make sure that data held on the system is accurate and that we are compliant with what is expected.

CUH submits records to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES). We also share data with partners as appropriate, for example clinical commissioning groups (CCGs). These data are used to plan and review the healthcare needs of the area.

Cambridge University Hospitals submitted 1,397,727 records during the reporting period, April 2018 – December 2018, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
- which included the patient’s valid NHS number was:
  99.5 for admitted patient care
  96.5 for outpatient care and
97.3 for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  100 for admitted patient care;
  100 for outpatient care; and
  95.6 for accident and emergency care.

**Information governance toolkit attainment levels**

All NHS organisations are required to comply with the 'Information Governance Toolkit'. This covers standards on data protection, confidentiality, information security, clinical information and corporate information.

The Cambridge University Hospital Data Security & Protection Toolkit submission for 2018/19 has met the standards.

**Clinical coding**

Cambridge University Hospitals was not subject to the Payment by Results clinical coding audit during 2018 by the Audit Commission.

Cambridge University Hospitals will be taking the following actions to improve data quality:

- Develop data quality dashboards and provide missing/invalid item reports for many of the national returns so that front line staff may see where improvements are possible.
- Data Governance and Stewardship Oversight Group to work with Divisional management and operational teams to better understand the quality of our data and the governance structures.
- Timetable deep dives into Divisional mandated returns to validate and improve data quality.
- Embed the RTT Forum as a function to reinforce development and learning for front line staff
- Audit documented clinic outcomes against evidence within Epic to provide process assurance

**Learning from Deaths**

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The implementation of this guidance is overseen by NHS Improvement and key milestones and timeframes were mandated for all NHS Providers from April 2017.

CUH launched its new policy and procedures in October 2017 in line with NHSI timeframes. The Learning from deaths policy within CUH is supported by the Trust learning from deaths oversight committee and reports to the Quality Committee bi-monthly via the Patient Safety Report and monthly to the Board via the Trust Integrated Report.

The data shown below reflects the mandated KPIs for reporting via the quality account. These numbers have been estimated using the Structured Judgement Review tool methodology for the required case review process (as recommended by the Royal College of Physicians).
(27.1) The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During 2018/19, 1445 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 355 in the first quarter; 347 in the second quarter; 361 in the third quarter; 382 in the fourth quarter.

(27.2) The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 01/04/2019, 245 case record reviews (SJR) and 10 serious incident investigations have been carried out in relation to 1445 of the deaths included in item 27.1. In 7 cases a death was subjected to both a case record review and a serious incident investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 55 in the first quarter; 60 in the second quarter; 68 in the third quarter; 64 in the fourth quarter.

(27.3) An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

In 2018/19, there were nine case record reviews (SJR) that identified that the death was more likely than not to have been due to problems in the care provided to the patient, representing 0.6% (9/1445) of patient deaths during this reporting period.

In relation to each quarter, this consisted of: 2 representing 0.5% (2/355) for the first quarter; 2 representing 0.5% (2/347) for the second quarter; 1 representing 0.2% (1/361) for the third quarter; 4 representing 1% (4/382) for the fourth quarter.

All nine of these deaths were subsequently investigated via the serious incident investigation process, as listed below:

i. Patient in a side room became disconnected from non-invasive ventilation tubing on the acute respiratory ward (SJR avoidability score 1).

ii. Cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient on a care of the elderly ward (SJR avoidability score 3).

iii. Delay in referral process to Papworth Hospital (SJR avoidability scores 3 for overall care, commissioned as a serious incident by Papworth Hospital).

iv. Intrapartum still birth (SJR avoidability score 3).
v. Cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient in the Emergency Department (SJR avoidability score 3).

vi. Delay in recognition and escalation of deterioration of an acutely ill patient on Transplant ward (SJR avoidability score 3).

vii. Delay in recognition and escalation of deterioration of an acutely ill patient on Respiratory ward (SJR avoidability score 3).

viii. Suboptimal care of a deteriorating paediatric patient on ward D2 (SJR avoidability score 3).

ix. Inpatient fall on MDU – (SJR avoidability score is pending)

In addition, four more deaths were investigated as unexpected/potentially avoidable death serious incidents; even though they did not trigger a SJR that judged care to be more likely than not to have been due to problems in the care provided to the patient:

x. Complication during neuro-coiling procedure (SJR not requested as SI commissioned).

xi. Malignant melanoma (patient died in prison), i.e. patient did not die in CUH.

xii. Potentially missed diagnosis of aortic dissection (originated as a complaint) – original SJR avoidability scored 4. SI was commissioned on receipt of post mortem result which identified previously unknown cause of death.

xiii. Delayed diagnosis of squamous cell cancer – patient died (in August 2017) pre- learning from deaths implementation and concerns in death were identified via the complaint process.

In summary there were 13 unexpected/potentially avoidable death serious incidents commissioned by CUH in 2018/19.

(27.4/27.5) A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3 (scores 1-3 in 2018/19).

The key theme that has emerged in 2018/19 is related to the suboptimal recognition and escalation of the deteriorating patient (6/13).

The deteriorating patient serious incidents were located across the Trust in six different wards/departments, and across five different specialities. In response to the findings from these investigations the Trust commissioned a Trust quality improvement plan for the deteriorating patient, which has oversight via the Trust Recognise and Respond Group and reports directly to the Quality Committee bi-monthly and to the Quality Steering Group monthly.

Key learning points identified from the serious incident investigations were:

- Delay in the recognition of deterioration including: inadequate frequency of the measurement and monitoring of vital signs; and ineffective clinical response to elevated early warning (NEWS) trigger points.

- Delay in the escalation of the deterioration to clinical staff skilled in the management of critically ill patients, e.g. senior ward-based doctors, critical care outreach team.
Lack of oversight by the Nurse-in-charge of the shift when patients were deteriorating, including: no awareness of deterioration; and inadequate supervision of the clinical response required.

Nurse staffing levels not aligned to the ward’s patient acuity due to inaccurate acuity scoring and identification of risk factors.

Some of the key recommendations from all the deteriorating patient SI reports:

- The NEWS-2 escalation protocol format (as stated in the new policy for the management of the acutely ill patient) to be used to aid recognition of emergency situations – in ward areas and training.
- An audit tool and schedule to be devised to monitor compliance with NEWS-2 escalation protocol.
- Explore how the triggers for the assessment and use of special observation can be improved across the organisation. Specifically, to explore the cultural and workload factors that appears to hinder staff assessing the need for a special.
- Review the nursing establishment for ward X, with reference to the acuity of patients and the impact the design of the ward has on staffing requirements. This review should take account of the experiences of the current nursing staff on ward X and should align to national and professional standards.
- Total revision of the Trust’s acutely ill patient educational programme for doctors, nurses and healthcare assistants.

Key learning points from the stillbirth serious incident investigation:

- A standard policy re CTG monitoring should operate for assessment of women presenting to Clinic 23 during its opening hours, and the same criteria for those presenting directly to Delivery Suite outside of these hours.
- An agreed definition of established labour should be in place to allow appropriate clinical decisions to be made in a timely fashion. The current Trust guideline may need to be updated in this regard.

Key learning points from the delayed diagnosis and treatment serious incident investigations:

- Cases where cancer is clinically strongly suspected but a negative result is received should be discussed at the weekly skin cancer MDT meeting.
- Support the implementation of a rolling programme in induction and teaching in the Emergency Department incorporating the recommendations of the Think Aorta campaign.
- Review of the feasibility of introducing a tracking list for high-risk patients not on an active cancer pathway.

Severe Mental Health

In 2018/19 there were eight case reviews (SJRs) triggered by the death of patient with severe mental health problems. One of these reviews judged the death as being more likely than not to have been due to problems in the care provided to the patient (cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient in the Emergency Department -SJR avoidability score 3). This was commissioned as a serious incident investigation.
Learning Disability Mortality Review (LeDeR)

The national Learning Disability Mortality Review (LeDeR) Programme is provided by Bristol University and funded by NHS England. There are a number of key activities related to the programme:

- Acts as a central point for the notification of deaths of people with learning disabilities
- Supports local areas to review the deaths of people with learning disabilities, identify learning and take forward lessons learnt into service improvements
- Collates and shares anonymised information so that common themes, learning points and recommendations can be identified and taken forward
- Supports a number of priority themes (deaths of young people aged 18 – 24 (inclusive) and deaths from Black and Minority Ethnic communities).

The LeDeR programme was commenced across Cambridgeshire and Peterborough on 01 May 2017. A total of 29 deaths at Addenbrooke’s have been notified to the LeDeR programme since May 2017. Deaths of patients from the age of 4-18 years will be reported to, but will not be reviewed by LeDeR. Instead, all child deaths (including those under the age of 4) will be reviewed under the national Child Death Overview Process (CDOP). A total of 8 child deaths (4-18 years) have been reported to the LeDeR programme since May 2017.

There has to date only been feedback from the LeDeR process for one patient who died at CUH (July 2017); no concerns with CUH care were identified.

(27.6) An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

Many of quality improvement actions identified in 2018/19 are still in progress. The deteriorating patients SI actions have resulted in strengthening the governance infrastructure of the Trust Recognise and Respond Group and the assurance framework that helps this forum measure and monitor key performance indicators. This is designed to help the Trust anticipate gaps in standards of care and drive improvement before harm occurs.

A Trust wide review of the education provision or deteriorating patient is in progress and learning from incidents is incorporated into the education content. Human factors elements i.e. team effectiveness, leadership and supervision, are given stronger emphasis in education to help staff understand the complexity of how errors occur.

A review of nursing staffing levels has occurred in one ward involved in SIs and has led to a more accurate measurement of patient acuity and the required capacity and capability of staff required.

The findings from Sis have also initiated a Trust improvement initiative to introduce Safety Huddles to ward areas to help staff recognise and escalate patients with emerging risks, e.g. falls, deteriorating.
Quality Report 2018/19
Cambridge University Hospitals NHS Foundation Trust

(27.7/27.8/27.9) The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.

In 2017/18, six of the deaths reviewed or investigated during that year were judged to be more likely than not to have been due to problems in the care provided to the patient. This represented 0.3% of the deaths that occurred during that financial year. In addition, 17 case record reviews and 0 investigations that related to deaths that took place during 2017/18 were completed after 31st March 2018. Of these, following an SJR and then a subsequent judgement no deaths were judged to be more likely than not to have been due to problems in the care provided to the patient.

Therefore, of all the deaths that occurred in 2017/18 and which were reviewed or investigated, a total of six deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. This represents 0.3% of the patient deaths that occurred during 2017/18.

Duty of Candour

When a patient has been adversely affected by an incident, staff have a duty to inform the patient, relatives, and/or carers as appropriate. This may fall under the Being Open process or the Duty of Candour (DOC) process, depending on the level of harm to the patient. Duty of Candour (Regulation 20) applies when a patient safety incident results in moderate harm, severe harm, or death.

Compliance with Duty of Candour stage 1 requires that an appropriately senior clinician informs the patient about the incident, explains the impact and consequences for the patient, apologises, and informs the patient that the incident will be investigated, and finally, all these elements are captured in a formal letter from the clinical team to the patient (or relative/carer) within 10 working days. Stage 2 pertains to ensuring that once the investigation is completed the Trust will share the findings of their investigation with the patient/relative/carer (within 10 days of the report being finalised), should they so wish.

Duty of candour is delivered by the relevant clinical teams and is recorded in the patient’s medical record and in QSIS/Datix; compliance is monitored and reported from QSIS by the corporate patient safety team. Compliance data is shared monthly with the Board via the Trust Integrated report, with Divisions via metrics in their Divisional board meetings, and with the Quality Committee via the Patient Safety Group’s bi-monthly Patient Safety Report.

In 2018/19 our compliance with Duty of Candour stage one was 100% until January 2019 (outstanding cases in February and March 2019 are still in progress); however, completion of stage one within 10 days was not fully compliant (see graph below).

In 2019/20 the governance infrastructure within the divisions had been strengthened to improve the timeliness of compliance with stage 1. In some cases the delays were appropriate due to the sensitivity of cases and the timing of the final letters shared with the family; in these cases the process is led by the Consultant overall in-charge of care and supported by good communication with the patient/family.
Compliance with Duty of Candour stage two was 100% (up until November 2018 (compliance with outstanding cases is still in progress); however, completion of stage two within 10 days was not fully compliant (see graph below).

Note: Until January 2019, category 2 hospital-acquired pressure ulcers were being graded as low harm. Following a review of all HAPU measuring and monitoring a decision was made to grade them as moderate harm, thereby triggering DOC requirement with an impact on compliance.

Whist compliance with stage one is good the improvement aim for 2019/20 is to ensure duty of candour letters sent to the patient are received within the regulation requirement of ten working days.
Staff Survey Results

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KF27</strong> % reporting most recent experience of harassment, bullying or abuse (Higher scores are better)</td>
<td>2017/18</td>
</tr>
<tr>
<td></td>
<td>42%</td>
</tr>
</tbody>
</table>

Relate to - Workforce Race Equality Standard:

| **KF21** (percentage believing that Trust provides equal opportunities for career progression or promotion) (Q16) (Higher scores are better) | | 85% | 83% |
|**KF26** (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) (Q15b-c) (Lower scores are better) | | 25% | 25% |

**KF27**: The process of reporting these experiences has been more widely promoted and encouraged. Greater attention has been paid to staff narrative and has been shared with the Board. The tackling bullying and harassment group has been formed and has staff side representation and multidisciplinary attendance; together these representatives have developed a ten step action plan, to address all issues identified. (Best score for acute trusts was 55%. National average for acute trusts was 45%).

**KF21**: It is recognised that cultural and behavioural changes that need to occur will take time to realise and therefore continued & focused effort is required to reduce the gender pay gap (Data as of 31st March 2017). (Best score for acute trusts was 94%. National average for acute trusts was 83%).

**KF26**: KF26: Since 2016 there has been continued focus to target areas where decline is evident and to encourage Divisional discussions with local plans in place to address specific issues that need to be owned and addressed. (Best score for acute trusts is 17%, the worst is 39%. National average for acute trusts was 27%).

In 2018/19 the Equality and Diversity Lead (EDI) completed the first cohort of NHS England WRES Experts Development programme. As a result best practice from other organisations has been shared, the governance arrangements were reviewed by the EDI lead and a new WRES Implementation group was established, to ensure the WRES action plan is monitored and remains focused. A deep dive exercise using a Quality Improvement approach focussed on specific indicators was developed. One of the actions from this was to ensure all acting up posts and secondment opportunities must be advertised centrally. The WRES action plan was further updated and approved by the Board in January 2019 with additional actions including introducing reverse mentoring, diverse interview panels and exploring ways to increase board diversity.
1.2.6 Independent assurance report

Independent auditor’s report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust on the Quality Report

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

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the “indicators”.

Respective responsibilities of the Directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement’s Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2018 to April 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from Commissioners, dated 23 April 2019;
Feedback from governors, dated 15 April 2019;
Feedback from local Healthwatch organisations, dated 15 April 2019;
Feedback from Overview and Scrutiny (Health) Committee, dated 24 April 2019;
The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019;
The latest national patient survey dated 13 June 2018;
The latest national NHS staff survey dated 26 February 2019;
Care Quality Commission inspection, dated 26 February 2019;
The Head of Internal Audit’s annual opinion over the trust’s control environment, dated 21 May 2019; and
Any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Cambridge University Hospitals NHS Foundation Trust as a body, in reporting Cambridge University Hospitals NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate that it has 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 Council of Governors as a body and Cambridge University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.
A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can 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 of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Cambridge University Hospitals NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement’s Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed:
Gareth Davies
Partner, for and on behalf of Mazars LLP
Date: 24 May 2019
Chartered Accountants and Statutory Auditor
Tower Bridge House
St Katharine’s Way
London
E1W 1DD

1.2.7 **Reporting against core indicators**

The Trust’s performance against the core indicators is described at *Appendix A.*
1.3 Part 3 - Other information

1.3.1 Reviewing performance against 2018/19 priorities for improvement

**Safe**

Our aim is to reduce avoidable harm to our patients by improving our safety culture, safety systems and how we learn from past harm.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-Wide Compliance with Sepsis 6 care bundle (ED and inpatient wards)</td>
<td>≥90%</td>
<td>2017/18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sepsis 6 bundle: ED Patients 63%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Inpatient wards baseline in was 20%)</td>
</tr>
</tbody>
</table>

**Why was this a priority?**

The management of patients with sepsis is a key programme of work under the domain of the deteriorating patient improvement programme. Each hour delay in the application of the Sepsis 6 bundle to individual patients significantly increases their risk of death, therefore all clinical areas within the Trust need to provide a consistent high standard of bundle delivery.

**What was our target?**

Compliance with the sepsis six care bundle of ≥90% by March 2019 in the Emergency department (ED) and inpatient wards.

**How did we measure and monitor our performance?**

Performance is measured by the case review of 50 patients each month (25 from ED and 25 from inpatient wards). Compliance goals within the Trust were aligned to the NICE guidance for sepsis; Compliance goals for the national Sepsis CQUIN had slightly different compliance criteria explaining the difference in data reported.

**How and where was progress reported?**

Compliance data is shared monthly with the Board via the Trust Integrated report, bi-monthly with the Trust Recognise and Respond Group, and bi-monthly with the Quality Committee via the Patient Safety Group’s Patient Safety Report.
Did we achieve our intended target?
The target was not achieved in either ED of inpatient wards. However, the improvements that were made in 2017/18 in ED have been sustained in 2018/19 (as shown by normal variance in the graphs below).

The data in the graphs above shows compliance with NICE standards, the CQUIN standard (compliance with antibiotics element of the bundle administered within one hour of ≥90%) are set at slightly lower threshold; this CQUIN was achieved by the Trust (ED and in patient wards) for each month in 2018 as shown in the graph below.
Our key achievements against this priority:

Compliance with the CQUIN standards was a key achievement in 2018/19 (antibiotic administration and screening of all patients).

Significant improvements were made in the inpatient wards compliance with the sepsis 6 bundle, with baseline compliance of 20% (April 2017) moving to improved standards in 2018/19 with normal variance around a mean of 62%.

The most essential element of the sepsis six bundle, administration of antibiotics within one hour, has shown sustained improvement in both ED and inpatient wards.

Improvement work in 2019/20 will focus on improving compliance with the other five elements of the sepsis bundle as well as achieving ≥95% compliance for antibiotic administration within one hour.
What did we measure?

Average reported patient safety incident rate per 1,000 bed days

<table>
<thead>
<tr>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>5% increase on baseline (45.24)</td>
<td>43.09 incidents per 1,000 bed days</td>
</tr>
<tr>
<td></td>
<td>Q1 and Q2 2017/18 NRLS data</td>
</tr>
<tr>
<td></td>
<td>2018/19</td>
</tr>
<tr>
<td></td>
<td>42.22 incidents per 1,000 bed days</td>
</tr>
<tr>
<td></td>
<td>Q1 &amp; Q2 2018-19 (NRLS data)</td>
</tr>
</tbody>
</table>

Why was this a priority?

Evidence of continuing improvements in patient safety incidents reporting reflecting a cultural shift to a proactive and learning safety culture.

What was our target?

The target was a 5% increase on baseline in 2017/18 (Q1 and Q2), of patient safety incidents reported per 1,000 bed days; that is an increase from 43.09 incidents per 1,000 bed days to 45.24).

How did we measure and monitor our performance?

The measurement is calculated by the National Learning and reporting System (NRLS) and the data is received by all trust in 6 monthly reports. However as this reporting is not timely i.e. at least six month in arrears, the data has also been run internally shared below.

How and where was progress reported?

Progress is monitored monthly by the Boards via the Integrated report and bimonthly by the Quality Committee via the Patient safety Report.

Did we achieve our intended target?

There was no increase in reporting in 2018/19, as compared to 42.22 incidents per 1,000 bed days reported to NRLS in Q1-Q2, 2018/19.

Using internal data analysis of the number of patient safety incidents the graph below shows the improvement in reporting from June 2017 has been sustained however it has not increased further in 2018/19.

Our key achievements against this priority:

The significant increase in reporting of patient safety incidents (from June 2017) has been sustained in 2018/19.
What did we measure?

<table>
<thead>
<tr>
<th>National Safety Standards for Invasive Procedures (NatSSIPs)</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of named leads appointed</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>% of clinical areas (main theatres) using new audit observational tool to measure effective compliance with WHO checklist, by trained auditors</td>
<td>&gt;50% in main theatres</td>
<td>0 50%</td>
</tr>
</tbody>
</table>

Why was this a priority?

The National Safety Standards for Invasive Procedures (NatSSIPs) programme brings together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures. This is designed to enhance the existing WHO Surgical Checklist focusing on human factors and patient safety culture and had been mandated by NHS Improvement via a Patient Safety Alert in 2015.

What was our target?

There were two process targets for the 2018/19 programme of work

1. To appoint Clinical Leads to each clinical domain supporting the implementation of the NatSSIPs programme.
2. To devise a new observation tool for the auditing of compliance with the sequential Local Safety Standards for Invasive Procedures (LocSSIPs), previously referred to as the WHO safety checklist.

How did we measure and monitor our performance?

The Clinical Leads were appointed by the Trust Director for NatSSIPs and serve on the Trust NatSSIPs implementation group.

The creation and testing of a new audit tool has been overseen by the NatSSIPs implementation group and supported by Band 7 nursing staff working in main theatres.

How and where was progress reported?

Progress has been monitored via the NatSSIPs implementation group which report to the Board via the Clinical Effectiveness Committee.

Did we achieve our intended target?

Both targets have been achieved. The newly designed observation audit tool will continue to be spread to all areas in main theatres and evolved for use in areas outside of the theatre environment. This progress will be supported by the NatSSIPs implementation programme, which will continue into 2019/20.

Our key achievements against this priority:

Two major milestones have been achieved this year by the NatSSIPs workstream: a) the sequential LocSSIPs have been devised and approved via the new NatSSIPs Implementation Group and implemented into main theatres; and b) the design of a new observational audit tool that focuses on safety systems and human factors, i.e. team effectiveness, leadership, team engagement.

This new way of auditing is a more effective measure of the impact of the NatSSIPs principles than ticking compliance with whether or not the process was carried out. This approach reflects a commitment by the Trust to implement this patient safety improvement initiative in a manner that supports staff to develop a mature safety culture that prioritises patients’ safety during invasive and surgical procedures.
Effective/Responsive

Our aim is to consistently deliver high quality care that is effective, timely, patient centred and efficient.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>Number of Discharges before midday</td>
<td>20%</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

**Why was this a priority?**
Earlier discharges create capacity, supporting correct patient placement and timely flow from ED. This measure contributes to the achievement of the 4hr standard.

**What was our target?**
To have 20% of patients scheduled to be discharged, to be discharged before midday.

**How did we measure and monitor our performance?**
Performance data was captured on our internal ‘ward dashboard’. Divisions monitored their performance against the metric.

**How and where was progress reported?**
Progress against the target was reviewed by relevant Divisional teams, with some central oversight by the Trust’s Transformation team. The data was used to inform improvements required across the wards selected for focused improvement. Progress is monitored through the quality accounts process on a quarterly basis.

**Did we achieve our intended target?**
The target was not achieved in 2018/19.

**Our key achievements against this priority:**
A key enabler of early morning discharges is the utilisation of the discharge lounge. In January 2019 an average of 410 patients were discharged per month via the discharge lounge, compared to 238 between April – December 2018.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>Patients that remain in an acute Trust bed for 7 days or more</td>
<td>10% reduction</td>
<td>453 patients</td>
</tr>
</tbody>
</table>

**Why was this a priority?**
A reduction in stranded patient numbers can indicate more effective and efficient patient pathways, improved patient experience (as they are more likely to be cared for in an appropriate environment) and the creation of much-needed capacity.
What was our target?
A 10% reduction on the 2017/18 baseline to 408.

How did we measure and monitor our performance?
Performance data was captured on our internal ‘ward dashboard’. Divisions monitored their performance against the metric.

How and where was progress reported?
Progress against the target was reviewed by relevant Divisional teams, with some central oversight by the Trust’s Transformation team. Progress is monitored through the quality accounts process on a quarterly basis.

Did we achieve our intended target?
The target was not achieved in 2018/19.

Our key achievements against this priority:
Stranded patients reduced significantly to 426 during December 2018 when the Trust made significant progress on its ‘acute hub’ programme of work. This focused medical, therapy and discharge planning resources to reduce the need for onward admission of medical patients into inpatients beds.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy of Clinically Fit Dates (CFDs)</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31%</td>
</tr>
</tbody>
</table>

Why was this a priority?
The Trust uses CFDs to predict patients’ likely date of discharge. The accuracy of CFDs is important and relevant as it enables the Trust to predict capacity availability, monitor patients’ length of stay and match activity with demand.

What was our target?
To achieve discharge as predicted, by a CFD for 40% of patients.

How did we measure and monitor our performance?
Performance data was captured on our internal ‘ward dashboard’. Divisions monitored their performance against the metric. Accuracy was also monitored through the regular bed management processes (3 times daily).

How and where was progress reported?
Progress against the target was reviewed by relevant Divisional teams. Feedback was provided via the Operations Centre through the ‘business as usual’ bed management processes. Progress is monitored through the quality accounts process on a quarterly basis.

Did we achieve our intended target?
The target was not achieved in 2018/19.

Our key achievements against this priority:
The Bed Planning Group produced an analysis of CFD data at its meeting in December 2018 due to the lack of progress made against this target. This identified that whilst a number of CFDs were inaccurate since patients were delayed due to complex discharge needs, there was an opportunity to improve accuracy among non-complex patients. This target is being rolled forward into 2019/20, when we will use this learning to drive our action plans.
Patient Experience/Caring

Our aim is to further improve our delivery of patient care against our values in relation to compassion and communication.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of complaints out of the annual total received which receive a response within 30 working days or by the date agreed with the complainant.</td>
<td>85%</td>
<td>87% 78%*</td>
</tr>
</tbody>
</table>

Why was this a priority?
Complainants should expect to receive a resolution to their complaint in a time period that is relevant to their particular complaint. Complaints should be addressed in a timely manner to help restore complainants’ confidence in the services provided by the Trust, and so that learning from complaints can be identified and disseminated as swiftly as possible.

What was our target?
The Trust aims to respond to complaints within 30 working days, but more complex cases may take longer to investigate: in those cases the complaints case managers communicate with complainants in order to negotiate an extended timeframe for response. We aim to respond to 85% of complaints within 30 working days or by the extended date agreed with the complainant.

How did we measure and monitor our performance?
The response time is measured by counting the number of working days from receipt of a complaint to sending the response. The dates of receipt of complaint and sending the response are recorded on the ‘QSIS’ database on a day to day basis, together with information about negotiated extensions to the timeframe for responding. Performance can therefore be monitored in real time using the reporting functionality of the QSIS system.

How and where was progress reported?
Performance against the 30 working day target and agreed extensions to the timeframe was reported monthly in the Integrated Quality Report and bi-monthly to the Patient Experience Group, and from there to the Quality Committee of the Board.

Did we achieve our intended target?
The target of 85% of complaints receiving a response within the initial timeframe or agreed extended timeframe is unlikely to be met for 2018/19 (*currently 78% - provisional figure as some cases remain open at the time of reporting). Failure to achieve the target was due to a marked increase in complaints received by the Trust: 20% increase from 2016/17 to 2017/18 and a further 17% increase from 2017/18 to 2018/19. A requirement for increased resourcing in the complaints team was recognised and a new post recruited to mid-year, which is assisting with maintaining the current position. A new system of grading complaints, designed to allow for more proportionate investigation timeframes was introduced in January
2019, and it is expected that this change in process, together with the increased resource will lead to improved performance.

**Our key achievements against this priority:**

Over the course of 2018/19, the volume of complaints received has increased. The staffing in the complaints team was also increased mid-year and focus was maintained meeting the timeframes for responding to complaints, but the increase in volume has meant that performance against the responding timeframes overall has not improved. A new complaint complexity/severity grading system with associated variation in initial responding timeframes (30, 45 or 60 working days) was introduced in January 2019 in order to better reflect investigation and response timeframes and manage complainants’ expectations in a more realistic way. We want to ensure that we improve and therefore we will continue to make timely responses to patients’ complaints a quality priority for the Quality Account for 2019/20.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of MyChart</td>
<td>My Chart available to all adult specialties by 2019</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Why was this a priority?**

MyChart is the electronic patient portal at CUH which allows patients to securely access parts of their health record held within the hospitals’ electronic patient record system, called Epic. MyChart is a tool to give patients access to parts of the health record on line to help them manage their own health care. CUH piloted MyChart initially and given the positive feedback wanted to make this available to adult patients.

**What was our target?**

The aim was to make MyChart available to all adult specialties so they could engage their patients with the tool.

**How did we measure and monitor our performance?**

Having made MyChart available to all adult specialties, we monitored the number of specialties using and the number of patients activated each month.

**How and where was progress reported?**

Progress was reported to the Board within the integrated report.

**Did we achieve our intended target?**

MyChart is available to all adult specialties. However the take up has been slow meaning that only a few patients (around 2200) are current activated on MyChart. Having identified some of the barriers, we are now working to refine our activation processes so that more patients can access MyChart.

**Our key achievements against this priority:**

Over 2000 patient activated to use MyChart.
**What did we measure?**

<table>
<thead>
<tr>
<th>Compliance with ‘ReSPECT’ programme across adult inpatient specialities</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolled out across all adult inpatient specialities by March 2019</td>
<td>N/A</td>
<td>100% (Fully implemented across all adult inpatient specialities)</td>
</tr>
</tbody>
</table>

**Why was this a priority?**

This measure relates to National best practice and has been developed by the royal colleges the RCP/GMC/BMA/RCN. This priority is also aligned to the improvements required by the CQC in how we approach resuscitation decisions within the organisation.

**What was our target?**

To have implemented the electronic version of ReSPECT across all inpatient areas. To ensure adequate education in the community to allow for smooth transition of patients with a ReSPECT form.

**How did we measure and monitor our performance?**

We have set up a system to report the use of ReSPECT and in addition the reporting of incidents.

**How and where was progress reported?**

Progress has been reported to a number of forums including the senior nurses meeting and the Trust Recognise and Respond Group, reporting to the Patient Safety Committee.

**Did we achieve our intended target?**

Yes.

**Our key achievements against this priority:**

- ReSPECT introduced across all inpatient areas.
- No inappropriate resuscitation attempts as a consequence of the introduction of ReSPECT.
- No complaints from ambulance clinicians/GP practices/Nursing homes/hospices about the transition to ReSPECT.
**Staff Experience/Well-led**

Our aim is to further improve the health and wellbeing of our staff to ensure we have a fit for purpose frontline workforce, leadership team, and organisational culture.

<table>
<thead>
<tr>
<th>What did we measure?</th>
<th>Our target</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KF 1</strong>: Staff recommendation of the organisation as a place to work or receive treatment.</td>
<td>2% improvement against previous year</td>
<td>73%  75%</td>
</tr>
<tr>
<td><strong>KF 29</strong>: % of staff reporting errors, near misses or incidents witnessed in the last month.</td>
<td>2% improvement against previous year</td>
<td>91%  91%</td>
</tr>
<tr>
<td><strong>KF 31</strong>: Staff confidence and security in reporting unsafe clinical practice.</td>
<td>2% improvement against previous year</td>
<td>68%  68%</td>
</tr>
</tbody>
</table>

**Why was this a priority?**

Our priorities for improvement in 2018/19 were to focus on advancing the skills and wellbeing of our staff, and ensuring that they are well led, as prerequisites for delivering safe and effective care to our patients. We also describe how we intend to measure our success in achieving this. We continue this work on staff engagement as it is an important measure to understand how staff perceive CUH as a place to work because engaged staff are more likely to provide quality care to patients and also have less sickness, stay longer with us and recommend CUH as an employer of choice. This measure forms part of our Workforce Strategy “a great place to work, people driven by CUH values and behaviours” and supports the Trust strategy around ‘Strengthening the Organisation’.

**What was our target?**

We aimed to improve on all three measures by 2% against previous years’ performance.

**How did we measure and monitor our performance?**

Through our national and local staff survey results we explore how staff perceive us as an employer, whether staff perceive that the organisation takes action when errors, near misses or incidents happening and that they feel confident that the organisation addresses unsafe clinical practice. We report this through the Integrated Quality/Performance report which is reviewed monthly by the Board.

**How and where was progress reported?**

In addition, the Workforce Integrated Report is being discussed at the Management Executive. The Workforce Experience Committee reviews the results quarterly and oversees any action plans resulting from these survey results.
Did we achieve our intended target?
We achieved an increase of 2% from last year for staff recommending the organisation as a place to work. Our results for Staff feel confident that the organisation would address concerns about unsafe clinical practice, remained the same against the question. “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again” and staff confidence in reporting remained the same.

Our key achievements against this priority:
We continue to implement our ambitious Organisational Development Plan incorporating Culture, Climate, Leadership and Engagement. During 2018/19 we deployed our Continuous Professional Development for our staff which will continue into 2019/20. Clear links to the refreshed CUH strategy have been made to strengthen the leadership and to improve staff experience.

The Trust’s overall response rate is 51.5% an increase of 2.1% on the previous year and above the national average of 44%. The Trust has an engagement score of 7.2 our or 10, this is above the national average 7.0 and an improvement on last year’s score of 7.1. The Trust scored above the national average for nine or the ten themes and of the nine themes that can be compared with previous years the trust significantly improved in four of those themes with no significant change for the other 5 themes.

1.3.2 Performance against indicators and performance thresholds
The Trust’s performance against the required indicators (limited to those that were included in both the Risk Assessment Framework and the Single Oversight Framework for 2018/19) is described below:

National targets – 2018/19 performance

<table>
<thead>
<tr>
<th>Indicator for disclosure</th>
<th>Target 2018/19</th>
<th>CUH performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral To Treatment (RTT)</td>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</td>
<td>≥92%</td>
</tr>
<tr>
<td>A&amp;E target</td>
<td>Maximum waiting time of four hours from arrival to admission/ transfer/ discharge</td>
<td>≥95%</td>
</tr>
<tr>
<td>All cancers - 62-day wait for first treatment from:</td>
<td>Urgent GP referral for suspected cancer</td>
<td>≥85%</td>
</tr>
<tr>
<td></td>
<td>NHS Cancer Screening Service referral</td>
<td>≥90%</td>
</tr>
</tbody>
</table>
### Indicator for disclosure

<table>
<thead>
<tr>
<th>Indicator for disclosure</th>
<th>Target 2018/19</th>
<th>CUH performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control</td>
<td>Clostridium difficile – variance from plan</td>
<td>&lt;49 cases</td>
</tr>
<tr>
<td>Summary Hospital-level Mortality Indicator (SHMI)</td>
<td>We are able to maintain our lower than expected mortality</td>
<td>88.2% (Latest period available: July 2017 - June 2018)*</td>
</tr>
<tr>
<td>Diagnostic waiting times</td>
<td>Maximum 6-week wait for diagnostic procedures</td>
<td>≤1%</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Venous thromboembolism (VTE) risk assessment</td>
<td>&gt;95%</td>
</tr>
</tbody>
</table>

*CUH has a lower than expected number of deaths and overall is ranked as 14/130 of the acute trust in England with the lowest SHMI in the Eastern Region.

### 1.3.3 Feedback on the quality report and quality account

If you would like further information on anything contained within this report, please write to:

**Director for Corporate Affairs**  
PO Box 146, Cambridge University Hospitals NHS Foundation Trust, Cambridge Biomedical Campus, Hills Road, Cambridge, CB2 0QQ  

Or email: trust.secretariat@addenbrookes.nhs.uk  

This document is also available on request in other languages, large print and audio format – please phone 01223 274648.
Governors’ statement on the quality account 2018/19

During 2018/19 the Council of Governors has been involved in i) the ongoing review of quality performance and ii) the development of the CUH quality priorities for the coming year.

At quarterly meetings attended by both governors and Non-Executive Directors (NEDs), governors have continued to scrutinise the Trust’s performance against national and local quality targets, seeking assurance that issues and concerns are being effectively addressed. Participation across hospital-led committees, and the invitation this year for governor representatives to attend Board sub-committees as observers, has provided opportunities for governors to improve our understanding of Trust activities and progress against quality targets.

During the CQC inspection of CUH in Nov 18 governors from each of the elected constituencies participated in a group discussion with the inspectors, sharing our experiences and perspectives on how the Trust was operating. The outcome from the inspection - a strong ‘Good’ performance with several domains improved this time to ‘Outstanding’ - reflected the governors’ view on improvements made across the Trust over the last two years.

As part of our responsibilities under the Quality Report, the Council of Governors selected the National Safety Standards for Invasive Procedures (NatSSIPs) as the indicator for focus during 2018/19, implementation of which is expected to i) reduce the number of safety incidents related to invasive procedures and ii) provide a key control against Never Events declared within the Trust. In line with the target, Leads have been appointed for each NatSSIPs working group. For 2019/20, and in line with our continued focus on capacity management and patient care, governors have selected ‘Accuracy of Clinically Fit Dates’ for discharge (CFD) as the quality metric to follow.

In common with the majority of NHS Trusts, CUH has again been operating within a challenging environment. During 2018/19 new initiatives have been implemented, aimed at improved management of patient flow and ultimately patient care. So far, these appear to be bringing some stability to performance. However, given the year-on-year increase in attendances, and the importance of i) strong ED performance, ii) effective discharge procedures and iii) adequate staffing on the delivery of high quality care, achievement of several of the quality targets has proved difficult. Governors will continue to scrutinise performance and progress in these areas.

Mindful of the impact vacancies can have on quality of care, governors play close attention to the results of the annual staff survey. In particular, we are keen to see i) improvements in staff morale and engagement, and ii) a correlation between this and improved retention of skilled staff. The 2018 survey results demonstrated improvements across most questions, though we were disappointed to see that results relating to i) bullying and harassment and ii) diversity and equality remained similar to the previous year despite the introduction of initiatives to address staff concerns in these areas. During 2019/20 Governors will
seek regular updates on steps being taken to sustain and improve staff engagement.

Strong progress has been made in defining the Trust’s strategic plan this year. Governors will request regular updates on the projects, all of which will ultimately improve quality of care for patients. In particular, progress with delivery of the Cambridgeshire & Peterborough STP objectives and with the planning of the regional children’s hospital will be reviewed by governors on a regular basis.

Julia Loudon, Lead Governor - CUH FT
15 April 2019

Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) statement for inclusion in the 2018/19 quality account

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Account produced by Cambridge University Hospitals NHS Foundation Trust (CUH) for 2018/19.

The CCG and CUH work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular oversight meetings in place between the CCG, CUH and other appropriate stakeholders to ensure the quality of CUH services are reviewed continuously with the commissioner throughout the year.

CUH is to be commended on a very readable and accessible quality account for 2018/19 which clearly outlines that hard work undertaken by the trust and the direct impact this has on patients and staff. The CQC report published in February 2019, based on inspections in October and November 2018, rated the trust as Good. This is a particular achievement as CUH continues to sustain and build on improvements and demonstrate Outstanding in Well-Led and End of Life Care, and maintain Outstanding for Caring overall.

This achievement should not be underestimated at a time of increasing complexity and system pressures. The CQC rated the Responsiveness domain as Required Improvement, and the CCG are impressed by the trust’s ability to identify and understand their risks, that they are open and transparent and plans are swiftly put in place which have an emphasis on the safety of patients. We have seen this particularly in the speciality of Ophthalmology.

The Quality Account discusses the trust’s continuing challenge of managing the flow of patients through the hospital and the targets that were not achieved in 2018/19 that they had hoped to achieve, this correlates with the CQC findings and has a direct impact on the experience of patients and carers. Complaints have increased and the CCG recognise that CUH are very aware of this and the new complaints process which went live in January is bedding in to ensure concerns are prioritised.

Within the Quality Account, ‘Improving Together’ demonstrates the overarching approach by the trust to the improvement of services and the emphasis on co-production including patients and the public; the CCG are eager to see how this evolves but increased and improved reporting is already apparent. This is already evident in the care of the deteriorating patient and it is really positive to see that
the trust has acted on key indicators including Serious Incidents and Mortality Reviews (Structured Judgement Reviews) to ensure this is a key priority for the trust for 2019/20.

What comes across strongly in the report is the high standards CUH sets for itself. There is excellent participation in clinical audit and research, the willingness to lead and roll out evidence based practice including the ‘ReSPECT’ programme and embrace new technologies including ‘My Chart’.

Karen Handscomb, Deputy Chief Nurse
Cambridgeshire and Peterborough CCG
23 April 2019

Cambridgeshire County Council Health Committee statement for inclusion in the 2018/19 quality account

The Health Committee within its scrutiny capacity has not called on representatives from Cambridgeshire University Hospital over the last year to attend scrutiny committee meetings. However, committee members have maintained an open dialogue with senior leadership at the Trust through the valuable quarterly liaison meetings which are seen as an essential part of the scrutiny function.

The Committee has found this quality account overall an interesting report, with evidence of careful attention being paid to some key quality concerns.

At the start, attention is drawn to increased levels of activity in outpatients, partly driven by increased referrals and the comment made that this will be challenging if it continues (p.5). While the increase in the level of A & E activity was lower than anticipated, the outpatient figures indicate that pressures on CUH are not reducing. Quality monitoring continues at a high level with 58 audits across the year.

There is greater emphasis in priority setting for 2019-20 on cultural change and ‘healthy and open communication’ (Section 4.2.1). The Health Committee has been interested in CUH improvement strategies and notes the ‘Improving Together’ strategy being steered by the Improvement and Transformation directorate. This is an ambitious programme of improving staff skills, awareness and distributed leadership working with external improvement partners. Part of this is a focus on supporting individuals to raise concerns using the speaking up service for employees (FTSUG), with a longer term aim of culture change that enables staff to raise, and managers to work with, them to resolve issues locally. Health Committee members have recommended to CUH to consider how the responses by concerns/groups reported to the Board are being used to drive quality improvement.

We understand that DTOC challenges continue although some improvements have been made and CUH sets itself four measures for 2019-20, including a target of 20% for early discharges (p.15-16). Early discharges are defined as ‘before midday’ and it is to be noted that this is very ambitious since performance actually declined from 15.3% to 13% between 17/18 and 18/19 (see p.44). The Health Committee encourage CUH to monitor the new process that started in January 2019.
The emphasis on culture change links to the staff experience/well led quality targets, including one related to appraisal that is a theme in the NHS National Survey. CUH should be commended that 99% of their staff received an appraisal. Whilst it noted that only 26% of CUH staff in 2018 agreed that ‘my appraisal helped me to improve how I do my job’ suggesting that appraisal is not currently integrated as part of a developmental process for staff. CUH’s target of improving the 2018 figure by only 2% does not seem to fit with their more ambitious culture change objectives set out in Section 4.2.1. However feedback received by the Health Committee from CUH around working to improve the quality of appraisals and the impact of staff’s perception of how it helps them improve how they do their work is encouraging. In particular it was good to hear that the percentage of managers supported to receive training, learning or development has increased significantly by 6%.

The national staff survey results indicate that CUH is average or slightly better in reporting of bullying/abuse and some other measures but not on staff confidence in equal opportunities. One aspect may be addressed through the equality and diversity lead drawing on best practice elsewhere (p.36). One improvement noted is CUH moving to central advertising of all acting up/secondment opportunities, an important marker for staff of fair and equal treatment.

Quality improvement in clinical practice is driven through engaging with patients and capturing ‘lessons learnt’. Work on ‘Learning from Death’ (p.29-34) includes in-depth analysis of the factors underlying sub-optimal care including training needs, staff levels, workload and cultural factors. The Health Committee has appreciated further clarification provided by CUH in regards to the ‘Duty of Candour’ (DOC) and new guidance published by NHSI which has impacted on the compliance position. It was good to hear that the safety team are working on establishing a revised process that prioritise the follow up of outstanding DOCs.

The Committee were pleased to see the CQC inspection outcome gave CUH an overall judgement of ‘Good’. Health committee members have been encouraged by the Trusts positive attitude to maintain an open dialogue and will be inviting representatives to attend a health scrutiny session around the CQC improvement plan in the near future.

*Kate Parker, Head of Public Health Business Programme*  
*Cambridgeshire County Council*  
*18 April 2019*

**Healthwatch Cambridgeshire and Peterborough statement for inclusion in the 2018/19 quality account**

**Performance**

Healthwatch Cambridgeshire and Peterborough is pleased to continue to have a positive relationship with the Trust.

We notice the increase in referral rates for outpatient appointments and recommend ample time for shared decision making is maintained at all stages of the patient journey, knowing the benefits this brings for system efficiency as well as patient outcomes.
Local people often tell Healthwatch about the long waits they experience for outpatient appointments, diagnostics and pharmacy on the hospital site. It is noted that the need for better information for people as they wait for these appointments would improve safety and give reassurance. We hear that better information would also improve people’s experiences of being discharged from hospital.

Healthwatch Cambridgeshire and Peterborough note that the Quality Account does not mention compliance with the NHS England Accessible Information Standard. We ask that the need for improvement in this area being recognised in future.

It is very pleasing to see that seven-day services are being delivered for patients. It is reassuring that the Trust participation in national audits is strong and that the associated action planning is being followed through. This gives confidence that high standards are being pursued and met.

**Priorities**

Healthwatch Cambridgeshire and Peterborough welcomes the priorities set out in this year’s Quality Account and the clear commitments to transparency and learning. The commitment to understanding patients’ journeys and involving patients in the redesign and co-production of services is particularly constructive and indicative of an open learning culture. We would value the sharing of your methods and learning from these activities through the year ahead.

The Trust’s commitment to 100% compliance with Duty of Candour is very welcome and Healthwatch look forward to improvements in reaching this target in coming years.

The commitment to implementing ReSPECT and My Chart is very welcome and presents the Trust with real opportunities to develop services that wrap around the patient and put people in control of their health care.

**Actions from previous Quality Accounts**

Healthwatch has previously highlighted the need to improve how the Trust keeps people informed regarding their complaint and the subsequent learning. It is pleasing therefore to see commitments to put a new process in place to facilitate this.

The work that Healthwatch Cambridgeshire and Peterborough has undertaken to support the emerging Rosie Maternity Voices Group has realised remarkable benefits. This group is now thriving and a true voice for local people.

**Challenges**

Healthwatch Cambridgeshire and Peterborough fully understand the pressures on the in health and care system and welcome the leadership role that the Trust has taken in the Sustainability and Transformation Partnership. Engagement with the public and patients is now vital to design and implement the local NHS long term plans.

**Sandie Smith, CEO - Healthwatch Cambridgeshire and Peterborough**

15 April 2019
Annex 2: Statement of directors’ responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality report meets the requirements set out in the *NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19*

- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to March 2019
  - papers relating to quality reported to the board over the period April 2018 to March 2019
  - feedback from commissioners dated 23 April 2019
  - feedback from governors dated 15 April 2019
  - feedback from local Healthwatch organisations dated 15 April 2019
  - feedback from overview and scrutiny committee dated 24 April 2019
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09 May 2019
  - the 2018/19 national patient survey (latest published – National inpatient survey) 13 June 2018
  - the 2018/19 national staff survey 26 February 2019
  - the Head of Internal Audit’s annual opinion of the Trust’s control environment dated 21 May 2019
  - CQC inspection report dated 26 February 2019

- the quality report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered

- the performance information reported in the Quality report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
• the quality report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.

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

**By order of the board**

Chairman
23 May 2019

Chief Executive
23 May 2019
## Appendix A: National Quality Indicators – 2018/19 performance

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>CUH performance 2017/18</th>
<th>CUH performance 2018/19</th>
<th>National average</th>
<th>Best performer among trusts</th>
<th>Worst performer among trusts</th>
<th>Trust statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>(a) The value and banding of the summary hospital-level mortality indicator (&quot;SHMI&quot;) for the Trust for the reporting period; and</td>
<td>Value 0.8539 Band: 3 (lower than expected) (Oct.16-Sep.17)</td>
<td>Value 0.882 Band: 3 (lower than expected) (Oct.17-Sep.18)</td>
<td></td>
<td></td>
<td></td>
<td>CUH considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○ The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○ The Trust will continue working to improve the accuracy and depth of coding whilst also implementing the new national mortality programme so that we continue to learn and improve our services.</td>
</tr>
<tr>
<td>18</td>
<td>(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.</td>
<td>36%, 35% and 36%(Apr.17 – Dec.17)</td>
<td>41.4% (Apr.18 – Mar.19)</td>
<td></td>
<td></td>
<td></td>
<td>CUH considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○ This should be a reflector of expected deaths and therefore nationally appears low.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○ Following the Trust’s End of Life Care Operational Group action plan and the Trust’s three-year End of Life Care Strategy.</td>
</tr>
</tbody>
</table>

During the reporting period, The Trusts usually reports on the Adjusted Average Health gain score, which is in the CUH performance column, however this does not have details of the highest and lowest performers readily available, so I have also
the Trust’s patient reported outcome measures scores for:

included the adjusted health gain score to enable a comparison, although these are not the figures normally published.

PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Historical data will be unaffected.

*National Best and Worst performer data is not available for these PROMs.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>CUH performance 2017/18</th>
<th>CUH performance 2018/19</th>
<th>National average</th>
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<th>Worst performer among trusts</th>
<th>Trust statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(i) groin hernia surgery</td>
<td>0.093 (Finalised published data @ Feb.18)</td>
<td>0.089 (to Sep.17)</td>
<td>0.089 (to Sep.17)</td>
<td>*</td>
<td>*</td>
<td>Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).</td>
</tr>
<tr>
<td></td>
<td>(ii) varicose vein surgery</td>
<td>Low questionnaire return (less than 30) - suppressed to protect confidentiality</td>
<td>-8.45 (to Sep.17)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).</td>
</tr>
</tbody>
</table>
|     | (iii) hip replacement surgery  | 22.645 (Finalised published data @ Aug.18) | 22.783 (Finalised published data @ Feb.19) | 22.7 | *                           | *                           | CUH considers that this data is as described for the following reasons:  
  o We are performing at expected levels despite a complex case mix who are operated on at CUH. |
|     | (iv) knee replacement surgery  | 15.6 (Finalised published) | 15.907 (Finalised published) | 17.3 | *                           | *                           | CUH considers that this data is as described for the following reasons:  
  o We are performing at the expected |
<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>CUH performance 2017/18</th>
<th>CUH performance 2018/19</th>
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<th>Worst performer among trusts</th>
<th>Trust statement</th>
</tr>
</thead>
</table>

|                  | data @ Aug.18) | data @ Feb.19) |                  |                  |                             |                           | case level despite a complex case mix at CUH. The knees PROMS have dipped from the last assessment the participation rate remains low as nationwide 46,099 knee replacements were performed however with a 6% return rate the statistical significant remains questionable, further analysis has been requested from NHS Digital. |
|                  |                |                |                  |                  |                             |                           |

CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by:

- Continuing to review this data at multi-disciplinary team meetings as well as staff appraisals, and continue to strive to improve these outcomes.

|                  | The percentage of patients aged: |                  |                  |                  |                             |                           |
|                  | (i) 0 to 15 and (Patients aged 0 – 14) | 12.4% (Apr.-Dec.18) |                  |                  |                             |                           |
|                  | (ii) 16 or over (Patients aged 15 and over) | 13.0% (Apr.-Dec.18) |                  |                  |                             |                           |

Comparison not provided nationally

NHS Digital has not published an update of this data since 2012; therefore we have not included this data in our 2017/18 Quality Account.

In the absence of NHS Digital data we have used our own PAS system data which provides information of patients who were re-admitted to the Trust within 30 days.

|                  |                  |                  |                  |                  |                             |                           |
|                  | 10.1% (Apr.-Dec.18) |                  |                  |                  |                             |                           |

The percentage of patients aged:

- 0 to 15
- 15 or over

re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>CUH performance 2017/18</th>
<th>CUH performance 2018/19</th>
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</tr>
</thead>
</table>
| 20  | The Trust’s responsiveness to the personal needs of its patients during the reporting period. | 71.1% (2016) | 69.5% (2017*) | 68.6% (2017) | 85% The Royal Marsden Hospital (2017) | 60.5% Barts Health NHS Trust (2017) | CUH considers that this data is as described for the following reasons:  
  o CUH performance was slightly above the national average for the indicator ‘responsiveness to the personal needs of its patients during the reporting period’ in the 2017 National Inpatient Survey (*the latest survey results available*).  
  o It was considered that there was room for improvement with respect to giving enough privacy when discussing individual conditions or treatment, ensuring that patients know there is a member of staff to talk to if they have any worries or fears, and telling our patients about medication side effects to watch for when they went home. |
<table>
<thead>
<tr>
<th>Ref</th>
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<th>CUH performance 2017/18</th>
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</tr>
</thead>
</table>
| 21  | The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. | 83%                     | 84%                     | 71%              | *                           | *                          | CUH considers that this data is as described for the following reasons:  
  o CUH performed in the top ten best performing non specialist trusts against this statement (as a Key Finding).  
  o This is an improvement on the previous score and well above the national average.  
  o Reasons for this improvement include the quality of staff that we recruit and develop, improved staff engagement and increased focus on quality and safety.  
  CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by: |

CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by:
  o An action plan addressing the above issues is created by a working group for the National Inpatient Survey, overseen by the Patient Experience Group.
  o Discussing the results in nursing meetings.
  o The ‘My Chart’ patient portal, which gives patients access to their electronic patient record, continues to be rolled out to new patients.
### Ref 23: The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Q1: 96.76% &lt;br&gt; Q2: 95.7% &lt;br&gt; Q3: 94.9% &lt;br&gt; Q4: 96.6%</td>
<td>Q1: 96.4% &lt;br&gt; Q2: 96.5% &lt;br&gt; Q3: 96.5% &lt;br&gt; Q4: 96.3%</td>
<td>95.2% (England – March 2018)</td>
<td>67% (MK University Hospital NHS - March 2018)</td>
<td>100% (Essex Partnership University Hospital NHS – March 2018)</td>
<td></td>
</tr>
</tbody>
</table>

CUH considers that this data is as described for the following reasons:
- The Trust has a robust process for clinical coding and review of VTE data so is confident that the data is accurate.

CUH intends to take the following actions to improve this percentage, and so the quality of its services:
- The Trust will continue working to improve the accuracy and depth of coding.
- The Trust VTE safety and quality group will continue to monitor VTE risk assessment across the Trust and identify areas where improvement is required.
## Quality Report 2018/19

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
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<th>Best performer among trusts</th>
<th>Worst performer among trusts</th>
<th>Trust statement</th>
</tr>
</thead>
</table>
| 24  | The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period. | | | | | | **CUH considers that this data is as described for the following reasons:**  
  ○ We are only able to calculate bed days using last year’s data as current data is not available.  
  ○ We do not have complete data for 2018/19 from all NHS acute trusts or Shelford group.  

| | Number of incidents reported: 6,979 | Number of incidents reported: 7,089 | Number of incidents reported: 5,583 | Number of incidents reported: 23,692 | Number of incidents reported: 566 | 91** (from all NHS acute trusts) |
| | Rate of reporting: 43.09 | Rate of reporting: 42.22 | Rate of reporting: 44.5 | Rate of reporting: 51.9 | Rate of reporting: 13.1 | From Shelford Group: 27.4* (2017/18 from University College Hospital London) |
| | Rate resulted in severe harm or death: 0.13 (21 incidents) | Rate resulted in severe harm or death: 0.11 (19 incidents) | Rate resulted in harm or death: 0.15 (18.9 incidents) | Rate resulted in harm or death: 0.19 (87 incidents) | Rate resulted in harm or death: 0.07 (3 incidents) | From Shelford Group: 7.9* (2017/18 from Guy’s & St. Thomas’ |
| | Based on NRLS data | Based on NRLS data | Based on NRLS data | Based on NRLS data | Based on NRLS data | **We use 2017/18’s bed days numbers for calculation**  
  **2018/19 data is not available at time of publication** |

25  | The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | | | | | | **CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by:**  
  ○ The Patient Safety Improvement Plan 2018/20 will continue to | | |
<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>CUH performance 2017/18</th>
<th>CUH performance 2018/19</th>
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<th>Worst performer among trusts</th>
<th>Trust statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q1/2, 2017/18</td>
<td>Q1/2, 2018/19</td>
<td>Q1/2, 2018/19</td>
<td>Q1/2, 2018/19</td>
<td>Q1/2, 2018/19</td>
<td>strengthen the quality and quantity of patient safety incident reporting to help the Trust learn and improve care for patients. In 2019/20 the improvement activities will focus on how the Trust can strengthen the psychological safety that staff feel in regards to reporting concerns and incidents by introducing a ‘Just Culture’ improvement programme and After Action Reviews.</td>
</tr>
</tbody>
</table>
Appendix B: HQIP National Clinical Audits
(Cut off for data inclusion: 12/02/2019)

<table>
<thead>
<tr>
<th>Title</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Intensive Care Audit Network (PICAnet) Annual Report 2017</td>
<td>The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The PICAnet audit aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes. It collects personal, organisational and clinical data on all children with a clinically determined need for paediatric intensive care. It audits the quality of care delivered against the Paediatric Intensive Care Society (PICS) standards, which cover the whole patient pathway from the initial referral to paediatric intensive care, specialist transport and then inpatient care. Key Findings and Learning: Nationally, paediatric intensive care units were operating under increased pressure as numbers of patients increased and specialist nursing staff was not always available for all shifts. The Paediatric Intensive Care Unit (PICU) in Addenbrooke’s had 1897 admissions during the audit period which represent 3.16% of the national audit. CUH monitors the mortality of our patients and it is within acceptable national standards including when adjusted for case mix. Admissions per consultant are high and would be expected to deteriorate in the 2017 data because of an additional consultant vacancy. There is a national shortage of paediatric intensive care consultants which makes this role difficult to recruit to. Nursing staffing on PICU is also lower than the national standard and this is addressed in innovative ways. Nurse advanced resuscitation training is below the national standard. Funding for nurse training was removed in the period leading up to this audit. However, overall CUH’s PICU continues to maintain a high national reputation and the audit outcomes match the best in the UK and Ireland. Planned Actions: CUH will continue the recruitment to the consultant and the nursing vacancies. Bank staff to cover any shortfalls whenever possible. Steps are being taken to reinstate access to training for our nursing team as part of the training and career development opportunities for nursing staff.</td>
</tr>
<tr>
<td>Raising to the Challenge, 4th SSNAP Annual Report 2017</td>
<td>The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS. Key Findings and Learning: The audit results showed CUH’s continued improvement in stroke care despite increasing difficulty with access to stroke unit beds due to lack of effective bed management policy. On a scale from A – E, with A being the best performers, CUH now scores a rating of B from previously D. This is largely due to better staffing since 2016. CUH are also able to support improved data collection for the audit and have a realistic ambition to get to an ‘A’ rating in the near future. The Trust</td>
</tr>
<tr>
<td>Title</td>
<td>Outcome</td>
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<tr>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td>is still limited in its ability to deliver many acute elements of care due to a limited number of beds. Planned Action: Bed management plan was reviewed with Chief Operating Officer and updated.</td>
<td></td>
</tr>
<tr>
<td>National Neonatal Audit Programme NNAP - 2017 Annual Report on 2016 data</td>
<td>The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The NNAP monitors the standard of care provided by specialist neonatal units is to inform efforts to give all babies the best possible chance of surviving and reaching their full potential. 8 standards are monitored in this audit. Key Findings and Learning: CUH performs better than the national average on the following standards: antenatal steroids, mothers who were given Magnesium Sulphate, consultation with parents, bronchopulmonary dysplasia, mother’s milk at time of discharge, clinical follow-up at 2 years of age. The Trust was the same as the national average for the baby’s temperature within range. CUH was below the national average for screening for retinopathy of prematurity with 87% compared to 94% nationally. Planned Actions: Active programme to continue to further increase number of babies receiving mother’s milk at discharge. Improve temperature control for babies on admission through raising staff awareness and education. Correct data input and reduction of manual double data entry could be improved by having a reliable interface between electronic patient record and the maternity system ‘Badgernet’. CUH is engaged with and supportive of initiatives to address this. Continue to work towards improving temperature control and pay greater attention to avoid hyperthermia which may have resulted from attempts to reduce hypothermia, which had been an issue in the past.</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant programme: MBRRACE-UK Perinatal Confidential Enquiry Report 2017 (Nov.17)</td>
<td>The Trust received the report in January 2018. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. Since the last confidential enquiry into intrapartum stillbirths and intrapartum-related deaths in 1993-1995, overall stillbirth rates have reduced by just over a fifth and neonatal death rates by over a third. Nevertheless the UK rates are still high compared with other European and other high income countries. The enquiry aimed to identify potentially preventable failures of care along the whole care pathway, but with a particular focus on care during labour, delivery and any resuscitation, which might have contributed to the death. The results are not broken down by Trusts. Key Findings and Learning: The overall key findings from the confidential enquiry are listed below:</td>
</tr>
<tr>
<td>Title</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Overall quality of care</strong></td>
<td><strong>Stillbirth</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Baby</strong></td>
</tr>
<tr>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Good care; no improvements identified</td>
<td>3</td>
</tr>
<tr>
<td>Improvements in care identified which would have made no difference to outcome</td>
<td>6</td>
</tr>
<tr>
<td>Improvements in care identified which may have made a difference to outcome</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

The consensus of the enquiry was that the care after delivery, physical and psychological outcome and/or future fertility for the mother, in just under half of intrapartum stillbirths (45%) and half of intrapartum-related neonatal deaths that improvements in care may have made a difference.

Capacity and staffing issues were identified in about 35% of cases, playing a role in the outcomes for mother and baby. Issues with delays in transfers to the delivery unit and delays in induction of labour or performing artificial rupture of membranes because if increased activity in the delivery unit. Such delays suggest that during periods of high activity the ability of the wider maternity service to cope with the demand for one-to-one care and/or timely review by obstetric or medical staff is sometimes compromised.100

**Planned Actions:**

The maternity services to note the findings and to integrate these into existing action plans.

---

**Annual Report of the National Lung Cancer Audit 2017**

The Trust received the National Lung Cancer Audit (NLCA) report in January 2018. Findings and planned actions were presented to the Clinical Audit Committee in April 2018.

The audit reviews covers the care and treatment of patients with a diagnosis of lung cancer. The data is broken down by England, Wales and Guernsey.

**Key Findings and Learning:**

CUH’s completeness of data submission is above the national mean for all metrics, including for stage and performance status.

Clinical results are above the national mean for all metrics, including pathologic confirmation of diagnosis, pathologic subtyping and patient access to lung cancer specialist nurse.

CUH unadjusted surgical resection rates and one year survival were above the national mean but not statistically significantly different to the national mean when adjusted for age, sex, stage, socio-economic status and co-morbidity.

There has been a marked improvement in data completeness in Cancer
<table>
<thead>
<tr>
<th>Title</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes and Services Dataset (COSD) submissions extracted from EPIC (2016 data) in comparison to the previous year.</td>
<td>CUH use of the systemic anti-cancer therapy (SACT) for advanced Non-small-cell lung carcinoma (NSCLC) has been above the national mean in previous reports. Although not an outlier in this report, SACT use appeared lower than in previous years. Planned Actions: No improvement action plan is required however patient level data from COSD has been reviewed to further understand key metrics.</td>
</tr>
<tr>
<td>Specialist rehabilitation for patients with complex needs following major injury (Dec.17)</td>
<td>The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The audit aims to determine the scope, provision, quality and efficiency of specialist rehabilitation services across England and improve the quality of care for adults with complex rehabilitation needs following major trauma. This audit is currently in the phase to define standards and improve the quality of the data collection. Key Findings and Learning: The East of England (EoE) has the lowest number of level 1 and level 2 beds for specialist and trauma rehabilitation per million populations. CUH provides 10 programmed activities rehabilitation consultant input to trauma patients which was only achieved by three other major trauma centres in the country. In additional the EoE trauma network has a dedicated rehabilitation consultant who is responsible for trauma rehabilitation. Therefore CUH was able to collect all four tools for the audit. Planned Actions: Rehabilitation development strategy across the region currently carried out by the Trauma Rehabilitation Network Coordinator. Service development and expansion of inpatient rehabilitation within the Major Trauma Centre and in the Cambridgeshire Clinical Commissioning Group (CCG) lead by the service lead in Rehabilitation at CUH.</td>
</tr>
<tr>
<td>National Bowel Cancer Clinical Audit Programme (NBOCAP) (Dec.17)</td>
<td>The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The National Bowel Cancer Audit (NBOCAP) describes and compares the care and outcomes of patients diagnosed with bowel cancer in England and Wales. Key Findings and Learning:  - Risk adjusted mortality rates in line with expected.  - Risk adjusted 18 month temporary stoma rate with expected range.  - Case ascertainment is above the expected standard of 80%.  - Risk adjusted post-operative length of stay - worse than national average.  - High resection rate of 69% undergoing potentially curative resection.  - Laparoscopic surgery rates were lower than the national average. All surgeons were trained to carry out laparoscopic surgery which should increase in laparoscopic surgery rate.  - CUH has a slightly higher than average emergency procedures – this is mostly due to factors beyond our control.</td>
</tr>
</tbody>
</table>
### National Oesophago-Gastric Cancer Audit Report (NOGCA) 2017 (Dec. 17)

The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018.

The National Oesophago-Gastric Cancer Audit covers the quality of care given to patients with oesophago-gastric (OG) cancer and oesophageal high-grade glandular dysplasia (HGD). Its long-term goals are to provide information that enables NHS cancer services to benchmark their performance and to identify areas where aspects of care could be improved.

**Key Findings and Learning:**

CUH performs well in endoscopic and surgical management of patients with HGD and invasive oesophago-gastric cancer.

207 surgical cases were entered by CUH with a 1.5% 90 day post-operative mortality, which is one of the lowest in England.

All other quality outcome measures were either within expected range or better, e.g. CUH’s average length of stay was 10 days which is 2 days shorter than the national average.

53 cases with HGD were entered by CUH, the second highest in the England with 97-100% data completeness.

The number of cases submitted remains at approximately 80% year on year.

25% of patients entered into the audit by CUH had an “unknown” referral source and only 77% were reported to have had a staging computerised tomography scan. CUH was an outlier for these data items compared with the best performing trusts and this is reviewed and addressed when collating and submitting the data to the national data collection.

**Planned Actions:**

- Working towards 100% of eligible cases to be entered into NOGCA and improve accuracy of data fields. Work to be undertaken to examine the process for data collection from electronic patient record and submission to NOGCA.
- A quarterly internal audit of data completeness and accuracy will be conducted for 12 months.

### Annual report 2017 National Prostate Cancer Audit (Nov. 17)

The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in July 2018.

The National Prostate Cancer Audit (NPCA) assesses the process of care and its outcomes in all men diagnosed with prostate cancer in England and Wales.

**Key Findings and Learning:**

Overall the CUH prostate cancer service performs above the national average. The data submitted for this report had been collected whilst the CUH electronic patient record was not built for this. A better process for data extraction is now in place and submitted data should be of better quality.

**Planned Actions:**

- Results from this audit has been reviewed and discussed by the Prostate Multidisciplinary Team which includes urologist and oncologists.
<table>
<thead>
<tr>
<th>Title</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>On-going work with the electronic patient records team about improving data extraction is part of the on-going process of improving data collection.</td>
<td></td>
</tr>
</tbody>
</table>
| National Diabetes Audit, 2016-17 Report 1: Care Process and Treatment Targets (Mar.18) | The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018.  
  The National Diabetes Audit provides a comprehensive view of diabetes care in England and Wales and measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards 1 and 2.  
  Key Findings and Learning:  
  The percentage of care processes carried out for patients with type 1 diabetes was higher than expected for average blood glucose (sugar) (HbA1c), blood pressure (BP), urine albumin, BMI and overall for all 8 care processes.  
  The percentage of care processes carried out in patients with type 2 diabetes was higher than expected for HbA1c urine albumin and recording of body mass index (BMI). 5 other care process where as expected with exception of foot surveillance which was lower than expected.  
  For treatment targets and structured education a comparison against the overall England figures is difficult to interpret as they include both primary and secondary care settings. CUH will compare itself against similar centres as part of the action plan.  
  Planned Actions:  
  Establish which specialist centres have similar patient populations for type 1 and 2 diabetes to enable comparison of performance against treatment target achievement, percentage offered/attending structured education with similar organisations.  
  Memorandum sent to health care professionals on better completion of above fields to improve recording. |
| Third Annual Report on National Diabetes Footcare Audit; 2014-2017 (Mar.18) | The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018.  
  There is a clear association between ulcer severity at first expert assessment and likelihood of admission for in-patient foot disease management.  
  Key Findings and Learning:  
  Key Findings and Learning are very similar to previous findings. This is to be expected with data drawn so soon after the previous report and with data derived from same source.  
  CUH’s patient demographics closely matched the “national profile” of foot patients. CUH 2.8% patients are in the bottom deprivation quintile versus 26% nationally.  
  While nationally 43 % of patients had met treatment target for long term glycaemic control (judged by HbA1c), only 32 % of CUH’s patients had met the target.  
  While nationally only 45% of ulcers presenting were “severe”, in CUH’s clinic 63% of ulcers presenting were rated as “severe”.  
  CUH’s patient outcomes were that at 24-weeks after the first assessment that 39 % of CUH’s patients were reported to be ulcer free versus 58% nationally. |
Title | Outcome
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60% of patients were admitted in the 6 months after presentation versus 50% nationally.
18% of CUH’s patients had a revascularisation procedure, compared to 8% nationally.
In many cases, patients present to our service for the first time later in the disease process when compared to the national average. CUH appears to have a lower rate of self-referral than national average (CUH 8% versus 28% nationally). This is despite CUH running 5 days a week service with "seen same day" offered if clinically needed to all patients and healthcare practitioners. It is of note, that 21% were not seen by CUH for 2 or more months after initial presentation to another healthcare professional versus 9% nationally).
2.1% of CUH’s patients had a major amputation compared to 1.7% nationally; this is to be expected for a regional intervention centre.
Planned Actions:
Findings and recommendations disseminated to specialty areas.
Service evaluation to be completed to give a clear steer as to why there are later referrals; no single location or referral source is apparent. Similar problems have been identified nationally in other centres running a foot service. A team will look forward to tackling this long standing problem with our partners.
CUH will also use the GIRFT ("getting it right first time") deep dive visit in October 2018 as an opportunity to focus on this crucial interaction between primary and secondary care.
CUH will be presenting the foot service and the issues highlighted by this report at the re-launch of the East of England Diabetic Footcare Network in September 2018 to discuss results and possible solutions.

National Diabetes Inpatient Audit, England and Wales 2017 (Mar.18) | The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018.
The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital.
Key Findings and Learning:
- Improvements have been achieved in medication error rates.
- In-patient hypoglycaemia rates have reduced.
- Understanding processes that underlie insulin timing errors.
- Early involvement of MDT foot team in care of patients with diabetes admitted with co-existing foot disease.
Planned Actions:
To conduct a case-based analysis of data from the NaDIA 2017 report to review the cases of ‘insulin given/prescribed at the wrong time’ to determine underlying themes.
Display posters of the ‘Diabetic Foot Pathway’ in admitting areas particularly in the Emergency Department (ED).
Member of foot team to organise visits to ED to raise awareness of pathway and profile of Diabetes Foot Team.
Results presented at Diabetes MDT meeting.
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| National Audit of Inpatient Falls Audit report 2017 (Nov.17)         | The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in July 2018.  
The National Audit of Inpatient Falls aims to improve the delivery of care for patients who have falls or sustain fractures through effective measurement against standards and feedback to providers.  
Key Findings and Learning:  
In the provision of call bells and the assessment of vision CUH was above the national average and CUH was 100% in the provision of mobility aids.  
The assessment and management of delirium and medication reviews specific to falls management were areas that were highlighted as requiring improvement nationally; however CUH was above the national average in both areas.  
The Trust provision of continence care was 40% (85% nationally) and none of the patients reviewed had a record of lying and standing blood pressure (compared to 19% nationally).  
Planned Actions:  
The audit results were presented at the Trust’s Falls and Pressure Ulcer Steering Group. The key actions for continence assessment and management and the recording of lying and standing blood pressure have been incorporated into the Trust Falls Quality Improvement plan. |
| National vascular registry 2017 annual report (Nov.17)                | The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in October 2018.  
The registry is designed to support quality improvement within NHS hospitals performing vascular surgery by providing information on their performance.  
Key Findings and Learning:  
Ruptured Abdominal aortic aneurysm (AAA) (2014-16 data) - Good outcomes with a good use of endovascular aneurysm repair (EVAR). CUH meets national guidance for offered EVAR with 58% of appropriate patients being offered an EVAR (national 25%).  
Outcomes such as mortality and stroke remain good.  
Delays in access to treatment remain a challenge, particular for carotid and AAA surgery, but a new pathway co-ordinator should improve this.  
Data entry for amputations and angioplasty remains low. New data clerk should improve data entry.  
Planned Actions:  
Pathway coordinator for both procedures appointed in March 2018. This should lead to improvement in our delays of treatments.  
Lower Limb Intervention - Data clerk to assist with data entry onto the NVR in post which will support better case ascertainment rates.  
Amputee Pathway Multidisciplinary Team (MDT) in place to improve care in line with the national recommended pathway.  
Further improvements and on-going pathway audits planned. |
| National Diabetes Insulin Pump Audit 2016-2017 (Jun.18)              | The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018.  
The Insulin Pump Audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reasons |
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<td><strong>for going on an insulin pump and the outcomes achieved since starting the pump.</strong>&lt;br&gt;<strong>Key Findings and Learning:</strong>&lt;br&gt;CUH is a large insulin pump centre with a high percentage of patients receiving insulin pump therapy. Hyperglycaemia is better controlled in patients attending CUH with or without insulin pump therapy compared to other centres.&lt;br&gt;Hyperglycaemia as judged by average blood sugar (HbA1c) was better controlled in patients receiving insulin pump therapy attending CUH compared to other participating hospitals. CUH had the highest number of patients receiving insulin pump therapy in this audit with 635 patients on insulin pumps.&lt;br&gt;36.5% of people with type 1 diabetes seen a CUH were receiving insulin pump therapy compared with 15.6% for all participating hospitals.&lt;br&gt;Hyperglycaemia was also better controlled in CUH patients not on an insulin pump compared to other participating hospitals.</td>
<td><strong>Findings presented at the speciality areas and disseminated to staff.</strong></td>
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<td><strong>National Mesothelioma Audit report 2018 (Jun.18)</strong></td>
<td><strong>The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018.</strong>&lt;br&gt;The National Mesothelioma Audits aim is to raise the profile of this asbestos-related cancer and to make recommendations to improve outcomes for mesothelioma patients.&lt;br&gt;<strong>Key Findings and Learning:</strong>&lt;br&gt;CUH performance is above the mean for England and has shown an improvement since the 2017 report to 66.7%.&lt;br&gt;Data capture still does not reflect clinical practice in some areas e.g. Specialty Nurse, Multidisciplinary Teams and Performance Status.</td>
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<td><strong>National Audit of Breast Cancer in Older Patients NABCOP: 2018 Annual Report (May.18)</strong></td>
<td><strong>The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018.</strong>&lt;br&gt;This national audit is designed to set the benchmark nationally for outcomes for older women with breast cancer.&lt;br&gt;<strong>Key Findings and Learning:</strong>&lt;br&gt;CUH amongst the leading Trusts for most parameters in women over 70 years.</td>
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<td><strong>Quality Report 2018/19</strong></td>
<td><strong>Cambridge University Hospitals NHS Foundation Trust</strong></td>
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| **National Maternity and Perinatal Audit (NMPA): Clinical report 2017 (May.18)** | The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The audit consists of three separate but related elements:  
- An organisational survey of maternity and neonatal care in England, Scotland and Wales providing an up-to-date overview of care provision, and services and options available to women  
- A continuous clinical audit of a number of key measures to identify unexpected variation between service providers or regions  
- A programme of periodic ‘sprint’ audits on specific topics.  
**Key Findings and Learning:**  
CUH was within expected for our ‘vaginal birth after caesarean section’ rate, instrumental delivery rate, early elective deliveries and small for gestational age at 40 weeks compared to all sites mean.  
CUH had a lower than expected rate for induction of labour, caesarean section and haemorrhage over 1500mls.  
The outlying parameters in the audit findings for CUH versus the ‘all sites mean’ were positive findings – lower caesarean section rate, lower haemorrhage rate and lower induction rate and the normal delivery rate.  
No significant concerns were identified for CUH.  
**Planned Actions:**  
No further actions required but continue to monitor our dashboard and work to maintain standards.  
Findings and recommendations presented at the specialities. |
| **MBRRACE-UK Perinatal Mortality Surveillance Report 2018 (Jun.18)** | The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The fourth MBRRACE-UK Perinatal Mortality Surveillance Report provides information on extended perinatal deaths in the UK and Crown Dependencies arising from births during 2016.  
**Key Findings and Learning:**  
CUH performance for perinatal mortality is up to 10% lower than group average.  
CUH’s compliance with data collection was over 90% for antenatal care, delivery and babies characteristics for still-births, delivery and babies characteristics for neonatal deaths as well as baby’s outcome.  
Further improvement is required for incomplete data on mother’s details (72.1%) and booking information (62.8%). The maternity team have been working on including smoking data as this is one of the ‘saving babies lives’ care bundle.  
**Planned Actions:**  
Workforce planning with birth rate plus. Funding agreed for new consultant. Audit regarding transfers started.  
Human Factors Faculty established and training rolled out September 2017 for 15 - 20 maternity, medical, anaesthetic and neonatal staff each month. |
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<td>Use of Perinatal Mortality Review Tool commenced locally for all stillbirths since January 2018.</td>
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<td>NCEPOD: Chronic Neurodisability - Each and Every Need Report 2018 (Jul.18)</td>
<td>The Trust received the report in July 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. This NCEPOD report focuses on the quality provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies. Key recommendations relating to:</td>
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<td>- Improving clinical coding and quality of routine data                                                                                     - Clinical care - diagnosis and management                                                   - Clinical care - clinical leads and care plans                                               - Transition and age appropriate care                                                   - Clinical care - communication                                                                 - Organisation of care</td>
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<td>Key Findings and Learning:                                                                                                                  Good working with community colleagues in complex neurological conditions. Joint working to implement the Cerebral Palsy Integrated Pathway UK. Joint training events supported by consultants. Children with epilepsy requiring rescue medication will have an epilepsy care plan if they are seen by the consultants in this region. Quality of data recording remains dependent on the clinician entering the data. Standard practice should be information in notes and clinical correspondence commencing with diagnosis, distribution and severity. Children from North Cambridgeshire do not have support from epilepsy nurses or an epilepsy care plan. Planned Actions:</td>
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<td>Planned Actions:                                                                                                                          All staff (including non-paediatric specialists) need to adopt standard nomenclature and grading of chronic conditions. The Community Service developed a &quot;Patient Passport&quot; on the community electronic patient record for parents of children with high levels of need. Discussions to include all Eastern community trusts. The template is based on the requirements of the NCEPOD guidance and would be updated at each clinical contact.</td>
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<td>National Paediatric Diabetes Audit (NPDA) (Aug.18)</td>
<td>The Trust received the report in August 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Pregnancy in Diabetes Audit measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. This audit addresses three high level questions whilst measuring results against updated NICE guideline:</td>
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<td>- Were women with diabetes adequately prepared for pregnancy?                                                                                - Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?                                                                 - Were adverse neonatal outcomes minimised?</td>
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|                                                                      | Key Findings and Learning:                                                                                                                  Improvements in the delivery of care processes. CUH moved from being an outlier to above the national average in two years. CUH had previously been
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<td>an outlier by not meeting all of the seven required care processes and achieved this only in 7.6% of our patients in 2014. In 2016 CUH achieved all seven care processes in 48% of our patients, above the national average of 43% and the regional average of 35%. Individual care process recording has improved since the 2015 cycle, particularly the collecting of urine samples from patients at annual review which was one of the action points for the team. In 2014 it was 8.8% and this year it is 64% which is much more aligned with the national average. CUH noted higher rates of microvascular complications such as microalbuminuria and abnormal retinal screening than the national averages despite having better metabolic control. This may be due to differences in the way results are classified in different units – for example CUH classes anything other than a completely normal retinal screen as abnormal, including background retinopathy. Planned Actions: All educators to remind patients and ensure that a sample has been given prior to the patient leaving. Team to be consistent with message regarding targets and advice.</td>
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<td>National Ophthalmology Database NOD Audit Report 2018 (Aug.18)</td>
<td>The Trust received the report in August 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Ophthalmology Database (NOD) Cataract Audit reports on two primary indicators of surgical quality. These are, firstly, the index surgical intraoperative complication of rupture of the posterior lens capsule or vitreous prolapse or both (abbreviated as PCR), and secondly Visual Acuity (VA) Loss (doubling or worse of the visual angle) related to surgery. Key Findings and Learning: CUH cataract service met national standards in relation to cataract outcomes. CUH complication rate for posterior capsule rupture was 0.75% and was comparable to major centres and below the national average of 1.4%. Successful data extraction from electronic patient records for the national audit. Data entry and resources for on-going audit require attention. Planned Actions: To continue to recording of essential data on electronic patient records to capture audit info for all cataract surgeries at CUH. Regular service meetings to train all surgeons, nurses and optometrists for cataract audit and to maintain standards.</td>
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<tr>
<td>National UK Parkinson’s Audit Report 2017 (May.18)</td>
<td>The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The audit measures the quality of care provided to people living with Parkinson’s against a range of evidence-based guidance about the care of people with the condition. This is only reported as national data. Key Findings and Learning: Timely specialist review - 98.1% of patients audited had received a specialist review in the preceding 12 months. There was an increased signposting to Parkinson’s UK.</td>
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<td>Maternal, Newborn and Infant Programme MBRRACE: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16 (Nov.18)</td>
<td>The Trust received the report in November 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. This year the report examines in detail the care of women who died during or up to one year after pregnancy between 2014 and 2016 in the UK and Ireland from mental health conditions, blood clots (thrombosis and thromboembolism), cancer, and homicide, and women who survived major bleeding (haemorrhage). Key Findings and Learning: CUH Performance: 2017 Audit showed quality standards met. 2 cases where post-partum hemorrhaging was underestimated and 1 case where no preventative measures were taken despite risk factors. No significant increase in the overall maternal death rate in the UK between 2011–13 and 2014-16. Planned Actions: Perinatal mental health service in process of being set up in conjunction with the mental health teams and specialist obstetric clinic. Referral pathways are being written and guideline is being updated to reflect the changes. Skills and drills training in place to raise awareness of how to treat post-partum hemorrhaging and referral pathways.</td>
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<td><strong>Antenatal magnesium sulphate, temperature on admission, consultation with parents, screening for retinopathy of prematurity, mother’s milk at time of discharge.</strong>&lt;br&gt;CUH was below the national rate for antenatal steroids, parents on ward rounds, screening for retinopathy of prematurity and was in line with the national average for follow-up at two years of age.</td>
<td><strong>Planned Actions:</strong>&lt;br&gt;Neonatal unit continues displayed the posters on the unit to be transparent about how the unit compares nationally.&lt;br&gt;Continued strong presence of senior medical staff on unit with almost every family having a consultation within the first 24 hours.</td>
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<td><strong>Planned Actions:</strong>&lt;br&gt;Neonatal unit continues displayed the posters on the unit to be transparent about how the unit compares nationally.&lt;br&gt;Continued strong presence of senior medical staff on unit with almost every family having a consultation within the first 24 hours.</td>
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<td>care, both curative and palliative, given to patients with oesophago-gastric cancer and oesophageal high-grade glandular dysplasia.</td>
<td>Key Findings and Learning:</td>
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<td>CUH performs well in its endoscopic and surgical management of patients with high-grade dysplasia and invasive oesophago-gastric cancer.</td>
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<td>CUH is now confident that 100% of eligible cases are entered into NOGCA. 172 patients from CUH were entered into the audit compared with an “expected” number of 251-300. This placed CUH in an “amber” category for case ascertainment. However, a local audit of case ascertainment has confirmed that all cases are added and CUH is now confident that the “expected” number for Cambridge is too high.</td>
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<td>This is supported by seeing that all our cancer units are at &gt;90% case ascertainment and our “expected” numbers of cancers increased by 50 from 2017 to 2018 without any explanation by the national audit team.</td>
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<td>The staging pathway for patients with oesophago-gastric cancer is complex and can lead to delays in starting treatment. NICE have updated its advice on the use of Endoluminal Ultrasound (EUS) for staging these cancers and now recommend a selective use of this imaging modality.</td>
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<td>Planned Actions:</td>
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<td>Upper Gastrointestinal Cancer Lead to challenge amber status with NOGCA team as “predicted” number of cancers for CUH is too high.</td>
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<td>EUS to be used selectively for staging of oesophageal cancer. Quarterly audits of proportion of cases having EUS and the reasons will be carried out.</td>
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Appendix C: Local audits
(Cut off for data inclusion: 08/02/2019)

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<th>Audit Title</th>
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| Comparison of current practice of median neuropathy screening in the Clinical Neurophysiology Department in Carpal Tunnel Clinics against current guidelines of the British Society for Clinical Neurophysiology | The audit shows:  
  - Compliance with ‘measuring and documenting hand temperature is good with 94.7% when compared to the target 100%.  
  - For 78% of patients no sensitivity test was performed when it may have been indicated. This was discussed at the presentation of the audit. Variation in practice may relate to individual interpretation of degree of abnormality and thus need for the test.  

The measurement and documentation of limb temperature is now standard departmental practice.  
Local guideline for clinics was updated on Q-Pulse in January 2019 as part of preparation for the Improving Quality in Physiological Diagnostic Services (IQIPS) accreditation. |
| An audit to measure the average improvement of vision in the amblyopic eye following 3 months of occlusion therapy | 1. 100% children who need treatment with patching occlusion therapy have an inter-ocular difference (IOD) of 2 lines or more. Standard met in 100% of cases.  
2. 100% children have a refraction adaptation of at least 12-18 weeks until the vision plateaus before starting occlusion therapy. Standard met in 97% of cases.  
3. 100% children are able to perform Sonksen LogMAR Test (with or without matching card). Standard met in 100% of cases.  
All actions to further improve on Standard 2 have been implemented. |
| NICE CG 191: Audit of use of CURB-65 score in patients diagnosed with Legionnaires’ Disease at CUH in 2018 | Key findings of this audit were:  
  - All patients with a diagnosis of community acquired pneumonia received a broad spectrum antibiotic within four hours of admission to hospital.  
Of a total of nine patients who were diagnosed with Legionnaires’ Disease none had a documented CURB-65 assessment to guide therapy.  
Six (66%) patients with a score of ≥2 were started on antibiotics active against Legionnaires’ disease within four hours of admission. Five (55.6%) were converted to a quinolone when the diagnosis was made.  
Three of the nine patients died with, on average, higher CURB-65 scores and other co-morbidities indicative of severity of illness compared with patients who survived. There were also other factors relating to management that may have impacted the outcome.  
Key actions were identified:  
  - Explore with Acute Medicine and Respiratory Physicians the use of flow charts/EPIC to improve management of CAP in relation to using CURB-65 score to guide management.  
  - Circulate the audit report to patient safety leads – A&E, Acute Medicine, Respiratory, and Haematology /Oncology to raise awareness of using CURB-65 to consider Legionella infection in patients admitted with severe pneumonia.  
  - Raise awareness of recommendation to use quinolones for specific management of patients with Legionella infection among microbiologists when communicating positive Legionella results. |
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<td>Re-audit of use of CURB-65 score will be undertaken as part of Trust</td>
<td>Re-audit of use of CURB-65 score will be undertaken as part of Trust audits being planned by the Antimicrobial Stewardship Team.</td>
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<td>audits being planned by the Antimicrobial Stewardship Team.</td>
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<td>NICE TA 298: Myopic choroidal neovascularisation</td>
<td>The audit established 100% compliance with NICE Technology Appraisal 298. No actions are required. The team to continue with current practice.</td>
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<td>Compliance with requirement to complete last menstrual period (LMP) form and record on Epic</td>
<td>Computerised Tomography (CT) scanning, inpatient x-ray and A&amp;E x-ray all demonstrated 100% compliance with completing the last menstrual period on Epic. Outpatient x-ray, fluoroscopy &amp; interventional radiology fell short of the target. Work to be undertaken to remind radiographers of the need to ensure that an LMP form is correctly completed, signed and scanned on Epic for all appropriate examinations.</td>
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<td>Audit of the Trust’s Chaperone Policy 2018</td>
<td>99% of staff had good knowledge of the Policy. 67% of patients were aware that they could ask for a chaperone. 71% of patients, where an intimate examination was completed, had a formal chaperone. Only 55% of patient records documented the presence of a chaperone or the reason for not having a chaperone present. Staff training has been completed and the audit report will be disseminated to the divisional nurses to increase awareness of the Policy.</td>
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<td>Audit of activity levels of the advice telephone service of the Rheumatology Practitioners and Metabolic Bone Specialist Nurse (2018)</td>
<td>The audit reviewed the activity levels of the Advice Telephone Line for the Rheumatology Practitioners and Metabolic Bone Specialist Nurse. Patients and primary care physicians can use the advice service. The standards related to response times during office hours as well as the appropriateness of the calls made to the advice line by the enquirers. Only 1.6% of calls were not answered within 48 hours in Rheumatology and 7.2% of calls in Osteoporosis. 78% of rheumatology calls were appropriate for the advice line and 96% were appropriate for the osteoporosis advice line. This is good overall performance, particular as the number of calls increased from 1625 calls in 2016/17 to 7931 in 2017/18. The audit identified some efficiency in the process which the service will address. However, if the service continues to grow, more resources will be required. The service will review and apply for either internal or commissioned funding to maintain the service.</td>
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<td>NICE CG 153: Detecting psoriatic arthritis in a dermatology clinic</td>
<td>The audit reviewed local practice against the NICE guideline CG153. 75% of CUH patients with psoriasis received an annual psoriatic arthritis (PsA) screening using a validated tool (e.g. PEST); or other musculoskeletal assessment (target = 75%). 5 out of 5 patients in which PsA was suspected were referred to rheumatology (target = 100%). The audit showed that the service met the NICE recommendations and no further action is required.</td>
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<td>Re-audit of the completion of the Modified Early Obstetric Warning Score (MEOWS)</td>
<td>Compliance for standard 1 has declined by 1% from 96% in 2016 to 95% in 2018. For standard 2, compliance has improved since the last audit (89% when compared with 86% in 2016). For standard 3, compliance has also improved from 85% in 2016 to 89%. Educational need for maternity support workers identified to focus on empowering them to make a 'continue present treatment' plan for when the</td>
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<td>observations are normal and do not require escalation. For standard 4 a</td>
<td>significant improvement has been noted as the unit improved from 8% in 2016 to 53% in this audit.</td>
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<td>1) To continue to encourage staff to make plans and to make sure they carefully complete the MEOWS score, even if the woman is well and the management will not change.</td>
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<td>2016 to 53% in this audit. Actions are: 1) To continue to encourage staff</td>
<td>2) Encourage plan making amongst MSWs by sending out a reminder email to all staff with the audit results with a focus on MSWs. Within this remind staff about carefully completing the MEOWS score.</td>
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<td>to make plans and to make sure they carefully complete the MEOWS score,</td>
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<td>about carefully completing the MEOWS score.</td>
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<td>Audit of Group B streptococcal (GBS) colonisation in pregnant women</td>
<td>For all 6 standards of the audit the compliance was consistently under the required 95%.</td>
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<tr>
<td>For all 6 standards of the audit the compliance was consistently under</td>
<td>Both standards 1 and 2: ‘GBS positive carriers result on Epic’ and ‘GBS positive carrier results</td>
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<td>the required 95%.</td>
<td>letter to home’ achieved 78% compliance,</td>
</tr>
<tr>
<td>Both standards 1 and 2: ‘GBS positive carriers result on Epic’ and ‘GBS</td>
<td>Standard 3 ‘Documented evidence of acknowledgment of GBS positive result in intrapartum episode’:</td>
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<tr>
<td>positive carrier results letter to home’ achieved 78% compliance,</td>
<td>88%,</td>
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<tr>
<td>Standard 3 ‘Documented evidence of acknowledgment of GBS positive result</td>
<td>Standard 4: ‘All women positive for Group B streptococcal colonisation have a patient alert in</td>
</tr>
<tr>
<td>in intrapartum episode’: 88%,</td>
<td>Epic’ was 77%.</td>
</tr>
<tr>
<td>Standard 4: ‘All women positive for Group B streptococcal colonisation</td>
<td>Standards 5: ‘GBS positive women have a letter to home address’ was 75%.</td>
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<tr>
<td>have a patient alert in Epic’ was 77%.</td>
<td>Standard 6: ‘Documented evidence of acknowledgment of positive result in intrapartum episode’ was</td>
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<tr>
<td>Standards 5: ‘GBS positive women have a letter to home address’ was 75%.</td>
<td>66%.</td>
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<tr>
<td>Standard 6: ‘Documented evidence of acknowledgment of positive result in</td>
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<tr>
<td>intrapartum episode’ was 66%.</td>
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<tr>
<td>Actions include: 1. Continue to promote use of the Epic report to improve</td>
<td></td>
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<tr>
<td>effective reporting.</td>
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<tr>
<td>2. Highlight guideline ‘Prevention of early onset neonatal infection</td>
<td></td>
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<tr>
<td>including management of Group B streptococcal colonisation in pregnant</td>
<td></td>
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<td>women’ (2017) to staff unfamiliar or unsure.</td>
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<tr>
<td>3. Consider updating the above guidance to include use of EPIC reporting</td>
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<tr>
<td>to identify women who have positive Group B streptococcal results.</td>
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<tr>
<td>Audit of the Trust’s adherence with the Ottawa knee rules</td>
<td>Key findings of the audit: 74% (37/50) of cases complied with the Ottawa Knee Rules, which is an</td>
</tr>
<tr>
<td>74% (37/50) of cases complied with the Ottawa Knee Rules, which is an</td>
<td>improvement compared to the 68% in the first audit cycle, however the audit target of 95% was</td>
</tr>
<tr>
<td>improvement compared to the 68% in the first audit cycle, however the</td>
<td>not achieved.</td>
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<td>audit target of 95% was not achieved. Below 15% of referrals for traumatic</td>
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<td>knee injury to the virtual fracture clinic had radiological evidence of</td>
<td></td>
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<tr>
<td>fracture. One in four patients had knee x-rays that might have been</td>
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<tr>
<td>avoided. Key actions: 1. Education of ED nurses/doctors to increase</td>
<td></td>
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<tr>
<td>awareness of rule. 2. Make the ED doctors/nurses aware of the OTTAWA</td>
<td></td>
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<tr>
<td>smart phrase on EPIC. 3. Email the results of the second audit cycle to</td>
<td></td>
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<tr>
<td>the ED doctors and share them on their intranet.</td>
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<tr>
<td>Re-audit of antibiotic prescribing: Are we reviewing continuing need for</td>
<td>Standard 1: Patients receiving antibiotics should have clearly documented indication / dose /</td>
</tr>
<tr>
<td>antibiotics for vascular patients adequately?</td>
<td>route in the clinical notes. Compliance with standard 1: 82% of clinical notes showed the</td>
</tr>
<tr>
<td>Standard 1: Patients receiving antibiotics should have clearly documented</td>
<td>indication, 6% the dose and 78% the route. Standard 2: Patients commenced on antibiotics should have</td>
</tr>
<tr>
<td>indication / dose / route in the clinical notes. Compliance with standard</td>
<td>clearly documented an antibiotic plan between 48-72 hours after commencement (if antibiotic</td>
</tr>
<tr>
<td>1: 82% of clinical notes showed the indication, 6% the dose and 78% the</td>
<td>treatment is on-going). Compliance with this standard was 61%.</td>
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<tr>
<td>route. Standard 2: Patients commenced on antibiotics should have clearly</td>
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<td>Audit Title</td>
<td>Action/response</td>
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<tr>
<td>Actions taken forward:</td>
<td>Continue to try to prioritise antibiotic review on ward rounds. On-going awareness and education of the Vascular Team.</td>
</tr>
<tr>
<td>Compliance with Trust’s Patient Identification Policy in Theatres</td>
<td>Trust policy is to have two ID bands on all patients coming to theatres. Compliance with this standard was 99.8% for adults and 96% for children. There was no documentation stating reasons for missing ID bands in patient notes for 12 patients that arrived to theatre without an ID Band. Awareness has been raised in the department.</td>
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<tr>
<td>Storage and security of medicine, Summary of Q2, 2018/19</td>
<td>This audit reviews a) medicine security and b) temperature monitoring on wards. Standards 1-6 relate to medicine security. While 98% of drug storage trolleys, cupboards and fridges are lockable, only 82% of them were locked. 94% of drugs trolleys were also secured to a wall and 91% of rooms where drugs are stored were also locked. Only in 67% of all cases all medicines were stored securely, while 88% of all boxes if IV fluids were stored off the floor in secure rooms. All clinical areas have a current min/max thermometer and there is a written record of daily fridge temperatures in 99% of areas. 96% of areas have a thermometer for the room temperature and 94% of areas had a written record of the temperature in drug or IV fluid storage rooms. However, in 73% of fridges the temperature remained within range in the last 7 days while this applied for 93% of rooms where drugs or IV fluids are stored. Compliance with holding the keys to drugs storage was good at 99% while 100% of areas that were not open 24 hours had appropriate arrangements in place. The audit has identified that work is still required to embed into daily ward routine the requirements for secure storage of medicines at all times.</td>
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<tr>
<td>Audit of completion of “Universal Form of Treatment Options” (UFTO)</td>
<td>10 standards are being reviewed quarterly in different wards to cover all wards throughout the year. For Quarters 1 to 4 of 2018/19 the same 9 Universal Form of Treatment Options (UFTO) standards were audited. Completion of an UFTO for inpatients within 72 hours of admission was adhered to between 64 and 76% throughout the year. The other six standards relating to the completion of the UFTO form were adhered to between 97-100% in all four quarters. 2 standards were included to understand the knowledge of nurses of the UFTO process. These highlighted that further work needs to be undertaken to ensure that nurses are familiar with the resuscitation status in their area (Q4 was 71%, improved from 58% in 2017). 69.8% of nurses were aware of the link on connect from Epic to access the East of England DNACPR form for community use. The Trust implemented the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in December 2018 to improve patient and family involvement in decision making. It allows consideration of resuscitation decisions in the context of broader care and treatment and records decisions on a standardised form. Non-compliances in previous audit cycles incorporated into the development</td>
</tr>
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<td>Audit Title</td>
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| Audit of Smoking in Pregnancy (NICE guidance PH26 and CG62)              | The results of this audit conclude that there was successful smoking cessation for women who delivered at CUH between March and May 2018 of 2.7%.  
The number of women delivering at CUH, who continue to smoke around the period delivery, is 1.5% which is below the DoH target of 8%.  
NICE recommends initial carbon monoxide monitoring at booking. It is unclear why carbon monoxide monitoring is not performed for all women (70.4% in this audit), but it is likely that this dependents on consent of the women and availability of equipment.  
There is a potential risk of foetal intra-uterine growth restriction in pregnancies where women are smoking at booking and have raised carbon monoxide readings. 46% women were offered growth scan scans at 30 and 36 weeks gestation. It is possible that many of these scans are being requested secondary to associated clinical indicators.  
Therefore additional education will be required to ensure scans are ordered by the midwife at time of the booking appointment when women meet the criteria. |
| Quality Colonoscopy bowel preparation 2018/2019 (Rolling Joint Advisory Group (JAG) Accreditation Audit Program) | The audit ascertained that the quality of the bowel preparation was unsatisfactory in 4%, suboptimal in 13% and satisfactory in 83% of cases. CUH is meeting the quality standard of 80%. No further quality improvement planned. |
| NICE NG 38: documentation of weight bearing status post operatively for lower limb fractures | Documentation of weight bearing status was 100% in the second cohort (improved from 88% in the first cohort). Full compliance of documenting weight bearing status was achieved following departmental education. |
| An audit to assess the appropriateness of antibiotic prescribing for Cellulitis at Addenbrooke's Hospital | The audit shows 100% compliance with not prescribing benzylpenicillin as a first line treatment for cellulitis and completing drug charts.  
The audit identified however that the prescribing of antibiotics (88-84% compliance) and the recording of patient’s antibiotics allergies (76%) were not meeting the 100% target.  
Actions identified in this audit are:  
- To amend the 'Skin and soft tissue infections' guideline to clarify the treatment of severe cellulitis.  
- Review to be undertaken whether the Trust doctor induction should include the appropriate treatment for cellulitis to improve adherence to the guidelines, with particular focus on flucloxacillin dose and the importance of documenting patients’ antibiotics allergies. |
| Compliance with safety checklist, WHO checklists and consent in CT guided nerve root injections | The audit of 44 patients showed that for 100% of computer tomography guided nerve root injection (NRI) consent and the NRI safety checklists were available on Epic.  
The 'WHO check-in' was completed by nurses in 90% of cases while 93% of radiographers and radiologists completed the check in. The 'WHO sign-out' |
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<th>Audit Title</th>
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<tr>
<td>Reporting of adverse prognostic features in colorectal cancer resections: an audit of cases reported at Addenbrooke’s Hospital up to December 2017</td>
<td>This re-audit is part of the NHS Bowel Cancer Screening Programme (BCSP) Quality Assurance visit recommendation to monitor reporting standards. All standards were met with no further actions to be implemented.</td>
</tr>
<tr>
<td>Completion of the Radiology WHO checklist prior to image guided breast intervention</td>
<td>This re-audit showed an improvement in completing the Radiology WHO checklist for image guided breast examinations. 68% of checklists were fully completed in 2018 compared with 28% in 2017. The target is 100%. On-going training of all relevant radiographers in the correct completion of the checklist. Re-audit in six months.</td>
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<tr>
<td>NICE CG 180: Management of Atrial Fibrillation following a Oesophagectomy</td>
<td>The audit showed that almost a quarter of CUH’s patients with elective Oesophagectomy developed post-operative atrial fibrillation (AF). CUH is adhering to the NICE guideline on the initial management of AF for these patients. However, the review of anti-coagulation, the documentation of AF and an ECG prior to discharge was not always completed. The documentation of the rationale not to give anti-coagulation and the plan to review at a later date was not documented for the three patients were this applied. Audit was presented at the monthly General Surgery Departmental Mortality and Morbidity and Audit Meeting on the 13/11/2018.</td>
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Appendix D: Glossary of terms and abbreviations used in this report

**BAME (BME)**
Black, Asian and minority ethnic (used to refer to members of non-white communities in the UK). BAME may also be referred to as ‘BME’ - black and minority ethnic.

**CBC (Cambridge Biomedical Campus)**
A long-term collaboration between Cambridge University Hospitals NHS Foundation Trust (CUH) and partners, the University of Cambridge, the Medical Research Council (MRC), Countryside Properties and Liberty Property Trust.

**CCG (Clinical Commissioning Group)**
CCGs are responsible for planning and buying local NHS services, such as the care people receive at hospital and in the community, as well as ensuring that providers deliver the best possible care and treatment for patients. Services at CUH are commissioned by Cambridgeshire and Peterborough CCG.

**C.difficile**
A clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital.

**CQC (Care Quality Commission)**
The independent regulator of all health and social care services in England. The Care Quality Commission monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety.

**CQUIN (Commissioning for Quality and Innovation) indicators**
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals.

**CUH**
Cambridge University Hospitals NHS Foundation Trust

**CUHP (Cambridge University Health Partners)**
An academic health science centre that brings together the University of Cambridge, Cambridge University Hospitals NHS Foundation Trust, Papworth Hospital NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust.

**DTOC (Delayed transfer of care)**
Medically fit patients who cannot be discharged from hospital until there are arrangements in place for their continuing care and support.

**EPR – Epic**
Electronic patient record - The Epic software based system used for eHospital.

**FTSUG (Freedom to Speak Up Guardian)**
The Freedom to Speak Up Guardians are members of Trust staff appointed to help protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement.
**GDE (Global Digital Exemplar)**

A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

**HQIP**

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales.

**Human Factors**

Human factors is the science which seeks to gain and apply knowledge of how people interact with each other and their environment, and how this affects behaviour, performance and wellbeing, particularly in the work setting.

**LocSSIPs (Local Safety Standards for Invasive Procedures)**

A set of locally implemented safety standards to support NHS hospitals provide safer surgical care. They aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur.

**MBRRACE**

MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The programme of work is now called the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health service.

**MDT (Multidisciplinary Team)**

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. Multidisciplinary Teams may specialise in certain conditions, such as Cancer.

**MRSA (Meticillin-Resistant Staphylococcus Aureus)**

MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

**National Quality Indicators**

NHS England has mandated that all organisations providing NHS commissioned care are required to review their performance against a common set of measures across the new NHS Outcomes Framework.

**NatSSIPs (National Safety Standards for Invasive Procedures)**

A set of national safety standards to support NHS hospitals provide safer surgical care. They aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur.
NCEPOD (National Confidential Enquiry into Patient Outcome and Death)
The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remediable factors in practice. NCEPOD’s purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

‘Never event’
A ‘never event’ is defined as serious, largely preventable incident that should never happen if the right measures are in place. A defined list of Never Events is published annually by the Department of Health.

NHSBT (NHS Blood and Transplant)
NHS Blood and Transplant is a Special Health Authority who manages blood and organ transplantation.

NHSE (NHS England)
NHS England responsible for overseeing the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.

NHSI (NHS Improvement)
NHS Improvement responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.

NICE (National Institute for Health and Care Excellence)
The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom, which publishes guidelines in four areas:
- the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures)
- clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)
- guidance for public sector workers on health promotion and ill-health avoidance
- guidance for social care services and users

Palliative care/End of Life Care
Palliative care focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.

PROMs (Patient reported outcome measures)
These are nationally mandated and provide a patient perspective of the effectiveness of the care they received - in simple terms, the improvement gain or loss following the procedure.

QSiS (Quality and Safety Information System)
QSiS is a bespoke electronic risk management system, based on the Datix software & used by the majority of NHS Trusts in the UK. The system is made up of a number of modules, including safety incident reporting, risk register, complaints, claims, CQC compliance, and has excellent reporting features.
RCA (Root cause analysis)
A systematic process for identifying "root causes" of problems or events and an approach for responding to them.

ReSPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

STP (Sustainability and Transformation Partnership)
STPs bring together NHS providers, CCGs, local authorities and other health and care services and are organised as 44 STP 'footprints'. A 'footprint' is the geographical area in which people and organisations are working together to develop plans to transform and sustain the delivery of health and care services. CUH is in the Cambridge and Peterborough STP.

UFTO (Universal Form of Treatment Options)
UFTO is an electronic form that records the treatment options that doctors discussed and agreed with a patient. This may include choices on End of Life care and resuscitation.

WRES (NHS Workforce Race Equality Standard)
The Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.